SHENANDOAH VALLEY
HEALTH AND REHAB

3737 Catalpa Avenue
Buena Vista, VA 24416
phone 540 261 7444
shenandoahrehabcenter.com

March 26, 2019

Nicole Keeney, LTC Supervisor
Division of Long Term Care
Office of Licensure and Certification
9960 Mayland Drive
Suite 401
Richmond, Va. 23233

RE: Shenandoah Valley Health and Rehab
Provider Number: 495168

Dear Ms. Keeney,

Attached is our Plan of Correction in response to the unannounced standard survey ending March 14, 2019. If additional information is needed or if you should have any questions please let me know.

Sincerely,

Janette Coleman

L. Janette Coleman
Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495168	A. BUILDING _____ B. WING _____	C 03/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH VALLEY HEALTH AND REHAB	3737 CATALPA AVE, PO BOX 711 BUENA VISTA, VA 24416

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 3/12/19 through 3/14/19. The facility's Emergency Preparedness Plan was reviewed and found to be in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/12/19 through 3/14/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey. The Life Safety Code survey/report will follow. The census in this ninety-three certified bed facility was 74 at the time of the survey. The survey sample consisted of eighteen current resident reviews and three closed record reviews.	F 000	**Shenandoah Valley Health and Rehab ("Facility") is filing this Plan of Correction for purposes of regulatory compliance. The facility is submitting this Plan of Correction to comply with applicable law. The submission of the Plan of Correction does not represent an admission or statement of agreement with respect to the alleged deficiencies.**	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident	F 584		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: R. Brett Coleman | TITLE: Administrator | (X6) DATE: 3/27/19

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

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F 584	Continued From page 1 independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a homelike environment. In Resident #54's room, the drywall around the ceiling was in ill repair and the commode was not functioning properly. The findings include: On 3/12/19 at 11 a.m., during the initial tour, Resident #54 stated there had been a problem with the commode and a crack in the ceiling since she had been admitted. The resident stated the	F 584	**1. Residents #54 and #73 remain in the facility. Maintenance repaired float/flapper in tank of commode of resident's bathroom during survey. Resident #54 requested waiting until after 4/1/19 to repair loose sheetrock tape around ceiling area.** **2. Residents in the facility with maintenance issues in their rooms have the potential to be affected by this deficient practice.** **3. Re-education will be provided to nurses/nursing assistants to enter any maintenance issues into TELS system available on the kiosk. Audits will be completed during Carekeeper Rounds 5x weekly for 3 months with any noted Maintenance issues also entered into the TELS system.** **4. Results of the audits will be taken to the monthly/quarterly Quality Assurance Performance Improvement Committee for review and recommendations for three months.** **5. Corrective action will be completed on April 3, 2019**	

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F 584	Continued From page 2 commode constantly runs after you flush it, we try jiggling the handle and sometimes it cuts off and sometimes it does not. Resident #54 opened the bathroom door and the commode was observed constantly running for about 2 minutes. Resident #54 continued and pointed to the ceiling and stated look at that crack in the ceiling. A crack was observed running around the right edge of the ceiling near bed A for approximately 12 feet heading towards overtop of the closet area. Resident #54 said she was not sure of the repair status but staff were aware of the problem. Resident #54 stated she was concerned and did not want the ceiling to fall in on her and her roommate. Resident #54 continued and stated it is the small, piddly things that get overlooked. On 3/12/19 at 3:15 p.m., Resident #54 approached this surveyor and stated the commode is still running. The commode was again observed running for approximately 2 minutes. On 3/13/19 at 8:22 a.m., the commode was observed constantly running. Resident #73 who also resided in the room stated she had tried jiggling the handle about 30 minutes ago, but the commode continued running. On 3/13/19 at 8:24 a.m., the certified nursing assistant (CNA #1) who routinely provides care for Residents #54 and #73, was interviewed about the commode and ceiling issues in the room. CNA #1 stated she was not aware of the issues. She stated she would let maintenance know. CNA #1 was asked how work order requests were made. CNA #1 stated they are put in when we chart using the electronic system.	F 584		

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F 584	Continued From page 3 On 3/13/19 at 8:26 a.m., the maintenance director (OS #3) was interviewed about the work order request for repairs. OS #3 stated he was told about the issue yesterday (3/12/19), but when he checked the commode was not running so there was not anything he could fix. Accompanied with OS #3 to the room, the commode was observed running. OS #3 removed the top off the back of the commode and stated the flapper/floater need replacing. OS #3 was interviewed about the crack in the ceiling. OS #3 stated he was sure it wasn't an actual ceiling issue more like a drywall issue. OS #3 was asked how did he receive work order requests. He stated the staff were able to enter them electronically. This findings were reviewed with the administrator, director of nursing and corporate staff during a meeting on 3/13/19 at 4:40 p.m. On 3/14/19, the facility administrator stated she and the maintenance director determined due to the nature of the ceiling repairs the residents would need to transfer to another room while the repairs were being made. The administrator stated Resident #54 did not want to transfer to another room at the time because she plans to discharge in a couple of weeks, therefore the ceiling repairs will be scheduled at a later date. No other information was received prior to the exit conference on 3/14/19 at 12:45 p.m.	F 584		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		

