State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ VA0086 B. WING 05/03/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 100 FRANCIS MARION LANE, PO BOX 880 FRANCIS MARION MANOR HEALTH & REHABILITATE MARION, VA 24354 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 000 Initial Comments F 000 An unannounced Medicare/Medicaid standard survey and biennial State Licensure Inspection was conducted 04/30/19 through 05/03/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 110 certified bed facility was 89 at the time of the survey. The survey sample consisted of 18 current Resident reviews and 3 closed record reviews. F 001 Non Compliance F 001 The facility was out of compliance with the Policies and Procedures following state licensure requirements: This RULE: is not met as evidenced by: F622, F623, F625 cross reference The facility was not in compliance with the to 12 VAC 5-371-140 (D) following Virginia Rules and Regulations for Licensure of Nursing Facilities. Resident Rights Policies and Procedures F550, F583 cross reference to 12 12 VAC 5-371-140 (D)- cross reference to F622, VAC 5-371-150 F623, and F625, Infection Control Resident Rights 12 VAC 5-371-150- cross reference to F550, and F880 cross referenced to 12 VAC F583 5-371-180 Infection Control 12 VAC 5-371-180- cross reference to F880 Director of Nursing F658 cross referenced to 12 VAC Director of Nursing 5-371-200 (B.1) 12 VAC 5-371-200 (B.1)- cross reference to F658

LABORATOR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Idministrator

RECEIVED MAY 28 2019 VDH/OLO

State of Virginia

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ B. WING VA0086 05/03/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 100 FRANCIS MARION LANE, PO BOX 880 FRANCIS MARION MANOR HEALTH & REHABILITATION MARION, VA 24354 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY F 001 Continued From page 1 F 001 **Nursing Services Nursing Services** F580, F677, F695, F698, F757, 12 VAC 5-371-220 (A, B, D, G, H)- cross F758, F760 cross referenced to reference to F580, F677, F695, F698, F757, F758, and F760 12 VAC 5-371-220 (A, B, D, G, H) Resident Assessment and Care Planning 12 VAC 5-371-250 (C)- cross reference to F657 Resident Assessment and Care **Pharmaceutical Services** Planning 12 VAC 5-371-300- cross reference to F755 F657 cross referenced to 12 VAC 5-371-250 (C) Dietary and Food Service 12 VAC 5-371-340- cross reference to F812 Pharmaceutical Services Clinical Records F755 cross referenced to VAC 5-12 VAC 5-371-360 (E)- cross reference to F842 371-300 Maintenance and Housekeeping 12 VAC 5-371-370- cross reference to F584 Dietary and Food Services F812 cross referenced to 12 VAC 5-371-340 Clinical Record F842 cross referenced to 12 VAC 5-371-360 (E) Maintenance and Housekeeping F584 cross referenced to 12 VAC 5-371-370

STATE FORM

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LOHOLO If configuration sheet 2 of 2

PRINTED: 05/16/2019 FORM APPROVED

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY	
	,	DENTI TONTON MONDER.	A. BUILD	ING _	Andrew Andrew	COMPLETED	
		495384	B. WING			05	C 5/03/2019
NAME OF P	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
FRANCIS	MARION MANOR HEALT			100 FRANCIS MARION LANE, PO BOX MARION, VA 24354			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E NTE	(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
F 000	survey was conducted The facility was in sub CFR Part 483.73, Red	ergency Preparedness d 4/30/19 through 5/3/19. estantial compliance with 42 quirement for Long-Term omplaint was investigated	F	000			
	An unannounced Medicare/Medicaid standard survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey.			TABLE TO THE PERSON OF THE PER	Francis Marion Manor Healt Rehabilitation is licensed for beds, not 110.		
F 550 SS=D	89 at the time of the si consisted of 18 curren closed record reviews. Resident Rights/Exerc CFR(s): 483.10(a)(1)(2)	ise of Rights 2)(b)(1)(2)	F s	550	F550 Ensuring Resident Rights are		,
	The resident has a right self-determination, and access to persons and	10(a) Resident Rights. esident has a right to a dignified existence, etermination, and communication with and s to persons and services inside and e the facility, including those specified in ection.			upheld is a priority for the tear at FMM  1. Resident #53 experienced r ill effects from the C.N.A. not	10	
	§483.10(a)(1) A facility must treat each resident with respect and dignity 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.				knocking on the door prior to entry. However, the C.N.A. responsible was re-educated to aware to knock on the door an request to enter the room prior entering any resident room.	d	
BORATORY D	IRECTOR'S OR PROVIDER/SU	PPLIER REPRESENTATIVE'S SIGNATURI		~	TITLE	·	X6) DATE

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.

RECEIVE Dontinuation sheet Page 1 of 116

MAY 28 2019

VDH/OLC Facility ID: VA0086

5/04/19

PRINTED: 05/16/2019 FORM APPROVED

STATEMENT OF DEPICENCIES AND PLAN OF CORRECTION  A BUILDING  RAD PLAN OF CORRECTION  A BUILDING  B WING  STREET ADDRESS, CITY, STATE, JP CODE  105/03/2019  STREET ADDRESS, CITY, STATE, JP CODE  105/03/2019  SUMMARY STATEMENT OF DEPICENCIES B WARRION, A 24358  ARRION, CA 24350  CROSS-PATEMENT OF DEPICENCIES STALL BENEFIT ADDRESS, CITY, STATE, JP CODE  105/03/2019  SUMMARY STATEMENT OF DEPICENCIES B WARRION, A 24358  ARRION, A 24358  ARRION, A 24358  ARRION, CA 24358  ARRION, CA 24358  CROSS-PATEMENT OF DEPICENCIES B WARRION, CA 24358  ARRION, CA 24358	OCIVICIO I OIX MICDIOAIXE & MICDIOAID SERVICES					OMB NO. 0938-0391			
### ### ### ### ### ### ### ### ### ##			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION				
STREET ADDRESS, CITY, STATE, ZIP CODE   109 FRANCIS MARION MANOR HEALTH & REHABILITATION   STREET ADDRESS, CITY, STATE, ZIP CODE   109 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24564			495384	B. WNG			1		
PRANCIS MARION MANOR HEALTH & REHABILITATION    109   FRANCIS MARION LAW, 2 2438   PROVIDERS PLAN OF CORRECTION SHOULD BE GROUNDERS PLA	NAME OF P	ROVIDER OR SUPPLIER					05	/03/2019	
CAG) ID   SUMMARY STATEMENT OF DEFICIENCIES   PROVIDER'S PLAN OF CORRECTION   PREFIX   PROVIDER'S PLAN OF CORRECTION   PREFIX   PROVIDER'S PLAN OF CORRECTION   PROVIDER'S PARK OF CORRECTION   PROVIDER'S PARK OF CORRECTION   PROVIDER'S PARK OF CORRECTIO		, to the city of the city			1				
F 550  Continued From page 1 \$483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of Pights.  The resident has the right to exercise his or her rights as a resident of the United States.  \$483.10(b)(1) The facility must ensure that the resident ensured that the resident can exercise his or her rights end to be supported by the facility in the exercise of his orher rights and to be supported by the facility in the exercise of his orher rights and to be supported by the facility in the exercise of his or her rights are equired under this subpart.  This REQUIREMENT is not met as evidenced by:  Based on observation, staff interview, facility document review and clinical record review, the facility and respect (Resident #53).  The findings included:  F 550  Continued From page 1  \$483.10(a)(2) The facility must provide equal access to quality care regardless of leginosis, severity of conditions of the same practice.  F 550  2. All residents have the potential to be affected by the same practice.  S. 5/2/19 the Skilled Nurse provided re-education to all team members regarding knocking on the doors and waiting for permission to enter, prior to entering a resident room. The Skilled Nurse will continue to provide education 1:1 with team members who may have missed the 5/2/19 education.  4. Weekly audits to ensure team members are knocking on the door and getting permission to enter the resident room, prior to entering a room. The Social Worker will conduct the audit 5 rooms x 12 weeks and 10 x monthly for 6 months. Data will be reported to the QAPI team for further evaluation.  The findings included:	FRANCIS	MARION MANOR HEALT	TH & REHABILITATION		1				
\$483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.  \$483.10(b) Exercise of Rights.  The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.  \$483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.  \$483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.  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 treat 1 of 18 residents with dignity and respect (Resident #53).  The findings included:  potential to be affected by the same practice.  3. 5/2/19 the Skilled Nurse provided re-education to all team members regarding knocking on the doors and waiting for permission to enter, prior to entering a resident room. The Skilled Nurse will continue to provide education 1:1 with team members who may have missed the 5/2/19 education.  4. Weekly audits to ensure team members are knocking on the door and getting permission to enter the resident room, prior to entering a room. The Social Worker will conduct the audit 5 rooms x 12 weeks and 10 x monthly for 6 months. Data will be reported to the QAPI team for further evaluation.  5. Corrective action will be complete by 06/07/19.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD E GROSS-REFERENCED TO THE APPROPRI	E ATE	COMPLETION	
announce themselves before entering Resident #53's room.  6. DON and Social Worker  The clinical record of Resident #53 was reviewed	F 550	§483.10(a)(2) The factor access to quality care severity of condition, and the severity of condition of services are residents regardless of \$483.10(b) Exercise of the severity o	regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source.  If Rights.  Ight to exercise his or her the facility and as a citizen ed States.  Illity must ensure that the his or her rights without, discrimination, or reprisal  Ident has the right to be percion, discrimination, and y in exercising his or her orted by the facility in the rights as required under this  Is not met as evidenced  In, staff interview, facility clinical record review, the east 1 of 18 residents with essident #53).  In the resident of the door or before entering Resident	F.	550	potential to be affected by the same practice.  3. 5/2/19 the Skilled Nurse provided re-education to all to members regarding knocking the doors and waiting for permission to enter, prior to entering a resident room. The Skilled Nurse will continue to provide education 1:1 with temembers who may have miss the 5/2/19 education.  4. Weekly audits to ensure teamembers are knocking on the door and getting permission to enter the resident room, prior entering a room. The Social Worker will conduct the audit rooms x 12 weeks and 10 x monthly for 6 months. Data w be reported to the QAPI team further evaluation.  5. Corrective action will be complete by 06/07/19.	eam on  am ed  to 5		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 8XB411

Facility ID: VA0086

If continuation sheet Page 2 of 116



	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING_		1	PLETED	
		40,004					С	
NAME OF F	ROVIDER OR SUPPLIER	495384	B. WING			0	5/03/2019	
INCINC OF F	ROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE			
FRANCIS	MARION MANOR HEAL	TH & REHABILITATION			00 FRANCIS MARION LANE, PO BOX 880			
(VA) ID	SHIMMADVET	ATTIENT OF OFFICIALISM			IARION, VA 24354			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	ON SHOULD BE IE APPROPRIATE		
F 550	550 Continued From page 2		F	550				
	the facility 5/22/18 with diagnoses, that included but not limited to sepsis, pneumonia, chronic		'	550				
	back pain, dementia,	high cholesterol, GÈRD		İ				
	(gastroesophageal reflux disease), anxiety, hypertension, depression, fatigue, and tiredness.				•			
	Resident #53's quarte	erly minimum data set						
	(MDS) assessment w	ith an assessment						
		of 4/5/19 assessed the						
	resident with a BIMS (brief interview for mental status) as 3/15. Resident #53 was not assessed with any signs or symptoms of delirium, psychosis, or behaviors that affected others.							
	poyonocio, or bongvio	is that alleoted outers.	Ī					
	Current comprehensiv	ve care plan was undated						
	but identified a focus	area that the resident had						
	impaired cognitive fun	tions: Communication:						
	Identify yourself at each							
	The surveyor observe	d incontinence care with						
	certified nursing assist	tant #1 on 5/2/19 at 7:01						
	a.m. C.N.A. #1 entere							
		ne door. When the surveyor						
		C.N.A. #1 turned around eyor she forgot to knock	İ					
	and then apologized.							
	-		-					
		the administrator and the						
		he above concern on 5/2/19 ed they would expect staff						
	to knock on the door b						] [	
		copy of Resident Rights.						
	The facility's "Resident	t Rights & Responsibilities"						
	found in the admission	packet was reviewed						
į		its included "1. Considerate						
[		ent including being fully						
	informed in advance a	bout care and treatment	.					

PRINTED: 05/16/2019 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 00120			· · · · · ·	C	
		495384	B. WING		•		03/2019	
	ROVIDER OR SUPPLIER  MARION MANOR HEALT	TH & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 100 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E .	(X5) COMPLETION DATE	
	and of any changes in may affect your well-k and dignity and 19. Property of further information exit conference on 5/3 Notify of Changes (Inj	n that care or treatment that being. 15. Personal freedom rivacy."  was provided prior to the 3/19. ury/Decline/Room, etc.)		550 580	F580	A CONTRACTOR OF THE CONTRACTOR		
	consult with the resided consistent with his or larepresentative(s) when (A) An accident involvation results in injury and has physician intervention; (B) A significant changemental, or psychosocial deterioration in health, status in either life-threadinical complications); (C) A need to alter treat a need to discontinue treatment due to adversommence a new form (D) A decision to transmesident from the facility \$483.15(c)(1)(ii).  (iii) When making notification (14)(i) of this section, the all pertinent information is available and provident physician.  (iii) The facility must all resident and the resident when there is-	ation of Changes. ediately inform the resident; ent's physician; and notify, her authority, the resident in there is- ing the resident which as the potential for requiring is justified in the resident's physical, all status (that is, a mental, or psychosocial eatening conditions or atment significantly (that is, an existing form of rise consequences, or to in of treatment); or fer or discharge the thy as specified in cation under paragraph (g) the facility must ensure that in specified in §483.15(c)(2) the discontinuation of the specified in galaxy is the control of the specified in galaxy is the control of the specified in galaxy is the control of the specified in galaxy is the control of the specified in galaxy is the control of the specified in galaxy is the control of the specified in galaxy is the control of the specified in galaxy is the control of the specified in galaxy is the control of the specified in galaxy is the control of the specified in galaxy is the control of the specified in galaxy is the control of the specified in galaxy is the control of the specified in galaxy is the control of the specified in galaxy is the control of the specified in galaxy is the control of the specified in galaxy is the control of the specified in galaxy is the control of the specified in galaxy is the control of the specified in galaxy is the specified in galaxy is the control of the specified in galaxy is the specified in galaxy is the control of the specified in galaxy is the specifie			Ensuring Residents, Resident Representatives and Physicial are notified of changes is a priority for the team at FMM  1. Resident #45 was assessed suicidal ideations on 5/1/19 at physician was consulted for orders for the resident to see LCSW on 5/2/19. She was evaluated and found to be saft and without suicidal ideations  2. All residents expressing suicidal ideations have the potential to be affected by the same practice.  3. All nursing team members will be re-educated regarding need to not only notify the Resident, Resident Representative and Physician change, but also the need to document those notification or changes in the resident record	ns I for nd e s.		

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: 8X8411

Facility ID: VA0086



STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	0400 440 1				O. 0938-0391
	F CORRECTION	IDENTIFICATION NUMBER:	F		CONSTRUCTION		E SURVEY
			A. BUILD	ING		СОМ	PLETED
							С
		495384	B. WING			05	/03/2019
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
FRANCIS	MARION MANOR HEALT	H & REHARII ITATION		1	00 FRANCIS MARION LANE, PO BOX 880		
				N	fARION, VA 24354		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	·	PROVIDER'S PLAN OF CORRECTION		248
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION
IAG	NECODATOR! OR L	SCIDENTIFTING INFORMATION)	TAG	i	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
				·····			
F 580	Continued From page		_		4. An audit of the 24 hour re	nort	
, 000	B .		F	580	will be conducted by the	port	
	as specified in §483.1				Assistant Nurse Managers		
	(b) A change in reside	ent rights under Federal or			(AND A) 1		
	(e)(10) of this section.	ns as specified in paragraph	-		(ANM) or designee to ensure	all .	
		ecord and periodically			changes in condition have be	en	
		nailing and email) and			reported to the Resident,	••	
	phone number of the			ĺ	Resident Representative and		
	representative(s).				Physician as needed. These		
	, , , ,				audits will be done 10 audits		
	§483.10(g)(15)				week with the dolle to audits	per	
	Admission to a compo	site distinct part. A facility			week x 12 weeks and 10 x		
	that is a composite dis	tinct part (as defined in		l	monthly for 6 months. If		
		in its admission agreement			notification is not documente	d, it	
		on, including the various			will be investigated. Notifica	tion	
		e the composite distinct the policies that apply to			will be made and documented	1	
	room changes betwee	n its different locations			and responsible staff member		
	under §483.15(c)(9).	to amorate todations			will be re-educated. The AN		
		is not met as evidenced		ı	on Designation (1)	VI	
	by:				or Designee will monitor the		
	Based on staff interview	ew and clinical record			above audits for trends and ne	ed	
İ	review the facility staff		Í		for additional education and o	r	
		in condition for 1 of 18			disciplinary action. Data will	he	
	residents in the survey	sample (Resident #45).		ı	reported to the QAPI team for	.	
	The findings included:				further evaluation and		
	The findings included:				interventions if needed.		
1	The facility failed to no	tify the physician of			mitor ventions if needed.		İ
	Resident #45's suicida				5 Camari		<b>.</b>
-		he facility staff on 2/26/19.			5. Corrective action will be		
	, ,	,			complete by 06/07/19.		
	Resident #45 was adm	itted to the facility on					
	7/23/28 with the follow	ing diagnoses of, but not	***************************************		6. Assistant Nurse Managers		
		blood pressure, diabetes,			The second secon		
		disorder. On the quarterly					ł
		set) with an ARD of 3/27/19				ĺ	
	coded the resident as I		-				ļ
		atus) score of 12 out of a					
	possible score of 15. If	resident #45 was also	1	1		ļ	- 1

