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 _____	06/08/2017

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 06/06/17 through 06/08/17. 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 34 at the time of the survey. The survey sample consisted of 12 current Resident reviews (Residents 1 through 10, 12 and 13) and 1 closed record reviews (Resident 11).	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F 157	1. Implement policy on notification of physician when there is a change in condition by 7/5/17. 2. Policy/procedure education to 100% of staff by 7/14/17 of new policy. 3. Charge nurse to complete daily log for any residents with change of condition. 4. One hundred percent of resident charts recorded by log will be reviewed for compliance for 12 months. Start date 7/17/17. 5. One hundred percent compliance by 10/1/17. RECEIVED JUN 30 2017 VDH/OLC	

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

Brenda Sheffield BS, RN Dir Risk Quality 6-28-17

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495374	A. BUILDING _____ B. WING _____	06/08/2017

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 157	Continued From page 1 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on staff interview, and clinical record review, the facility staff failed to notify the physician of a change in condition for 1 of 13 residents (Resident #6). The findings include: Resident #6 was admitted to the facility on 7/16/15 with diagnoses of dementia with behaviors, depression, anxiety, hypertension, hypothyroidism, anemia, malnutrition, rheumatoid arthritis, peripheral vascular disease, Vitamin D	F 157		

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 _____	06/08/2017

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 157	Continued From page 2 deficiency, chronic obstructive pulmonary disease, gastro esophageal reflux disease, and urinary tract infection. The annual Minimum Data Set (MDS) with a reference date of 7/7/16 assessed the resident with a cognitive score of "5" of "15". The resident was assessed requiring supervision for bed mobility, transfers, ambulation, dressing, eating, toileting, bathing and hygiene. The clinical record was reviewed. The April physician orders contained an order to administer the antihypertensive medication, Metoprolol 25 mg., by mouth daily. A nurse documented on the back of the April medication administration record (MAR) the Metoprolol had been held at 2200 (10:00 p.m.) due to a blood pressure reading of 85/59. The nurse failed to notify the physician of the change in condition and also failed to obtain an order to hold the medication. The director of nursing (DON) was asked about the holding of the medication on 6/7/17 at approximately 8:30 a.m. The DON provided the facility policy on vital signs. The policy stated any abnormal vital signs were to be reported to the primary care nurse. The DON stated the physician should have been notified. The DON, quality assurance nurse, and chief nursing officer, were informed of the findings during a meeting with the survey team on 6/7/17 at 4:00 p.m.	F 157		
F 164 SS=D	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS	F 164		

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 _____	06/08/2017

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 164	Continued From page 3 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation	F 164	1. Patient privacy policy implemented by 7/5/17. The policy will include the resident's right to privacy which addresses medical treatment, written/ telephone communications, personal care, visits and meetings with family. It will also address the right to secure and keep medical records confidential. 2. One hundred percent staff education on new policy by 7/14/17. 3. Five staff observations a week for medication pass and pour starting 7/17/17 to observe resident privacy is being met. 4. Two months of observation to be completed by 9/15/17. 5. One hundred percent compliance by 8/1/17.	

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 _____	06/08/2017

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 164	Continued From page 4	F 164		

purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview the facility staff failed to ensure personal privacy was provided for 1 of 13 Residents, Resident #13

The findings included:

For Resident #13, the facility staff failed to provide privacy while administering an insulin injection.

Resident #13 was admitted to the facility on 12/03/15. Diagnoses included but not limited to diabetes mellitus.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 06/01/17 coded the Resident as 8 out of 15 in section C, cognitive patterns. This is a quarterly MDS.

The surveyor observed LPN #3 (licensed practical nurse) during a medication pass and pour on 06/07/17 at approximately 0730. LPN #3 prepared Resident #13's insulin injection, and then informed Resident #13 that she was going to administer insulin injection. LPN #3 administered Resident #13's insulin injection in her abdomen. LPN #3 did not pull privacy curtain, nor shut the door prior to administering injection.

Surveyor asked LPN #3 if she should have pulled the privacy curtain, and LPN #3 stated that she should have.

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 _____	06/08/2017

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 164	Continued From page 5 The concern of not providing privacy during an insulin injection was discussed during a meeting with the administrative team on 06/07/17 at approximately 1615. No further information was provided prior to exit.	F 164		
F 167 SS=C	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by:	F 167	1. Posting of survey results located on bulletin board on east end of unit now moved to area on board so that residents can easily access results independently. Completed on 6/7/17. 2. Utilize visual management to ensure ease of finding results on east end bulletin board by 7/20/17. 3. Results to be posted on west end of bulletin board by 7/1/17 with visual management by 7/20/17. 4. Notice of survey results availability to be posted in resident dining area by 7/10/17.	

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 _____	06/08/2017

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 167	Continued From page 6 Based on observations, staff interviews, and facility document review, it was determined that the facility staff failed to post survey results in a location that was accessible to all residents. The findings include: The facility staff failed to post the facility's survey results in a location that made them readily accessible to residents; the facility staff also failed to post a notice of the survey results availability. This surveyor was unable to find the facility's survey results and was unable to find the posting of the notice of the survey results on 6/7/17. The survey results were found posted on the hallway at the east end of the building on a bulletin board on the back hallway(the east end of the building also contained resident rooms) while the elevators, dining room/day room, and therapy department was located on the west end of the building. The survey results were pinned on the bulletin board higher than any resident could reach from a wheelchair. The chief nursing officer was asked about the location and notice of survey results on 6/7/17. The survey results were located on the bulletin board on the back hallway and it was reported that no notice of the availability of the survey results were posted. The failure to post a notice of the survey results availability and the failure to post the survey results in a location that made them readily accessible was discussed for a final time during a survey team meeting with the facility's nurse manager and social worker on 8/25/11 at 4:50 P.M.	F 167		

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 _____	06/08/2017

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 167	Continued From page 7 The director of nursing , chief nursing officer, and quality assurance nurse were informed of the failure to post a notice of the survey results availability and the failure to post the survey results in a location that made them readily accessible during a meeting with the survey team on 6/7/17 at 4:00 p.m.	F 167		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility staff failed to provided dignity and respect during a Resident meeting. The findings included: The facility staff failed to provide respect to Residents involved in a private meeting behind closed doors by entering the room without knocking. The surveyor met with four alert and oriented Residents of the facility for a private group meeting behind closed doors on 06/07/17 at approximately 1030. During the meeting at approximately 1035, a housekeeping staff entered the room without knocking, went to the refrigerator, then left. The activities director also entered the room without knocking at	F 241	One hundred percent education on Resident Privacy complete by 7/5/17. Begin utilizing "Meeting in Progress" sign for all resident meetings. Complete by 7/5/17.	

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 _____	06/08/2017

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 241	Continued From page 8 approximately 1040, walking through the room and into her office. The concern of the staff entering the room without knocking during a private meeting was discussed with the administrative staff during a meeting on 06/07/17 at approximately 1615. No further information was provided prior to exit.	F 241		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning.	F 272	1. Print CAA worksheets with every MDS. Changed process and currently in use. 2. Audit all comprehensive assessments monthly for CAA worksheet and correct documentation on CAA for 12 months. Starting 7/1/17. 3. One hundred percent compliance of charts reviewed by 9/1/17.	

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 _____	06/08/2017

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 272	Continued From page 9 (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure an accurate comprehensive MDS (minimum data set) for 6 of 13 Residents, Resident #2, Resident # 3, Resident #4, Resident #1, Resident #5 and Resident #6. The findings included: 1. For Resident #2 the facility staff failed to accurately name the location of CAA (care area assessment) documentation. Resident #2 was admitted to the facility on 10/05/10 and readmitted on 04/12/17. Diagnoses included but not limited to anemia, peripheral vascular disease, gastroesophageal reflux disease, benign prostatic hyperplasia, chronic	F 272		

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 _____	06/08/2017

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 272	Continued From page 10 kidney disease, hypothyroidism, seizure disorder, malnutrition, anxiety, depression and chronic obstructive pulmonary disease. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 04/20/17 coded the Resident as 15 of 15 in section C, cognitive patterns. Section V, care area assessment, was reviewed. The facility staff had not identified the location of the CAA information used to determine care plans in the areas of vision, incontinence, dehydration, dental care, pressure ulcer, psychotropic drug use, and pain. The only documentation was "see CAA worksheet dated 04/27/17". The CAA worksheet was reviewed and the information could not be located. Surveyor spoke with the MDS coordinator on 06/07/17 at approximately 1515. MDS coordinator stated that she had not completed these sections of the CAA. MDS coordinator stated that she needed to re-educate the other staff on how to complete the CAA. The concern of the missing CAA documentation was discussed with the administrative staff during a meeting on 06/07/17 at approximately 1615. No further information was provided prior to exit. 2. For Resident #3, the facility staff failed to accurately name location of CAA documentation. Resident #3 was admitted to the facility on 02/16/17. Diagnoses included but not limited to anemia, hypertension, urinary tract infection, wound infection, osteoporosis, dementia, anxiety, malnutrition, and depression.	F 272	Print CAA worksheets with every MDS.	