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F 656	Continued From page 4 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 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.	F 656	**1. Resident #13 remains in the facility. Resident #13's care plan was updated to include supervision related to inappropriate behaviors as well as problems/ goals/ interventions were developed to include supervision when the resident is out of the room, the door alarm, and the resident's response to the alarm placement.** **2. Residents with inappropriate behaviors have the potential to be affected by this deficient practice. An audit was completed by Director of Nursing/ designee of the current residents to ensure care plans which include problems/ goals/ interventions have been developed to include supervision related to inappropriate behaviors and resident response to placed devices.** **3. The Interdisciplinary Care Team will be re-educated by the Director of Nursing to ensure care plans are created and updated as needed to include supervision related to inappropriate behaviors and ensure that care plans reflect the resident's current status and overall condition. Care Plans will be audited weekly over the next 3 months following the routine care plan schedule to ensure that they are current and accurate.** **4. Results of audits will be taken to Quality Assurance Performance Improvement Committee for review and recommendations for three months.** **5. Corrective action will be completed by April 3, 2019.**	

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F 656	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to develop a comprehensive plan of care for one of 21 residents in the survey sample. Resident #13 did not have a comprehensive care plan developed regarding required supervision related to inappropriate behaviors. The findings include: Resident #13 was admitted to the facility on 8/20/15 with a re-admission on 9/27/18. Diagnoses for Resident #13 included atrial fibrillation, diabetes, high blood pressure, COPD (chronic obstructive pulmonary disease), macular degeneration and depression. The minimum data set (MDS) dated 12/26/18 assessed Resident #13 as cognitively intact. Resident #13's clinical record documented on 1/11/19 that a staff member witnessed the resident with his hand down a female resident's shirt while in the dining room. A facility reported incident form sent to the State Agency dated 1/16/19 documented the resident was evaluated by psychiatry and had medications reviewed/adjusted in response to the incident. The facility also documented a motion detector was applied to the resident's doorway to alert staff of resident exiting room and staff were required to closely monitor the resident when in the corridor, when attending activities and when in the dining room. Resident #13's plan of care (revised 3/11/19) listed the resident had a history of "inappropriate touching of female resident." The interventions	F 656		

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F 656	Continued From page 6 listed included a sensor alarm to room to alert staff but documented no other interventions concerning the behavior. The care plan made no mention of the supervision required for the resident when out of the room. There were no problems, goals and/or interventions regarding the door alarm and the resident's response to the alarm placement. On 3/14/19 at 8:08 a.m., the director of nursing (DON) was interviewed about Resident #13's care plan. The DON stated staff were educated about supervising Resident #13 when out of the room to prevent other residents from any inappropriate behaviors. The DON reviewed Resident #13's care plan and stated she did not see anything on the plan about the supervision. The DON stated regarding the care plan for behaviors, "I don't see the supervision piece on there." These findings were reviewed with the administrator and DON during a meeting on 3/14/19 at 11:45 a.m.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(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	F 657	**1. Resident # 57 and #13 remain in the facility. The IDT team identified this as an area of concern during our Monthly Quality Assurance Process Improvement Meeting conducted on 2/28/19. A Process Improvement Plan was developed and initiated to address the identified area of concern. The interdisciplinary team met with Resident #57 and a care plan meeting was conducted. A meeting is scheduled with Resident #13s family to accommodate her schedule. Resident #57 and #13 care plans were reviewed and revised by interdisciplinary team.**	

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F 657	Continued From page 7 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 staff interview, clinical record review, and facility document review, the facility staff failed to ensure an interdisciplinary team was in attendance at care plan meetings for two of 21 residents, Resident #57 and Resident #13. The facility also failed to invite one of 21 residents, Resident #13 to his care plan meeting. 1. Resident #53's, (a resident with significant weight loss) care plan was not reviewed by an interdisciplinary team from 06/12/2018 through 02/19/2019. 2. For two consecutive quarters, Resident #13's care plan was not reviewed/revised by an interdisciplinary team. In addition, Resident #13 was not invited to participate in his quarterly care plan meetings. Findings were:	F 657	**2. Residents in the facility have the potential to be affected by this deficient practice. An audit was completed by the interdisciplinary team to ensure current residents are being invited to care plan meetings and their care plans have been reviewed and revised as required.** **3. The interdisciplinary team was re-educated by the Director of Nursing/ Administrator related to ensuring residents and resident representatives are being invited to care plan meetings and care plans are reviewed and revised as required. Audits will be conducted weekly over the next 3 months following the routine care plan schedule utilizing the QAPI Audit Tool.** **4. Results of audits will be taken to Quality Assurance Performance Improvement Committee for review and recommendations for three months.** **5. Corrective action will be completed by April 3, 2019.**	