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	/Y2\ MIII	TIDLE	CONCEDUCTION		O. 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:	E .		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495384	B. WING			١ ,.	C=(02)2040
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 05	5/03/2019
FRANCIS	MARION MANOR HEALT	U & DEUADH ITATION		1	00 FRANCIS MARION LANE, PO BOX 880		
					IARION, VA 24354		
(X4) ID		ATEMENT OF DEFICIENCIES	ID.	<u>.                                    </u>	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF	- 1	(EACH CORRECTIVE ACTION SHOULD B	OULD BE co	
			iAG	'	CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	DATE	
F 580	Continued From page	5	F	580			
	coded as requiring ex	tensive assistance of 1 staff	•				
	member for dressing	and personal hygiene and					
	was totally dependent	on 1 staff member for					
	bathing.						
	The surveyor reviews	d the clinical record of					
	Resident #45 on 5/1/1	9. In the "Care Focus"					
		for 2/27/19, the surveyor					
	noted under the area	of "Review area(s) of					
	Concern", it read in pa	art:					
	" "02/26 nurse ca	alled to res (resident) room					
	by CNA (certified nurs	ing assistance), CNA stated					
	graphing) her own the	ne wanted to kill herself (by pat) when she had asked					
	her to pull herself up in	hed but when nurse					
	walked in res was sitti	ng on the toilet and noted to					
	be crying"						
	The Care Focus sign is	n sheet had the following					
ŀ	signatures that were in	i attendance: assistant					
	director of nursing, die	titian, wound care nurse					
	#1, director of nursing,	activities coordinator and					
	MDS (minimum data s	et) nurse #1.					
	Under the section "Inte	erdisciplinary					
	Recommendation of the						
	documentation, the foll	owing entions were suggested:					
	" fred (frequent)	risual checks made"					
	may (noquent	indui dildoka isiada				·	
	The surveyor also note						
	documentation dated for	or 2/26/19 at 2130 (9 pm)					
	which reads, "Called	to res room by CNA, CNA					
	stated that res had told						
	nerseir (by grabbing he	r own throat) when she erself up in bed but when					
	nau askeu ner 10 pull N this nurse walked in re-	ersell up in bed but when s was sitting on tollet and					
-	noted to be crying upor	1 questioning on tollet and				-	
		why she was crying but					
		home encouraged res to			·		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495384	B. WING				С
NAME OF P	ROVIDER OR SUPPLIER		L	s	TREET ADDRESS, CITY, STATE, ZIP CODE	08	5/03/2019
FRANCIS	MARION MANOR HEALT	TH & REHABILITATION		100 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354			
(X4) ID PREFIX TAG			1	ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		E TE	(X5) COMPLETION DATE
	go home soonNo s for the few minutes I van Resident #45's care p area or interventions to On 3/6/19, the survey for "Buspar 10 mg (mi (twice a day)". On 3/5 note read in part " E crying/anxious  There was no docume that the physician had documented findings.  The surveyor notified to the above documented pm. The surveyor ask physician of Resident: The administrator state back to talk to the resididn't know why she diphysician was not notified to the surveyor was given that the social worker I at 2056 (8:56 pm). It may see that the social worker I at 2056 (8:56 pm). It may see that the social worker I at 2056 (8:56 pm). It may see that the social worker I at 2056 (8:56 pm). It may see that the social worker I at 2056 (8:56 pm). It may see that the social worker I at 2056 (8:56 pm). It may see that the social worker I at 2056 (8:56 pm). It may see that the social worker I at 2056 (8:56 pm). It may see that the social worker I at 2056 (8:56 pm). It may see that the social worker I at 2056 (8:56 pm). It may see that the social worker I at 2056 (8:56 pm). It may see that the social worker I at 2056 (8:56 pm). It may see that	by and she would be able to uicidal actions were noted was in the room(sic)"  lan did not reflect a focus to be utilized by the staff.  or noted a physician order (ligram) po (by mouth) BID (b) 19, the physician progress pisodes of screaming out (entation in the clinical record (been notified of the above (the administrative team of d findings on 5/1/19 at 4:45 (ed if the staff notified the (#45's suicidal thoughts. (ed, "When the staff went dent, the resident said she id that. This is why the fied."  on a copy of a progress note had documented for 5/1/19 (ead as follows: 1) on first floor and	F	580			
		like harming herself at	-				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495384  DESCRIPTION  A. BUILDING  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  100 FRANCIS MARION LANE, PO BOX 880  MARION, VA 24354  (X4) ID PREFIX TAG  COMPLETED  STREET ADDRESS, CITY, STATE, ZIP CODE  100 FRANCIS MARION LANE, PO BOX 880  MARION, VA 24354  (X4) ID PREFIX TAG  COMPLETED  C	ION
A BUILDING COMPLETED  COMPLETED	ION
A 495384  NAME OF PROVIDER OR SUPPLIER  FRANCIS MARION MANOR HEALTH & REHABILITATION  STREET ADDRESS, CITY, STATE, ZIP CODE 100 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354  (X4) ID PREFIX TAG  CAUCH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 580  Continued From page 7 having a room by herself. SW asked how she likes the first floor and she stated she liked it.	ION
NAME OF PROVIDER OR SUPPLIER  FRANCIS MARION MANOR HEALTH & REHABILITATION  STREET ADDRESS, CITY, STATE, ZIP CODE  100 FRANCIS MARION LANE, PO BOX 880  MARION, VA 24354   (X4) ID PREFIX TAG  PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  F 580  Continued From page 7  having a room by herself. SW asked how she liked it.	ION
FRANCIS MARION MANOR HEALTH & REHABILITATION  STREET ADDRESS, CITY, STATE, ZIP CODE  100 FRANCIS MARION LANE, PO BOX 880  MARION, VA 24354  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 580  Continued From page 7 having a room by herself. SW asked how she likes the first floor and she stated she liked it.	ion
FRANCIS MARION MANOR HEALTH & REHABILITATION  100 FRANCIS MARION LANE, PO BOX 880  MARION, VA 24354  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  FOR THE PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)  FOR THE PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)  FOR THE PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)	ION
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 580 Continued From page 7 having a room by herself. SW asked how she likes the first floor and she stated she liked it.	ion
(X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 580 Continued From page 7 having a room by herself. SW asked how she likes the first floor and she stated she liked it.	ion
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 580 Continued From page 7 having a room by herself. SW asked how she likes the first floor and she stated she liked it.	ION
F 580 Continued From page 7 having a room by herself. SW asked how she likes the first floor and she stated she liked it.	ION
F 580 Continued From page 7 having a room by herself. SW asked how she likes the first floor and she stated she liked it.	
F 580 Continued From page 7 F 580 having a room by herself. SW asked how she likes the first floor and she stated she liked it.	
having a room by herself. SW asked how she likes the first floor and she stated she liked it.	
having a room by herself. SW asked how she likes the first floor and she stated she liked it.	
likes the first floor and she stated she liked it.	
likes the first floor and she stated she liked it.	
The surveyor was also given a copy of a	
physician order dated for 5/2/19 at 1310 (1:10	
pm) which stated "Consult with (name of	
counseling services).	
estationing services).	1
No further information was provided to the	
two facilities information was provided to the	1
surveyor prior to the exit conference on 5/3/19.	
F 583 Personal Privacy/Confidentiality of Records F 583	
SS=D CFR(s): 483.10(h)(1)-(3)(i)(ii) F583	
	İ
§483.10(h) Privacy and Confidentiality.  Maintaining personal privacy of	- 1
The resident has a right to personal privacy and residents during dressing changes	ı
confidentiality of his or her personal and medical and providing a private place for	
records.  residents to meet is important to	
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
§483.10(h)(i) Personal privacy includes the team at FMM	- 1
accommodations, medical treatment, written and	
telephone communications, personal care, visits,  1. (a) Team members were re-	
and mostings of family and socidant server to	
this does not require the facility to provide a coucated to provide privacy	
private room for each resident.  during care of residents,	
including pulling the privacy	
§483.10(h)(2) The facility must respect the curtain, closing the door and	
residents right to personal privacy including the	
right to privacy in his or her oral (that is, spoken), shutting the blinds.	1
written, and electronic communications, including (b) Team members and	
the right to send and promptly receive unopened volunteers will be re-educated to	
mam t  mam al material = t = t = 0.0	
materials delivered to the facility for the recident	
including those delivered through a means other during resident council.	
than a postal service.	
2. All residents have the	
0.400 400 300 900	
and confidential personal and medical records.	- 1

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Event ID: 8XB411

Facility ID: VA0086

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 11 201201			"	C	
		495384	B. WING			O.F	5/03/2019	
	ROVIDER OR SUPPLIER  MARION MANOR HEAL	TH & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 100 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354		L	700,2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFIGIENCY)	E NTE	(X5) COMPLETION DATE	
	of personal and medi provided at §483.70(i federal or state laws. (ii) The facility must a Office of the State Lo to examine a resident administrative records law.  This REQUIREMENT by: Based on observation facility staff failed to p for 1 of 18 residents (i ensure a private locat to meet. Volunteers in council meeting for fiv.  The findings included:  1. The facility staff failed during a wound care of #73.  The clinical record of I 4/30/19 through 5/3/18 admitted to the facility 2/22/19 with diagnose limited to, wound and anemia, chronic kidne (cerebrovascular accid (congestive heart failu arthritis, hypertension, vein thrombosis), CAE and chronic peripheral Resident #73's signification.	ne right to refuse the release cal records except as (2) or other applicable (3) or other applicable (4) or other applicable (5) or other applicable (5) or other applicable (6) or other applicable (7) or other applicable (	F	583	3. Team members will be reeducated regarding protecting privacy of residents during car and while they are having priv meetings. Team members and volunteers will be re-educated provide privacy for residents during resident council. A "meeting in progress – do not enter" sign will be placed on the door during resident council meetings.  4. The RN Skilled Nurse will audit privacy practices (for closing blinds, privacy curtains and closing the door during car 3 x weekly x 12 weeks and monthly for six months. Activities Coordinator will monitor privacy during resident council meetings monthly for smonths. If variances are observed during the above audit responsible team members/volunteers will be reeducated at the time. Data will be reported to the QAPI team.	re e tate l to ne sere)		
	minimum data set (MD	ant change in assessment S) with an assessment of 4/19/19 assessed the		***************************************		974*-		

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	All and the second seco	COMPLETED		
		495384	B. WING				C	
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 05	5/03/2019	
FRANCIA	### PIGAL AT 411000 1100 41			i	00 FRANCIS MARION LANE, PO BOX 880			
FRANCIS	MARION MANOR HEALT	H & REHABILITATION			IARION, VA 24354			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ΙĎ	<u> </u>	PROVIDER'S PLAN OF CORRECTION			
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(X5) COMPLETION DATE	
F 583	Continued From page	9	_	583				
	•	(brief interview for mental		J03	5. Corrective action will be			
		ith no signs or symptoms of			complete by 06/07/19.		1	
		r behaviors affecting others.			_			
		_			6. RN Skilled Nurse and			
	The surveyor observed wound care 5/3/19 beginning at 9:52 a.m. with registered nurse #1				Activities Coordinator			
	and registered nurse t	. with registered nurse #1 #2. The surveyor asked						
	Resident #73 if care o	ould be observed and the						
	resident stated yes.	out po observed and the						
	Both registered nurses took part in wound care							
	however, registered no caregiver.	urse #1 was the primary						
		nd R.N. #2 both entered						
	curtain was not pulled	er knocking. The privacy the door was not closed,						
		ot closed. R.N. #1 and R.N.						
	#2 entered and exited	the resident's room on five						
-	different occasions wit	hout closing the door or						
	pulling the privacy curt re-entry.	ain with each exit and	•					
	The surveyor interview	red registered nurse #1 on					Tomassu Las	
	5/3/19 at 10:29 a.m. F	R.N. #1 was informed of the						
		and agreed that the door						
	had not been closed, to							
	pulled and the blinds n	ot closed.						
	The surveyor informed	the administrator and the					-	
	director of nursing of th	e above observation						
	during wound care on	5/3/19 at 3:52 p.m.						
		the admission packet and						
	the Resident Rights &							
	there. The Resident R and respectful treatmer	ights read "1. Considerate						
		oout care and treatment						
		that care or treatment that						

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLI	E CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN U	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING_			PLETED	
		495384	,,,,,,				С	
NAME OF P	ROVIDER OR SUPPLIER	49904	B. WNG			05	5/03/2019	
				ŀ	STREET ADDRESS, CITY, STATE, ZIP CODE			
FRANCIS	MARION MANOR HEALT	TH & REHABILITATION			00 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	<u> </u>	PROVIDER'S PLAN OF CORRECTION	CTION		
PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD BE	E	(X5) COMPLETION	
		, , , , , , , , , , , , , , , , , , ,	IAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DEFICIENCY)		
Fran								
F 583	o o manage i tom page		F:	583				
	may affect your well-being. 15. Personal freedom and dignity and 19. Privacy."							
	No further information	was provided prior to the						
	exit conference on 5/3	1/19.			,			
	2. The facility staff fail	led to ensure the resident						
	council had a private p	place to meet. The resident						
	council meeting was in	nterrupted when two meeting and stayed for						
	approximately five min	utes.						
ľ	The surveyor conducte	ed a resident council						
	meeting on 5/1/19 beg	inning at 1:30 p.m. with				į		
	seven (7) resident cour	ncil members. The council vity director stay in the						
	meeting.	vity director stay in the						
	During the meeting, tw	o volunteers entered the						
	resident council meetin	ng without knocking. One						
	volunteer asked, "Are y	you all still coloring?" The ne activity director's (AD)	•					
	desk, one of the volunt	eers chatted with the AD						
F	and the second volunte	er sat down in a chair for		ľ				
-	approximately five minu	utes before leaving.						
	The surveyor stopped t	the group meeting until						
	both volunteers left app	proximately 5 minutes later.						
-	The surveyor interviewe	ed the activity director on						
	5/1/19 after the meeting	3. The activities director		l				
	stated she had not put a the meeting.  The AD si	a sign on the doors prior to						
],	volunteer's works at the	state hospital and should						
	know better than to ente	er the meeting.						
-	The surveyor informed t	the administrator and the						
(	director of nursing of the	e resident council concern						
	during the end of the su	rvey meeting on 5/3/19 at						

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Facility ID: VA0086

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495384	B. WING			ļ	С
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	. 05/	03/2019
	MARION MANOR HEALT		100 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE	
F 583	3:52 p.m.	11 was provided prior to the e	F	583			
	exit conference on 5/3 Safe/Clean/Comfortat CFR(s): 483.10(i)(1)-( §483.10(i) Safe Enviro The resident has a rig comfortable and home but not limited to recei supports for daily living The facility must provie §483.10(i)(1) A safe, of homelike environment use his or her personal possible. (i) This includes ensuri receive care and servic physical layout of the fi independence and doc (ii) The facility shall exit the protection of the re or theft. §483.10(i)(2) Houseke services necessary to i and comfortable interior	ple/Homelike Environment  ple/Homelike Envir	F	584	F584 Ensuring a clean homelike environment is important to team at FMM  1. Environmental Services (EVS) team members conduct a deep cleaning on the day roand resident #53's room. Resident #53 received no ill effects from the practice.  2. All residents have the potential to be affected by the same practice. Environmental rounds will be made by the EManager, Supervisor and Administrator.	eted om	
		ified in §483.90 (e)(2)(iv); and comfortable lighting				**************************************	

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA (X2) MIJI		X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-0391		
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED			
			A. BUILD	ing "		COM	reten		
		495384	D MANO			1	C		
NAME OF D	ROVIDER OR SUPPLIER	499904	B. WNG			05/	03/2019		
HAMME OF P	KONIDER OK SOPPLIER			ŀ	TREET ADDRESS, CITY, STATE, ZIP CODE				
FRANCIS	MARION MANOR HEALT	TH & REHABILITATION		1	00 FRANCIS MARION LANE, PO BOX 880				
				N	MARION, VA 24354				
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(76)		
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION		
ind	, industrial of the	SO IDEATH THE IN GRANATION	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE		
					- Country				
F 584	Continued Faces	.40							
1 304	Continued From page	112	F	584	2 Toom				
					3. Team members were				
	§483.10(i)(6) Comfort	able and safe temperature			counseled on the importance	of			
	levels. Facilities initial	ly certified after October 1,			routine high dusting as		,		
	1990 must maintain a	temperature range of 71 to			scheduled. Team members a	1.			
	81°F; and				counseled on impact	uso	1		
	C400 40/0/mp m //				counseled on importance of				
		maintenance of comfortable			working with nursing to notif	fy			
·	sound levels.	: ta ==4 ==4 == =			them when a resident has bee	n			
		is not met as evidenced			moved in order to do deep				
	by:	n, staff interview, facility			cleaning for certain areas of t	<b>.</b>			
		ical record review, racility			rooms.	ne	-		
		aint investigation, the facility	-		1001115.				
	staff failed to ensure a	clean and comfortable							
		in 1 of 18 resident rooms			4. The EVS Manager,	[			
		1 of 2 day/activity rooms.		ĺ	Administrator or designee wil	1			
	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	t of 2 day/abavity tooliis.			five audits will be done weekl	.			
	The findings included:				for twelve weeks and then	V	,		
	•				monthly Continued and then				
İ	The facility staff failed	to ensure Resident #53's			monthly for six months to ens	ure			
	room was clean and fa	ailed to ensure the 1st floor			high dusting and dusting in the	e l			
	day room was clean.				corners of the rooms is				
Į.	·			-	completed. If dust is detected				
	The surveyor and the I	nousekeeping supervisor			the EVS supervisor will addre	· .			
		st floor on 5/2/19 at 10:12			deficience will addre	SS	İ		
		n 5/2/19 of the 1st floor day			deficiency with the EVS work	er			
	room, dust was observ	red on the wall across from		Ī	and the variance will be	1			
		dust was hanging near			corrected. Results of the audit				
		appeared to be a spider's			will be presented to the QAPI				
	web attached with a de			ĺ	team for further				
- 1		sor confirmed the presence							
		the housekeepers should			recommendations.				
	have removed the dust				The state of the s				
	a challenge. The surve	sor stated high dusting was					1		
		eyor observed hes above the chair railing,				l			
	dark black marks on th								
		d black shoe marks. The			٠.	1			
		sor stated that was part of							

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Event ID: 8XB411

Facility ID: VA0086



STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(20) 131	7101		OMB NO. 0938-0391		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY		
			A. BUILD	ING .		co	MPLETED	
			-				С	
		495384	B. WING			١.	_	
NAME OF F	PROVIDER OR SUPPLIER		·····		STREET ADDRESS, CITY, STATE, ZIP CODE	10	5/03/2019	
	<b>F. A. Th. C. D. C.</b> C. C. C. C. C. C. C. C. C. C. C. C. C.			1				
FKANCIS	MARION MANOR HEALT	TH & REHABILITATION			100 FRANCIS MARION LANE, PO BOX 880			
					MARION, VA 24354			
(X4) ID PREFIX	SUMMARY ST/	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID		PROVIDER'S PLAN OF CORRECTION	· · · · · · · · · · · · · · · · · · ·		
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD I	}F	(X5) COMPLETION	
		THE IN CHARLION	TAG		CROSS-REFERENCED TO THE APPROPRI	ATE	DATE	
					DEFICIENCY)			
E ED4								
F 584	Continued From page		F	584				
	maintenance's upkeep	to do painting. The	•					
	housekeeping superv	isor stated the black			5. Corrective action will be			
	markings were from the	ne higher chairs hitting the	-		complete by 06/07/19.			
	wall. A large picture of	n the wall behind the row of						
	Chairs was covered wi	ith dust on the top. The			6 PVC 14-			
	nicture was losed and	removed by the surveyor			6. EVS Manager, Administra	tor		
	and the housekeeping	g supervisor and taken to			or designee			
	the 1st floor unit mans	y supervisor and taken to						
	housekeeping comes i	ger's office for safety. The						
	monseveehing anheivi	sor stated the picture was						
	WODDIY and difficult to	clean. The housekeeping					i	
	supervisor stated, "In	at's one of our biggest		1				
	challenges in houseke	eping."						
	the surveyor and the	housekeeping supervisor						
1	checked Resident #53	's room for cleanliness. In		- 1				
	the corner of the reside	ent's room near the hospital						
ŀ	bed, a collection of dus	st was observed behind the		- 1				
1	chair and a folding cha	ir in the room. The						
ĺ	housekeeping supervis	sor confirmed and stated						
	housekeeping should I	nave gotten the dust. The			•			
	housekeeping supervis	sor stated when the		- 1			1	
. 1	residents are in the roo	m, the staff can't move the						
ĺ	chairs and therefore so	me of the corners don't	1.	- 1				
	get cleaned.	01 210 00111010 00111			÷			
1	•			l				
	The housekeeping sup	ervisor stated five (5) room						
1	inspections were comp	leted each week						
	Resident #53's most ro	cent room inspection was	1.					
	4/24/10 and ecored 16/	18-unsatisfactory in lights		1				
	and high dueting and w	ents. The housekeeping						
	supervisor stated the is	one was corrected the			•			
	navi day and stated (116 15	aud was currected the						
] ;	in the ream when the	resident may have been						
	room. The besselves the n	ousekeeper cleaned the						
	ioon. The nousekeepi	ng supervisor stated there						
1.	were seven (/) staff me	mbers in the building-one						
	n laundry, one supervis	sor, and five employees		ļ				
1	hat were on the floor.	The housekeeping		ĺ				
1	supervisor stated one e	mployee takes care of						
	projects and stated ther	e were four (4) wing		1				

i e	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495384	B. WING	<b></b>			C
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	0	5/03/2019
FRANCIS	MARION MANOR HEALT	H & REHABILITATION		1	00 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION S		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	HOULD BE COMP	
	housekeeping superviday a week, there wer housekeepers to clear rooms due to projects housekeeping supervistripping floors in the land 27 resident rooms room was scheduled fithe floors on 8/14/19 p. Assurance Performance The issue/concern was and waxed on a scheduled from the housekeeping. The Environmental Set List for 1st floor East W. 7:00 a.m. Sign in EVS 7:05 a.m. Assemble ca 7:15 a.m. High profile cobreak room 7:45 a.m. Clean/Eye W. 7:55 a.m. Supply Room 8:05 a.m. Soiled Utility 8:15 a.m. Break 9:30 a.m. EVS daily me 9:45 a.m. High Profile 0:15 a.m. Break 9:30 a.m. EVS daily me 9:45 a.m. High Profile 0:15 a	alternate weekends. The sor stated at least one (1) in the units and the resident and days off. The sor stated projects included obby, rehab unit, activities is thus far. Resident #53's or stripping and waxing of er the QAPI (Quality be Improvement) Plan. It is resident rooms stripped luled basis. If the job description for ally schedule of tasks done is supervisor on 5/2/19.  The provided by th	F	584			
	Daily Focus						