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 _____	06/08/2017

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 272	Continued From page 11 The most recent comprehensive MDS with an ARD of 03/01/17 coded the Resident as 11 of 15 in section C, cognitive patterns. Section V, care area assessment, was reviewed. The facility staff had not identified the location of the CAA information used to determine care plans in the areas of ADL (activities of daily living), incontinence, falls, nutritional status, dehydration, dental care, pressure ulcer, and return to community. The only documentation was "see CAA worksheet dated 03/01/17". The CAA worksheet was reviewed and the information could not be located. Surveyor spoke with the MDS coordinator on 06/07/17 at approximately 1515. MDS coordinator stated that she had not completed these sections of the CAA. MDS coordinator stated that she needed to re-educate the other staff on how to complete the CAA. The concern of the missing CAA documentation was discussed with the administrative staff during a meeting on 06/07/17 at approximately 1615. No further information was provided prior to exit. 3. For Resident #4, the facility staff failed to accurately name location of CAA documentation. Resident #4 was admitted to the facility on 12/04/14. Diagnoses included but not limited to anemia, hypertension, depression, hypothyroidism, congestive heart failure and cirrhosis. The most recent comprehensive MDS with an ARD of 01/12/17 coded the Resident as 15 of 15	F 272	Print a CAA worksheet with every MDS.	

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 _____	06/08/2017

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 272	Continued From page 12 in section C, cognitive patterns. Section V, care area assessment, was reviewed. The facility staff had not identified the location of the CAA information used to determine care plans in the areas of vision, ADL, falls, nutrition, dental care, pressure ulcer, psychotropic drug use, and pain. The only documentation was "see CAA worksheet dated 01/12/17". The CAA worksheet was reviewed and the information could not be located. Surveyor spoke with the MDS coordinator on 06/07/17 at approximately 1515. MDS coordinator stated that she had not completed these sections of the CAA. MDS coordinator stated that she needed to re-educate the other staff on how to complete the CAA. The concern of the missing CAA documentation was discussed with the administrative staff during a meeting on 06/07/17 at approximately 1615. No further information was provided prior to exit. 4. The facility staff failed to ensure the care area assessment (CAA) summary was complete for the significant change Minimum Data Set (MDS) with a reference date of 2/12/17 for Resident #1. Resident #1 was re-admitted to the facility on 1/31/17 with diagnoses of dementia with behavior, agitation, anxiety, hypertension, anemia, malnutrition, arthritis, coronary artery disease, gastro-esophageal reflux disease, and urinary tract infection. The significant change Minimum Data Set (MDS) with a reference date of 2/12/17 assessed the resident with long and short term memory deficit. The resident was assessed requiring total	F 272	4. One hundred percent of education with MDS staff on correct completion of CAA worksheets by 6/29/2017. Audit all comprehensive assessments each month for complete documentation for 6 months beginning 7/1/2017. One hundred percent compliance of all charts reviewed as evidenced by complete CAA documentation achieved by 8/1/17.	

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 _____	06/08/2017

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 272	Continued From page 13 dependence for bed mobility, transfers, ambulation, dressing, eating, toileting, bathing and hygiene. The nurse completing the CAA summary failed to document on the CAA summary the location and date of the CAA information for the areas triggered for ADL functioning, urinary incontinence, psychosocial well being, falls, feeding tube, dehydration, dental care, pressure ulcer and pain. The DON, quality assurance nurse, and chief nursing officer, were informed of the findings during a meeting with the survey team on 6/7/17 at 4:00 p.m. 5. The facility staff failed to ensure the care area assessment (CAA) summary was complete for the significant change Minimum Data Set (MDS) with a reference date of 2/12/17 for Resident #5. Resident #5 was admitted to the facility on 12/21/16 with diagnoses of depression, anxiety, hypertension, insomnia, obesity, osteoarthritis, chronic kidney disease, and right ankle fracture. The significant change Minimum Data Set (MDS) with a reference date of 9/16/16 assessed the resident with a cognitive score of "15" of "15". The resident was assessed requiring supervision of 1 person for bed mobility, transfers, ambulation, dressing, eating, toileting, bathing and hygiene. The nurse completing the CAA summary failed to document on the CAA summary the location and date of the CAA information for the areas triggered for urinary incontinence, falls, dehydration, dental care, and pressure ulcer.	F 272	5. Audit all comprehensive assessments each month for complete documentation for 6 months 7/1/17.	

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 _____	06/08/2017

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 272	Continued From page 14 The DON, quality assurance nurse, and chief nursing officer, were informed of the findings during a meeting with the survey team on 6/7/17 at 4:00 p.m. 6. The facility staff failed to ensure the care area assessment (CAA) summary was complete for the annual Minimum Data Set (MDS) with a reference date of 7/7/16 for Resident #6. Resident #6 was admitted to the facility on 7/16/15 with diagnoses of dementia with behaviors, depression, anxiety, hypertension, hypothyroidism, anemia, malnutrition, rheumatoid arthritis, peripheral vascular disease, Vitamin D deficiency, chronic obstructive pulmonary disease, gastro esophageal reflux disease, and urinary tract infection. The annual Minimum Data Set (MDS) with a reference date of 7/7/16 assessed the resident with a cognitive score of "5" of "15". The resident was assessed requiring supervision for bed mobility, transfers, ambulation, dressing, eating, toileting, bathing and hygiene. The nurse completing the CAA summary failed to document on the CAA summary the location and date of the CAA information for the areas triggered for urinary incontinence, falls, dehydration, dental care, and pressure ulcer. The DON, quality assurance nurse, and chief nursing officer, were informed of the findings during a meeting with the survey team on 6/7/17 at 4:00 p.m.	F 272	6. Audit all comprehensive assessments each month for complete documentation for 6 months beginning 7/1/17.	
F 279	483.20(d);483.21(b)(1) DEVELOP	F 279		

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 _____	06/08/2017

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 279 SS=D	Continued From page 15 COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 279		

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 _____	06/08/2017

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 279	Continued From page 16 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to develop a comprehensive care plan for 3 of 13 residents (Resident #1, #6, and #3). The findings include: 1. The facility staff failed to develop a comprehensive care plan to address behaviors for Resident #1. Resident #1 was re-admitted to the facility on 1/31/17 with diagnoses of dementia with behavior, agitation, anxiety, hypertension, anemia, malnutrition, arthritis, coronary artery disease, gastro-esophageal reflux disease, and	F 279		

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 _____	06/08/2017

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 279	Continued From page 17 urinary tract infection. The significant change Minimum Data Set (MDS) with a reference date of 2/12/17 assessed the resident with long and short term memory deficit. The resident was assessed requiring total dependence for bed mobility, transfers, ambulation, dressing, eating, toileting, bathing and hygiene. Resident #1 was observed on 6/7/17 at 1:20 p.m. in bed. Two nurses assisted the resident to turn to her side for observation of her skin. The resident was cooperative and did not resist as both nurse stated she could resist care. The clinical record was reviewed. The record contained orders to administer the antipsychotic medication, Seroquel 25 mg twice daily based on the physician diagnosis of dementia with behaviors. The comprehensive care plan was reviewed. There was no care plan developed to address what behaviors the resident exhibited. The care plan listed the resident received psychotropic medications and the intervention was to monitir for anxiety and agitation. The director of nursing (DON) was asked about the care plan on 6/7/17 at 10:20 a.m. and stated she had not deveoped the care plan. The DON, quality assurance nurse, and chief nursing officer, were informed of the findings during a meeting with the survey team on 6/7/17 at 4:00 p.m. 2. The facility staff failed to develop a	F 279	1. One hundred percent of education to Care Plan coordinator and Interdisciplinary team on utilizing MDS and CAA to trigger the CCP needs for all residents by 6/30/17. Audit all MDS, CAA and CCP to ensure that One Hundred Percent of resident triggered problems are addressed on the CCP for 12 months starting 7/1/17. One hundred percent compliance being achieved by 10/1/17.	

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 _____	06/08/2017

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 279	Continued From page 18 comprehensive care plan to address the use of a trunk restraint for Resident #6. Resident #6 was admitted to the facility on 7/16/15 with diagnoses of dementia with behaviors, depression, anxiety, hypertension, hypothyroidism, anemia, malnutrition, rheumatoid arthritis, peripheral vascular disease, Vitamin D deficiency, chronic obstructive pulmonary disease, gastro esophageal reflux disease, and urinary tract infection. The annual Minimum Data Set (MDS) with a reference date of 7/7/16 assessed the resident with a cognitive score of "5" of "15". The resident was assessed requiring supervision for bed mobility, transfers, ambulation, dressing, eating, toileting, bathing and hygiene. Resident #6 was observed sitting in a wheelchair in her room with the responsible party visiting. The resident had a lap buddy across her lap. The clinical reocrd was reviewed. There were orders for the use of the restraint and consent by the responsible party for the use of the restraint. The record also contained monitoring of the use of the restraint. The comprehensive care plan was reviewed. The facility staff failed to develop a care plan to address the use of the restraint. The director of nursing (DON)was asked about the care plan on 6/7/17 at 9:00 a.m. and stated she had not deveoped the care plan. The DON, quality assurance nurse, and chief nursing officer, were informed of the findings	F 279	2. Audit all MDS, CAA and CCP to ensure that 100% of each residents triggered problems are addressed in the CCP. Beginning 7/1/17 for 12 months.	