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F 657	Continued From page 8 1. Resident #53 was admitted to the facility on 10/01/2014. Her diagnoses included but were not limited to: Major depressive disorder, anxiety, hypertension, hypothyroidism, dementia with behavioral disturbances, atherosclerotic heart disease, atrioventricular block (with subsequent pacemaker insertion) and cancer (per facility staff report). A quarterly MDS (minimum data set) with an ARD (assessment reference date) of 02/13/2019, assessed Resident #53 as severely impaired in cognitive status with a summary score of "00". Resident #53 had a significant weight loss of 24.49 % in six months from September 2018 until March 2019. Her current weight at the time of the survey was 96.2 pounds. Resident #53's care plan meeting information was requested on 03/14/2019 at approximately 9:30 a.m. The care plan conference sheet contained information for care plan meetings held on the following dates: 06/12/2018, 09/04/2018, 11/27/2018, and 02/19/2019. The form, "Resident Care Planning Conference" had spaces for information to be entered regarding who was in attendance for the meeting and what was discussed. There were signature areas for all attendees to sign. There were no entries by the RD (registered dietitian) or the DM (dietary manager) that either of them had been in attendance at any of Resident #53's care plan meetings since June 2018; nor had the physician or nurse practitioner been in attendance at any of the meetings An end of survey meeting was held with the DON (director of nursing), the administrator, the MDS	F 657		

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F 657	Continued From page 9 coordinator and the corporate nurse consultant. The above information was discussed. The MDS nurse stated that she did a schedule of when the care plan meetings would be held for each resident based on their MDS dates, and posted it with the staff that needed to attend. She was asked about involvement of the RD or the DM for Resident #53 who had a significant weight loss. She stated, "The RD isn't always here on care plan days, the dietary manager sometimes attends...they have weight meetings every week and discuss the residents...the RD does all of her own care plans and she will go in and update them with information from the weight meetings." The administrator stated, "We identified this as a problem and started a PIP [performance improvement plan]...the first part is to get everyone to the meeting the second part is to get the form filled out correctly." No further information was obtained prior to the exit conference on 03/14/2019. 2. Resident #13 was admitted to the facility on 8/20/15 with a re-admission on 9/27/18. Diagnoses for Resident #13 included atrial fibrillation, diabetes, high blood pressure, COPD (chronic obstructive pulmonary disease), macular degeneration and depression. The minimum data set (MDS) dated 12/26/18 assessed Resident #13 as cognitively intact. On 3/12/19 at 3:30 p.m., Resident #13 was interviewed about quality of life/care in the facility. During this interview, Resident #13 stated he did not participate in his care plan meetings and did not recall any invitations to the meetings.	F 657		

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F 657	Continued From page 10 Resident #13's clinical record documented no invitation, participation or refusals by the resident regarding his care plan meetings. There was no explanation included in the clinical record indicating the resident's participation in the care plan meeting was not practicable. On 3/13/19 at 2:25 p.m., the social worker was interviewed about Resident #13's involvement and/or invitation to care plan meetings. The social worker stated an invitation letter was sent to the resident's family member but nothing in writing was provided to the resident about the meetings. The social worker stated she thought the resident was verbally invited but nothing was documented about his refusal or attendance at the meetings. A copy of the care plan schedule for Resident #13 was requested at this time. The social worker stated residents were not routinely sent a written invitation to care conferences unless they were listed as their own responsible party. On 3/13/19 at 4:06 p.m., the social worker presented a copy of Resident #13's past care conference schedule. The social worker stated at this time that Resident #13's last care plan meeting was held on 1/4/19 and was only attended by one registered nurse (RN) and the MDS coordinator. The social worker stated the entire interdisciplinary team did not conduct care plan reviews. The social worker stated the facility did not routinely invite residents but only sent invitations to family members or designated representatives. The social worker stated the administration had recently recognized the lack of staff attendance at care plan meetings as a process improvement concern. The social worker stated no nurses from Resident #13's	F 657		

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F 657	Continued From page 11 living unit attended the last care conference on 1/4/19. The care conference sheet provided by the social worker documented care plan meetings were held for Resident #13 on 10/17/18 and 1/4/19. These meetings did not include participation by an interdisciplinary team or the resident. Only the director of nursing (DON), MDS coordinator and the unit #1 manager (RN #3) attended the conference on 10/17/18. The care conference on 1/4/19 included the unit #2 manager (RN #1), who was not responsible for care of Resident #13, and the MDS coordinator. The care conferences on 10/18/18 and 1/4/19 did not include representation of a nurse aide involved with the resident's care, a staff member from food/nutrition services, social services or recreation/activities. On 3/13/19 at 4:15 p.m., the unit #2 manager (RN #1) was interviewed about Resident #13's care plan meetings. RN #1 stated care plans were reviewed as a team and that all staff members attending the conference signed the care conference sheets. RN #1 stated she was not responsible for the care of Resident #13 as he did not reside on her unit. RN #1 stated she did not know why staff members from unit #1 did not attend the care conference on 1/4/19. RN #1 stated the entire interdisciplinary team was supposed to review care plans and attend care conferences. On 3/13/19 at 4:20 p.m., the MDS coordinator (RN #4) was interviewed about lack of an interdisciplinary team at the care conferences and no invitation to Resident #13. RN #4 stated she set up the care conference schedules each	F 657		

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F 657	Continued From page 12 month and the social worker sent the family/representative invitation letters for the meetings. RN #4 stated the resident was issued an invitation letter for the care conference only if they were listed as their own RP (responsible party). RN #4 stated for those residents not listed as their own RP, no formal invitation was provided. When asked why all the facility disciplines were not represented at the last two meetings for Resident #13, RN #4 stated she was not sure who was available on those days to attend. On 3/14/19 at 8:08 a.m., the DON was interviewed about Resident #13's care conferences. The DON stated they had recognized the lack of interdisciplinary team attendance at care conferences as a pattern throughout the facility. The DON stated the expectation was that all departments were to attend and/or be represented at care conferences. The DON stated there were no follow up notes documented in clinical records regarding resident participation or refusal in care conferences. The DON stated the administration started a process improvement project on 2/28/19 concerning the care conference attendees and the interventions were ongoing. These findings were reviewed with the administrator and DON during a meeting on 3/14/19 at 11:45 a.m.	F 657		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on	F 690		