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SURDILED/CLIA	2/20 14/4			<u>OMB N</u>	<u>O. 0938-0391</u>
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DAT	E SURVEY
			A. BUILD	ING_		СОМ	IPLETED
							C .
114115.05.5		495384	B. WING			O.E	5/03/2019
NAMEOFF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FRANCIS	MARION MANOR HEALT	TH & REHABILITATION		1	00 FRANCIS MARION LANE, PO BOX 880		
					MARION, VA 24354		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	OI	L	PROVIDER'S PLAN OF CORRECTION	···	
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	X	(EACH CORRECTIVE ACTION SHOULD R	=	(X5) COMPLETION
TAG	NEGOLATORT OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA	TE.	DATE
					DEFICIENCY)		
F 584	Cambinous d Succession						
1 304	Continued From page		F t	584			
	Monday-High dust/tra	sh cans					
	Tuesday-Sinks, comm	odes, stainless steel					
	Wednesday-Corners,	edges, door, walls					
	Thursday-Window gla	ss, drinking fountains					
	Friday-Disinfect furnitu	JFB m munnafa àtalian fo					
	Sunday-Terminal clear 9:30-10:30 a.m.	nurse's station from					
	0.00-10.00 a.m.						
	High profile cleaning r	ead "1. Knock, enter room					
	& cheerfully greet nation	ents, using names. 2. (T)	ſ	ĺ			
	Empty waste can/trash	n. 3. (D) High dust. 4.					
	(DIS) Disinfect Horizon	ntal Surfaces. 5. (DIS)		ĺ			
	Disinfect Vertical Surfa	ices. 6. (RR) Disinfect					
	bathroom. 7. (V) Dust	mop. 8. Inspect your					
	work. 9. (D) Damp mo	p. 10. Thank you and say					
	"Goodbye".	•				-	
		-					
	The surveyor informed	the administrator and the					
j	director of nursing of th	e observation during the					<u> </u>
	tour with the housekee	ping supervisor on 5/2/19					
		eeting on 5/2/19 at 4:34					
	p.m.					1	
	The clinical record of P	lesident #53 was reviewed			·	]	l
		esident #53 was reviewed ent #53 was admitted to					
		diagnoses, that included					
	but not limited to sepsis	s pneumonia chronic					
	back pain, dementia, hi	igh cholesterol GERD					
	(gastroesophageal reflu	ıx disease), anxietv.		İ			
	hypertension, depression	on, fatigue, and tiredness.				1	
1						İ	
	Resident #53's quarterl	y minimum data set				1	
	(MDS) assessment with	n an assessment					l
	reference date (ARD) o	f 4/5/19 assessed the				į	j
	resident with a BIMS (b	rief interview for mental					
!	status) as 3/15. Reside	ent #53 was not assessed					•
,	with any signs or sympt	oms of delirium,					
	psychosis, or behaviors	that affected others.					İ

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Event ID: 8XB411

Facility ID: VA0086

If continuation sheet Page 16 of 116



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STATEMENT	OF DEFICIENCIES	CAT BEOLEGE POR TOP TO THE	T			OMB NO. 0938-0391		
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLI	E CONSTRUCTION	(X3) DATE SURVEY		
		TO ESTATION TO THE PARTY.	A. BUILD	ING_		COMPLETED		
						1	С	
		495384	B. WNG				_	
NAME OF P	ROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE	1 05	/03/2019	
	********				00 FRANCIS MARION LANE, PO BOX 880			
PRANCIS	MARION MANOR HEALT	TH & REHABILITATION		1				
044115	C) HHADW OT			<u> </u>	MARION, VA 24354			
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD B	E	COMPLETION	
		,	i no		CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ALE.	DATE	
F 584	Continued From page	. 16						
	minage ( 10m page		F :	584				
	No further information	was provided prior to the						
	exit conference on 5/3	3/19.						
	This is a complaint do	fining						
E 622	This is a complaint de	niciency.	_		,			
00.22	Transfer and Discharg	je kequirements	F6	522				
55=E	CFR(s): 483.15(c)(1)(	i)(ii)(∠)(i)-(iii)						
	8492 15(a) Transfer -	ad allo ale						
	§483.15(c) Transfer a				F622	:		
	§483.15(c)(1) Facility	requirements-			Following the discharge and	i		
	(i) The facility must per remain in the facility, a	end est transfer or				1		
	discharge the regident	t from the facility unless-		-	transfer requirements is an			
	(A) The transfer or die	charge is necessary for the			important priority for the team	n		
	resident's welfare and	the resident's peeds			at FMM			
	cannot be met in the fa				WE I IVALVE			
	(B) The transfer or disc				1 D 11 . 10 150 150 150			
1	because the resident's	health has improved			1. Residents #9, #73, #6, #29,			
	sufficiently so the resid	lent no longer needs the	Ī		#28 and #49 received no ill			
	services provided by the	ne facility:			effects due to the required	ĺ		
	(C) The safety of indivi				information not being sent to t	he		
	endangered due to the	clinical or behavioral			ED or not documented as have			
	status of the resident;							
	(D) The health of indivi	iduals in the facility would			been sent. Each resident return	ned		
	otherwise be endanger	red;			to FMM.			
1	(E) The resident has fa	illed, after reasonable and			•		i	
	appropriate notice, to p	pay for (or to have paid			2. All residents who are		1	
	under Medicare or Med	dicaid) a stay at the facility.					į	
	Nonpayment applies if	the resident does not			transferred to the ED have the	1		
	submit the necessary p	paperwork for third party			potential to be affected by the	İ		
	payment or after the th				same practice.			
	Medicare or Medicaid,	denies the claim and the						
	resident refuses to pay	for his or her stay. For a						
	resident who becomes	eligible for Medicaid after			•	1		
	admission to a facility,	the facility may charge a				1		
1		charges under Medicaid;					1	
I I	or (5) The first						1	
	(F) The facility ceases to				•			
] 1	(ii) The facility may not	transfer or discharge the		-				
į				- 1		- 1		

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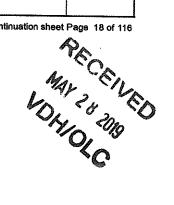
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		*****					C
NAME OF E	ROVIDER OR SUPPLIER	495384	B. WING			1	03/2019
	MARION MANOR HEALT	H & REHABILITATION		1	TREET ADDRESS, CITY, STATE, ZIP CODE 00 FRANCIS MARION LANE, PO BOX 880 IARION, VA 24354		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ITE	(X5) COMPLETION DATE
	§ 431.230 of this chap exercises his or her ridischarge notice from 431.220(a)(3) of this or discharge or transfer or safety of the reside facility. The facility muthat failure to transfer \$483.15(c)(2) Docume When the facility trans resident under any of in paragraphs (c)(1)(i) section, the facility mu or discharge is docume medical record and apcommunicated to the rinstitution or provider. (i) Documentation in the must include:  (A) The basis for the transfer include:  (B) In the case of parasection, the specific resident the service facility to meet the needs, and the service facility to meet the needs (ii) The documentation (2)(i) of this section muthat (A) The resident's physicischarge is necessary (A) or (B) of this section when the necessary under paragethis section.	eal is pending, pursuant to oter, when a resident ght to appeal a transfer or the facility pursuant to § hapter, unless the failure to would endanger the health not or other individuals in the last document the danger for discharge would pose.  Intation.  Interest or discharges a general factor of the circumstances specified (A) through (F) of this last ensure that the transfer lented in the resident's propriate information is ecceiving health care  The resident's medical record lenser per paragraph (c)(1)  Ingraph (c)(1)(i)(A) of this lensed (b) that cannot less to meet the resident lensed the receiving dots).  The required by paragraph (c) stomet the transfer or under paragraph (c) (1) or under paragraph (c) (1) or under paragraph (c) (1) or under paragraph (c) (1) or under paragraph (c) (1) or under paragraph (c) (d) or (D) of led to the receiving provider	F	622	3. The nursing team will be reducated regarding the requirements of transfer and discharge, including DNR/Advance Directive, 30 do of Nurses Notes, SBAR, Care plan goals, MAR/TAR, Labs (most recent), H&P, any x-rays pertinent, immunization, bed hold policy and nursing skilled/LTC Weekly Evaluation (minimum of 2). The Notice of Transfer and Discharge form in PCC will be revised to include checklist of items to be sent to the ED or given to the resident upon transfer. The form will all be edited so that all fields are no required for completion so that the user is not forced to put "na in the block.	ays  n of n a	

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Event ID: 8XB411

Facility ID: VA0086

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		495384	B. WNG				С
NAME OF P	ROVIDER OR SUPPLIER	1 100007	D. VIIITO			05/	/03/2019
FRANCIS	MARION MANOR HEAL			10	TREET ADDRESS, CITY, STATE, ZIP CODE 00 FRANCIS MARION LANE, PO BOX 880 NARION, VA 24354		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E NTE	(X5) COMPLETION DATE
F 622	(A) Contact information responsible for the cat (B) Resident represe contact information (C) Advance Directive (D) All special instruction ongoing care, as app (E) Comprehensive of (F) All other necessary of the resident's consistent with §483, any other documenta a safe and effective to this REQUIREMENT by:  Based on staff intervine review, and clinical refailed to ensure the of documentation of information of information in the resident when transfaffected Resident #9, Resident #29, Resident #29, Resident #29, Resident to the emergency Resident #9.  The clinical record of 4/30/19 through 5/3/19 admitted to the facility included but not limite infections, sepsis, hypheart failure), hypothy gastrointestinal gas, or	on of the practitioner are of the resident. Intative information including a information itions or precautions for ropriate. Interpretate are plan goals; in information, including a discharge summary, 21(c)(2) as applicable, and ition, as applicable, to ensure ansition of care. Is not met as evidenced arew, facility document cord review, the facility staff inical record contained armation sent with 6 of 18 erred from the facility that Resident #73, Resident #6, and #28, and Resident #49.  Iled to ensure the clinical area area area area area area area ar	F	622	4. The DON or designee will audit to ensure all information sent with the resident when transferred as required. An at will be conducted of the record for residents who have been transferred two times a week: 12 weeks and then five record per month will be reviewed for accuracy x 6 months. Any discrepancy will be addressed with the nurse in charge of the transfer. Data will be reported the QAPI team for further intervention.  5. Corrective action will be complete by 06/07/19.  6. DON or designee	udit rds for ls or	

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MI	TIDLE	CONSTRUCTION	OMR M	O. 0938-0391
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD			(X3) DATE SURVEY COMPLETED	
		495384	B. WING				С
NAME OF F	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 08	5/03/2019
ED 4 11010	. 88 5 10 10 10 10 10 10 10 10 10 10 10 10 10			1	00 FRANCIS MARION LANE, PO BOX 880		
FRANCIS	MARION MANOR HEALT	H & REHABILITATION			MARION, VA 24354		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		<u> </u>			
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREF	ΙΥ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	_	(X5)
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA	E ATF	COMPLETION DATE
					DEFICIENCY)		
F 622	Continued F						
1 022	Continued From page	19	F	622			
	Desident 401						
	Resident #9's quarter	y minimum data set (MDS)					
	(ARD) of 2/10/10 acco	ssessment reference date essed the resident with a					
	BIMS (brief interview )	for mental status) as 3/15.					
	Resident #9 was asse	ssed without any signs or					
	symptoms of delirium.	psychosis, or behaviors					
	that affected others.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
:							
	The clinical record pro	gress note dated 2/4/19 at					
	17:30 (5:30 p.m.) reve	aled the resident was found		1			
	In the moor by a certific	ed nursing assistant on					
	and pook poin Bones	o (complained of) left hip					
	new order to send to E	ted to medical doctor with D (emergency department)					
	for eval (evaluation).	Ambulance called for					
	transport (name omitte						
		•					
	2/4/19 18:30 (6:30 p.m	.) Ambulance service here					
	to transport to ED (em	ergency department) for		İ			
	eval (evaluation) & tx (	treatment) re: fail. Report					]
	called to ED.						
	The clinical record did	not have documentation of					
Ì	information sent to the						
	completed transfer/disc	charge form or information				İ	
***************************************	about bed holds for res	ident #9's emergency					
ŀ	room visit on 2/4/19.	5				İ	
1	Desident #61 Prof.						
		ecord revealed the resident					
	was found in the floor 4						
	roommate's hed. Resident	s found lying in front of her dent was lying in the prone					
	position with her face a	gainst the floor and stated					
1	she had stood up and v	vas bending over to pick		İ			
	something up from the	floor when she lost her					
	balance and fell. The r	esident stated she did not		-			[
	lose consciousness. R	esident was wearing					
	tennis shoes but was n	ot using walker. Call light					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495384	B. WING				C
	ROVIDER OR SUPPLIER  MARION MANOR HEALT	H & REHABILITATION		11	TREET ADDRESS, CITY, STATE, ZIP CODE 00 FRANCIS MARION LANE, PO BOX 880 IARION, VA 24354	U:	5/03/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	blood noted in the floor Resident assessed for was then assisted to report noted to have a discolar right eye. Small lacent eye. Raised discolorer Resident stated she was practitioner, on call for contacted and new order resident to ED (emerge (7:48 p.m.). TAS (ambiguity for transport at 1947 (7) hospital ED at 2003 (8) brother notified of fall at (8:10 p.m.). Upon TAS p.m.) resident was transfor assist from floor to stabilized. Paperwork  The clinical record did paperwork was sent with redid was offered and iff completed for 4/30/19.  The surveyor interview #1 on 5/2/19 at 2:49 p.m. was sent with residents emergency room.  L.P.N. #1 stated face s medication administration pertinent labs, ER (emeadvanced directives, Pland emergency transfer asked if the facility sent plan goals with the residoesn't send them and	assist. Small amount of a bove resident's head. I back and neck injury and oll on to her back. Resident ored, raised area over her ation also noted over right d area noted to right hand. as hurting all over. Nurse MD (medical doctor) der was received to send ency department) at 1948 bulance service) contacted 7:47 p.m.) report called to :03 p.m.), resident's and transport to ED at 2010 as ferred on to backboard stretcher. Resident given to ambulance staff.  Inot document what the the resident, if a bed a transfer form had been ed licensed practical nurse m. on what information is when they are sent to the heet, history and physical, on records (MARs)s, any ergency room) order, OA# (power of attorneys), if sheet. L.P.N. #1 was at the comprehensive care dent. L.P.N. #1 stated she	F	622			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	(2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN O	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING_			MPLETED	
							С	
NAMEOGR	DOMOCO OD GUDDUNO	495384	B. WING			05	5/03/2019	
INVINE OF P	ROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE			
FRANCIS	MARION MANOR HEALT	TH & REHABILITATION		100 FRANCIS MARION LANE, PO BO				
			MARION		MARION, VA 24354			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREF	ıv	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B		(X5)	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA	E ATE	COMPLETION DATE	
					DEFICIENCY)			
F 622	0							
FOZZ		21	F	622				
	the bed holds.	•						
	The surveyor interview	wad the admicsions						
		2:57 p.m. The admissions						
	assistant stated bed h	old information was						
		but not when the residents						
	were sent to the emer	gency room.						
	-		ſ					
	F/2/10 at 2:57 p.m. ab	the director of nursing on					1	
		out the transfer form sent DON stated "I looked and						
		I spoke with the staff						
	responsible for the tra							
	completed was 8/25/1							
	·							
	The surveyor requeste	ed from the DON the facility						
	policy on transfers/disc	charges on 5/2/19.		ĺ				
	The DON did provide t	the european with						
		nergency room visits on						
	2/4/19 and 4/30/19; ho	wever, the paperwork did					]	
Į.	not include a transfer f							
		linical record did not state						
1	what paperwork was s	ent with the resident.						
	The everyone informed	Abo odnobolotovi o od 11.						
		the administrator and the ne above concern about						
İ	paperwork not provide	d to the receiving provider		1				
		sent to the emergency						
		and 4/30/19 and lack of				ļ		
	documentation of infor	mation sent with the						
		4/30/19 in the end of the		İ				
	day meeting on 5/2/19	at 4:34 p.m.						
	No futbor information :	seen manifolded to the		-				
	No further information	was provided to the cit conference on 5/3/19.						
.	anivayor prior to trie ex	at comerence on 5/3/19.						
	2. The facility staff faile	ed to ensure the clinical						
		mentation of information						

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	/X2\ MI II	TIDI	E CONSTRUCTION	UNID 140. 0930-0391	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:					E SURVEY PLETED
			A. BUILD	טאויי		1 001	
		495384	B. WING				С
NAME OF F	PROVIDER OR SUPPLIER	770007	D. 71114G			05	6/03/2019
is and or i	NOTICE OF THE PARTY			ŧ	STREET ADDRESS, CITY, STATE, ZIP CODE		
FRANCIS	MARION MANOR HEAL	TH & REHABILITATION			100 FRANCIS MARION LANE, PO BOX 880		
	I				MARION, VA 24354		
(X4) ID PREFIX	SUMMARY ST	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	. al		PROVIDER'S PLAN OF CORRECTION		(X5)
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD B	Ę_	COMPLETION
		•	1/10		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(TE	DATE
				-			
F 622	Continued From page	e 22	E .	622			]
	• -	ry room for Resident #73.	• '	022			
		y toom of resident #75.					
	The clinical record of	Resident #73 was reviewed					
	4/30/19 through 5/3/1	9. Resident #73 was					
	admitted to the facility	7/26/15 and readmitted					
	2/22/19 with diagnose	es, that included but not					]
	limited to, wound and	cellulitis of right leg,					
	anemia, chronic kidne	ey disease stage 3, CVA					
	(cerebrovascular acci						]
	(congestive neart failt	ure), depression, rheumatoid					1
	vein thrombosis\ CAI	, acute decline, DVT (deep D (coronary artery disease)					
	and chronic periphera	d edema					ĺ
	and officino poripricio	ii odema.					
	Resident #73's signific	cant change in assessment	ĺ				
	minimum data set (MI	OS) with an assessment				:	
	reference date (ARD)	of 4/19/19 assessed the					
	resident with a BIMS (	(brief interview for mental					
	status) as 5/15 and wi	ith no signs or symptoms of					
	delirium, psychosis, o	r behaviors affecting others.					
	The elipioni record as-						
	0035 that the pure w	ogress note dated 2/9/19 at					
	aide-resident citting or	as called to the room by n side of bed-c/o (complains					
	of) increase in pain RL	F /right lower					1
Ī	extremity)-dark purple					Í	l
	increasing in size-app	•				ļ	
		ider skin-resident grimaces				ı	
		no other c/o (complaints					
	of)-v/s (vital signs) 97.	7, 97%, 72, 221/85.			·		
	0/0/40 000= **						
	2/9/19 0037 Nurse pra	ctitioner, on call,					
	contacted-new order re						
	(emergency departme tx (treatment).	nt) for eval (evaluation) and					
	ν (πραπιωιπ).						
[	2/9/19 0041 resident fa	amily notified					
		anny nounce					
	2/9/19 0045 tas (ambu	lance service) contacted					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					Address of the second of the s		C
NAME OF S		495384	B. WING			0.	5/03/2019
	MARION MANOR HEALT	H & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE  100 FRANCIS MARION LANE, PO BOX 8  MARION, VA 24354			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	4	ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)		E TE	(X6) COMPLETION DATE
F 622	Continued From page for transport 2/9/19 0054 report cal nurse) at name of hos	led in to rn (registered	F	622			
	(patient) was on her w been removed from he been wrapped.  The clinical record did what information was a emergency department was unable to locate a the clinical record.  The surveyor interview #1 on 5/2/19 at 2:49 p.	report from ed-stated pt ay back-stated clot had amatoma and area has not have documentation of sent with the resident to the at on 2/9/19. The surveyor transfer/discharge form in red licensed practical nurse m. on what information is when they are sent to the					
The second secon	medication administrat pertinent labs, ER (em- advanced directives, P and emergency transfe asked if the facility sen plan goals with the resi doesn't send them and	OA# (power of attorneys), ir sheet. L.P.N. #1 was t the comprehensive care dent. L.P.N. #1 stated she		THE PARTY OF THE P			
7.11	assistant stated bed ho	:57 p.m. The admissions ld information was but not when the residents				-	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495384	B. WNG			1	C
	ROVIDER OR SUPPLIER  MARION MANOR HEALT	H & REHABILITATION		10	TREET ADDRESS, CITY, STATE, ZIP CODE 00 FRANCIS MARION LANE, PO BOX 880 (ARION, VA 24354	05/	/03/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	5/2/19 at 2:57 p.m. ab with Resident #73. The there was none done. The surveyor requested policy on transfers/discrete policy on transfers/discrete policy on transfers/discrete policy on transfers/discrete policy on transfers/discrete policy on transfers/discrete policy on transfers/discrete policy on transfers/discrete policy on transfers/discrete paperwork not provide when the resident was department on 2/9/19 meeting on 5/2/19 at 4.  No further information surveyor prior to the example of the provider with information surveyor prior to the example of the provider with information surveyor prior to the example of the provider with information on 2/1/19.  The clinical record of R 4/30/19 through 5/3/19 admitted to the facility sincluded but not limited acute renal failure, hyp bronchitis, acute-on-chippeumonia, anemia, chipulmonary disease (CC) (chronic kidney disease)	d the director of nursing on out the transfer form sent he DON stated "I looked and"  and from the DON the facility charges on 5/2/19.  If the administrator and the he above concern about d to the receiving provider a sent to the emergency in the end of the day :34 p.m.  was provided to the cit conference on 5/3/19.  and to provide the receiving pon that included Resident are plan goals and failed to ation was sent with the ted to the emergency  desident #6 was reviewed. Resident #6 was 9/1/18 with diagnoses that it o syncope, weakness, onatremia, acute ronic respiratory failure, pronic obstructive OPD), obesity, CKD of (stage 4), depression, rtension, hypothyroidism,	. F6	522			
	Resident #6's quarterly	minimum data set (MDS)					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
	495384	B. WING	B. WNG			С
ME OF PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	0	5/03/2019
ANCIS MARION MANOR HEALT	H & REHABILITATION	:	100	FRANCIS MARION LANE, PO BOX 880 RION, VA 24354		
REFIX (EACH DEFICIENCY	ITEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	JE ATE	(X5) COMPLETION DATE
4/29/19 assessed the interview for mental str #6 was assessed with of delirium, psychosis, others.  The surveyor interview at 9:43 a.m. Resident been any recent hospif responded her right an about seven (7) month clinical record revealed sent to the emergency (7:10 p.m.). There was what information was p provider when the residemergency room or who where the clinical record did about bed holds  The clinical record did about bed holds  The clinical record did about bed holds  The clinical record did about bed holds  The surveyor interviewed which included the code present condition, contapractitioner and emerge record did not have document to the provider.  The surveyor interviewed #1 on 5/2/19 at 2:49 p.n. was sent with residents emergency room.  L.P.N. #1 stated face standication administration pertinent labs, ER (eme	eference date (ARD) of resident with a BIMS (brief atus) as 14/15. Resident out any signs or symptoms or behaviors that affected red Resident #6 on 5/1/19 #6 was asked if there had talizations and the resident ikle /leg had been broken is ago during a fall. The id Resident #6 had been room on 2/1/19 at 19:10 is no documentation of brovided to the receiving dent was sent to the iten the resident returned not contain any information contain a form titled int Referral" dated 2/1/19 is estatus, brief history of act information of the ency contact. The clinical cumentation of information when they are sent to the ineet, history and physical, on records (MARs)s, any orgency room) order, DA# (power of attorneys).	F	622			