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 _____	06/08/2017

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 279	Continued From page 19 during a meeting with the survey team on 6/7/17 at 4:00 p.m. 3. For Resident #3, the facility staff failed to develop a care plan for "return to community". Resident #3 was admitted to the facility on 02/16/17. Diagnoses included but not limited to anemia, hypertension, urinary tract infection, wound infection, osteoporosis, dementia, anxiety, malnutrition, and depression. The most recent comprehensive MDS with an ARD of 03/01/17 coded the Resident as 11 of 15 in section C, cognitive patterns. Section V, care area assessment, was reviewed. Section V, care area assessment summary, triggered the Resident for "return to community" and indicated that a CCP would be developed. This is an admission MDS. Resident #3's CCP (comprehensive care plan) was reviewed on 06/07/17 and surveyor could not locate a care plan for "return to community". Surveyor spoke with the MDS coordinator on 06/07/17 at approximately 1515. MDS coordinator stated a care plan for "return to community" should have been developed. The concern of the missing care plan was discussed with the administrative team on 06/07/17 at approximately 1615. No further information was provided prior to exit.	F 279	3. Audit all MDS, CAA and CCP to ensure that One hundred percent of all resident triggered problems are addressed in the CCP. Beginning 7/1/717 for 12 consecutive months.	
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10	F 280		

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 _____	06/08/2017

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 280	Continued From page 20 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21	F 280		

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 _____	06/08/2017

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 280	Continued From page 21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on family interview, facility document	F 280		

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 _____	06/08/2017

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 280	Continued From page 22 review, and clinical record review, the facility staff failed to invite the responsible party to care plan meetings for 1 of 13 residents (Resident #6) and also failed to review and revise the comprehensive care plan for 1 of 13 residents(Resident #1). The findings include: 1. The facility staff failed to invite the responsible party to the care plan meetings for Resident #6. Resident #6 was admitted to the facility on 7/16/15 with diagnoses of dementia with behaviors, depression, anxiety, hypertension, hypothyroidism, anemia, malnutrition, rheumatoid arthritis, peripheral vascular disease, Vitamin D deficiency, chronic obstructive pulmonary disease, gastro esophageal reflux disease, and urinary tract infection. The annual Minimum Data Set (MDS) with a reference date of 7/7/16 assessed the resident with a cognitive score of "5" of "15". The resident was assessed requiring supervision for bed mobility, transfers, ambulation, dressing, eating, toileting, bathing and hygiene. The responsible party (RP) was interviewed on 6/7/17 at 9:20 a.m. The RP was asked if she was invited to the care plan meetings and stated she was invited to one in the past and was invited to a meeting next week, but had not been invited on a consistent basis. The director of nursing (DON) was asked to provide proof the RP was invited to care planning meetings. The DON obtained information from the social worker the RP was invited to care	F 280	1. Create a log to document the CCP meeting. Log to include Resident name and notification of meeting. Responsible party notification and appointment time for meeting if applicable. Review log weekly at CCP meeting for One hundred percent compliance as evidenced by proper invitations to meeting and communication. Review will begin 7/6/17 and will continue for 12 months. Achieve One hundred percent compliance by 8/3/17. A copy of the letter issued to resident and responsible party will by maintained in a file in the Social Services Office.	7/1/17 6/29/17

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 _____	06/08/2017

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 280	Continued From page 23 planning meetings and was only able to obtain the current copy of a letter sent to the RP of a meeting planned for June 15, 2017. The DON, quality assurance nurse, and chief nursing officer, were informed of the findings during a meeting with the survey team on 6/7/17 at 4:00 p.m. 2. The facility staff failed to review and revise the comprehensive care plan for Resident #1 to indicate the resident was not receiving comfort care services . Resident #1 was re-admitted to the facility on 1/31/17 with diagnoses of dementia with behavior, agitation, anxiety, hypertension, anemia, malnutrition, arthritis, coronary artery disease, gastro-esophageal reflux disease, and urinary tract infection. The significant change Minimum Data Set (MDS) with a reference date of 2/12/17 assessed the resident with long and short term memory deficit. The resident was assessed requiring total dependence for bed mobility, transfers, ambulation, dressing, eating, toileting, bathing and hygiene. The comprehensive care plan was reviewed. The care plan contained a problem listed the resident "is receiving comfort care". The care plan was initiated on 5/11/17 with an intervention the family wished to keep the resident comfortable with no further invasive intervention including IV medication and no transfer off the the unit. The director of nursing was asked if the resident was receiving comfort care and stated the family	F 280	2. Audit all CCP with the CAA and MDS to ensure all resident CCP are up to date with the current MDS and CAA starting 7/6/17. This review will be a part of the weekly CCP every Thursday. Starting 7/6/17 for twelve consecutive months. One hundred percent compliance as evidenced by the CCP being up to date with the CAA and MDS by 8/31/17.	

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 _____	06/08/2017

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 280	Continued From page 24 changed their mind and wanted everything done now. The resident was no longer on comfort care. The facility staff failed to revise the comprehensive care plan to remove the comfort care. The DON, quality assurance nurse, and chief nursing officer, were informed of the findings during a meeting with the survey team on 6/7/17 at 4:00 p.m.	F 280		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review the facility staff failed to follow professional standards of nursing practice for 1 of 13 Residents, Resident #11. The findings included: For Resident #11 the facility staff failed to follow professional standards of nursing practice while administering medications by not comparing medication label to Resident's MAR (medication administration record) and physician's order. Resident #11 was admitted to the facility on 03/13/17. Diagnoses included but not limited to	F 281		

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 _____	06/08/2017

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 281	Continued From page 25 hypertension, atrial fibrillation, diabetes mellitus, gastroesophageal reflux disease, and anxiety The most recent MDS (minimum data set) with an ARD (assessment reference date) of 04/20/17 coded the Resident as 13 of 15 in section C, cognitive patterns. This is a significant change MDS. Surveyor observed Resident #11 receiving her medications during a medication pass and pour completed by LPN (licensed practical nurse) #1 on 06/07/17 at approximately 0930. One of the medications observed being administered was Flonase, 1 spray to each nostril. Resident #11's medications were reconciled with the clinical record on 06/08/17 at approximately 1000. The clinical record contained a signed POS (physician's order summary) dated 05/30/17 which read in part "Fluticasone SPR 50mcg 2 sprays in nostril(s) daily For: Flonase". The Resident's eMAR (electronic medication administration record) was reviewed and contained an entry which read in part "Fluticasone SPR 50mcg 2 sprays in nostril(s) daily For: Flonase". This entry was scheduled for 10 am and had been initialed by LPN #1 as having been administered. Surveyor spoke with LPN #1 on 06/07/17 at approximately 1100 regarding Resident #11's Flonase. Surveyor asked LPN #1 how many sprays of Flonase she had administered to Resident #11 and LPN #1 stated that she had administered 1 spray to each nostril. Surveyor then asked LPN #1 to look at the physician's order with her and LPN#1 did so. LPN #1 stated that the order read to administer 2 sprays to each	F 281	Education of One hundred percent of LPN and RN staff on Safe Medication Administration Practices by 7/14/17. Medication Pass and Pour observations starting 7/17/17. Fifteen observations a month for months to include real time instruction and correction. With the goal of One hundred percent compliance as evidenced by adherence to the Six Rights of Medication Administration. One hundred percent of compliance to be achieved by 7/17/17.	

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 _____	06/08/2017

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 281	Continued From page 26 nostril. Surveyor then asked LPN #1 to see the medication packaging for the Flonase. LPN #1 removed Flonase from medication cart. Flonase was labeled as follows: 1 spray in each nostril daily as needed Fluticasone SPR 50 mcg For: Flonase. Surveyor spoke with pharmacist #1 on 06/08/17 at approximately 0845. Pharmacist stated that Resident #11's current order for Flonase was 2 sprays/nostril daily and that the label was from the admission order which was discontinued on 04/20/17 when the current order went into effect. Surveyor requested a copy of the standard of practice for medication administration used by the facility. Clinical nurse leader provided the surveyor with a copy of "Medication Administration" which read in part "Policy Medications are administered, as prescribed, in accordance with good nursing principles and practices and only by persons legally authorized to do so to comply with Federal Laws governing Medication Administration and in order to ensure the safe, accurate and timely administration of medications. Guidelines B. Medications are administered in accordance with written orders of attending physicians." The concern of not following standards of nursing practice was discussed with the administrative team during a meeting on 06/07/17 at approximately 1615. No further information was provided prior to exit.	F 281		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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 _____	06/08/2017

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 309	Continued From page 27 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review the facility staff failed to follow	F 309		

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 _____	06/08/2017

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 309	Continued From page 28 physician's orders for 2 of 13 Residents, Resident #4 and Resident #6. The findings included: 1. For Resident #4, the facility staff failed to administer the antihypertensive medication "propranolol" as prescribed by the physician. Resident #4 was admitted to the facility on 12/04/14. Diagnoses included but not limited to anemia, hypertension, depression, hypothyroidism, congestive heart failure and cirrhosis. The most recent MDS with an ARD of 04/13/17 coded the Resident as 15 of 15 in section C, cognitive patterns. This is quarterly MDS. Resident #4's clinical record was reviewed on 06/07/17. It contained signed POS (physician's order summary) dated 02/02/17 which read in part "Propranolol tab 40mg 1 tablet PO (by mouth) twice daily *HOLD FOR HR (heart rate) < 60*". Resident #4's MAR (medication administration record) for the month of February was reviewed. It contained an entry which read in part "Propranolol tab 40mg 1 tablet PO (by mouth) twice daily *HOLD FOR HR (heart rate) < 60*". This entry had not been initialed as having been administered on 02/11/17 or 02/12/17. Heart rate was recorded as being within the parameters for medication to be administered. Surveyor discussed the missing documentation with the clinical nurse leader on 06/07/17 at approximately 1530. Clinical nurse leader stated	F 309	1. Education to One hundred percent of all LPN and RN staff on the Safe Medication Administration Practices to include the Six Rights of Medication Administration. To be completed by 7/14/17. Weekly MAR reviews for One hundred percent compliance as evidenced by the sixth right correct documentation. Audits to begin on 7/17/17 for 6 months ending on 1/17/18. One hundred percent compliance to be achieved by 8/1/17.	