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F 690	Continued From page 13 admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to anchor the tubing for a Foley urinary catheter for one of 21 residents in the survey sample. Resident #184 did not have the Foley catheter tubing anchored to her thigh as required	F 690	1. **Resident #184 remains in the facility. A catheter anchor was affixed to Resident #184's thigh during the survey by the licensed nurse.** 2. **Residents in the facility with foley catheters have the potential to be affected by this deficient practice. An audit was completed by the Director of Nursing/ designee of the current residents with Foley urinary catheters to ensure that catheters are anchored to the thigh as required.** 3. **Nursing staff will be re-educated on the use of catheter anchors with all patients who have foley catheters. The Director of Nursing / designee will complete audits weekly for 3 months to ensure Foley catheters continue to be anchored to the thigh. Care keeper rounds will also be used to ensure compliance.** 4. **Results of audits will be taken to Quality Assurance Performance Improvement Committee for review and recommendations for three months.** 5. **Corrective action will be completed by April 3, 2019.**	

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F 690	Continued From page 14 in her plan of care. The findings include: Resident #184 was admitted to the facility on 3/11/19 with diagnoses that included femur fracture, urinary retention, lung cancer, pleural effusion, diabetes and COPD (chronic obstructive pulmonary disease). The admission nursing assessment documented Resident #184 was alert and oriented with some confusion. On 3/12/19 at 4:11 p.m., Resident #184 was observed in bed. The resident's Foley catheter tubing was visible and not anchored to the resident's thigh. Resident #184 was interviewed at this time about the tubing. Resident #184 stated the tubing had not been attached to her thigh since her admission. Resident #184's clinical record documented a physician's order dated 3/11/19 for a Foley urinary catheter due to urinary retention. The resident's initial care plan (print date 3/13/19) documented the resident had an indwelling catheter due to urinary retention. Care plan interventions to prevent complications from catheter use included, "Anchor catheter, avoid excessive tugging on the catheter during transfer and delivery of care..." On 3/12/19 at 4:15 p.m., the licensed practical nurse (LPN #2) caring for Resident #184 was interviewed about a tubing anchor. LPN #2 stated the Foley catheter tubing was supposed to be attached and/or anchored. Accompanied by LPN #2, Resident #184 was observed in bed without an anchor for the tubing. LPN #2 stated at this time that thigh straps were available to anchor the tubing.	F 690		

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F 690	Continued From page 15 On 3/13/19 at 12:53 p.m., the registered nurse unit manager (RN #3) was interviewed about an anchor for Resident #184's catheter tubing. RN #3 stated there was no standing order for a tubing anchor and she did not know if there was a protocol requiring an anchor. On 3/13/19 at 1:30 p.m., the director of nursing was interviewed about Resident #184's catheter tubing. The DON stated there was supposed to be enough "play" in the tubing so that it did not pull. On 3/13/19 at 4:30 p.m., the DON presented a copy of the facility's protocol for Foley catheter care. The protocol (undated) titled Indwelling Urinary Catheter Care and Removal documented, "...Make sure the catheter is properly secured. Assess the securement device daily and change it when clinically indicated and as recommended by the manufacturer...If a securement device isn't available, use a piece of adhesive tape to secure the catheter...Provide enough slack before securing the catheter to prevent tension on the tubing, which could injure the urethral lumen and bladder wall..." The Lippincott Manual of Nursing Practice 10th edition on page 781 documents regarding care of an indwelling catheter, "...Secure the indwelling catheter to patient's thigh using tape, strap, adhesive anchor, or other securement device...Properly securing the catheter prevents catheter movement and traction on the urethra...Pulling on the catheter may be painful. Backward and forward displacement of the catheter introduces contaminants into the urinary tract..." (1)	F 690		

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F 690	Continued From page 16 These findings were reviewed with the administrator and director of nursing during a meeting on 3/13/19 at 4:40 p.m. (1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014.	F 690		
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to maintained acceptable parameters of nutritional status for one of 21 residents in the survey	F 692	**1. Resident #53 remains in the facility. The nursing staff was re-educated during the survey by the Dietician related to fortified foods and a labeling system was implemented so that staff could easily identify Resident #53's fortified foods on the meal tray. Resident #53 was reviewed by the dietician during the survey with an alternative juice supplement ordered and percent intake documentation was added to the snack documentation.** **2. Residents in the facility with end stage dementia and gradual weight loss have the potential to be affected by this deficient practice. An audit was completed by Director of Nursing/designee to ensure current residents with weight loss have been reviewed by the dietician, the residents' fortified foods are labeled on the food tray, percent of intake documentation is included on the snack intake documentation, and preventative interventions are in place.**	