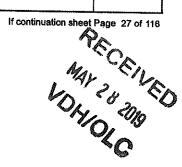
PRINTED: 05/16/2019 FORM APPROVED

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIÓN NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495384	B. WING			C	
	ROVIDER OR SUPPLIER  MARION MANOR HEALT	H & REHABILITATION		_1	STREET ADDRESS, CITY, STATE, ZIP CODE 00 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354	<u>  U:</u>	5/03/2019
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		RECH ATORY OR LOS INSTITUTE OF THE PRESENT OF THE P		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E NTE	(X5) COMPLETION DATE
	asked if the facility serplan goals with the reddoesn't send them and holds. L.P.N. #1 states the bed holds.  The surveyor interview assistant on 5/2/19 at assistant stated bed holds assistant stated bed holds assistant stated bed holds.  The surveyor requester policy on transfers/discontractor of nursing of the comprehensive care policy on transfers/discontractor of nursing of the comprehensive care policy on transfers/discontractor of nursing of the comprehensive care policy on transfers/discontractor of nursing of the comprehensive care policy on transfers/discontractor of nursing of the comprehensive care policy on transfers/discontractor of nursing of the comprehensive care policy on transfers/discontractor of the end and the lack of document of the facility staff falls information was contained for Resident #29 was adm 5/16/16 with the followill limited to cancer, anem disease, neurogenic blad disorder. On the annual Set) with an ARD (Asset of 3/4/19, the resident was contained to the surveyor prior to the end of the surveyor prior to	nt the comprehensive care sident. L.P.N. #1 stated she didn't know about bed and the business office does wed the admissions 2:57 p.m. The admissions old information was a but not when the residents gency room.  In the definition of the facility charges on 5/2/19.  If the administrator and the ne above concern about the fan goals not sent with ergency room on 2/1/19 centation of the information 19 in the end of the day 132 p.m.  In the end of the end of the day 132 p.m.  In the end of the end of the end of the day 132 p.m.  In the end of t	F	622			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 8XB411

Facility ID: VA0086



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			7.0.00.00			С		
11445 05 0		495384	B. WING			o	5/03/2019	
	ROVIDER OR SUPPLIER  MARION MANOR HEALT			1	TREET ADDRESS, CITY, STATE, ZIP CODE 00 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E NTE	(X5) COMPLETION DATE	
	surveyor noted there a "Notice of Transfer or 4/24/19. On this date labs and the physician to ER (emergency roo nursing notes dated 4 the following was doct " "Face sheet, Cod (History and Physical) current progress note provider), discharge degree (name of hospita " 4/24/19 at 20:57 (patient admitted to roo The surveyor reviewed Discharge" dated for 4 items were checked: " "7. The safety is endangered due to 1 status exhibited by you evidenced by"  " 7a. This section w " "9. You (the reseasonable and appropriate the nursing facility  The surveyor notified to the above documented pm in the conference in No further information is surveyor prior to the extension of the facility staff failed.	ord review on 5/3/19, the was documentation on the Discharge" dated for the third that abnormal in had ordered for him to go by the been decid	F	622				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL		(X3) DATE SURVEY COMPLETED		
		495384	B. WING	B. WNG		C	
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	05	5/03/2019
	MARION MANOR HEALT			1	00 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E TE	(X5) COMPLETION DATE
	2/23/19 with the follow limited to atrial fibrillat disease, high blood prodiabetes and arthritis. MDS (Minimum Data is (Assessment Reference resident was coded as Interview for Mental States possible score of 15. Incoded as only requiring and limited assistance bathing.  During the clinical reconstruction on the Transfer sheet of " "7. The safety of its endangered due to the status exhibited by you evidenced by:"  In addition, a transfer solution with the bostonecked: " "4. The discharge collaboration with you (resident representative of such"  7. The safety of incompanion with the bostonecked: " "4. The discharge collaboration with you (resident representative of such"  7. The safety of incompanion with the bostonecked: " "4. The discharge collaboration with you (resident representative of such"  7. The safety of incompanion with the bostonecked: " "4. The discharge collaboration with you (resident representative of such"  7. The safety of incompanion with the bostonecked: " "4. The discharge collaboration with you (resident representative of such"	dmitted to the facility on ing diagnoses, but not ion, coronary artery essure, renal failure, On the significant change Set) with an ARD be Date) of 3/3/19; the shaving a BIMS (Brief latus) score of 15 out of a Resident #28 was also g supervision with dressing for personal hygiene and lated for 1/18/19; of individuals in the facility the clinical or behavioral (the resident) as I cease to operate on ummary sheet dated for ontain the following wes beside of these were ge has been planned in the resident) and/or your and represents the choice lividuals in the facility is clinical or behavioral	F	622			
\	vould otherwise be end	angered as evidenced by:					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION INTERPOLITATION IN IMPEDI		(X2) MULTIPLE CONSTRUCTION				OMB NO. 0938-0391 (X3) DATE SURVEY	
AND FLAN O	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		and the state of t	COMPLETED		
		495384	B. WING				C	
NAME OF PROVIDER OR SUPPLIER				s	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	5/03/2019	
FRANCIS MARION MANOR HEALTH & REHABILITATION		TH & REHABILITATION		1	00 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354			
(X4) ID	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES		ID.		<del></del>			
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E NTE	(X5) COMPLETION DATE	
F 622	Continued From page	29	F	622				
	" 9 You (the reside	ent) have failed, after						
	reasonable and appro	priate notice, to pay for (or						
	to have paid under Me at the nursing facility.	edicare or Medicaid) a stay					7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	
	The surveyor potified	the administrative team of						
	the above documente	d findings on 5/3/19 at 3:52						
	pm in the conference	room.						
	No further information	was provided to the						
	surveyor prior to the e	xit conference on 5/3/19.						
	6. For Resident #49 th	e facility staff failed to						
	ensure the transfer/dis	charge form was correct.						
	Resident #49 was adm	nitted to the facility on						
	U3/23/18 and readmitte	ed on 03/14/19. Diagnoses						
	heart failure hypertens	d to anemia, congestive sion, neurogenic bladder,						
	diabetes mellitus, dem	entia, depression, chronic						
[	obstructive pulmonary	disease, respiratory failure,						
	end stage renal diseas hypothyroidism.	e, atrial fibrillation and		•				
-	The most recent MDS	(minimum data set) with						
	an ARD (assessment r	eference date) of 04/01/19						
	coded the Resident as	15 of 15 in section C,		İ				
	cognitive patterns. This	s is a quarterly MDS.						
	Resident #49's clinical	record was reviewed on						
1	05/01/19. It contained a	a signed physician's order						
ĺ	dated 03/11/19, which	read in part "Sent (sic) to						
		ed) ER (emergency room) notassium renal failure".						
	The clinical record also							
		/11/19, which read in part						
!	"3/11/19 09:24 LAB CA	LL WITH CRITICAL						
	POTASSIUM (sic) CAL	L (name omitted) AND						
	(riame omitted) ORD	ER PT (Patient) TO GO	<u></u>					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 8XB411

Facility ID: VA0086

If continuation sheet Page 30 of 116

MAY 28 2016

PRINTED: 05/16/2019 FORM APPROVED

STATEMENT	OF DEFICIENCIES	AN ODOMODOUS PROPERTY				OMB N	IO. 0938-0391
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i i		CONSTRUCTION	(X3) DATE SURVEY	
		<u>,                                    </u>	A. BUILD	ING_		COMPLETED	
		405004				C	
NAMEOED	BOYADED OD SUDDIVED	495384	B. WNG			l o	5/03/2019
140-WIE OF I	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FRANCIS	MARION MANOR HEALT	H & REHABILITATION		1	00 FRANCIS MARION LANE, PO BOX 880		
				N	MARION, VA 24354		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		OI D		PROVIDER'S PLAN OF CORRECTION	CTION (X5)		
PREFIX TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD B	E	COMPLETION
			IAG		CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ATE.	DATE
					,		
F 622	Continued From page	30		522			
		omitted) ER CALL (name	1 '	JZZ			
	omitted) AMBULANCI	E SERVICE TO					
		ER, (name omitted)					
	KNOWS AND UNDER	RSTANDS, REPORT CALL					
	TO ER AT (facility i	name omitted) (name					
	omitted) HERE PT ON	NWAS TO (facility name					
	omitted) ER". This not	e did not contained any					
	information on what ty	pe of documentation was		ļ			
	sent to hospital with th	le Resident.					
	The Resident's clinical	record contained a "Notice				-	
		ge" form, dated 03/11/19.		l			
	This form contained ch	neck boxes of different					
	reasons for transfer/dis			- 1			•
	reading "6. The transfe	er or discharge is					
	necessary for your (the	Resident's) welfare and					
	your (the Resident's) n	eeds cannot be met in the					
	facility as evidenced by	y:", "7. The safety of					
ĺ	individuals in the facilit	y is endangered due to the				•	
	Resident) as evidence	tatus exhibited by you (the ed by:", "8. The health of					
٠	individual in the facility	would otherwise be					
	endangered as eviden	ced by:" "9. You (the					
	Resident) have failed,	after reasonable and		l			]
	appropriate notice, to p	pay for (or to have paid					
	under Medicare or Med	dicaid) a stay at the nursing					
	facility", "9a. Total amo	unt due to the facility is",					
	"9b. You and/or your re	presentative were					
	previously given notice	of payment due on", "10.					
	facility will assist you w	o operate on" and "11. The					
1	discharge If discharge	does not occur within 30					
	days, it is the intent of t	the facility discharge you"					
ттине .	were all checked as rea	ason for the Resident's					
	discharge.	· · · · · · · · · · · · · · · · · ·					
	-						
		prrect form was discussed					
		team during a meeting on			,		
1	05/02/19 at approximat	ely 1635. The DON					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l l	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		405204			COMPLETED
NAME OF DO	OMPED OF CURRYIER	495384	B. WING		05/03/2019
FRANCIS N	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 100 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354	1 00100/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION ATE DATE
	have not been checke No further information	ated all of the boxes should d. was provided prior to exit.	F 62	F623 Following the notice	
SS=D  ()  ()  ()  ()  ()  ()  ()  ()  ()  (	CFR(s): 483.15(c)(3)-( §483.15(c)(3) Notice be Before a facility transferesident, the facility must be resident a representative(s) of the che reasons for the moanguage and manner facility must send a copersentative of the Cong-Term Care Ombusti) Record the reasons discharge in the reside accordance with paragend iii) Include in the notice paragraph (c)(5) of this paragraph (c)(5) of this paragraph (c)(5) of this paragraph (c)(6) of this paragraph (c)(6) of this paragraph (c)(7) Timing of the content of the facility at least the paragraph (c)(6) of this paragraph (c)(7) Timing of the paragraph (c)(8) of this section, the paragraph (c)(8) of this section, the paragraph (c)(8) of this section, the paragraph (c)(8) of this section, the paragraph (c)(8) The safety of individe endangered under pais section; 3) The health of individed in the paragraph (c)(6) Timing or the paragraph (c)(6) Timing or the paragraph (c)(7) Timing or the paragraph (c)(8) of this section, the paragraph (c)(8) The safety of individed endangered under pais section; 3) The health of individed the paragraph (c)(8) The health of individed the paragraph (c)(8) The health of individed the paragraph (c)(8) The health of individed the paragraph (c)(8) The health of individed the paragraph (c)(8) The health of individed the paragraph (c)(8) The health of individed the paragraph (c)(8) The health of individed the paragraph (c)(8) Th	efore transfer. ers or discharges a ust- nd the resident's e transfer or discharge and ve in writing and in a they understand. The by of the notice to a effice of the State edsman. for the transfer or ent's medical record in raph (c)(2) of this section; et the items described in section.  If the notice. In paragraphs (c)(4)(ii) and e notice of transfer or er this section must be east 30 days before the or discharged. e as soon as practicable	F 62:	requirements before discharand transfer is an important priority for the team at FMM  1. Residents #9, #73 and #6 received no ill effects due to receiving a copy of the transfer/discharge form as required before being transfer the ED or not documented as have been sent.  2. All residents who are transferred to the ED have the potential to be affected by the same practice.  3. The nursing team will be reeducated regarding the requirements of giving the resident or resident representative a copy of the transfer and discharge form. If form is being revised so that it allows clear documentation of what was given to the resident/resident representative and to the accepting ED.	not red

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED				
		495384	B. WNG	B. WNG		С	
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	05/	/03/2019
FRANCIS MARION MANOR HEALTH & REHABILITATION		TH & REHABILITATION		1	00 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354		•
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E NTE	(X5) COMPLETION DATE
THE POST OF THE PO	allow a more immedia under paragraph (c)(1 (D) An immediate trar required by the reside under paragraph (c)(1 (E) A resident has not days.  §483.15(c)(5) Content notice specified in parmust include the follow (i) The reason for trar (ii) The effective date (iii) The location to what transferred or discharg (iv) A statement of the including the name, as and telephone number receives such request to obtain an appeal for completing the form an hearing request; (v) The name, address telephone number of the Long-Term Care Ombo (vi) For nursing facility and developmental disabilities, the mailing telephone number of the protection and adv developmental disability C of the Developmental and Bill of Rights Act ocodified at 42 U.S.C. 1 (vii) For nursing facility	alth improves sufficiently to the transfer or discharge, (i)(i)(B) of this section; asfer or discharge is int's urgent medical needs, (i)(i)(A) of this section; or resided in the facility for 30 is of the notice. The written agraph (c)(3) of this section wing: asfer or discharge; of transfer or discharge; ich the resident is ged; resident's appeal rights, address (mailing and email), or of the entity which is; and information on how im and assistance in and submitting the appeal is (mailing and email) and the Office of the State address with intellectual abilities or related in and email address and the agency responsible for ocacy of individuals with the sestablished under Part all Disabilities Assistance if 2000 (Pub. L. 106-402, 5001 et seq.); and residents with a mental abilities, the mailing and	F	623	4. The DON or designee will audit to ensure the transfer/discharge form is give to the resident or resident representative prior to being transferred or discharged from FMM. At least five records p month will be reviewed for accuracy x 6 months. Any discrepancy will be addressed with the nurse in charge of the transfer. Data will be reported the QAPI team for further intervention.  5. Corrective action will be complete by 06/07/19.  6. DON or designee	n er	

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
						С	
		495384	B. WNG			05/03/2019	
	ROVIDER OR SUPPLIER  MARION MANOR HEALT	'H & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 100 FRANCIS MARION LANE, PO BOX 886			
~~10	SHAMADV ST	ATEMENT OF DEFICIENCIES			MARION, VA 24354		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E JE	(X5) COMPLETION DATE
F 623	Continued From page	33	F	623			
	agency responsible for advocacy of individua	or the protection and Is with a mental disorder Protection and Advocacy	THE CONTRACT OF THE CONTRACT O	020			
	effecting the transfer of must update the recipion	es to the notice. e notice changes prior to or discharge, the facility ients of the notice as soon e updated information					
	In the case of facility of the administrator of the written notification priot to the State Survey Ag State Long-Term Care the facility, and the reswell as the plan for the relocation of the reside 483.70(I). This REQUIREMENT by:  Based on staff intervier review, and clinical recipied to provide a writt resident and resident residents when transfer	or to the impending closure ency, the Office of the Ombudsman, residents of sident representatives, as a transfer and adequate ents, as required at § is not met as evidenced ew, facility document cord review, the facility staff een notice of transfer to the epresentative for 3 of 18					
	The findings included:						
		e resident and the resident esident #9 was sent to the		The state of the s			
1	The clinical record of R	lesident #9 was reviewed					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 8XB411

Facility ID: VA0086

If continuation start Page 34 of 116

PRINTED: 05/16/2019 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIED/CLIA					OMB N	IO. 0938-0391	
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495384	B. WING			0.	C 5/03/2019
NAME OF P	ROVIDER OR SUPPLIER			S.	TREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	5,00,20 TO
FRANCIS	MARION MANOR HEALT	H & REHABILITATION		10	00 FRANCIS MARION LANE, PO BOX 880 IARION, VA 24354		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	3	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E TE	(X5) COMPLETION DATE
	included but not limite infections, sepsis, hyp heart failure), hypothy gastrointestinal gas, o schizophrenia, depress and thrombocytopenia. Resident #9's quarterl assessment with an ac (ARD) of 2/10/19 asses BIMS (brief interview of Resident #9 was asses symptoms of delirium, that affected others.  The clinical record pro 17:30 (5:30 p.m.) revein the floor by a certifical record pro 17:30 (5:30 p.m.) revein the floor by a certifical record pro 17:30 (5:30 p.m.) revein the floor by a certifical record of transport (name omitted 2/4/19 at 5:30 p.m. c/24/19 at 5:30 p.m. c/24/19 at 5:30 p.m. c/24/19 transport (name omitted transport (name omitted 2/4/19 18:30 (6:30 p.m.) to transport to ED (emeteval (evaluation) & tx (called to ED.)  The clinical record did written transfer/discharprovided to the resident representative when transport common 2/4 emergency room on 2/4	9. Resident #9 was 17/13/16 with diagnoses that d to acute urinary tract loxia, CHF (congestive roidism, excessive upper besity, paranoid sion, hypertension, anemia, besity, paranoid sion, hypertension, anemia, consideration, ane	F	623			
	was found in the floor 4						

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		MEDICAID SERVICES			OMB NO. 0938-0391		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495384	B. WING				С
NAME OF P	ROVIDER OR SUPPLIER	I.			STREET ADDRESS, CITY, STATE, ZIP CODE	05	/03/2019
FRANCIS	MARION MANOR HEALT	FU & DEUARII ITATION		i i	100 FRANCIS MARION LANE, PO BOX 880		
				1	MARION, VA 24354		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE ATE	(X5) COMPLETION DATE
F 623	roommate's bed. Resposition with her face she had stood up and something up from the balance and fell. The lose consciousness, tennis shoes but was had not been used for blood noted in the floor Resident assessed for was then assisted to moted to have a discolinght eye. Small lacer eye. Raised discolore Resident stated she with practitioner, on call for contacted and new orderesident to ED (emerging the she was the stated and new orderesident to ED (emerging the she was the stated and new orderesident to ED (emerging the she was	vas found lying in front of her sident was lying in the prone against the floor and stated was bending over to pick a floor when she lost her resident stated she did not Resident was wearing not using walker. Call light assist. Small amount of or above resident's head. It back and neck injury and foll on to her back. Resident fored, raised area over her ation also noted over right area noted to right hand. It was hurting all over. Nurse MD (medical doctor) der was received to send ency department) at 1948	F	623			
	for transport at 1947 (hospital ED at 2003 (8 brother notified of fall a (8:10 p.m.). Upon TAS p.m.) resident was transfor assist from floor to stabilized. Paperwork  The clinical record did written transfer/dischal provided to the resider representative when transfer or on a 4 draw transfer o	and transport to ED at 2010 S arrival at 2000, (8:00 Insferred on to backboard stretcher. Resident given to ambulance staff.  not have documentation of rge information that was and the resident ansferred to the					

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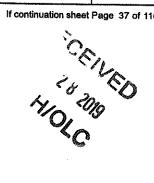
<u> </u>	TOT OR WILDIOMICE &	INCDIONID SCINVICES	<del></del>			OM	IB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRU	(X3)	(X3) DATE SURVEY COMPLETED		
		495384	B. WNG				C 05/03/2019	
NAME OF P	PROVIDER OR SUPPLIER			STREET ADD	DRESS, CITY, STATE, ZIP CODE			
FRANCIS	MARION MANOR HEALT	TH & REHABILITATION		100 FRANC MARION, \	IS MARION LANE, PO BOX 880 VA 24354			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 623	Continued From page	<del>3</del> 6	F	623				
	the staff responsible for the transfer and the last one completed was 8/25/18."						170000	
	The surveyor request policy on transfers/dis	ed from the DON the facility charges on 5/2/19.				·		
	2/4/19 and 4/30/19; he not include a transfer	mergency room visits on owever, the paperwork did form and the clinical record did not state						
	director of nursing of t regarding transfer/disc to the resident and the when transferred on 2	the administrator and the he above concern charge forms not provided resident representative /4/19 and 4/30/19 in the g on 5/2/19 at 4:34 p.m.						
77.77	No further information surveyor prior to the e	was provided to the xit conference on 5/3/19.	THE PARTY OF THE P	T THE THIRD PROPERTY OF THE THE THE THE THE THE THE THE THE THE				
	and the resident repre	led to provide the resident sentative with a written sident #73 was transferred n on 2/9/19.	-					
To the state of th	4/30/19 through 5/3/19 admitted to the facility 2/22/19 with diagnoses limited to, wound and anemia, chronic kidney (cerebrovascular accid (congestive heart failur arthritis, hypertension,	7/26/15 and readmitted s, that included but not cellulitis of right leg, y disease stage 3, CVA lent), falls, CHF re), depression, rheumatoid acute decline, DVT (deep (coronary artery disease)						

FORM CMS-2567(02-99) Previous Versions Obsolete .