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 _____	06/08/2017

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 309	Continued From page 29 that she did not know why the MAR had not been initialed and could not confirm whether the medication had been administered as ordered. The concern of the medication not being administered as ordered was discussed with the administrative team during a meeting on 06/07/17 at approximately 1615. No further information was provided prior to exit. 2a. The facility staff failed to follow the physician orders for Resident #6 for administration of medication. Resident #6 was admitted to the facility on 7/16/15 with diagnoses of dementia with behaviors, depression, anxiety, hypertension, hypothyroidism, anemia, malnutrition, rheumatoid arthritis, peripheral vascular disease, Vitamin D deficiency, chronic obstructive pulmonary disease, gastro esophageal reflux disease, and urinary tract infection. The annual Minimum Data Set (MDS) with a reference date of 7/7/16 assessed the resident with a cognitive score of "5" of "15". The resident was assessed requiring supervision for bed mobility, transfers, ambulation, dressing, eating, toileting, bathing and hygiene. The clinical record was reviewed. The April physician orders contained an order to administer the antihypertensive medication, Metoprolol 25 mg., by mouth daily. A nurse documented on the back of the April medication administration record (MAR) the Metoprolol had been held at 2200 (10:00 p.m.) due to a blood pressure reading of 85/59. The	F 309	2a. Weekly MAR review for One hundred percent compliance as evidenced by the sixth right of medication administration the correct documentation. Audits will begin on 7/17/17 and will end on 1/17/18.	

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 _____	06/08/2017

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 309	Continued From page 30 nurse failed to obtain an order to hold the medication. The comprehensive care plan was reviewed. The care plan contained a problem listed the resident was at risk for complications related to hypertension. The interventions included to administer medications per order. The director of nursing (DON) was asked on 6/7/17 about the nurse holding the medication and stated the nurse should have called the physician. The DON, quality assurance nurse, and chief nursing officer, were informed of the findings during a meeting with the survey team on 6/7/17 at 4:00 p.m. The facility staff also failed to follow the physician order with a start date of 12/08/16 to administer the medication, Humira 40 mg., monthly for rheumatoid arthritis for Resident #6. The medication administration record (MAR) for March 2017 was reviewed. The nurse had circled the Humira indicating the medication was not given and documented on the back of the MAR the Humira pen was not available for March 8, 2017 and the pharmacy had been notified. The medication was not given for the month of March. The DON was asked about the medication on 6/7/17 and shook her head and stated the medication should have been administered when received. The DON, quality assurance nurse, and chief nursing officer, were informed of the findings	F 309		

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 _____	06/08/2017

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 309	Continued From page 31 during a meeting with the survey team on 6/7/17 at 4:00 p.m. 2b. The facility staff failed to ensure Resident #6 had a bowel movement every three days as ordered by the physician. Resident #6 had a diagnosis of chronic constipation and was care planned the resident had a history of constipation. The interventions on the care plan noted the resident would be monitored every shift and bowel tracking would be completed. The clinical record was reviewed. The physician had a standing order to administer Milk of Magnesia 30 ml as needed if the resident did not have a bowel movement every three days. The start date was 4/9/17. The bowel movement record was reviewed. The resident was documented without a bowel movement from 5/18, 5/19 5/20, 5/21, and 5/22 for a total of 5 days. There was no evidence any interventions were implemented to assist the resident with having a bowel movement. The DON, quality assurance nurse, and chief nursing officer, were informed of the findings during a meeting with the survey team on 6/7/17 at 4:00 p.m.	F 309	2b. One hundred percent of staff education on correct documentation on the Bowel Movement Record(BMR) completed by 7/5/17. Daily monitoring by the Charge Nurse of the BMR beginning 7/5/17 with interventions orders being obtained as appropriate for residents not having a BM within 3 days. Monthly review of the BMR and documentation of interventions taken on One percent of residents by the DON for twelve months beginning 7/5/17. Compliance will mean 100% completed documentation and One hundred percent of all residents requiring interventions will have orders obtained by 8/1/17.	
F 329 SS=E	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug	F 329		

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 _____	06/08/2017

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 329	Continued From page 32 therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to administer medication with the appropriate monitoring and also failed to administer PRN (as needed) medications with nonpharmacological interventions for 5 of 13 residents (Residents #1,	F 329		

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 _____	06/08/2017

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 329	Continued From page 33 #6, #8, #4 and #11). The findings include: 1. The facility staff failed to monitor behaviors for Resident #1 for the use of the antipsychotic medication, Seroquel. Resident #1 was re-admitted to the facility on 1/31/17 with diagnoses of dementia with behavior, agitation, anxiety, hypertension, anemia, malnutrition, arthritis, coronary artery disease, gastro-esophageal reflux disease, and urinary tract infection. The significant change Minimum Data Set (MDS) with a reference date of 2/12/17 assessed the resident with long and short term memory deficit. The resident was assessed requiring total dependence for bed mobility, transfers, ambulation, dressing, eating, toileting, bathing and hygiene The clinical record was reviewed. The physician had ordered the antipsychotic medication, Seroquel 25 mg twice daily with a start date of 2/6/17. The clinical record contained a form entitled "Psychoactive Medication Monthly Flow Record". Section I was noted for "Target Behavioral Symptoms" and Section II was for "Side Effects". These areas were not marked for the May and June 2017 forms. The form for May 2017 had 2 areas marked under target symptoms for the dates 5/9/17 and 5/18/17. There was no corresponding behaviors noted either on the form or in the nursing notes.	F 329	1. One hundred percent of all LPN and RN staff will be educated on F 329, Behavior Monitoring Flowsheets (BMF), and narrative nursing documentation. BMF will be audited on a bi-weekly basis on all Residents prescribed Anti-psychotics. Beginning 7/17/17 for a period of twelve consecutive months. One hundred percent of compliance with be achieved as complete documentation of BMF. Monthly Audits of narrative nursing documentation for behaviors noted will be completed by the DON and will begin on 7/17/17 for 12 consecutive months. One hundred percent compliance will be achieved as evidenced by the documentation of narrative nursing notes on behaviors assessed by the nurse.	7/14/17 8/15/17 10/1/17

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 _____	06/08/2017

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 329	Continued From page 34 The June 2017 form had one area marked under behavior symptoms for 6/6/17. Again there was no corresponding documentation of what the behavior was either on the form or in the nursing notes. The director of nursing (DON) was asked about the forms on 6/7/17 at approximately 1:20 p.m. The DON stated she had implemented these forms and they should be completed by the nurses. The DON, quality assurance nurse, and chief nursing officer, were informed of the findings during a meeting with the survey team on 6/7/17 at 4:00 p.m. 2. The facility staff failed to monitor behaviors for Resident #6 for the use of the antipsychotic medication, Seroquel. Resident #6 was admitted to the facility on 7/16/15 with diagnoses of dementia with behaviors, depression, anxiety, hypertension, hypothyroidism, anemia, malnutrition, rheumatoid arthritis, peripheral vascular disease, Vitamin D deficiency, chronic obstructive pulmonary disease, gastro esophageal reflux disease, and urinary tract infection. The annual Minimum Data Set (MDS) with a reference date of 7/7/16 assessed the resident with a cognitive score of "5" of "15". The resident was assessed requiring supervision for bed mobility, transfers, ambulation, dressing, eating, toileting, bathing and hygiene. The clinical record was reviewed. The physician	F 329	2. Bi-weekly monitoring of the BMF on One hundred percent of all residents prescribed Anti-psychotic medications. Monthly monitoring of narrative nursing notes for documentation of behaviors assessed. Implement 7/6/17.	