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F 692	Continued From page 17 sample, Resident #53. Resident #53 had a significant weight loss of 24.49 % in six months. Facility staff were not aware of what foods on Resident #53's tray were fortified at meal times, and minimal assistance was offered during meal time observations. Findings were: Resident #53 was admitted to the facility on 10/01/2014. Her diagnoses included but were not limited to: Major depressive disorder, anxiety, hypertension, hypothyroidism, dementia with behavioral disturbances, atherosclerotic heart disease, atrioventricular block (with subsequent pacemaker insertion) and cancer (per facility staff report). A quarterly MDS (minimum data set) with an ARD (assessment reference date) of 02/13/2019, assessed Resident #53 as severely impaired in cognitive status with a summary score of "00". Under "Section G Functional Status", Resident #53 was coded as 2/2 for eating, indicating the need for limited assistance with one person physical assist. Under "Section K Swallowing//Nutritional Status, Resident #53 was identified as having wt loss of 5 % or more in the last month or a loss of 10% or more in 6 months and not on a physician prescribed weight loss program. On 03/12/2019 during the lunchtime meal, a dining observation was done in the "day room"' area of the facility. On one side of the room was a square table with four chairs. Observed across the room was a wall that separated the day room from the hallway, a small table was attached to	F 692	**3. The nursing staff and the interdisciplinary team will be re-educated by the Administrator/ Director of Nursing related to encouraging liquids/finger foods/fortified options for residents during meals, ensuring the registered dietician review current residents who are at risk for weight loss or who have had a weight loss, and ensure the dietary manager/ dietician participate in the weekly weight meeting. Audits will be completed by the Dietary manager weekly for 3 months to ensure fortified foods continue to be identified on the meals trays, nursing staff continue to encourage liquids/fortified foods/finger foods options during meals, and snack documentation continue to include % intake documentation.** **4. Results of audits will be taken to Quality Assurance Performance Improvement Committee for review and recommendations for three months.** **5. Corrective action will be completed by April 3, 2019.**	

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F 692	Continued From page 18 the wall. Directly around the corner from that table was another table also attached to the wall. At approximately 12:30 p.m., Resident #53 was brought to the day room area in her wheelchair. She was placed at the first table described above. Her view was only of the wall in front of her, she was unable to see the resident seated to her left around the corner at the second table, or the residents seated at the larger square table behind her. Her tray contained an egg salad sandwich, a tossed salad, green beans, butterscotch pudding, and a piece of garlic bread. The sandwich was on a plate, the beans and salad were in bowls. The garlic bread was not taken out of the wrapper and the pudding was not opened. Resident #53 pushed herself away from the table and self propelled around the day room area. She propelled herself over to the larger table where four residents were seated with staff members assisting them with lunch. No one spoke to Resident #53 or attempted to redirect her. CNA (Certified nursing assistant) #2 came to the day room area and assisted Resident #53 back to the table where her tray was. CNA #2 then pulled a folding chair over between Resident #53 and the other resident seated at the wall table. CNA #2 began assisting the other resident with her lunch. CNA #2 looked over at Resident #53's tray and stated, "[Name] eat your sandwich, do you want some green beans?" CNA #2 picked up Resident #53's fork and put some green beans on it. Resident #53 shook the green beans off of the fork and attempted to get some green beans out of the bowl for herself. She was unable to pick up the food with her fork, but after several attempts got one green bean to her mouth. Resident #53 then pushed herself away from the table, and self propelled down the hallway. Her tray card was	F 692		

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F 692	Continued From page 19	F 692		

observed and contained the following: "Fortified foods; Loves Green Beans."

The clinical record was reviewed on 03/12/2019 at approximately 2:00 p.m. The physician orders for March contained the following: "Regular diet mechanical Soft texture, Provide fortified foods Start date: 08/23/2018; Snacks TID [three times a day] between meals Start date: 06/09/2018; Weekly weights Start date: 12/24/2018"

The following weights, recorded in pounds were observed in the clinical record:

08/06/2018: 134.2 (wheelchair)
08/13/2018: 129
09/01/2018: 127.4 (wheelchair)
10/03/2018: 114.8 (wheelchair)
10/08/2018: 116.6 (wheelchair)
10/22/2018: 112.8 (wheelchair)
10/29/2018: 110 (wheelchair)
11/05/2018: 111.4 (wheelchair)
11/12/2018: 117.8 (wheelchair)
11/14/2018: 114.6 (wheelchair)
11/21/2018: 115 (wheelchair)
12/05/2018: 111 (lift)
12/24/2018: 108.2 (wheelchair)
12/31/2018: 108.8 (wheelchair)
01/01/2019: 108.8 (lift)
01/07/2019: 103.6 (wheelchair)
01/10/2019: 103.4 (wheelchair)
01/14/2019: 103.8 (wheelchair)
01/21/2019: 105.4 (wheelchair)
01/28/2019: 106.3 (wheelchair)
02/04/2019: 101.6 (wheelchair)
02/11/2019: 102.2 (wheelchair)
02/18/2019: 104.5 (wheelchair)
02/25/2019: 101 (wheelchair)
03/04/2019: 100.8 (wheelchair)