Event ID: 8XB411

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	1	IO. 0938-0391	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD				E SURVEY	
				_		6		
		495384	B. WNG			_	C	
NAMEOFP	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	5/03/2019	
FRANCIS	MARION MANOR HEALT				00 FRANCIS MARION LANE, PO BOX 880			
11041010	MANION MINNOR HEAL!	H & REHABILITATION			MARION, VA 24354			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ΙĐ	L	PROVIDER'S PLAN OF CORRECTION			
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD B	Ε	(X5) COMPLETION	
1/10	THE CODE TO THE OWN	SO DENTIFTING INFORMALION)	TAG		CROSS-REFERENCED TO THE APPROPRIA	ATE.	DATE	
					JEI IOIEIOI)			
F 623	Continued From page	37	-	600				
	page 0,		F '	623				
	Resident #73's signific	cant change in assessment						
	minimum data set (Mi	DS) with an assessment						
	reference date (ARD)	of 4/19/19 assessed the						
	resident with a BIMS	(brief interview for mental						
	status) as 5/15 and wi	ith no signs or symptoms of						
-	deilium, psychosis, o	r behaviors affecting others.						
	The clinical record pro	gress note dated 2/9/19 at						
	0035 that the nurse w	as called to the room by						
	aide-resident sitting or	n side of bed-c/o (complains						
	of) increase in pain RI	E (right lower						
	extremity)-dark purple	, raised area to RLE						
	increasing in size-app	ears to have large						
	nematoma of blood un	ider skin-resident grimaces	] .			•		
	of)-v/s (vital signs) 97.	no other c/o (complaints						
	or, the (vital signs) or.	1, 91 70, 12, 22 1705.		İ				
	2/9/19 0037 Nurse pra	ctitioner, on call.						
	contacted-new order re	eceived to send to ed						
		nt) for eval (evaluation) and						
	tx (treatment).			ĺ				
	2/9/19 0041 resident fa	amily matified					-	
	2/3/13 CO4   Testueill Id	army nonnec						
	2/9/19 0045 tas (ambu	lance service) contacted						
	for transport	,						
1								
	2/9/19 0054 report call	ed in to rn (registered						
	nurse) at name of hosp	oital ed.						
	2/9/19 0058 tas here fo	or transmort						
	to 0000 tab light ic	a demoporti						
	2/9/19 0230 received re	eport from ed-stated pt						
1	(patient) was on her wa	ay back-stated clot had				ļ		
[1	been removed from he	matoma and area has						
	peen wrapped.							
-	The clinical record did :	not house documentation						
	rue ciimcai fecolo (MO I	not have documentation	i					

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STATEMENT	OF DEFICIENCIES	OAL PROPERTIES AND LEGICIES				<u> </u>		
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495384	B. WING			0	C 5/03/2019	
NAME OF F	PROVIDER OR SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP CODE	1 0	010312013	
FRANCIS	MARION MANOR HEALT	TH & REHABILITATION		100 FRANCIS MARION LANE, PO BOX MARION, VA 24354				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID					
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E Ate	(X5) COMPLETION DATE	
F 623	623 Continued From page 38			623				
	•	arge form was provided to	1	02.0				
	the resident and the re	esident representative or arge form was completed						
	The surveyor was una	able to locato a						
		m in the clinical record.						
	5/2/19 at 2:57 p.m. ab	d the director of nursing on out the transfer form sent ne DON stated "I looked and	THE PROPERTY OF THE PROPERTY O	William Charles and Charles an				
	director of nursing of t regarding transfer/disc to the resident and the	charge forms not provided resident representative /9/19 in the end of the day	The state of the s				97.00	
***************************************	No further information surveyor prior to the ex	was provided to the xit conference on 5/3/19.						
	and the resident repre-	Resident #6 was sent to						
	4/30/19 through 5/3/19 admitted to the facility included but not limited acute renal failure, hypbronchitis, acute-on-ch pneumonia, anemia, cl pulmonary disease (CC (chronic kidney disease)	9/1/18 with diagnoses that if to syncope, weakness, conatremia, acute ironic respiratory failure, nronic obstructive DPD), obesity, CKD a (stage 4), depression, irtension, hypothyroidism,						

						OMB M	<u>0. 0938-0391</u>
t .	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495384	B. WING			1	C /03/2019
NAME OF P	ROVIDER OR SUPPLIER		,	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FRANCIS	MARION MANOR HEALT	'H & REHABILITATION			00 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E NTE	(X5) COMPLETION DATE
F 623	Continued From page	39	F	323			
	with an assessment re 4/29/19 assessed the interview for mental st #6 was assessed with	y minimum data set (MDS) eference date (ARD) of resident with a BIMS (brief ratus) as 14/15. Resident out any signs or symptoms or behaviors that affected	A CONTRACTOR OF THE CONTRACTOR	OF THE PARTY OF TH			
The second secon	at 9:43 a.m. Resident been any recent hosp responded her right ar about seven (7) month clinical record revealer	ved Resident #6 on 5/1/19 #6 was asked if there had italizations and the resident inkle /leg had been broken is ago during a fall. The d Resident #6 had been proom on 2/1/19 at 19:10					
THE PROPERTY OF THE PROPERTY O	that included the code present condition, con practitioner and emerg record did not indicate	ent Referral" dated 2/1/19 status, brief history of tact information of the tency contact. The clinical the resident and the the were given a copy of the		,			
	The surveyor requeste policy on transfers/disc	d from the DON the facility charges on 5/2/19.	77			1	
	director of nursing of the evidence the resident a representative were girdischarge when Reside the emergency room of day meeting on 5/3/19	ven a written notice of ent #6 was transferred to n 2/1/19 in the end of the at 4:32 p.m.		***************************************		THE PARTY OF THE P	
İ	No further information	was provided to the	}	- 1		l	

PRINTED: 05/16/2019 FORM APPROVED OMB NO. 0938-0391

1	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495384	B. WING			1	C
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>  U5/</u>	03/2019
FRANCIS	MARION MANOR HEALT			1	00 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E VTE	(X5) COMPLETION DATE
SS=E	Notice of Bed Hold Pc CFR(s): 483.15(d)(1)(1)(1)(1)(2)(3)(4)(3)(1)(1)(1)(2)(3)(4)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	xit conference on 5/3/19.  Alicy Before/Upon Trnsfr 2)  Ded-hold policy and returnated resident to a hospital or nerapeutic leave, the rovide written information to at representative that  State bed-hold policy, if resident is permitted to idence in the nursing anyment policy in the state of this chapter, if any; is policies regarding the must be consistent with a section, permitting a section, permitting a section of the peutic leave, a nursing the resident and the a written notice which of the bed-hold policy		623	F625 Following the requirement to give notice of Bed Hold Pollobefore / upon transfer is an important priority for the tear at FMM  1. Residents #9, #73, #6, #29, and #49 received no ill effects due to not receiving a copy of bed hold policy prior to being sent to the ED. Each resident returned to FMM, without issue 2. All residents who are transferred to the ED have the potential to be affected by the same practice. Residents who are currently in the hospital and have not returned to the facility will be provided a copy of the bed hold notice. Residents bei	the le.	
	by: Based on staff intervie	is not met as evidenced w, facility document ord review, the facility staff de written information			sent to the ED will be provided of the facility bed hold notice.	<b>Г</b>	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 8XB411

Facility ID: VA0086

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PRINTED: 05/16/2019 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		<u> </u>			OMB NO. 0938-0391		
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	4	E SURVEY PLETED
		495384	B. WING			0.5	C 3/03/2019
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03	10312013
FRANCIS	MARION MANOR HEALT	H & REHABILITATION		1	00 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	<u> </u>	DROVED EDIS DI ANI OF CORDESTION	<del></del>	T
PRÉFIX TAG	(EACH DEFICIENC) REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E VTE	(X5) COMPLETION DATE
F 625	Continued From page	41	F	625	3. Nursing, Social Worker and	1	
	transferred to the hospital (Resident #9, Resident #73, Resident #6, Resident #29, and Resident		٠		Business Office team member		
	#49).			.	will be re-educated regarding	the	
					requirement to provide each		
	The findings included:				resident or resident		
	4 2001 4 111				representative a copy of the be	d	
	1. The facility staff fai	led to offer and provide			hold policy, prior to the reside	nt	
written bed hold information when Resident #9 was transferred to the emergency room on				leaving the facility or in the ca	111		
	4/30/19.	emergency room on			of an emergency, within 24	IDG	
	-700/10.				hours.		
	The clinical record of I	Resident #9 was reviewed			nours.		
	4/30/19 through 5/3/19						
		7/13/16 with diagnoses that			4. The DON or designee will	i	
		d to acute urinary tract			audit to ensure a copy of the b	ed	
		oxia, CHF (congestive		ĺ	hold policy is given to the		
	heart failure), hypothy	roldism, excessive upper			resident or resident	ļ	
	gastrointestinal gas, o	besity, paranoid			representative when being		
Ī	and thrombocytopenia	sion, hypertension, anemia,			transformed as assistant to the		
	and unombodytopenia	•	-		transferred as required. Audits	3	
1	Resident #9's quarterly	/ minimum data set (MDS)			will be done twice weekly, wh	en	
	assessment with an as	ssessment reference date			transfers occur, for 12 weeks a	nd	
		ssed the resident with a			then monthly x 6 months. Any	, ]	
	BIMS (brief interview f	or mental status) as 3/15.		1	discrepancy will be addressed		
	Resident #9 was asset	ssed without any signs or			with the nurse in charge of the		
		psychosis, or behaviors			transfer. Data will be reported		
-	that affected others.	•			the QAPI team for further	.	
	The clinical record pro-	gress note dated 2/4/19 at			intervention.		
		aled the resident was found		-	· HILL VOILUOII.		
	in the floor by a certifie					1	
Ī	2/4/19 at 5:30 p.m. c/	o (complained of) left hip			5. Corrective action will be	l	
	and neck pain. Report	ed to medical doctor with			complete by 06/07/19.		
	new order to send to E	D (emergency department)					
	for eval (evaluation). A		1		6. DON or designee	-	
	transport (name omitte	a).			The state of the s	pine-res	
	2/4/19 18:30 (6:30 p.m	.) Ambulance service here					

495384 B. WING COMPI	C 03/2019
	03/2019
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  100 FRANCIS MARION LANE, PO BOX 880  MARION, VA 24354	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Continued From page 42 to transport to ED (emergency department) for eval (evaluation) & tx (treatment) re: fail. Report called to ED.  The clinical record did not have documentation that bed holds were offered and information about bed holds provided to Resident #9 on 2/4/19.  Resident #9's clinical record revealed the resident was found in the floor 4/30/19 at 1945 (7:45 p.m.). The resident was found lying in front of her roommate's bed. Resident was lying in the prone position with her face against the floor and stated she had stood up and was bending over to pick something up from the floor when she lost her balance and fell. The resident stated she did not lose consciousness. Resident was wearing tennis shoes but was not using walker. Call light had not been used for assist. Small amount of blood noted in the floor above resident's head. Resident assessed for back and neck injury and was then assisted to roll on to her back. Resident noted to have a discolored, raised area over her right eye. Small aceration also noted over right eye. Raised discolored area noted to right hand. Resident stated she was hurting all over. Nurse practitioner, on call for MD (medical doctor) contacted and new order was received to send resident to ED (emergency department) at 1948 (7:48 p.m.). TAS (ambulance service) contacted for transport at 1947 (7:47 p.m.) report called to hospital ED at 2003 (8:03 p.m.), resident's brother notified of fall and transport to ED at 2010 (8:10 p.m.). Unon TAS arrival at 2000, (8:00 p.m.) resident was transferred on to backboard for assist from floor to stretcher. Resident stabilized. Paperwork given to ambulance staff.  The clinical record did not have documentation	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		200 1111			OWR V	IO. 0938-0391	
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495384	B. WING				C 5/03/2019
NAME OF F	PROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>, v</u>	3/03/2019
FRANCIS	MARION MANOR HEAL	TH & REHABILITATION		100 FRANCIS MARION LANE, PO BOX 6 MARION, VA 24354			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E ATE	(X5) COMPLETION DATE
F 625	Continued From page	<b>3</b> 43	F	625			
	that bed holds were offered and information about bed holds provided to Resident #9 on 4/30/19.						
	#1 on 5/2/19 at 2:49	wed licensed practical nurse o.m. on what information ats when they are sent to the	The state of the s		·		
,	medication administration pertinent labs, ER (en advanced directives, and emergency transities asked if the facility seplan goals with the redoesn't send them and	sheet, history and physical, ation records (MARs)s, any nergency room) order, POA # (power of attorneys), fer sheet. L.P.N. #1 was nt the comprehensive care sident. L.P.N. #1 stated she d didn't know about bed ed the business office does		THE PROPERTY OF THE PROPERTY O			
THE PROPERTY OF THE PROPERTY O	assistant stated bed h	2:57 p.m. The admissions old information was but not when the residents					
`	director of nursing of to 5/2/19 at 4:32 p.m. The every resident was we	the administrator and the he above concerns on he administrator stated elcomed back and bed holds be urveyor requested a copy of holds.		***************************************			
	Readmission Policy-Fr	les information for first notice is given on		eri erinaka ka ka ka ka ka ka ka ka ka ka ka ka			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
							С
		495384	B. WING			0.5	5/03/2019
	ROVIDER OR SUPPLIER  MARION MANOR HEALT	TH & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE  100 FRANCIS MARION LANE, PO BOX 880  MARION, VA 24354			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		E NTE	(X5) COMPLETION DATE
	leave. VII. Procedure resident or legal represident or legal represident Notice of Bed-Ho is transferred to a hos leave, they will receive Hold. A. In cases of enotification is provided hours of the transfer. The resident's copy of other papers to the hour of the resident's copy of other papers to the hour of the papers to the hour of the end of the papers to the end of t	pital or takes therapeutic  ix: A. On admission the esentative will receive the ld. 1. Whenever a resident spital or takes therapeutic e another Notice of Bed emergency transfer, d within twenty-four (24) i. This requirement is met if the notice is sent within espital."  was provided to the exit conference on 5/3/19.  led to offer and provide nation when Resident #73 emergency room on  Resident #73 was reviewed 9. Resident #73 was 7/26/15 and readmitted s, that included but not cellulitis of right leg, y disease stage 3, CVA dent), falls, CHF re), depression, rheumatoid acute decline, DVT (deep 0 (coronary artery disease)	F	62:	5		

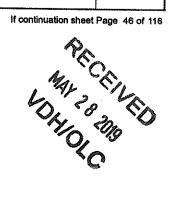
PRINTED: 05/16/2019 FORM APPROVED

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING_	And the state of t	1 ' '	PLETED	
		495384	B. WING			0.5	C 5/03/2019	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		#00/2013	
FRANCIS	MARION MANOR HEALT	TH & REHABILITATION			00 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	<b>L</b>	PROVIDER'S PLAN OF CORRECTION	OF CORRECTION		
PREFIX TAG	(EACH DEFICIENC REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E NTE	(X5) COMPLETION DATE	
F 625	Continued From page	45	F	625				
		ogress note dated 2/9/19 at						
		as called to the room by						
	of) increase in pain R	n side of bed-c/o (complains						
	extremity)-dark purple							
	increasing in size-app	ears to have large						
		nder skin-resident grimaces						
	of)-v/s (vital signs) 97.	no other c/o (complaints						
	Olj-v/a (vital signs) 31	.1, 9170, 12, 221/03.						
	2/9/19 0037 Nurse practitioner, on call,							
		eceived to send to ed						
	(emergency departme tx (treatment).	ent) for eval (evaluation) and						
	2/9/19 0041 resident f	amily notified						
1777	2/9/19 0045 tas (ambu for transport	ulance service) contacted	**************************************					
	2/9/19 0054 report cal nurse) at name of hos	led in to rn (registered pital ed.	**************************************					
-	2/9/19 0058 tas here f	or transport.						
	(patient) was on her w	report from ed-stated pt ay back-stated clot had ematoma and area has						
THE THE PROPERTY OF LAND	The clinical record did bed hold information.	not have documentation of		***************************************				
	#1 on 5/2/19 at 2:49 p.	red licensed practical nurse m. on what information s when they are sent to the						
	L.P.N. #1 stated face s	sheet, history and physical.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 8XB411

Facility ID: VA0086



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STATEMENT	OF DEFICIENCIES	(V4) PDO/8DCD/01/201/50/01/4				<u>OMR M</u>	O. 0938-0391
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ECONSTRUCTION		E SURVEY IPLETED
			A. BOILL	MING_	****	00%	
		495384	B. WING			n,	C 5/03/2019
NAME OF P	ROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE		//USIZU13
FRANCIS	MARION MANOR HEALT	W & DEMARII ITATION		1	00 FRANCIS MARION LÂNE, PO BOX 880		
		THE REPORT OF			MARION, VA 24354		
(X4) ID	SUMMARY ST/	ATEMENT OF DEFICIENCIES	ID	<u> </u>	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION
1710	1.2000 (101(1) 0)(1	OODERIN THO INFORMATION)	TAG	i	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΙŒ	DATE
			<del> </del>		DE ROLLACT)		
F 625	Continued From page	46	_	^^=			
	· -		F	625			
	netinent lanc ED (en	ition records (MARs)s, any nergency room) order,					
:	advanced directives I	POA# (power of attorneys),					
	and emergency transf	er sheet. L.P.N. #1 was					
	asked if the facility ser	nt the comprehensive care					
	plan goals with the res	sident. L.P.N. #1 stated she					
	doesn't send them and	didn't know about bed					
	holds. L.P.N. #1 state	d the business office does					
	the bed holds.						
	•						]
	The surveyor interview	ved the admissions					
	assistant on 5/2/19 at	2:57 p.m. The admissions			•		]
	assistant stated bed he			İ			
	were sent to the emer	but not when the residents					
İ	were sent to the enter	gency room.					
	The surveyor informed	the administrator and the	,				
	director of nursing of the	ne above concerns on	Ī	ı			
1	5/2/19 at 4:32 p.m. Th	e administrator stated					
[	every resident was we	comed back and bed holds					
	were not done. The su	rveyor requested a copy of		ļ		İ	
	the facility policy on be	d holds.					
	The facility nation titled	"i. Title: Bed-Hold and					[
	Readmission Dollor Er	ancis Marion Manor" read					
	in part "VI. Policy: A F	Residents or their legal					
	representative will rece	ive two (2) hed-hold					
	notifications that includ	es information for					
	readmission. B. The						
-	admission and the sec	ond anytime they are					
	transferred to the hosp	ital or takes therapeutic					
	leave. VII. Procedure:	A. On admission the					
-	resident or legal repres	entative will receive the				ĺ	
		l. 1. Whenever a resident					
	is transferred to a hosp	ital or takes therapeutic				***************************************	
	leave, they will receive	another Notice of Bed				-	
	Hold. A. In cases of en	nergency transfer,					
	nouncation is provided	within twenty-four (24)					
	nours of the transfer. i.	This requirement is met if					

TEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DAT	E SURVEY PLETED
·	495384	B. WING				С
ME OF PROVIDER OR SUPPLIER		J. 741110			05	/03/2019
RANCIS MARION MANOR HEALTI	H & REHABILITATION		10	TREET ADDRESS, CITY, STATE, ZIP CODE 00 FRANCIS MARION LANE, PO BOX 880 1ARION, VA 24354		
PREFIX (EACH DEFICIENCY			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E NTE	(X5) COMPLETION DATE
other papers to the hose No further information surveyor prior to the example of the facility staff fails written bed hold inform was transferred to the 2/1/19.  The clinical record of R 4/30/19 through 5/3/19 admitted to the facility sincluded but not limited acute renal failure, hypotronchitis, acute-on-chipneumonia, anemia, chipulmonary disease (CC (chronic kidney disease diabetes mellitus, hyperpsychosis and insomnia Resident #6's quarterly with an assessment refiniterview for mental star #6 was assessed without of delirium, psychosis, cothers.  The surveyor interviewer at 9:43 a.m. Resident #6 been any recent hospital surveyor interviewer at 9:43 a.m. Resident #6 been any recent hospital surveyor interviewer at 9:43 a.m. Resident #6 been any recent hospital surveyor interviewer at 9:43 a.m. Resident #6 been any recent hospital surveyor interviewer at 9:43 a.m. Resident #6 been any recent hospital surveyor interviewer at 9:43 a.m. Resident #6 been any recent hospital surveyor interviewer at 9:43 a.m. Resident #6 been any recent hospital surveyor interviewer at 9:43 a.m. Resident #6 been any recent hospital surveyor interviewer at 9:43 a.m. Resident #6 been any recent hospital surveyor interviewer at 9:43 a.m. Resident #6 been any recent hospital surveyor interviewer at 9:43 a.m. Resident #6 been any recent hospital surveyor interviewer at 9:43 a.m. Resident #6 been any recent hospital surveyor interviewer at 9:43 a.m. Resident #6 been any recent hospital surveyor interviewer at 9:43 a.m. Resident #6 been any recent hospital surveyor interviewer at 9:43 a.m. Resident #6 been any recent hospital surveyor interviewer at 9:43 a.m. Resident #6 been any recent hospital surveyor interviewer at 9:43 a.m. Resident #6 been any recent hospital surveyor interviewer at 9:43 a.m. Resident #6 been any recent hospital surveyor interviewer at 9:43 a.m. Resident #6 been any recent hospital surveyor interviewer at 9:43 a.m. Resident #6 been any recent hospital surveyor interviewer at 9:43 a.m. Resident #6 been any recent hosp	the notice is sent within spital."  was provided to the kit conference on 5/3/19.  ed to offer and provide lation when Resident #6 emergency room on  tesident #6 was reviewed. Resident #6 was 19/1/18 with diagnoses that 1 to syncope, weakness, onatremia, acute ronic respiratory failure, pronic obstructive DPD), obesity, CKD at (stage 4), depression, rtension, hypothyroidism, a.  minimum data set (MDS) desident with a BIMS (brief trus) as 14/15. Resident ut any signs or symptoms or behaviors that affected and Resident #6 on 5/1/19 f6 was asked if there had alizations and the resident side /leg had been broken ago during a fall. The Resident #6 had been	F	625			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATI	E SURVEY PLETED
	495384	B. WING			l	C / <b>03/2019</b>
NAME OF PROVIDER OR SUPPLIER FRANCIS MARION MANOR HEALTH &	REHABILITATION		10	TREET ADDRESS, CITY, STATE, ZIP CODE 00 FRANCIS MARION LANE, PO BOX 880 IARION, VA 24354	<u> </u>	103/2019
PREFIX (EACH DEFICIENCY MU	IENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E NTE	(X5) COMPLETION DATE
what information was proprovider when the resider emergency room or when The clinical record did not about bed holds  The surveyor was unable that bed hold information resident on 2/1/19.  The surveyor interviewed #1 on 5/2/19 at 2:49 p.m. was sent with residents where emergency room.  L.P.N. #1 stated face sheem edication administration pertinent labs, ER (emergency advanced directives, POA and emergency transfer shasked if the facility sent the plan goals with the resider doesn't send them and did holds. L.P.N. #1 stated the bed holds.  The surveyor interviewed the assistant on 5/2/19 at 2:57 assistant stated bed hold in provided on admission but were sent to the emergence.  The surveyor informed the director of nursing of the assistant was welcome were not done. The surveyor informed the director of nursing of the assistant was welcome were not done. The surveyor informed the director of nursing of the assistant was welcome were not done. The surveyor informed the director of nursing of the assistant was welcome were not done. The surveyor informed the director of nursing of the assistant was welcome were not done. The surveyor the facility policy on bed how the facility policy on the fa	at was sent to the at the resident returned. It contain any information to locate any evidence was offered to the licensed practical nurse on what information hen they are sent to the et, history and physical, records (MARs)s, any ency room) order, # (power of attorneys), heet. L.P.N. #1 was e comprehensive care int. L.P.N. #1 stated she in the know about bed e business office does the admissions of p.m. The admissions formation was anot when the residents by room.  It administrator and the bove concerns on diministrator stated ned back and bed holds yor requested a copy of		325			

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	CVANABI	7101	-001077147714	T	<u>0. 0938-0391</u>
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD		ECONSTRUCTION		E SURVEY PLETED
			~ BOILD				
		495384	B. WING	<del></del>		1	C
NAME OF F	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	05	//03/2019
EDANCIE	MADION REAMOD HEALS	FILE BELLAMI IMPONE		1	00 FRANCIS MARION LANE, PO BOX 880		
FRANCIS	MARION MANOR HEALT	H & REHABILITATION			MARION, VA 24354		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	L	PROVIDER'S PLAN OF CORRECTION		T
PREFIX		Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION
TAG	REGULATORT OR	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
					our out of		
F 625	Continued From page	e 49	F	625			
	1	d "I. Title: Bed-Hold and	'	020			
	Readmission Policy-F	rancis Marion Manor" read					
		Residents or their legal					
	representative will rec	ceive two (2) bed-hold					
	notifications that inclu						
		e first notice is given on	-				
		cond anytime they are					
	transferred to the hos	pital or takes therapeutic					
		: A. On admission the esentative will receive the					
		ld. 1. Whenever a resident					
		pital or takes therapeutic					
	leave, they will receive	e another Notice of Bed					
	Hold. A. In cases of e	mergency transfer,					
	notification is provided	within twenty-four (24)			,		
		i. This requirement is met if					
		the notice is sent within					
	other papers to the ho	spital."			•	ļ	
	No further information	was provided to the					
	surveyor prior to the e	xit conference on 5/3/19.		1			
	4. The facility staff fail	led to offer a bed hold when					
ĺ		nitted to the hospital on					
	4/24/19.						
	Resident #29 was adm	oitted to the facility on					
ľ		ring diagnoses of, but not		- 1			
	limited to cancer, anen						
<b>V</b>	disease, neurogenic b						
	disorder. On the annu	al MDS (Minimum Data					
. [	Set) with an ARD (Ass	essment Reference Date)	ĺ				
		was coded as having a					1
		for Mental Status) score of					
	15 out of a possible so	ore of 15.					
	During the clinical reco	ord review on 5/2/19, the			·		
	surveyor noted that the						ļ
		al on 4/24/19. There was					1
		ed in the clinical record that	1			1	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	li .		E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		495384	B. WING			l	C //03/2019
	PROVIDER OR SUPPLIER  MARION MANOR HEALT	H & REHABILITATION		1	TREET ADDRESS, CITY, STATE, ZIP CODE 00 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354	<u>  03</u>	103/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E VTE	(X5) COMPLETION DATE
	the resident or resider offered a bed hold.  The surveyor notified above documented fir approximately 3:30 pm "We don't offer a bed take them back." The business office staff # resident of a bed hold hospital. The busines tell them about a bed I first admitted to the fact when they are sent out.  The surveyor notified to the above documented pm in the conference of the above documented pm in the conference of the above documented pm in the conference of the above documented pm in the conference of the above documented pm in the conference of the above documented pm in the conference of the above documented pm in the conference of the above documented pm in the conference of the above documented pm in the conference of the above documented pm in the conference of the above documented pm in the conference of the above documented pm in the conference of the above documented pm in the conference of the above documented pm in the conference of the above documented pm in the conference of the above documented pm in the conference of the above documented the above documented the above documented pm in the conference of the above documented pm in the conference of the above documented pm in the conference of the above documented the above documented the above documented pm in the conference of the above documented the	the administrator of the addings on 5/2/19 at an. The administrator stated, hold because we always surveyor interviewed the 1 of when she notified the if they were admitted to the soffice staff #1 stated, "I hold when the resident is cility but I don't tell them this to the hospital."  The administrative team of a findings on 5/3/19 at 3:52 froom.  Was provided to the kit conference on 5/3/19, e facility staff failed to offer esident was transferred to anemia, congestive sion, neurogenic bladder, entia, depression, chronic disease, respiratory failure, e, atrial fibrillation and (minimum data set) with eference date) of 04/01/19 15 of 15 in section C,	F	325			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		495384	B. WING			<b>.</b>	C
	ROVIDER OR SUPPLIER  MARION MANOR HEALT	H & REHABILITATION	• • • • • • • • • • • • • • • • • • • •	1	STREET ADDRESS, CITY, STATE, ZIP CODE 100 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354		5/03/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E VIE	(X5) COMPLETION DATE
	05/01/19. It contained dated 03/11/19, which (facility name omitt Dx (diagnosis) critical The clinical record als progress note dated 0 "3/11/19 09:24 LAB C.POTASSIUM (sic) CA (name omitted) OR TO (facility name comitted) AMBULANCE TRANSPORT PT TO KNOWS AND UNDER TO ER AT (facility romitted) HERE PT ON omitted) ER". This not information on what ty sent to hospital with thhold had been offered. The surveyor spoke with on 05/02/19 at approxioffering of bed holds. The stated that she only prograding bed holds up assistant stated that she when Residents are sell we always keep their The surveyor requeste provided a copy of a fall "Bed-Hold and Readmin part "VI. Policy: B. Tadmission and the sec Resident) are transferra therapeutic leave".	I record was reviewed on a signed physician's order read in part "Sent (sic) to ded) ER (emergency room) potassium renal failure".  o contained a nurse's 3/11/19, which read in part ALL WITH CRITICAL LL (name omitted) AND DER PT (Patient) TO GO omitted) ER CALL (name ESERVICE TO ER, (name omitted) (name omitted) and the admissions assistant mately 1530 regarding the The admissions assistant ovides information on admission. Admissions are does not offer bed hold and the administrator and the administrator decility policy entitled ission Policy", which read the first notice is given on ond anytime they (the ed to the hospital or takes	F	625			
	The concern of not offe	ering the bed hold was					

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Event ID: 8XB411

Facility ID: VA0086

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		495384	B. WING				С
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	0.5	5/03/2019
	MARION MANOR HEALT	TH & REHABILITATION		1	00 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E SE	(X5) COMPLETION DATE
F 625 F 657 SS=D	discussed with the ad meeting on 05/02/19	ministrative team during a at approximately 1635.  was provided prior to exit.  Revision		625 657	F <b>657</b>		
	be- (i) Developed within 7 the comprehensive as (ii) Prepared by an interincludes but is not limit (A) The attending physical (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent practite the resident and the real explanation must be medical record if the parand their resident represent practicable for the cresident's care plan. (F) Other appropriate standing as determined as requested by the (iii) Reviewed and revisiteam after each assess comprehensive and quassessments. This REQUIREMENT in the comprehensive and process as the comprehensive and quassessments.	days after completion of sessment. erdisciplinary team, that ted to-sician. with responsibility for the esponsibility for the and nutrition services staff. icable, the participation of sident's representative(s). e included in a resident's estaticipation of the resident esentative is determined development of the staff or professionals in ed by the resident's needs resident. ed by the interdisciplinary ement, including both the arterly review			Updating care plans for all residents is a priority for the at FMM  1. Resident #49 has not experienced any ill effects from the past care plans/meetings. bedside care plan meeting is scheduled for 5/30/19.  2. All residents have the potential to be affected by the same practice during their care plan development and meeting.  3. The DON will re-educate the to update the care plan per regulations and to include the interdisciplinary team during the development and the bedside care plan meeting with the resident and/or resident representative. Participation we be documented in the medical record.	om A e e g.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 8X8411

Facility ID: VA0086



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STATEMENT	OF DEFICIENCIES	C4) D00/4000/00/00/100/100/11	T			OMB N	IO. 0938-0391
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		E CONSTRUCTION	1	TE SURVEY MPLETED
		495384	B. WING	****			C
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>  U:</u>	5/03/2019
FRANCIS	MARION MANOR HEALT	TH & REHABILITATION		100 FRANCIS MARION LANE, PO BOX 80 MARION, VA 24354			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES					
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E ATE	(X5) COMPLETION DATE
F 657	Continued From page	53	F	657	4 The DON on days		
	review and revise a ca	are plan for 1 of 18					
	residents.	,			audit care plans 3 x weekly x	12	
	The findings included:				weeks and 5 x monthly x 6 months. Any variating in the requirement will be identified		
	1. For Resident #49 th	ne facility staff failed to			and should will be identified		
	ensure that all membe	ers of the interdisciplinary			and shared with the team for		
	team were included in	the care plan process.			correction. Data will be		
	5 11 1446				reported to the QAPI team.		
	Resident #49 was adn	nitted to the facility on			-		
	US/23/16 and readmitt	ed on 03/14/19. Diagnoses			5. Corrective action will be		
	heart failure, hypothon	d to anemia, congestive sion, neurogenic bladder,			complete by 06/07/19.		
	diabetes mellitus, dem	entia, depression, chronic			6 DON on doi:		
	obstructive nulmonary	disease, respiratory failure,			6. DON or designee		
77 77	end stage renal diseas hypothyroidism.	se, atrial fibrillation and					
	The most recent MDS	(minimum data set) with					
	an ARD (assessment r	reference date) of 04/01/19					]
	coded the Resident as	15 of 15 in section C,					
	cognitive patterns. This	s is a quarterly MDS.					
	The surveyor spoke wi	ith Resident #49 on					
	04/30/19 at approxima	tely 1430. Surveyor asked					
-	Resident #49 if she wa	is invited to and attended					
		and she stated that she		ı	•		
		The last meeting I had, the					
		ed up was the kitchen girl,				1	
	because I had been co	mplaining about the food".					
		record was reviewed on					
		a sign in sheet for a care		-			
		4/04/19. The only staff					
		were the unit nurse and a				,	
	guest relations speciali	st (dietary staff).	İ		•		
	The concern of all men	nbers of the					
	interdisciplinary team n	ot participating in the care	1			]	

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Event ID: 8XB411

Facility ID: VA0086

If continuation sheet Page 54 of 116



	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE	SURVEY
	:		A. BUILD	ING_			PLETED
		495384	B. WING			l	C /03/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		00/2010
FRANCIS	MARION MANOR HEALT	H & REHABILITATION			00 FRANCIS MARION LANE, PO BOX 880 IARION, VA 24354		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E VTE	(X5) COMPLETION DATE
F 657	Continued From page	54	F	657	F658		
	plan process was disc		1		Providing services that meet		
	administrative team d	uring a meeting on 05/01/19			professional standards is prior	itv	
	at approximately 1635	5.			for the team at FMM	,	
	No further information	was provided prior to exit.					
F 658		et Professional Standards	F	658	1. (a) Resident #9 had a change	ge	
SS=E	CFR(s): 483.21(b)(3)(	i)	**************************************		in the order of Claritin. The		
	6492 24/b)/2\ Campus	handin Care Blanc			nurses were all counseled		
	§483.21(b)(3) Compre	or arranged by the facility,			regarding signing off medicati	ion	
		prehensive care plan,			as given, when not available.		
	must-				Pharmacy was notified and		
	(i) Meet professional s				medication was sent on 5/2.		
	by:	is not met as evidenced			(b) Resident #28 was assessed		
		n, staff interview, clinical			upon her return from the ED o		
	record review, and a n	nedication pass and pour			1/18/19 as the documentation	in	
	observation the facility				the progress note demonstrate	d.	
	residents (Resident #9	s of practice for 3 of 18			Resident #28 was readmitted		
	Resident #54).	, resident has and			from a short stay at the hospital	al	
					on 2/23/19. The record shows		
	The findings included:				Nursing Admission Assessme	nt	
	1. For Resident #9 the	facility staff failed to follow			was completed upon resident		
	professional standards	of practice for the			return. (see appendix 1)		
		cations as evidenced by			(c) Resident #54 did not have	a	
	signing for a medication administration.	n that was unavailable for			diagnosis associated with the		
	wastiingu quyii,		-		medication on the written orde	er.	
[	Resident #9 was admi				Both medications have		
		ncluded but not limited to			associated diagnosis in the		
	anemia, congestive he and schizophrenia.	art failure, hypertension			electronic medical record. Zo	loft	
	· · · · · · · · · · · · · · · · · · ·				50 mg is for depression and		}
awata.		(minimum data set) with			Ibuprofen BID is for pain.		
ŀ		reference date) of 02/10/19			Orders were clarified on 5/22	to	
ļ	coded the Resident as	3 of 15 in section C,			include the diagnosis		