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 _____	06/08/2017

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 329	Continued From page 35 had ordered the antipsychotic medication, Seroquel 25 mg three times daily with a start date of 11/19/16. The clinical record contained a form entitled "Psychoactive Medication Monthly Flow Record". Section I was noted for "Target Behavioral Symptoms" and Section II was for "Side Effects". These areas were not marked for the March and April 2017 forms. The forms for March and April were blank. There was no corresponding behaviors noted either on the form or in the nursing notes. The resident was skilled for June 2017 and the EPIC computer documentation contained no behavior monitoring. The DON, quality assurance nurse, and chief nursing officer, were informed of the findings during a meeting with the survey team on 6/7/17 at 4:00 p.m. 3. The facility staff failed to implement nonpharmacological interventions prior to administering a PRN (as needed) psychoactive medication, Xanax for Resident #8. Resident #8 was admitted to the facility on 5/24/17 with diagnoses of anxiety, urinary tract infection, anemia, diabetes, congestive heart failure, and chronic obstructive pulmonary disease. The computer documentation was reviewed. The resident had a physician order with a start date of 5/24/17 for Xanax 0.5 mg twice daily as neeeded for anxiety.	F 329	3. One hundred percent of staff education on appropriate non-pharmacological interventions for anxiety, agitation and pain. The documentation of interventions. Monthly chart audits of One hundred percent of all residents prescribed anti-anxiety medications or pain medications for proper implementation and documentation of non-pharmacological interventions. Beginning 7/17/17 for six months with the goal of One hundred percent compliance by 8/15/17.	7/14/17

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 _____	06/08/2017

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 329	Continued From page 36 The medication administration record (MAR) for May 2017 was reviewd. The resident had received Xanax 0.5 mg on 5/24/17 at 2206 (10:06 p.m.) and again on 5/25/17 at 2216 (10:16 p.m.). The clinical record did not contain any nonpharmacological interventions attempted prior to administration of the Xanax. The DON, quality assurance nurse, and chief nursing officer, were informed of the findings during a meeting with the survey team on 6/7/17 at 4:00 p.m. 4. For Resident #4 the facility staff failed to monitor heart rate per physician's orders. Resident #4 was admitted to the facility on 12/04/14. Diagnoses included but not limited to anemia, hypertension, depression, hypothyroidism, congestive heart failure and cirrhosis. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 04/13/17 coded the Resident as 15 of 15 in section C, cognitive patterns. This is a quarterly MDS. Resident #4's clinical record was reviewed on 06/07/17. It contained signed POS (physician's order summary) dated 02/02/17 which read in part "Propranolol tab 40mg 1 tablet PO (by mouth) twice daily *HOLD FOR HR (heart rate) < 60*". Resident #4's MAR (medication administration record) for the month of February was reviewed. It contained an entry which read in part "Propranolol tab 40mg 1 tablet PO (by mouth)	F 329	4. Weekly MAR reviews on One hundred percent of resident MAR for the six right of medication administration. Correct documentation beginning 7/17/17 for six consecutive months.	

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 _____	06/08/2017

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 329	Continued From page 37 twice daily *HOLD FOR HR (heart rate) < 60*". There was no documentation to indicate that Resident's pulse had been taken on 02/11/17 or 02/12/17 prior to 10am dose, or 02/24/17 prior to 10pm dose. Surveyor discussed the missing documentation with the clinical nurse leader on 06/07/17 at approximately 1530. Clinical nurse leader stated that she did not know why the documentation of the pulse was missing, nor could she confirm that the pulse had been taken per physician's orders. The concern of the pulse not being monitored as ordered was discussed with the administrative team during a meeting on 06/07/17 at approximately 1615. No further information was provided prior to exit. 5. For Resident #11 the facility staff failed to offer non-pharmacological interventions prior to administering the prn (as needed) pain medication, hydrocodone. Resident #11 was admitted to the facility on 03/13/17. Diagnoses included but not limited to hypertension, atrial fibrillation, diabetes mellitus, gastroesophageal reflux disease, and anxiety The most recent MDS (minimum data set) with an ARD (assessment reference date) of 04/20/17 coded the Resident as 13 of 15 in section C, cognitive patterns. This is a significant change MDS. Surveyor observed Resident #11 receiving her medications during a medication pass and pour completed by LPN (licensed practical nurse) #1	F 329	5. Monthly chart audits of all residents charts that are prescribed pain medications or anti anxiety medications, for proper implementation and documentation of non-pharmacological interventions. Beginning 7/17/17 for six consecutive months with One hundred percent compliance achieved by 8/15/17.	

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 _____	06/08/2017

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 329	Continued From page 38 on 06/07/17 at approximately 0930. One of the medications observed being administered was Flonase, 1 spray to each nostril. While administering Resident #11's medications, LPN #1 asked Resident #11 if she was in pain, and Resident #11 answered that her back was hurting. LPN #1 then stated to Resident #11 "OK, I'll get you your pain pill". LPN#1 did not offer Resident #11 any non-pharmacological interventions prior to offering pain medication. Surveyor spoke with LPN #1 on 06/07/17 at approximately 0945 regarding the non-pharmacological interventions. Surveyor asked LPN #1 if she ever offered Resident #11 non-pharmacological interventions prior to administering the pain medication and LPN #1 stated that she had, but Resident #11 usually refused. The concern of not offering non-pharmacological interventions prior to administering pain medication was discussed with the administrative team during a meeting on 06/07/17 at approximately 1615. No further information was provided prior to exit.	F 329		
F 334 SS=C	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and	F 334	Policy will be updated with appropriate Regulatory language by 6/29/2017.	

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 _____	06/08/2017

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 334	Continued From page 39 potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;	F 334		

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 _____	06/08/2017

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 334	Continued From page 40 (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to ensure the last requirement for the Federal regulation was addressed in the policy for both influenza and pneumococcal vaccine. The director of nursing (DON) provided a copy of the facility policy for "Resident Immunizations: Influenza/Pneumococcal". The policy failed to include "the resident's medical record includes documentation that indicates, at a minimum, the following: That the resident or resident's representative was provided education regarding benefits and potential side effects of influenza and pneumococcal immunization: and that the resident either received the immunization or did not receive the immunization due to medical contraindications or refusal".	F 334		

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 _____	06/08/2017

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 334	Continued From page 41 The quality assurance nurse was informed of the finding on 6/8/17 at 1:30 p.m.	F 334		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format.	F 356		

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 _____	06/08/2017

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 356	Continued From page 42 (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to post complete and accurate daily nurse staffing information with the appropriate hours worked and staff present. The findings include: The facility staff failed to post within the facility complete and accurate daily nurse staffing information with the appropriate number of hours worked. The daily nurse staffing was observed during initial tour of the facility on 6/6/17 to be posted in the back hallway of the unit. The staffing information was dated 6/6/17. All shifts for 7am-7pm and 7 pm-7 a.m. had been filled out for the number of RNs(Registered nurses), LPNs(licensed practical nurses) and CNA (Certified nursing assistants) scheduled to work. There were no actual hours worked posted on the form. The DON, quality assurance nurse, and chief	F 356	One hundred percent of all RN staff education completed. Daily audit for complete and correct documentation by the DON for six weeks starting 6/26/17 as evidenced by DON signature of staffing sheet. With one hundred percent compliance achieved by 7/1/17	6/22/17

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 _____	06/08/2017

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 356	Continued From page 43 nursing officer, were informed of the findings during a meeting with the survey team on 6/7/17 at 4:00 p.m.	F 356		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure a clean, sanitary kitchen environment with food items stored appropriately. The findings include:	F 371		

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 _____	06/08/2017

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 371	Continued From page 44 The initial tour of the kitchen was conducted on 6/6/17 at 1:40 p.m. with the kitchen manager. The food slicer was uncovered from a plastic covering and observed to have dried, crusty food items on the slicer. The industrial mixer was also uncovered from a plastic covering. The mixer was observed to have dried food drips on the base and also on the mixer blade. A freezer was free standing and observed to have an opened bag of frozen onion rings with out a date of when opened or when to discard. There was also a bag of frozen french fries opened without an open or discard date on them. The dietary manager removed them and discarded the bags. The director of nursing, chief nursing officer , and quality assurance nurse were informed of the findings during a meeting with the survey team on 6/7/17 at 4:00 p.m.	F 371	1. The slicer/mixer will be covered at all times while not in use. It will be inspected daily for cleanliness by staff assigned to equipment. Will be monitored and documented on a log sheet. Effective date 7-1-17 2. Any food that is opened will have the open/closed date on each bag of opened perishable items. Will monitored daily by kitchen staff and any items not dated shall be pulled and discharged. Effective date immediately.	
F 372 SS=F	483.60(i)(4) DISPOSE GARBAGE & REFUSE PROPERLY (i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure the dumpster area was clean and free of debris with lids closed. The findings include: The facility staff failed to ensure the dumpster	F 372		