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F 692	Continued From page 20 03/11/2019: 96.2 (wheelchair) From 09/01/2018 until 03/11/2019 (six months), Resident #53 lost a total of 31.2 pounds equivalent to 24.49 % of her total body weight. On 03/13/2019 at approximately 8:00 a.m., Resident #53 was observed self propelling in the day area. Three residents and three CNAs were sitting at the square table. An unoccupied seat had a covered tray in front of it. Observed on the tray was Resident #53's tray card. The CNAs were asked if Resident #53 had eaten breakfast. One of the CNAs stated, "She didn't want to eat." The tray lid was lifted. An egg covered with cheese, a piece of dry toast, and bowl of oatmeal were observed. Nothing on the tray appeared to have been eaten. The CNAs were asked which food on Resident #53's tray was fortified. All three stated that they did not know. At approximately 8:40 a.m., while observing medication pass, two of the three CNAs came up the hall. One stated, "Ma'am, we have the answer now...the oatmeal was what was fortified on [name of Resident #53] tray...they put extra butter and sugar in it to increase the calories." They were asked who had given them the information. They stated, "[Name of administrator]...[Name of RN-registered nurse #1] is going to try to get her to eat." Resident #53 was observed sitting in the day area at the square table at approximately 8:45 a.m. Her lap was covered with bread crumbs. RN #2 was coming down the hallway. She was asked if she had gotten Resident #53 to eat breakfast. She stated, "Yes, she ate her toast...I gave her that because she can eat it on the go." RN #2	F 692		

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F 692	Continued From page 21 was asked if finger foods had been attempted with Resident #53 as part of her diet. She stated, "I don't know...I know that we talked to her daughter, who is her RP [responsible party] about trying some supplements but she didn't want us to do it...she doesn't want her to have milk products...we tried to explain that they don't contain lactose but she still said no." On 3/13/2019 at approximately 12:30 p.m., Resident #53 was observed sitting in her wheelchair in the day area, a bedside table had been placed in front of her. She did not have a lunch tray. Two CNAs were observed sitting at the square table with other residents. They were asked about Resident #53's lunch tray. One CNA stated, "Her tray is already over in the cart...she's done with it." Resident #53's lunch tray was observed in the tray cart. The lid was lifted. Resident #53's egg salad sandwich had been pulled apart, her bowl of cooked apples had not been opened. The CNAs sitting at the table were asked what Resident #53 had eaten. One CNA stated, "We scraped the egg salad off of her sandwich and she ate some of that." Further review of the clinical record was conducted. A care plan was with the focus area: [Name] is at nutrition/hydration risk RT self-care deficit, severe dementia, AEB [as evidenced by] is dependant upon staff for provision of all food, fluids with diagnosis often accompanied by decreased PO intake and potentially unavoidable weight loss." Interventions included: "Assist to dine as needed. Monitor for increased need of assistance; diet as ordered; honor food preferences; monitor lab data...; monitor meal consumption daily; provide mouth care as needed; RD to follow nutrition interventions as	F 692		

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F 692	Continued From page 22 appropriate, supplements between meals; wt monitoring as ordered." A physician note dated 11/16/2018 was observed and contained the following information: "...Dementia with behavior including aggression; pt has [sic] beginning to feed herself; continue to monitor." Dietary documentation in the clinical record was reviewed. A weight note dated 11/26/2018 written by the RD (registered dietitian) contained the following: "...significant weight loss noted 10/3/2018...team reviewed weight change of 13 [pounds]. MD aware at this time. Weight stable and slightly increased X 7 weeks. MD advises that with advanced age, 97 yo, and severe dementia, weight loss may be unavoidable. Appetite stimulant medication determined to be not best choice per MD. Continue to monitor weight. Honor all food/beverage preferences. Assist to dine as needed." A quarterly nutrition assessment dated 02/16/2019 (date reflects a late entry assessment completed by the RD on 11/21/2018), contained the following information: Ideal weight range 113-138, current weight 115, average meal intake per day 50%. The summary note contained the following: "Late entry for 11/21/2018. Significant weight loss. PO intake appears to continue to not meet 100% estimated needs for weight maintenance. MD aware, and suggests that weight loss may be unavoidable. Appetite stimulant declined by MD. Suggests not the best choice for this 97 year old patient at this time. Food preferences honored. Snacks provided TID. Follow with weights, team review and PRN [as needed]."	F 692		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH VALLEY HEALTH AND REHAB	3737 CATALPA AVE, PO BOX 711 BUENA VISTA, VA 24416

(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 692	Continued From page 23 A quarterly nutrition assessment dated 02/16/2019 and completed by the dietary manager was reviewed. Resident #53's ideal body weight range was documented as 113-138 pounds. Her average meal intake percentage per day was listed as 33%. The summary note for the assessment contained the following: "Labs drawn 1/3/19. Diet is mech. soft regular. weekly weights per order. Current weight is 102 [pounds]. August weight was 129 [pounds]. Significant loss noted in past 180 days (21% loss). Weight loss attributed to resident's advanced dementia, and loss of appetite, and may be unavoidable. RD weight note 11/26/18. 1/24/19 MD note: Appetite waxes and wanes...Snacks TID between meals per order. Diuretic per order...no chewing or swallowing difficulties noted in nurses notes...Resident's daughter fills out selective menus for her mother weekly. Resident feeds herself after tray set up. PO intake at meals averages 33% with occasional refusal per ADL documentation. Appetite stimulant medication determined to not be the best choice per MD (RD note 11/26/18). The RD (registered dietitian) and the administrator were interviewed on 03/13/2019 at approximately 1:30 p.m. regarding meal time observations. The administrator was asked why some residents ate in the day area and other residents that needed assistance to eat were in the dining room. She stated, "The residents in the dining room are higher functioning...they may just need cueing or some assistance... the residents in the day room area need more assistance and feeding." The RD and the administrator were asked how weight losses such as Resident #53's were addressed in the facility.	F 692		