F 658 Continued From page 55 cognitive patterns. This is a quarterly MDS.  Surveyor observed LPN # 1 (licensed practical nurse) on 05/01/19 at approximately 0835 during a medication pass and pour. Surveyor observed LPN #1 prepare and administer the Residents medications.  Surveyor reconciled the medications with the clinical record on 05/01/19 at approximately 0930. Resident #9's clinical record contained a signed physician's order summary for the month of May  TAG  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  2. All residents have the potential to be affected by the same practice. (a) An audit will be conducted to ensure all medications are available as ordered. Any discrepancy will be reported to the pharmacy and/or physician for clarification and nursing leadership. (b) Licensed Nursing staff will be reeducated on the facility protocol		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '		CONSTRUCTION		SURVEY
NAME OF PROVIDER OR SUPPLIER  FRANCIS MARION MANOR HEALTH & REHABILITATION  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 658  Continued From page 55 cognitive patterns. This is a quarterly MDS.  Surveyor observed LPN # 1 (licensed practical nurse) on 05/01/19 at approximately 0835 during a medications are available as medications.  Surveyor reconciled the medications with the clinical record on 05/01/19 at approximately 0930. Resident #9's clinical record on to 5/01/19 at approximately 0930. Resident #9's clinical record contained a signed physician's order summary for the month of May  STREET ADDRESS, CITY, STATE, ZIP CODE 100 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  2. All residents have the potential to be affected by the same practice. (a) An audit will be conducted to ensure all medications are available as ordered. Any discrepancy will be reported to the pharmacy and/or physician for clarification and nursing leadership. (b)  Licensed Nursing staff will be reeducated on the facility protocol				155,				C
FRANCIS MARION MANOR HEALTH & REHABILITATION  (X4) ID PREFIX TAG  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 658  Continued From page 55  cognitive patterns. This is a quarterly MDS.  Surveyor observed LPN # 1 (licensed practical nurse) on 05/01/19 at approximately 0835 during a medication pass and pour. Surveyor observed LPN #1 prepare and administer the Residents medications.  Surveyor reconciled the medications with the clinical record on 05/01/19 at approximately 0930. Resident #9's clinical record contained a signed physician's order summary for the month of May  STREET ADDRESS, CITY, STATE, ZIP CODE  100 FRANCIS MARION LANE, PO BOX 880  MARION, VA 24354  PROVIDER'S PLAN OF CORRECTION (CEACH CORRECTION HOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  2. All residents have the potential to be affected by the same practice. (a) An audit will be conducted to ensure all medications are available as ordered. Any discrepancy will be reported to the pharmacy and/or physician for clarification and nursing leadership. (b)  Licensed Nursing staff will be reeducated on the facility protocol			495384	B. WING	····			-
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 658  Continued From page 55 cognitive patterns. This is a quarterly MDS.  Surveyor observed LPN # 1 (licensed practical nurse) on 05/01/19 at approximately 0835 during a medication pass and pour. Surveyor observed LPN #1 prepare and administer the Residents medications.  Surveyor reconciled the medications with the clinical record on 05/01/19 at approximately 0930. Resident #9's clinical record contained a signed physician's order summary for the month of May  MARION, VA 24354  D PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  2. All residents have the potential to be affected by the same practice. (a) An audit will be conducted to ensure all medications are available as ordered. Any discrepancy will be reported to the pharmacy and/or physician for clarification and nursing leadership. (b)  Licensed Nursing staff will be reeducated on the facility protocol	NAME OF P	ROVIDER OR SUPPLIER						
(X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 658  Continued From page 55 cognitive patterns. This is a quarterly MDS.  Surveyor observed LPN # 1 (licensed practical nurse) on 05/01/19 at approximately 0835 during a medication pass and pour. Surveyor observed LPN #1 prepare and administer the Residents medications.  Surveyor reconciled the medications with the clinical record on 05/01/19 at approximately 0930. Resident #9's clinical record contained a signed physician's order summary for the month of May  D PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  2. All residents have the potential to be affected by the same practice. (a) An audit will be conducted to ensure all medications are available as ordered. Any discrepancy will be reported to the pharmacy and/or physician for clarification and nursing leadership. (b)  Licensed Nursing staff will be reeducated on the facility protocol	FRANCIS	MARION MANOR HEAL	TH & REHABILITATION					
F 658  Continued From page 55 cognitive patterns. This is a quarterly MDS.  Surveyor observed LPN #1 (licensed practical nurse) on 05/01/19 at approximately 0835 during a medications.  Surveyor reconciled the medications with the clinical record on 05/01/19 at approximately 0930. Resident #9's clinical record contained a signed physician's order summary for the month of May  PREFIX TAG  PREFIX TAG  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  OCMPLETION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  OCMPLETION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  OCMPLETION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  OCMPLETION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  OCMPLETION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  OCMPLETION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  OCMPLETION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  OCMPLETION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  OCMPLETION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  OCMPLETION  OCMPLETION  SAME TO THE APPROPRIATE  OCMPLETION  OCMPLETIO		C. D. D. D. D. D. D. D. D. D. D. D. D. D.			N			
cognitive patterns. This is a quarterly MDS.  Surveyor observed LPN # 1 (licensed practical nurse) on 05/01/19 at approximately 0835 during a medication pass and pour. Surveyor observed LPN #1 prepare and administer the Residents medications.  Surveyor reconciled the medications with the clinical record on 05/01/19 at approximately 0930. Resident #9's clinical record contained a signed physician's order summary for the month of May  F 658  potential to be affected by the same practice. (a) An audit will be conducted to ensure all medications are available as ordered. Any discrepancy will be reported to the pharmacy and/or physician for clarification and nursing leadership. (b)  Licensed Nursing staff will be reeducated on the facility protocol	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
(Loratadine) Give 1 tablet by mouth one time a day for possible drug reaction". This order is listed as active with a start date of 03/28/19. The surveyor did not observe LPN #1 administer Claritin to the Resident.  Resident #9's eMAR (electronic medication record) for the month of May 2019 was reviewed. It contained an entry, which read in part "Claritin Tablet 10 mg (Loratidine) Give 1 tablet by mouth one time a day for possible drug reaction". This entry was initialed as administered on 05/01/19 at 0900.  Surveyor spoke with LPN #1 on 05/01/19 at approximately 1125. Surveyor asked LPN #1 if he had administered the Resident's Claritin, and he stated, "I'm sure I did". He then proceeded to check the medication cart for the Resident's Claritin. The Claritin could not be located in the medication cart.  Surveyor spoke with the pharmacist on 05/01/19 at approximately 1450 regarding Resident #9's Claritin. Pharmacist stated the Claritin had not been sent to the facility spince 03/26/19 and they	F 658	cognitive patterns. The Surveyor observed Linurse) on 05/01/19 at a medication pass and LPN #1 prepare and medications.  Surveyor reconciled to clinical record on 05/0 Resident #9's clinical physician's order sum 2019, which read in possible drug listed as active with a surveyor did not obsect Claritin to the Resident Resident #9's eMAR record) for the month It contained an entry, Tablet 10 mg (Loratidione time a day for posentry was initialed as 0900.  Surveyor spoke with It approximately 1125. Shad administered the stated, "I'm sure I did" check the medication Claritin. The Claritin comedication cart.  Surveyor spoke with that approximately 1450 Claritin. Pharmacist states of the states of t	PN # 1 (licensed practical tapproximately 0835 during di pour. Surveyor observed administer the Residents  the medications with the 01/19 at approximately 0930. record contained a signed amary for the month of May part "Claritin Tablet 10 mg ablet by mouth one time a reaction". This order is start date of 03/28/19. The erve LPN #1 administer int.  (electronic medication of May 2019 was reviewed. which read in part "Claritin ine) Give 1 tablet by mouth administered on 05/01/19 at Surveyor asked LPN #1 if he Resident's Claritin, and he did the Claritin the pharmacist on 05/01/19 or regarding Resident #9's tated the Claritin had not	F	358	potential to be affected by the same practice. (a) An audit we be conducted to ensure all medications are available as ordered. Any discrepancy wis be reported to the pharmacy and/or physician for clarificate and nursing leadership. (b) Licensed Nursing staff will be educated on the facility protofor assessing a resident on ret from the ED and/or hospitalizations (c) All Physician Order Sheets for the month of May have diagnoses associated with the medication An audit will be conducted to check all orders written after POS was signed in the month May to ensure a diagnosis is associated with each medication of the deficient practice is found, physician will be notified and will provide a clarification or of the same procedure will be educated proper procedure will be educated proper procedure will be a same procedure will be educated proper procedure will be a same procedure will be educated proper procedure will be a same procedure will be educated proper procedure will be a same p	vill  ion e re- col urn e s ns. the of on. the der.	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA ·	(X2) MUL	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED			
							С	
		495384	B. WING			1	03/2019	
NAME OF F	PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	03/2013	
FRANCIS	MARION MANOR HEALT	'H & REHABILITATION		1	00 FRANCIS MARION LANE, PO BOX 880			
				N	MARION, VA 24354			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENGED TO THE APPROPRIA DEFIGIENCY)	E VTE	(X5) COMPLETION DATE	
	had received a discort on 03/27/19.  Surveyor reviewed the month of April and cort of Claritin for Resident pharmacy manifest for entry that read in part, (Resident #9), Descrip Quantity: 14, Status: It Resident #9's eMAR for was reviewed and contin part "Claritin Tablet tablet by mouth one tin reaction -Start date- 00 been initialed as being of the month.  Surveyor spoke with the approximately 1600 re Claritin. DON provided of a physician's order of in part "Decrease Loraday)". DON also provided of a physician's order of in part "Decrease Loraday)". DON also provided of a physician's order of in part "Decrease Loraday)". DON also provided of a physician's order of in part "Decrease Loraday)". DON also provided of a physician's order of in part "Decrease Loraday)". The nurse computer from the han paper chart".  Surveyor informed the medication, Claritin was medication cart to be a nurses had been signir	e pharmacy manifest for the ald not locate any deliveries at #9. Surveyor reviewed the ro3/26/19. It contained an "Patient Name: otion: Loratidine 10 mg, Delivered". Or the month of April 2019 stained an entry which read 10 mg (Loratidine) Give 1 me a day for possible drug 3/28/19". This entry had administered for each day administered for each day the surveyor with a copy dated 03/27/19, which read tidine 10 mg qd (every led the surveyor with a commendation dated in part "2. Resident on BID in consider reducing to one the DON how the facility armacy, and DON is input the orders in the dwritten orders in the dwritten orders in the dministered, but the ig for it. Surveyor also the medication had not	F	658	proper documentation on the MAR. (The physician will be notified to receive new orders pharmacy and/or nurse leadership will be notified alor with resident and resident representative). (b) A review findings for assessments will be completed with nursing team a reinforcement of need for assessments upon any return to the facility. (c) Education will reinforced to include diagnosis with every medication order received.  4. The DON or designee will audit (a) medication passes for five residents to ensure medications are available as ordered weekly x 12 weeks an monthly x 6 months. (b) An au of all residents who transfer to and return from the ED will be conducted to ensure there is a mini-assessment documented if the progress note weekly x 12 weeks and monthly x 6 months.	ng of oe and o be s		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 8XB411

Facility ID: VA0086

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		495384	B. WNG			1	С
NAME OF P	ROVIDER OR SUPPLIER					05	/03/2019
	MARION MANOR HEALT	TH & REHABILITATION		10	TREET ADDRESS, CITY, STATE, ZIP CODE 00 FRANCIS MARION LANE, PO BOX 880 IARION, VA 24354		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	Κ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E VIE	(X5) COMPLETION DATE
The state of the s	O3/26/19.  The surveyor request standards of practice administration and the surveyor on 05/03/19 have a one.  According to "Lippinco Medication Administration rights of medication. Right Patient. 2. The right medication. 3. The right dose. 4. The right time. 5. The right document. 7. The right document. 7. The right action. 8. The right form. 9. The right response. The concern of not followed at approximately 1625. No further information. 2. The facility staff fail assessment after Resifrom ER (emergency rows). Resident #28 was read. 2/23/19 with the follow limited to atrial fibrillatid disease, high blood prince.	ed a copy of the facility for medication a DON informed the that the facility does not  of Procedures Safe ation Practices, General" the ion administration are:  In  dministration ation  lowing professional was discussed with the uring a meeting on 05/02/19  .  was provided prior to exit. led to document an dent #28 returned to facility loom) visits on 1/18/19 and  dmitted to the facility on ing diagnoses, but not on, coronary artery lessure, renal failure, On the significant change loset with an ARD	Fe	658	(c) An audit of all new medication orders will be conducted to ensure a diagnosis present with each medication weekly x 12 weeks and month x 6 months. Variances in the above audits will be investigated and correction made as appropriate. The DON/design will monitor the audit results are trends and needed actions. Date will be reported to the QAPI team for further recommendations.  5. Corrective action will be complete by 06/07/19.  6. DON or designee	on aly ted nee for	

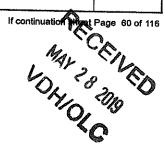
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
	495384					С	
NAME OF P	ROVIDER OR SUPPLIER		B. WING	S	TREET ADDRESS, CITY, STATE, ZIP CODE	0	5/03/2019
FRANCIS	MARION MANOR HEALT			1	00 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E VTE	(X5) COMPLETION DATE
F 658	Interview for Mental S possible score of 15. coded as only requirir and limited assistance bathing.	is having a BIMS (Brief tatus) score of 15 out of a Resident #28 was also ig supervision with dressing for personal hygiene and	F	658	·		
	clinical record review. the resident had been 2/20/19. There was deprogress notes dated in part pm) which read in part resident r/t (related to) extremity edema." documentation which is(name of hospital	shortness of breathe-lower At 2215 (9:15 pm), there was read, "returned from I ER) via (by) stretcher via on) Skin w/d (warm and		THE PROPERTY OF THE PROPERTY O			
	documented in the nur nurse was called to roo (wheelchair) slumped pecolor and cyanotic arousesponse to touch or verespirations 20 O2 (oxyunable to obtain blood bed." There was not a	/gen) sat (saturation) 88% pressure; assisted back to		THE PROPERTY OF THE PROPERTY O			
1   1   (   t	the above documented om and again on 5/3/19 conference room. The (director of nursing) wh the facility from being a expect your nurses' to p	surveyor asked the DON en a resident returns to		THE PROPERTY OF THE PROPERTY O			

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) 148 II	TIOL		OMB NO. 0938-039		
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY	
	A SOLDAYS			1 60	MPLETED			
		495384	B. WNG				С	
NAME OF P	ROVIDER OR SUPPLIER			-		0	5/03/2019	
				E	STREET ADDRESS, CITY, STATE, ZIP CODE		,	
FRANCIS	MARION MANOR HEALT	TH & REHABILITATION			00 FRANCIS MARION LANE, PO BOX 880			
~~					MARION, VA 24354			
(X4) ID PREFIX	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	. ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA	E	COMPLETION	
					DEFICIENCY)	VIE.	DATE	
_								
F 658	- on and or rom page		F	658	,			
	DON stated, "Yes". T	he surveyor requested a	ĺ					
	copy of the facility's st	andard of practice					•	
	concerning performing	assessments of the						
	resident that returns to	the facility from the ER.						
	O= 5/0/40 × 4.00							
	On 5/3/19 at 4:30 pm,	the surveyor notified the						
	practice for purson an	rneeded a standard of rforming assessments.			,			
	The DON stated "Mo	have looked and I don't		.				
	have one. But I do ex	nect the nurses' to do			•			
	assessments on the re	esidents when they come						
1	back to us from the EF	S."		1				
ľ	No further information	was provided to the						
	surveyor prior to the ex	kit conference on 5/3/19.						
	O The section of section							
İ	3. The facility staff faile	ed to document a						
ļ	diagnosis for medication	ons that the nurses' ers from the physician for						
	Resident #54.	ers from the physician for		İ				
1	. 100100111 110-4.							
	Resident #54 was adm	itted to the facility on						
	7/27/18 with the followi	ng diagnoses of, but not						
[ ]	limited to anemia, dem	entia, anxiety disorder						
(	depression, psychotic o	disorder and asthma. On			,			
1	the quarterly MDS (Min	imum Data Set) with an						
1	ARD (Assessment Refe	erence Date) of 4/5/19, the						
	resident was coded as	having a BIMS (Brief						
[ ]	interview for Mental Sta	atus) score of 11 out of a						
	possible score of 15. R	Resident #54 was also	ļ.					
	staff members for dress	nsive assistance from 2						
1	otally dependent on 2	staff members for bathing.						
[		monuora for patillity.			·			
7	The surveyor conducted	d a review of Resident						
#	54's clinical record and	noted that on the dates						
<b>]</b> t	elow, these medication	ns did not have a						
[ c	liagnosis as to tell what	t the medication was						
b	eing taken for:							
DIA CHE OCOZIO	23 00) Description Management Character						·	

Event ID: 8XB411

Facility ID: VA0086



STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE SURVEY		
MADICANC	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	A. BUILDING		COMPLETED		
		495384	B. WING	B. WING			С	
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 08	5/03/2019	
FRANCIS	MARION MANOR HEALT	H & REHABILITATION		1	00 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354			
(X4) ID PREFIX	SUMMARY STA	ATEMENT OF DEFICIENCIES	GI		PROVIDER'S PLAN OF CORRECTION		(X5)	
TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI TAG	×	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E VTE	COMPLETION DATE	
F 658	Continued From page	60	F	558				
	mouth) qd (every day)	50 mg (milligram) po (by " 300 mg Ibuprofen BID (twice	AND THE PROPERTY OF THE PROPER					
	office on 5/3/19 at 10 a requested a copy of the	documented findings in her am. The surveyor e facility's policy or at the facility uses as an						
	findings. The surveyor had copies of the items DON stated, "We don't on how to write a verba asked the DON does s include a diagnosis whorder for such. The DO should be included on	the above documented did ask the DON if she so documented above. The have a standard or policy all order." The surveyor he expect her staff to en they are writing a verbal DN stated, "Yes, this the order sheet."	The state of the s	THE PROPERTY OF THE PROPERTY O	<b>F676</b>			
F 676 SS=D	No further information of surveyor prior to the ex Activities Daily Living (A CFR(s): 483.24(a)(1)(b	it conference on 5/3/19. ADLs)/Mntn Abilities	F 67	76	Ensuring residents maintain the abilities and receive proper incontinence care is a priority f			
	§483.24(a) Based on the assessment of a reside resident's needs and characteristic provide the necessary consure that a resident's daily living do not dimin	ne comprehensive Int and consistent with the Incices, the facility must care and services to Incites in activities of Incites in activities of Incites and the condition demonstrate		Section 1997 and 1997	the team at FMM  1. Resident #53 experienced no infections or skin breakdown due to improper incontinence care. The two C.N.A.s were counseled and re-educated regarding incontinence care.	o ue		

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MAKE OF PROVIDER OR SUPPLIER  FRANCIS MARION MANOR HEALTH & REHABILITATION  SITERET ADDRESS, CITY, STATE, 2P CODE 100 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24384  SECULATION OF ILSE IDENTIFYING INFORMATION)  F 576  Continued From page 61 includes the facility ensuring that:  \$483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including the second with paragraph (a) of this section  \$483.24(b) (Activities of daily living:  \$483.24(b) (Activities of d	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED			
SABS 24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, \$483.24(b)(2) Mobility-transfer and ambulation, including walking, \$483.24(b)(3) Elimination-toileting, \$483.24(b)(3) Elimination-toileting, (ii) Language, (iii) Other functional communication systems. This REGUIREMENT is not met as evidenced by:   Based on observation, staf interview, facility totic propagation and procured in the course of a complaint investigation, the facility totic provided recourse of a complaint investigation, the facility totic provided recourse of a complaint investigation, the facility to carrow and the course of a complaint investigation, the facility through the carrow services in the course of a complaint investigation, the facility through the carrow and in the course of a complaint investigation, the facility tother functional communication systems.    Sabs 24(b)(2) Communication investigation, the facility tother functional communication investigation, the facility tother functional communication investigation, the facility tother functional communication investigation, the facility tother functional communication investigation, the facility tother functional communication investigation, the facility tother functional communication investigation, the facility tother functional communication investigation, the facility tother functional communication investigation, the facility tothe functional communication investigation, the facility tother functional communication investigation, the facility tother functional communication investigation, the facility and functional communication investigation, the facility tother functional communication investigation, the facility tother functional communication investigation, the facility and functional communication investigation, the facility and functional communication investigation in facility and functional communication in facility and functional communication in facility and functional communication investigation in facility and functional communication in facility				T. Bullet						
FRANCIS MARION MANOR HEALTH & REHABILITATION  (C4) ID PREFIX 1/AG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 676  Continued From page 61 includes the facility ensuring that: \$483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section  \$483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living; S483.24(b) (1) Hygiene-bathing, dressing, grooming, and oral care,  \$483.24(b)(2) Mobility-transfer and ambulation, including walking,  \$483.24(b)(3) Elimination-toileting,  \$483.24(b)(4) Dining-eating, including meals and snacks,  \$483.24(b)(4) Dining-eating, including meals and snacks,  \$483.24(b)(4) Dining-eating, including meals and snacks,  \$483.24(b)(4) Dining-eating, including meals and snacks,  \$483.24(b)(5) Communication systems. This REGUIREMENT is not met as evidenced by. Based on observation, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, the facility staff falialet to provide incontinent care to 1 of 18	NAME OF 6		495384	-						
PREFIX TAG  FREGULATORY OR LSC IDENTIFYING INFORMATION)  FROM REGULATORY OR LSC IDENTIFYING INFORMATION)  FROM CORRECTION ACT OF LSC IDENTIFYING INFORMATION)  FROM CONTROL INC. IDENTIFYING INFORMATION)  FROM CONTROL INC. IDENTIFYING INFORMATION)  FROM CONTROL INC. IDENTIFYING INFORMATION)  FROM CONTROL INC. IDENTIFYING INFORMATION)  FROM CORRECTION CALL OF CROSS-REFERENCE OF THE AMPROPRIATE DEFICIENCY  CROSS-REFERENCE OF THE AMPROPRIATE DEFICIENCY  FROM CROSS-REFERENCE OF THE AMPROPRIATE DEFICIENCY  FROM CROSS-REFERENCE OF THE AMPROPRIATE DEFICIENCY  FROM CROSS-REFERENCE OF THE AMPROPRIATE DEFICIENCY  FROM CROSS-REFERENCE OF THE AMPROPRIATE DEFICIENCY  FROM CROSS-REFERENCE OF THE AMPROPRIATE DEFICIENCY  FROM CROSS-REFERENCE OF THE AMPROPRIATE DEFICIENCY  FROM CROSS-REFERENCE OF THE AMPROPRIATE DEFICIENCY  FROM CROSS-REFERENCE OF THE AMPROPRIATE DEFICIENCY  FROM CROSS-REFERENCE OF THE AMPROPRIATE DEFICIENCY  FROM CROSS-REFERENCE OF THE AMPROPRIATE DEFICIENCY  FROM CROSS-REFERENCE OF THE AMPROPRIATE DEFICIENCY  FROM CROSS-REFERENCE OF THE AMPROPRIATE DEFICIENCY  CROSS-REFERENCE OF THE AMPROPRIATE DEFICIENCY  ICAM CORRECTION OF THE AMPROPRIATE DEFICIENCY  SAB3.24(a)(1) A resident is given the appropriate treatment have the potential to be affected by the same practice.  3. The Skilled Nurse provided reducation to team members regarding proper continence care.  4. The DON or designee will conduct weekly audits to ensure team members are performing proper incontinence care. Audits will linded 5 residents x 12 weeks and 10 x monthly for 6 months. Any variation in proper skills will be addressed at that time and counseling provided to that team member. Data will be reported to the QAPI team for further evaluation.  5. Corrective action will be complete by 06/07/19.  6. DON or designee  6. DON or designee	FRANCIS	MARION MANOR HEALT			STREET ADDRESS, CITY, STATE, ZIP CODE  100 FRANCIS MARION LANE, PO BOX 880					
includes the facility ensuring that:  §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section  §483.24(b) Activities of daily living.  The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:  \$483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,  \$483.24(b)(2) Mobility-transfer and ambulation, including walking,  \$483.24(b)(3) Elimination-toileting,  \$483.24(b)(4) Dining-eating, including meals and snacks,  \$483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by:  Based on observation, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, the facility staff falled to provide incontinent care to 1 of 18	PREFIX	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL				₹ √ΤΕ	COMPLETION			
The findings included:  The facility staff failed to provide incontinence		includes the facility er  §483.24(a)(1) A reside treatment and service or her ability to carry of living, including those of this section  §483.24(b) Activities of The facility must provit accordance with paragactivities of daily living §483.24(b)(1) Hygiene grooming, and oral car §483.24(b)(2) Mobility including walking, §483.24(b)(3) Eliminat §483.24(b)(4) Dining-es snacks, §483.24(b)(5) Commu (i) Speech, (ii) Language, (iii) Other functional co This REQUIREMENT by: Based on observation document review, clinic the course of a compla staff failed to provide ir residents (Resident #5 The findings included:	ent is given the appropriate is to maintain or improve his put the activities of daily specified in paragraph (b)  of daily living. de care and services in graph (a) for the following: e-bathing, dressing, re, -transfer and ambulation,  ion-toileting, eating, including meals and inication, including  mmunication systems. is not met as evidenced , staff interview, facility cal record review, and in thint investigation, the facility incontinent care to 1 of 18 3).	F 6	76	incontinent have the potential be affected by the same practions. The Skilled Nurse provided education to team members regarding proper continence conduct weekly audits to ensure team members are performing proper incontinence care. Audit will include 5 residents x 12 weeks and 10 x monthly for 6 months. Any variation in proposkills will be addressed at that time and counseling provided that team member. Data will be reported to the QAPI team for further evaluation.  5. Corrective action will be complete by 06/07/19.	re- are. re lits er			