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 _____	06/08/2017

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 372	Continued From page 45 area was free of debris and clean with dumpster lids closed. The dumpster area was observed during the initial tour of the facility on 6/6/17 at 1:45 p.m. The area was toured with the dietary manager. The gate surrounding the dumpsters was open. There were 4 dumpsters of varying sizes. All lids on all 4 dumpsters were open. The smallest dumpster had the lid folded and was resting inside the dumpster. The largest dumpster had bags of garbage protruding form the top of the open lid of the dumpster. The other 2 dumpsters were empty with the lids open. Trash could be observed all around the area on the ground to include used gloves. The surveyor observed the dumpsters with the maintenance director on day 3 of the survey on 6/8/17 at 8:00 a.m. The gate was observed open and all lids on the dumpsters were open. The largest dumpster again had garbage bags protruding from the top of the dumpster. The chief nursing officer, quality assurance nurse , and director of nursing were informed of the findings during a meeting with the survey team on 6/8/17 at approximately 4:00 p.m. The dumpsters could be observed from the window of the meeting room. Once again the dumpster lids were left open.	F 372	Plant ops placed signs at dumpster areas the day of the survey. He has also ordered rods which keep the dumpster lids closed that were missing. These rods will be installed as soon as they arrive at the facility. Area around dumpsters will be monitored every shift for trash on the ground. Implemented immediately. The gate which closes off dumpsters to the public will be closed and monitored daily for compliance by EVS and plant ops. Effectively immediately.	
F 425 SS=E	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 425		

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 _____	06/08/2017

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 425	Continued From page 46 biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) 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, facility document review and clinical record review the facility staff failed to ensure physician ordered medications were available for administration for 4 of 13 Residents, Resident #2, Resident #4, Resident #1 and Resident #6. The findings included: 1. For Resident #2 the facility staff failed to ensure the physician ordered medications Flomax, Ibuprofen, Tegretol, and Lyrica were available for administration. According to the 2016 Nursing Drug Handbook Flomax is a medication used to treat benign prostatic hyperplasia, Ibuprofen is a non-steroidal anti-inflammatory used to treat mild to moderate pain, Tegretol is an anticonvulsant used to treat seizures, and Lyrica is an anticonvulsant used to treat seizures and in the management of neuropathic pain. Resident #2 was admitted to the facility on 10/05/10 and readmitted on 04/12/17. Diagnoses included but not limited to anemia, peripheral vascular disease, gastroesophageal reflux disease, benign prostatic hypertrophy, chronic kidney disease, hypothyroidism, seizure disorder,	F 425	1. Update policy for Unavailable Medications by 6/29/17. One hundred percent of education of all LPN and RN staff of Policy and Procedure by 7/5/17. Log created to document reordering of medications by 7/5/17. Nursing Admin to begin utilizing Pharmacy reporting network to daily review and monitor delivery of medications 7/14/17. Stat box medication list and Narcotic stat box medication list placed in each MAR book for staff to reference by 6/28/17. Daily medication reorder log review and daily Nursing Admin review of Pharmacy reporting network for medication delivery. Daily MAR review by CN for medication availability. One hundred percent compliance will be achieved by 7/17/17.	

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 _____	06/08/2017

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 425	Continued From page 47 malnutrition, anxiety, depression and chronic obstructive pulmonary disease. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 04/20/17 coded the Resident as 15 of 15 in section C, cognitive patterns. This is a significant change MDS. Resident #2's clinical record was reviewed on 06/06/17. It contained a signed POS (physician's order summary) dated 04/29/17 which read in part "Tamsulosin cap 0.4mg 1 capsule po (by mouth) twice daily For: Flomax" and "Ibuprofen 400mg TID (three times daily) x 1 week". The Resident's MAR (medication administration record for May was also reviewed and contained the following entries which read in part "Flomax 0.4mg po BID (twice daily)" and Ibuprofen 400mg TID x 1 week". The entry for the Flomax had been initialed with initials circled on 05/05 and 05/06/17 for the 10 am dose. Notation on the back of the MAR for these dates read in part "Flomax 0.4mg not available". The entry for the Ibuprofen had been initialed with initials circled on 05/05/17 for the 6am, 12pm, and 6pm doses and on 05/07/17 for the 6am dose. Notation in the back of the MAR read in part "Ibuprofen not available". Resident #2's clinical record also contained a signed POS dated 04/20/17 which read in part "Carbamazepine TAB 100 mg 1 tablet PO three time daily For: Tegretol" and "Lyrica 75mg PO BID". The Resident's MAR for April was reviewed and contained the following entries which read in part Carbamazepine TAB 100 mg 1 tablet PO three time daily For: Tegretol" and "Lyrica 75mg PO BID". The entry for the Tegretol had been	F 425		

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 _____	06/08/2017

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 425	Continued From page 48 initialed with initials circled on 04/23/17 for the 6:30 am dose. Notation on the back of the MAR for this date read in part "Tegretol not given, not available". The entry for the Lyrica had been initialed with initials circled on 04/23/17 for the 10pm dose, 04/24/17, 04/25/17 and 04/26/17 for both 10 am and 10 pm doses. Notation on the back of the MAR for these dates read in part "Lyrica 75mg po not available for pharmacy". Surveyor spoke with unit manager on 06/07/17 at approximately 0845 regarding the circles around initials on Resident #2's MAR. Unit manager stated that the circled initials indicated that the medication had not been administered. Surveyor requested and was provided with a copy of policy entitled "Unavailable Medications" which read in part "Policy: 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." Surveyor requested and was provided with a copy of the medications maintained in the STAT box. This list included Tegretol 100mg tablets. Surveyor spoke with the clinical nurse leader regarding Resident #2's medications not being available. Clinical nurse leader stated that she did not know why the medications that were available in the STAT box were not utilized. She also stated that the hospital pharmacy was the facility's back up pharmacy.	F 425		

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 _____	06/08/2017

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 425	Continued From page 49 The concern of the medications not being available for administration was discussed during a meeting with the administrative staff on 06/07/17 at approximately 1615. No further information was provided prior to exit. 2. For Resident #4 the facility staff failed to ensure the medications azelastine nasal spray, Flonase nasal spray, hydrochlorothiazide, Atrovent, Zaditor eye drops, and torsemide were available for administration. According to the 2016 Nursing Drug Handbook azelastine is a medication used to treat seasonal allergies, Flonase is a medication used to treat seasonal allergies, hydrochlorothiazide is a diuretic (fluid pill) used to treat hypertension (high blood pressure), Atrovent is a bronchodilator used to treat COPD (chronic obstructive pulmonary disease), Zaditor is an antihistamine eye drop used to treat seasonal allergies, and torsemide is an antihypertensive used to treat hypertension, edema associated with CHF (congestive heart failure, and renal disease. Resident #4 was admitted to the facility on 12/04/14. Diagnoses included but not limited to anemia, hypertension, depression, hypothyroidism, congestive heart failure and cirrhosis. The most recent MDS with an ARD of 04/13/17 coded the Resident as 15 of 15 in section C, cognitive patterns. This is a quarterly MDS. Resident #4's clinical record was reviewed on 06/07/17. It contained a signed POS dated	F 425	2. Daily medication reorder log review and daily Nursing Admin review of Pharmacy reporting network for medication delivery. Daily MAR review by CN for medication availability. One hundred percent compliance will be achieved by 7/17/17.	

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 _____	06/08/2017

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 425	Continued From page 50 02/02/17 which read in part "azelastine spr 0.1% 2 sprays in nostril(s) twice daily", "fluticasone spr 50mcg 2 sprays in nostril(s) daily For: Flonase", "ipratropium spr 0.06% Inhale 2 sprays in nostril(s) three times daily (reorder 3 days before needed) For: Atrovent", "ketotif fum dro 0.025% Instill 1 drop in both eyes twice daily For: Zaditor" and "torsemide tab 5mg 1 tablet daily". Resident #4's MAR's for the month of February were reviewed and contained the following entries which read in part "azelastine spr 0.1% 2 sprays in nostril(s) twice daily", HCTZ (hydrochlorothiazide) 25mg po daily", "fluticasone spr 50mcg 2 sprays in nostril(s) daily For: Flonase", "ipratropium spr 0.06% Inhale 2 sprays in nostril(s) three times daily (reorder 3 days before needed) For: Atrovent", "ketotif fum dro 0.025% Instill 1 drop in both eyes twice daily For: Zaditor", and "torsemide tab 5mg 1 tablet daily". The entry for azelastine nasal spray had been initialed with initials circled on 02/01/17 for the 10 am dose. Notation on the back of the MAR read in part "no azelastine spray-pharmacy notified". The entry for the HCTZ had been initialed with the initials circled on 02/01/17. Notation on the back of the MAR read in part "HCTZ not given, not available-pharmacy notified". The entry for Flonase nasal spray had been initialed with initials circled on 02/01/17 for both the 10 am and 10 pm doses. Notation on the back of the MAR read in part "no Flonase spray-pharmacy notified" for both doses. The entry for Atrovent had been initialed with initials circled on 02/01/17 for the 2 pm and the 10 pm doses. Notation on the back of the MAR read in part "No Atrovent spray-pharmacy notified" for both doses. The entry for Zaditor eye drops had been initialed with initials circled on 02/01/7 for the 10 am dose.	F 425		