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F 692	Continued From page 24 The administrator stated, "We hold weekly weight meeting, [Name of Resident #53] is discussed each week." The RD stated, "Her daughter does not want supplements, she believes because they look milky they are milk based, in spite of trying to educate her that they are lactose free...I have discussed her with [name of doctor] and he said that the weight loss may be unavoidable due to her advanced dementia." The RD and the administrator were asked who had spoken with the RP regarding the supplements. The RD stated that she wasn't sure. Concerns were voiced to the RD and the administrator regarding lack of staff involvement with Resident #53 during meal time observations and the CNA staff not knowing which foods on Resident #53's tray were fortified. The RD was asked if finger foods had been attempted with Resident #53. She stated, "No, but we could try that." The RD was asked what percentage of snacks was Resident #53 consuming. The RD stated, "I don't know but I will bring you the log." The snack log was presented at approximately 2:50 p.m. The RD stated, "They just check off on the MAR [medication administration record] that they give her the snacks three times a day...it looks like she gets them at 9 [a.m.], 1 [p.m.] and again at 7 [p.m.]...the check just shows that they gave it to her, they don't track how much she eats...but we usually don't track snack percentages like we do for supplements." At approximately 3:15 p.m., the RD was seen in the hallway. She stated, "I am inservicing the staff right now about fortified foods...we are going to start a new process..we are going to put "FF" for fortified food on the lids of the items that are fortified so the staff will know."	F 692		

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F 692	Continued From page 25 At 3:35 p.m. the nurse practitioner came to the conference room to discuss Resident #53's weight loss. The above observations were discussed. She stated, "She does have advanced dementia, but I agree we need to educate the staff on what to feed her...we may need to get her daughter [RP] up here to discuss the supplements." The NP was asked if she or the physician had spoken with the RP in the past about the use of supplements for Resident #53. She stated, "I have not...I can't speak for [name of physician]...we can give her what we can and we can certainly try finger foods that she can take on the go." The above information was discussed with the DON [director of nursing], the administrator, and the corporate nurse consultant on 03/13/2019 at approximately 4:45 p.m. On 03/14/2019 at approximately 7:50 a.m., Resident #53 was observed in the day room. She was holding a coffee cup with a lid and a straw. She was sitting still and drinking the liquid. When she was done she shook the cup and self propelled to the square table to set the cup down. She then self propelled around the day room to a vending machine. She stopped and looked at the food vending machine briefly then self propelled to the drink machine. She stopped in front of the machine for several seconds and then turned to leave the area. Breakfast trays were delivered and Resident #53 was brought back to the square table by facility staff. She was handed a glass of orange juice from her tray. She drank the entire glass, and pushed herself away from the table. CNA #1 was in the area and asked Resident #53 if she wanted more juice. She left and got a	F 692		

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F 692	Continued From page 26	F 692		

second orange juice glass for Resident #53. She drank all of the second glass. CNA #1 asked Resident #53 if she would like more. Resident #53 stated, "No, that's enough." She then self propelled out of the day area. She did not eat any breakfast.

The DON came to the conference room at approximately 9:30 a.m. She stated, "I wanted to show you this...we have been adjusting [name of Resident #53] synthroid for some time now...she's up to 200 mcg [micrograms] now...I also called yesterday and we ordered some Boost Breeze which is more of a fruit juice base supplement. Her daughter agreed to that, it should be here today...also I found the original note about the supplements...they were ordered in September...it was 2 cal supplement and the daughter didn't want it se we discontinued it." The note referenced was reviewed and contained the following:

"09/05/2018 05:26 [a.m.] Per resident's daughter, resident is lactose intolerant. Please d/c order for 2 calorie supplement."

"09/05/2018 13:45 [1:45 p.m.] Pt seen by FNP this afternoon. New orders to d/c 2 cal supplement due to daughter requesting/stating patient is lactose intolerant. Will continue to monitor."

At approximately 10:45 a.m., Resident #53's physician arrived at the facility to speak with this surveyor. He was asked about Resident #53's weight loss. He stated, "I don't think this is any one thing...she has dementia, she has hypothyroidism, she has cancer on her face and her ear...I don't think you can say that any one

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F 692	Continued From page 27 thing is causing it [weight loss]...she wants to move, I don't want to force feed her...but we can certainly educate and work with the staff to provide additional assistance with her eating...I really hadn't thought about finger foods but we can try that." The RD was interviewed at approximately 11:25 a.m. She was asked why the boost breeze had not been implemented/suggested when the RP refused the 2 cal supplements for Resident #53. She stated, "My memory is that I did speak to the daughter and she said, 'No Supplements'." I may not have heard that it was not milk based or creamy like the 2 cal, but my memory is that I did talk to her...but I can't find any documentation about it." The RD was asked if she or the DM had watched Resident #53 during meal time. She stated, "Not lately." An end of survey meeting was held with the DON, the administrator, the MDS coordinator and the corporate nurse consultant. The above information was discussed. No further information was obtained prior to the exit conference on 03/14/2019.	F 692		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761	**1. The identified vial of PPD solution on Unit 2 was discarded by the licensed nurse. The refrigerator temperature on Unit 2 was checked by the Unit Manager/Director of Nursing and adjusted to ensure the temperature was in the acceptable range of 36-46 degrees. The pharmacy was notified and the affected medications that were stored in the refrigerator were discarded per the pharmacy direction. Digital thermometers were ordered and the temperature ranges were added to the Medication refrigerator temp logs.**	