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 _____	06/08/2017

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 425	Continued From page 51 Notation on the back of the MAR read in part "no Zaditor eye gtts (drops)-pharmacy notified". The entry for torsemide had been initialed with initials circled on 02/01/17 and 02/02/17. Notation on the back of the MAR read in part "No torsemide pharmacy called" and "torsemide not available-pharmacy notified". Surveyor spoke with unit manager on 06/07/17 at approximately 0845 regarding the circles around initials on Resident #4's MAR. Unit manager stated that the circled initials indicated that the medication had not been administered. Surveyor requested and was provided with a copy of policy entitled "Unavailable Medications" which read in part "Policy: 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." Surveyor requested and was provided with a copy of the medications maintained in the STAT box. This list included HCTZ 25mg tabs and torsemide 10mg tablets. Surveyor spoke with the clinical nurse leader regarding Resident #4's medications not being available. Clinical nurse leader stated that she did not know why the medications that were available in the STAT box were not utilized. She also stated that the hospital pharmacy was the facility's back up pharmacy.	F 425		

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 _____	06/08/2017

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 425	Continued From page 52 The concern of the medications not being available for administration was discussed during a meeting with the administrative staff on 06/07/17 at approximately 1615. No further information was provided prior to exit. 3. The facility staff failed to ensure medications were available for administration for Resident #1. Resident #1 was re-admitted to the facility on 1/31/17 with diagnoses of dementia with behavior, agitation, anxiety, hypertension, anemia, malnutrition, arthritis, coronary artery disease, gastro-esophageal reflux disease, and urinary tract infection. The significant change Minimum Data Set (MDS) with a reference date of 2/12/17 assessed the resident with long and short term memory deficit. The resident was assessed requiring total dependence for bed mobility, transfers, ambulation, dressing, eating, toileting, bathing and hygiene. The clinical record was reviewed. The nurses had documented on the back of the medication administration records (MAR) that the medications, Morphine, Namenda, , Reglan, and Norco were not available for administration for Resident #1. The March 2017 MAR was reviewed. The physician had ordered Morphine 15 mg every 8 hours with a start date of 2/19/17. The nurse documented on 3/22/17 at 1400 (2:00 p.m.) that the Morphine was unavailable. The nurse also documented the medication was not available on 3/24 at 2200 (10:00 p.m.), and on 3/25 at 0600 and 1400.	F 425	3. Daily medication reorder log review beginning 7/6/17. Daily Nursing Admin review of Pharmacy reporting network for medication delivery beginning 7/14/17. Daily MAR review by CN for medication availability. One hundred percent compliance achieved by 7/17/17.	

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 _____	06/08/2017

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 425	Continued From page 53	F 425		

The April 2017 was reviewed. The nurse documented on 4/16 at 1600 (4:00 p.m.) that Reglan 10 mg was not available.

The May 2017 MAR was reviewed. The nurse documented the medication, Namenda 10 mg., was not available for administration on 5/24/at 2200.

The physician had ordered the pain medication, Norco 7.5/325 mg. on 5/2/17. The May 2017 MAR contained documentation the medication was not available for administration on 5/2 at 2200, 5/3 at 0600, 5/3 at 1400, 5/4 at 2200, 5/4 at 1400, 5/25 at 1400, 5/25 at 2200, and 5/26 at 0500.

The director of nursing (DON) was asked on 6/7/17 about the policy for unavailable medications. The DON stated if the resident was skilled then the pharmacy in the hospital was used and if long term care , then an outside pharmacy was used, but the hospital pharmacy was the back-up pharmacy for both.

The DON provided the facility policy for "Unavailable Medications". The policy stated the nurse should check the STAT box and then notify the after hours pharmacy. The policy stated to notify the physician and obtain alternate therapy. The policy stated to document the medication not available in the medical record and also on the MAR. The DON also provide a copy of the medications kept in the STAT box. The Norco 7.5/325 mg was available in the box. None of the other medications were in the STAT box.

The nurses failed to document in the clinical

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 _____	06/08/2017

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 425	Continued From page 54 record the medications were not available. The DON, quality assurance nurse, and chief nursing officer, were informed of the findings during a meeting with the survey team on 6/7/17 at 4:00 p.m. 4. The facility staff failed to ensure medications were available for administration for Resident #6. Resident #6 was admitted to the facility on 7/16/15 with diagnoses of dementia with behaviors, depression, anxiety, hypertension, hypothyroidism, anemia, malnutrition, rheumatoid arthritis, peripheral vascular disease, Vitamin D deficiency, chronic obstructive pulmonary disease, gastro esophageal reflux disease, and urinary tract infection. The annual Minimum Data Set (MDS) with a reference date of 7/7/16 assessed the resident with a cognitive score of "5" of "15". The resident was assessed requiring supervision for bed mobility, transfers, ambulation, dressing, eating, toileting, bathing and hygiene. The clinical record was reviewed. The physician had ordered the medication, Aspirin 81 mg. every Monday, Wednesday, and Friday, with a start date of 7/6/15. The medication administration record (MAR) for March 2017 contained documentation the nurse noted on the back of the MAR the Aspirin was not available on 3/29 at 10:00 a.m. and the "RX notified". The nurse did not notify the physician or document in the nurses notes about the medication.	F 425	4. Daily medication reorder log review beginning 7/6/17. Daily Nursing Admin review of Pharmacy reporting network for medication delivery by 7/14/17. Daily MAR review by CN for medication availability. One hundred percent compliance by 7/17/17.	

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 _____	06/08/2017

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 425	Continued From page 55 The nurse also documented the medication, Humira 40 mg. was unavailable on 3/8/17. The Humira was ordered on 12/8/16 by the physician to be given monthly. There was no further documentation on the medication in the clinical record. The physician also ordered the antianxiety medication, Xanax 1.5 mg. at bedtime. The nurse documented the Xanax was not available on 5/12, 5/13, 5/14, 5/15, and 5/16 at bedtime. The nurse obtained an order to administer 1 mg of Xanax until the medication arrived on 5/16/17. The STAT box was noted to contain Xanax 0.5 mg and this was not used by the nursing staff. The DON, quality assurance nurse, and chief nursing officer, were informed of the findings during a meeting with the survey team on 6/7/17 at 4:00 p.m.	F 425		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) 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) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 431		

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 _____	06/08/2017

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 431	Continued From page 56 (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical	F 431		

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 _____	06/08/2017

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 431	Continued From page 57 record review the facility staff failed to ensure proper labeling of medications per pharmacy professional standards for 1 of 13 Residents, Resident #11. The findings included: For Resident #11 the facility staff failed to ensure Flonase nasal spray was labeled correctly Resident #11 was admitted to the facility on 03/13/17. Diagnoses included but not limited to hypertension, atrial fibrillation, diabetes mellitus, gastroesophageal reflux disease, and anxiety The most recent MDS (minimum data set) with an ARD (assessment reference date) of 04/20/17 coded the Resident as 13 of 15 in section C, cognitive patterns. This is a significant change MDS. Surveyor observed Resident #11 receiving her medications during a medication pass and pour completed by LPN (licensed practical nurse) #1 on 06/07/17 at approximately 0930. One of the medications observed being administered was Flonase, 1 spray to each nostril. Resident #11's medications were reconciled with the clinical record on 06/08/17 at approximately 1000. The clinical record contained a signed POS (physician's order summary) dated 05/30/17 which read in part "Fluticasone SPR 50mcg 2 sprays in nostril(s) daily For: Flonase". The Resident's (medication administration record) was reviewed and contained an entry which read in part "Fluticasone SPR 50mcg 2 sprays in nostril(s) daily For: Flonase". This entry was scheduled for 10 am and had been initialed by	F 431	Education the Six Rights of Medication Administration to all LPN and RN staff by 7/14/17. Fifteen observations a month for Med Pass and Pour beginning on 7/17/17. Observations to provide real time instruction and correction. With the goal of One hundred percent compliance as evidenced by the adherence to the Six Rights of Medication Administration. Compliance to be achieved by 7/17/17.	

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 _____	06/08/2017

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 431	Continued From page 58 LPN #1 as having been administered. Surveyor spoke with LPN #1 on 06/07/17 at approximately 1100 regarding Resident #11's Flonase. Surveyor asked LPN #1 how many sprays of Flonase she had administered to Resident #11 and LPN #1 stated that she had administered 1 spray to each nostril. Surveyor then asked LPN #1 to look at the physician's order with her and LPN#1 did so. LPN #1 stated that the order read to administer 2 sprays to each nostril. Surveyor then asked LPN #1 to see the medication packaging for the Flonase. LPN #1 removed Flonase from medication cart. Flonase was labeled as follows: 1 spray in each nostril daily as needed Fluticasone SPR 50 mcg For: Flonase. Surveyor spoke with pharmacist #1 on 06/07/17 at approximately. Pharmacist stated that Resident #11's current order for Flonase was 2 sprays/nostril daily and that the label was for a previous order which was discontinued on 04/20/17 when the current order went into effect. Pharmacist stated that a new label should have been placed on the packaging with the current order instructions. The concern of not ensuring correct labeling of medication was discussed with the administrative team during a meeting on 06/07/17 at approximately 1615. No further information was provided prior to exit.	F 431		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program.	F 441		

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 _____	06/08/2017

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 441	Continued From page 59 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the	F 441		

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 _____	06/08/2017

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 441	Continued From page 60 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review the facility staff failed to follow facility established procedure for infection control for 2 of 13 Residents, Resident #12 and Resident #13. The findings included: For Resident #12 the facility staff failed to clean scissors prior to using them to open a medication packet. Resident #12 was admitted to the facility on 05/23/17. Diagnoses included but not limited to	F 441	1.Education to One hundred percent of staff on Infection Control Policies by 7/14/17. Med Pass and Pour observations to observe the adherence to Infection Control Polices by using proper infection control techniques. Fifteen observations a month for six weeks with a goal of one hundred percent compliance by 7/17/17.	

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 _____	06/08/2017

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 441	Continued From page 61 benign prostatic hyperplasia, hypertension, dementia, and constipation. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 05/30/17 coded the Resident as 12 of 15 in section C, cognitive patterns. This is an admission MDS. Surveyor observed Resident #12 during a medication pass and pour completed by LPN (licensed practical nurse) #1 on 06/07/13 at approximately 0755. LPN #1 removed an individual dose pack of Miralax from the medication cart and attempted to open it with her hand, but could not tear the packet open. LPN #1 then asked the unit manager if she had a pair of scissors, and the unit manager stated that she did, removed the scissors from the pants pocket and handed them to LPN #1. LPN #1 used the scissors to open the Miralax packet. LPN #1 did not clean the scissors prior to using them to cut open the Miralax packet. The surveyor requested and was provided with a facility policy entitled "Infection Control" which read in part "Policy: The facility will maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection." The surveyor spoke with LPN #1 on 06/07/17 at approximately 1100 regarding Resident #12. Surveyor asked LPN #1 if she should have cleaned the scissors prior to using them to open the medication packet, and LPN #1 stated that she should have. The concern of not cleaning the scissors prior to	F 441		

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 _____	06/08/2017

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 441	Continued From page 62 using them to open medications was discussed with the administrative team during a meeting on 06/07/17 at approximately 1615. No further information was provided prior to exit. 2. For Resident #13 the facility staff failed to change gloves and failed to cover insulin needle prior to giving and injection. Resident #13 was admitted to the facility on 12/03/15. Diagnoses included but not limited to diabetes mellitus. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 06/01/17 coded the Resident as 8 out of 15 in section C, cognitive patterns. This is a quarterly MDS. The surveyor observed LPN #3 (licensed practical nurse) during a medication pass and pour on 06/07/17 at approximately 0730. LPN #3 donned gloves, then removed MAR (medication administration record) book from the medication cart. She opened the book, removed Resident's insulin vial from the med cart, retrieved an insulin syringe, removed the cap from the needle, dropping cap to the floor. LPN #3 drew up the insulin into the syringe, then carried the syringe with needle exposed across the room and administered the insulin injection to Resident #13. LPN #3 did not change her gloves during this time. Surveyor asked LPN #3 if she should have donned her gloves after handling the MAR book and items from med cart, and LPN #3 stated that she should have.	F 441	2. Education to One hundred percent of staff on Infection Control Polices by 7/14/17. Med pass and pour observations to observe the adherence to Infection Control Policies by using proper infection control techniques. Fifteen observations a month for six weeks with a goal of one hundred percent compliance by 7/17/17.	

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 _____	06/08/2017

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 441	Continued From page 63 The surveyor requested and was provided with a facility policy entitled "Infection Control" which read in part "Policy: The facility will maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection." The concern of not changing gloves and not covering the insulin needle was discussed with the administrative team during a meeting on 06/07/17 at approximately 1615. No further information was provided prior to exit.	F 441		
F 500 SS=D	483.70(g)(1)(2)(i)(ii) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT (g) Use of outside resources. (1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g)(2) of this section. (2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for- (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and	F 500		

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 _____	06/08/2017

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 500	Continued From page 64 (ii) The 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 ensure a current contract for dialysis services was in place for 1 of 13 residents(Resident #7). The findings include: The facility staff failed to ensure a current dialysis contract with the dialysis center for Resident #7. Resident #7 was admitted to the facility on 12/4/16 with diagnoses of end stage renal disease, diabetes, hypertension, chronic obstructive pulmonary disease, atrial fibrillation, and congestive heart disease. The significant change Minimum Data set (MDS) with a reference date of 3/16/17 assessed the resident with a cognitive score of "15" of "15". The resident was assessed as independent for bed mobility, transfers, ambulation, dressing, eating, toileting, bathing , and hygiene. The clinical record was reviewed. A staff nurse (RN#3) was interviewed on 6/8/17 at 10:40 a.m. about communication with the dialysis center. There was documentation in the nursing notes of communication with the dialysis center and orders written and approved for any changes. The chief nursing officer was asked to see the dialysis contract on 6/8/17 at 1:15 p.m. The chief nursing officer stated there was no current contract and the contract was tied up in the legal department of the corporation and not available.	F 500	Dialysis contract signed and completed by 10/1/17.	

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 _____	06/08/2017

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 500	Continued From page 65 The director of nursing, quality assurance nurse, and chief nursing officer, were informed of the findings during a meeting with the survey team on 6/8/17 at 4:00 p.m.	F 500		
F 502 SS=D	483.50(a)(1) ADMINISTRATION (a) Laboratory Services (1) 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 13 Residents, Resident #4. The findings included: For Resident #4 the facility staff failed to obtain the physician ordered laboratory tests for wound culture ordered on 05/14/17, CBC (complete blood count) and CMP (comprehensive metabolic panel) ordered 10/21/17. Resident #4 was admitted to the facility on 12/04/14. Diagnoses included but not limited to anemia, hypertension, depression, hypothyroidism, congestive heart failure and cirrhosis. The most recent MDS with an ARD of 04/13/17 coded the Resident as 15 of 15 in section C, cognitive patterns. This is a quarterly MDS.	F 502	Create log for diagnostic orders by 7/13/17. One hundred percent of staff education on work flow and log by 7/14/17. Daily audit of log by the CN for results beginning 7/14/17 for twelve months. With one hundred percent compliance being achieved as evidenced by all diagnostic orders having results by 8/1/17.	

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 _____	06/08/2017

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 502	Continued From page 66 Resident #4's clinical record was reviewed on 06/06/17. It contained a signed physician's order dated 05/14/17 which read in part "obtain wound culture". The clinical record also contained a signed physician's order dated 10/20/17 which read in part "CBC and CMP in AM". Surveyor could not locate the results of these tests in the Resident's clinical record. Surveyor asked the clinical nurse leader if she could locate the results of the lab tests and she could not. The concern of the missing lab results was discussed with the administrative team during a meeting on 06/07/17 at approximately 1615. No further information was provided prior to exit.	F 502		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain-	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 _____	06/08/2017

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 67 (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to maintain a complete and accurate clinical record for 1 of 13 Residents, Resident #3. The findings included: The facility staff failed to maintain an accurate clinical record for Resident #3 by filing information belonging to another Resident in Resident #3's record. Resident #3 was admitted to the facility on 02/16/17. Diagnoses included but not limited to anemia, hypertension, urinary tract infection, wound infection, osteoporosis, dementia, anxiety, malnutrition, and depression. The most recent comprehensive MDS with an ARD of 02/23/17 coded the Resident as 11 of 15 in section C, cognitive patterns. This is an	F 514	Monthly audit of one hundred percent of all charts for appropriate filing of all documentation for six months starting 6/29/17. After four months of one hundred percent compliance monthly audits will decrease to ten charts a month for six months to monitor continuing compliance.	

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 _____	06/08/2017

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 68 admission MDS. Resident #3's clinical record was reviewed on 06/07/17. It contained an MDS form belonging to another Resident of the facility. This was brought to the attention of the clinical nurse leader on 06/07/17 at approximately 1030. Clinical nurse leader stated that the form was filed in the wrong record and that she would make sure it was filed in the correct Resident's record. The concern of the misfiling of the MDS was discussed with the administrative team during a meeting on 06/07/17 at approximately 1615. No further information was provided prior to exit.	F 514		
F 520 SS=F	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must :	F 520		

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 _____	06/08/2017

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 520	Continued From page 69 (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review the facility staff failed to ensure a quality assurance program to meet the needs of the facility The findings included: The facility staff failed to provide documentation of quarterly QA (quality assurance) meetings and failed to provide a program to meet the needs of the facility. Surveyor met with the clinical nurse leader on 06/08/17 to discuss the facility's QA program. Surveyor asked the clinical nurse leader how often the QA committee met and the clinical nurse leader stated they met every 2 months.	F 520	Sign-in sheets created with each members name and title listed with place for individuals signature out from their name. PI results reviewed and tracking and trending reported at all QA meetings with results sent to Medical Director for his review prior to each meeting. Open QA meeting to front line staff to attend and report any quality issues that they come into contact with.	6/28/17

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 _____	06/08/2017

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 520	Continued From page 70 Surveyor then asked to see the sign-in sheets for the QA meetings and the clinical nurse leader could only produce sign in sheets for the months of February 2017, and April 2017. The QA program failed to meet the needs of the facility as evidenced by repeated deficiencies in the areas of Resident's rights, quality of care, pharmacy services, and laboratory services. The concern of the QA program not meeting the needs of the facility was discussed with the administrative team during a meeting on 06/08/17 at approximately 1530. No further information was provided prior to exit.	F 520		