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F 761	Continued From page 28 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(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. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review the facility staff failed to ensure medications and biologicals were properly stored and labeled on one of 2 units: Unit 2. One of 2 opened vials of PPD (tuberculin skin test) solution was expired and available for administration. The refrigerator temperatures for February 2019 and March 2019 were out of range with no adjustment made. Findings include: On 3/13/19 at 8:00 a.m. an inspection of the medication room and refrigerator was conducted with LPN (licensed practical nurse) # 1. One of 2 open PPD vials was opened and identified as expired. The vial had an open date of 2/6/19. LPN # 1 was asked when it should be discarded. She stated "I think 30 days after opening; let me check." LPN # 1 looked at a laminated sheet on	F 761	**2. Residents in the facility have the potential to be affected by this deficient practice. The refrigerators in the facility were checked and/ or adjusted to ensure that the temperature ranges are 36-46 degrees as required. The medication refrigerators in the facility were checked for expired medications. The refrigerator temperature logs were also updated to include the required temperatures as well as the temperature adjustment ranges.** **3. Nursing will be re-educated by the Director of Nursing/ designee on the temperature log which now includes the temperature parameters of 36-46 degrees and shaded areas to identify when the refrigerator temps need to be adjusted. Audits of facility refrigerator temperatures will be completed by the Director of Nursing/Designee 5x weekly with expired medication audit weekly for 3 months to ensure refrigerators medications and temperatures continue to be monitored.** **4. Results of audits will be taken to Quality Assurance Performance Improvement Committee for review and recommendations for three months.** **5. Corrective action will be completed by April 3, 2019.**	

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F 761	Continued From page 29 a cork board and stated "Yes, after 30 days." She then removed the vial of PPD from the refrigerator. A copy of the sheet referencing the storage instructions for the PPD was requested. The sheet, titled "Special Storage Instructions" from the facility pharmacy documented "Please DATE (sic) the following medications when opened: 4. PPD (tuberculin)...Date box when opened, Expires 30 days from date opened." The refrigerator temperature log was reviewed and no temperature ranges were identified on sheet. Several dates in February 2019 recorded temps below 36 degrees. LPN # 1 was asked for clarification of ranges. She stated she was not sure but would find out. (It should be noted that at the top of the "Special Storage Instructions" Directed "Medication refrigerator temperature should be between 36 and 46 degrees F.) The temperatures recorded for February 2019 documented three days the temperature was 36 degrees; for March 2019 one day was recorded at 36 degrees. LPN # 1 then left the medication room to get clarification for the temperature ranges. A few moments later, the unit manager, identified as RN (registered nurse) # 1 returned to the medication room with LPN # 1 and stated "We are calling the pharmacy to see what we should do about the medications that are in the refrigerator. I will let you know what they tell us." RN # 1 further stated they were immediately implementing a new temperature log that had the temperature ranges clearly identified. On 3/13/19 at 9:45 a.m. the DON (director of nursing) stated "The pharmacy stated that since the medications weren't visibly frozen they should be OK." The DON was then asked if that was per the manufacturer's guidelines since it is clearly	F 761		

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F 761	Continued From page 30 documented the temperatures should be 36-46 degrees, why ensure the range was maintained? The DON stated that on further questioning the pharmacy was researching further. The DON was also asked for a copy of the package insert information for the medications stored in the refrigerator. During a meeting on 3/13/19 at 4:40 p.m. with the DON, Administrator, and corporate nurse consultant were informed of the above findings. The DON was asked again at that time for the package insert information of medications in the refrigerator. The requested information was not received. No further information was provided prior to the exit conference.	F 761		

State of Virginia

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F 000	Initial Comments An unannounced biennial State Licensure Inspection survey was conducted on 3/12/19 through 3/14/19. The facility was not in compliance with the Virginia Rules & Regulations for the Licensure of Nursing Facilities. One complaint was investigated during the survey. The census in this ninety-three certified bed facility was 74 at the time of the survey. The survey sample consisted of eighteen current residents and three closed record reviews.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities. 12 VAC 5-371-370 (A) Cross reference to F584 12 VAC 5-371-250 (A), (G) Cross reference to F656 12 VAC 5-371-250 (A), (I) Cross reference to F657 12 VAC 5-371-220 (A), (C) Cross reference to F690 12 VAC 5-371-220 (A), (C) (5) Cross reference to F692 12 VAC 5-371-300 (A), (B) Cross reference to F761	F 001	**Cross Reference to POC F584** **Cross Reference to POC F656** **Cross Reference to POC F657** **Cross Reference to POC F690** **Cross Reference to POC F692** **Cross Reference to POC 761**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: R. Janette Coleman | TITLE: Administrator | (X6) DATE: 3/27/19

State of Virginia

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