STATEMENT OF DEFICIEN AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR		TH & REHABILITATION	······································	1	STREET ADDRESS, CITY, STATE, ZIP CODE 00 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354	1 0:	5/03/2019
(X4) ID PREFIX (E/ TAG RE	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E VIE	(X5) COMPLETION DATE
The clinic 4/30/19-5 the facility but not lin back pain (gastroes hypertens)  Resident: (MDS) as reference resident we status) as with any sepsychosis Resident: one person assessed and bowel.  Current con but identification performant impaired be pain as we extensive leares for interest that the residementia, (urinary transchronic kidd peri-area we bed, offer the toilet. She	/3/19. Residential formation of the sepsion of the		F	676			

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER					05	/03/2019	
FRANCIS	MARION MANOR HEALT	TH & REHABILITATION	-	STREET ADDRESS, CITY, STATE, ZIP CODE  100 FRANCIS MARION LANE, PO BOX 880  MARION, VA 24354				
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F 676	Tom page		F	576				
	The surveyor observed certified nursing assis a.m. C.N.A. #1 enters without knocking on the knocked on the door, and stated to the surveyor and then apologized, and donned a pair of gobserved prior to glow was pulled on both sid mid-bed. When C.N.A surveyor observed the incontinent of urine. C and placed a clean brief and failed to care to the resident. Coresident up with a blan the bed. C.N.A. #1 has gloves after changing to contine the liner with a blan the bed. C.N.A. #1 has gloves after changing to c.N.A. #1 put the soile removed the trashcan replaced the liner with the regloves, walked down utility room, and threw thandwashing or hand the when C.N.A. #1 left the when the charger, and computer on wheels) to then went to the break and clocked out.  The surveyor observed.	d incontinence care with tant #1 on 5/2/19 at 7:01 ed the resident's room ne door. When the surveyor C.N.A. #1 turned around eyor she forgot to knock C.N.A. #1 closed the door gloves. No handwashing e use. The privacy curtain le of the bed to about the president had been continence to provide incontinence c						
	#2 in Resident #53's roo	om on 5/2/19 at 9:36 a.m.						

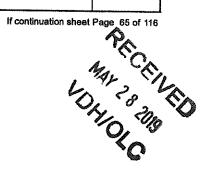
PRINTED: 05/16/2019 FORM APPROVED

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY MPLETED		
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NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	3/03/2019		
FRANCIS	MARION MANOR HEAL	TH & REHABILITATION		100 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354					
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(X4) ID PREFIX		TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID		PROVIDER'S PLAN OF CORRECTION		(X5)		
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			1/10		DEFICIENCY)	IAIE	DAIE		
F 676	Continued From pag	e 64	F	676					
	CNA #2 was starting	to provide incontinent care.					ļ		
	C.N.A. #2 had donne	d gloves on and removed							
	the brief, which was :	soiled and placed in							
		put a clean pull-up on the							
•	resident. No incontin	ence care was provided.							
		stant #3 came to assist	1						
		applied gloves. No hand							
		iene observed prior to							
		.A. #3 assisted with the							
		and shoes. The surveyor							
	observed a pad and a	a towel in Resident #53's							
		elt was placed around the							
	resident, then assiste	d to the side of the bed by							
	both c.n.a.s, and ther	transferred to the	1	ĺ			1		
		t #53's top was changed.							
	C.N.A. #2 took the tra	ish out to the buggy and							
		The surveyor did not							
	observe handwashing	g or hand hygiene after							
	C.N.A. #2's gloves we	ere removed. C.N.A. #3		-					
1	removed her gloves a						-		
1		en washed her hands after	-						
	combing hair and left								
	pushed the resident to	the hallway. Mouth care							
	not provided. No han								
		o the roommate and was							
ĺ		over the bed table and		1					
		esident. Before C.N.A. #2							
	exited the room, hand	is were washed.							
	The surveyor interview	wed certified nursing		***************************************					
		at 10:00 a.m. about the							
		servations made by the					]		
I .	surveyor. C.N.A. #2 s						***************************************		
				ĺ					
		d the administrator and the							
		ON) of the above concern							
	•	and requested information					<b>*</b>		
	***	ice care. The DON was							
	asked if incontinence	care should have been	1						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 8XB411

Facility ID: VA0086



	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
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	ROVIDER OR SUPPLIER  MARION MANOR HEALT	H & REHABILITATION		1	TREET ADDRESS, CITY, STATE, ZIP CODE 00 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354	1 03	/03/2019
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E TE	(X5) COMPLETION DATE
F 676	done after the remova DON stated yes.  The surveyor reviewed sheet on 5/3/19. The Perineal care involves the patient's external gakin. Gloves must be because of the risk of Patients who are incorrequire more frequent cleansing is performed. Female Perineal Care 1. Perform hand hygie 2. Introduce yourself to 10. b. Using a clean wwipe from the perineur back). Repeat this prousing a new washoloth and dry the area thorous 18. Discard supplies, rehand hygiene."	d the Perineal Care skill skill sheet read "Overview: a thorough cleansing of genitalia and surrounding worn during perineal care contracting an infection. Interest of urine or stool perineal care. Perineal d with soap and water.  The and don gloves. The patient ashcloth or perineal wipe, in to the rectum (front to process on the opposite side, for perineal wipe. C. Rinse ughly. The period of the period was provided prior to the was provided prior to the	F	676		F	
SS=D	out activities of daily liv services to maintain go personal and oral hygie This REQUIREMENT by:	Dependent Residents  In who is unable to carry ing receives the necessary and nutrition, grooming, and	F6	77	Providing ADL care for dependent residents is a priorit for the team at FMM  1. The C.N.A. caring for resid #53 will be counseled regarding proper oral care for residents.  Resident #53 is expressing no complaints with her oral cavity	ent g	

PRINTED: 05/16/2019 FORM APPROVED OMB NO. 0938-0301

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		495384	B. WNG			05/03/2019	
	ROVIDER OR SUPPLIER  MARION MANOR HEALT	TH & REHABILITATION		1	TREET ADDRESS, CITY, STATE, ZIP CODE 00 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354		100/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA (DEFICIENCY)	E VTE	(X5) COMPLETION DATE
	the course of a complestaff failed to provide residents (Resident # The findings included: The facility staff failed Resident #53.  The clinical record of 14/30/19-5/3/19. Resident #53.  The clinical record of 14/30/19-5/3/19. Resident facility 5/22/18 with but not limited to seps back pain, dementia, 14 (gastroesophageal ref hypertension, depress Resident #53's quarter (MDS) assessment wireference date (ARD) resident with a BIMS (status) as 3/15. Reside with any signs or symposychosis, or behavior Resident #53 required one person for toilet us assessed to be frequent and bowel. Section Lecoded for mouth or facilificalty with chewing.  Current comprehensive but identified a focus a ADL (activities of daily performance deficit r/t impaired balance, fatig pain as well. Interventing	ical record review, and in aint investigation, the facility mouth care to 1 of 18 53).  to provide mouth care to  Resident #53 was reviewed lent #53 was admitted to a diagnoses, that included is, pneumonia, chronic high cholesterol, GERD lux disease), anxiety, ion, fatigue, and tiredness.  Ity minimum data set the an assessment of 4/5/19 assessed the brief interview for mental ent #53 was not assessed bottoms of delirium, is that affected others. extensive assistance of se. Resident #53 was not pladder Oral/Dental Status was ial pain, discomfort or e care plan was undated rea that the resident had living) self-care	F	677	<ol> <li>All residents are have the potential to be affected by the same practice.</li> <li>The Skilled Nurse will reeducate team members regard proper oral care.</li> <li>The DON or designee will conduct weekly audits to ensute team members are performing proper oral care. Audits will include 5 residents x 12 week and 10 x monthly for 6 month Any variation in proper skills will be addressed at that time counseling provided to that teamember. Data will be reported to the QAPI team for further evaluation.</li> <li>Corrective action will be complete by 06/07/19.</li> <li>DON or designee</li> </ol>	ding ure s s. and	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 8XB411

Facility ID: VA0086

If continuation sheet Page 67 of 116



	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE SURVEY		
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NAME OF	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	7/03/2019	
FRANCIS	MARION MANOR HEALT	TH & REHABILITATION			100 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			QI I	<u> </u>	PROVIDER'S PLAN OF CORRECTION			
PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREF TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E VTE	(X5) COMPLETION DATE	
F 677	Continued From page	· 67		677				
	her to brush and rinse	her natural teeth twice	[	011				
	daily as needed during	g the day. A second focus						
	area was for oral/dent (related to) poor oral h	ai neaith problems r/t ivolene. Alzheimer's						
	cognition. Intervention	ns: Provide mouth care as						
	needed at least 2 time	s daily as tolerated.						
	The surveyor observe	d certified nursing assistant						
	#2 in Resident #53's re	oom on 5/2/19 at 9:36 a.m. o provide incontinent care.						
	Upon completion of inc	continence care and						
	dressing Resident #53	, C.N.A. #2 pushed the						
	resident to the hallway offered and not provide	ed. No hand washing after						
	care. C.N.A. #2 then v	vent to the roommate and						
	Was observed touching	the over the bed table and sident. Before C.N.A. #2						
	exited the room, hands	s were washed.						
	The surveyor interview	red Resident #53 after						
	being placed in the hall	The resident was asked						
	if her teeth had been be already been complete	rushed. (Breakfast had d and the trays removed						
	from the rooms). Resid	dent #53 stated, "I don't						
	think so."	·						
	The surveyor interviewe	ed certified nursing						
	assistant #2 on 5/2/19 a care provided and obse	at 10:00 a.m. about the						
	surveyor. C.N.A. #2 sta							
	The surveyor informed	the administrator and the						
-	director of nursing (DOI	N) of the above concern						
	on 5/2/19 at 4:34 p.m. a	and requested information						
	on mouth care provided previous 2 months and	to Resident #53 the						
	care.				•			
	The surveyor was provi	ded the oral care report						

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	/2019
FRANCIS MARION MANOR HEALTH & REHABILITATION  100 FRANCIS MARION LANE, PO BOX 880  MARION, VA 24354	
	(X5) COMPLETION DATE
for the previous 2 months. Oral care was provided three times in the past 2 months—47/19, 4/21/19, and 5/2/19.  The surveyor reviewed the Oral Hygiene Skills Quick Sheet on 5/3/19. The quick sheet read in part, "Frequency of oral care should be based on the condition of the patients oral cavity and his or her level of comfort.  8. Perform hand hygiene and don gloves. 9. Explain the procedure to the patient and ensure that he or she agrees to treatment. 16. Apply toothpaste to toothbrush bristles while holding the brush over the emesis basin. Pour a small amount of water over the toothpaste. 17. Brush the patients teeth or assist the patient in brushing. 19. Allow the patient to finse the mouth thoroughly with water. 20. Allow the patient finse the teeth with therapeutic mouth rinse, and then spit the rinse into the emesis basin. 28. Discard supplies, remove gloves, and perform hand hygiene.  No further information was provided prior to the exit conference on 5/3/19.  This is a complaint deficiency.  F 695 Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care, including tracheostomy care and tracheal suctioning, is provided such	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/16/2019 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING \_ COMPLETED С 495384 B. WING 05/03/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 100 FRANCIS MARION LANE, PO BOX 880 FRANCIS MARION MANOR HEALTH & REHABILITATION MARION, VA 24354 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 2. All residents who utilize F 695 Continued From page 69 F 695 oxygen have the potential to be care, consistent with professional standards of affected by the same practice. So, practice, the comprehensive person-centered an audit is being conducted to care plan, the residents' goals and preferences, and 483.65 of this subpart. ensure oxygen is set on the This REQUIREMENT is not met as evidenced proper settings for all residents. bv: When needed, education will be Based on observation, staff interview and clinical provided. record review, the facility staff failed to ensure physician's orders were followed for the administration of oxygen for 2 of 18 residents in 3. Team members will be the survey sample (Resident #27 and #28). responsible for checking oxygen settings at the first of the shift The findings included: during rounds. Any variances 1. The facility staff failed to follow physician will be reported to the charge orders for the administration of oxygen to nurse for investigation and Resident #27. correction. Resident #27 was admitted to the facility on 5/18/17 with the following diagnoses of, but not 4. The DON or designee will limited to renal failure, neurogenic bladder, observe oxygen setting for five diabetes, arthritis, Stage 3 pressure ulcer, high residents 4 x weekly x 12 weeks blood pressure and depression. On the quarterly MDS (Minimum Data Set) with an ARD of 3/3/19, and 4 x monthly thereafter. If the the resident's BIMS (Brief Interview for Mental oxygen is not on the correct Status) score of 15 out of a possible score of 15. setting, the variance will be Resident #27 was also coded as requiring investigated, corrected and the extensive assistance of 1 staff member for dressing and personal hygiene and was totally nurse will be counseled. Data

dependent on 1 staff member for bathing.

On 4/30/19 at 10:25 am, the surveyor observed the resident's oxygen was at 1 1/2 l/min via NC (nasal cannula). The surveyor asked RN

(registered nurse) #1 to come to the resident's

room and check to see if the oxygen was being administrated per physician order. RN #1 stated, "This is supposed to be on 2 l/min." RN #1

adjusted the oxygen so that it would administer 2

team.

will be reported to the QAPI

5. Corrective action will be

complete by 06/07/19.

6. DON or designee

NAME OF PROVIDER OR SUPPLIER  FRANCIS MARION MANOR HEALTH & REHABILITATION  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  100 FRANCIS MARION LANE, PO BOX 880  MARION VA. 24254	IDENTIFICATION NUMBER:	STATEMENT O AND PLAN OF
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  FRANCIS MARION MANOR HEALTH & REHABILITATION  100 FRANCIS MARION LANE, PO BOX 880	495384	
FRANCIS MARION MANOR HEALTH & REHABILITATION  100 FRANCIS MARION LANE, PO BOX 880		NAME OF PR
MARION, VA 24354		
(X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETIC DATE DEFICIENCY)	/ MUST BE PRECEDED BY FULL	PREFIX
Continued From page 70  I/min and would follow the physician's order.  The surveyor reviewed Resident #27's cilnical record on 4/30/19. According to the physician's order, the resident was to oxygen on at 2 I/min by nasal cannula.  The surveyor notified the administrative team of the above documentation on 5/1/19 at 4:45 pm and again on 5/3/19 at 3:52 pm.  No further information was provided to the surveyor prior to the exit conference on 5/3/19.  2. The facility staff failed to follow physician's order for the administration of oxygen to Resident #28.  Resident #28 was readmitted to the facility on 2/23/19 with the following diagnoses, but not limited to atrial fibrillation, coronary artery disease, high blood pressure, renal failure, diabetes and arthritis. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/3/19; the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #28 was also coded as only requiring supervision with dressing and limited assistance for personal hygiene and bathing.  During the initial tour on 4/30/19 at 10:35 am, the surveyor observed the resident stiting in her wheelchair and reading a book. The surveyor checked the oxygen to see if was on the right settings and according to the physician's order.	the physician's order.  d Resident #27's clinical cording to the physician's is to oxygen on at 2 l/min by the administrative team of ion on 5/1/19 at 4:45 pm is 3:52 pm.  was provided to the kit conference on 5/3/19.  ed to follow physician's ation of oxygen to Resident finitted to the facility on ing diagnoses, but not on, coronary artery essure, renal failure, On the significant change iet) with an ARD ie Date) of 3/3/19; the having a BIMS (Brief atus) score of 15 out of a desident #28 was also in supervision with dressing for personal hygiene and in 4/30/19 at 10:35 am, the resident sitting in her is a book. The surveyor see if was on the right to the physician's order.	# F2 lid d A (, milip c ab D sw c) se

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495384	B. WING			1	C /03/2019
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 05	103/2019
FRANCIS	MARION MANOR HEALT		100 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES ID  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX  REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
F 698 SS=D	nursing assistant) #1 I/min. CNA #1 adjuste that it would correct.  The surveyor reviewer Resident #28 on 4/30/ordered the oxygen to by nasal cannula.  The surveyor notified the above documented the above documented that again on 5/3/10.	stated it should be at 3 and the flow of the oxygen so did the clinical record for 19. The physician had be administrated at 3 l/min the administrative team of difindings on 5/1/19 at 4:45 9 at 3:52 pm.	Fe	695			
	with professional stand comprehensive persor the residents' goals an This REQUIREMENT by: Based on staff intervie and facility document r to coordinate care with	e such services, consistent lards of practice, the lards of practice, the larcentered care plan, and dipreferences.  is not met as evidenced law, clinical record review eview the facility staff failed the contracting dialysis dents, Resident #49 and layer facility staff failed to imunication forms.		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	F698 Completing dialysis communication forms is a priority for the team at FMM  1. Residents #13 and #49 have not experienced any ill effects from the communication forms not being completely filled in. However, all charge nurses hav been re-educated regarding the importance of completing the communication forms in full. Communication forms are bein completed and sent to dialysis with the residents.	re	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495384	B. WING				C
	PROVIDER OR SUPPLIER  MARION MANOR HEALT	TH & REHABILITATION	<u></u>	1	STREET ADDRESS, CITY, STATE, ZIP CODE 00 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354	<u> </u>	5/03/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 698	03/23/18 and readmit included but not limite heart failure, hyperter diabetes mellitus, den obstructive pulmonary end stage renal disea hypothyroidism.  The most recent MDS an ARD (assessment coded the Resident as cognitive patterns. The Resident #49's CCP (was reviewed and cor "Chronic renal failure, (facility name omitted) outside facility on Mor Fridays, via subclavial catheter". Intervention "observe subclavian cedema, drainage, dressite for drainage, redn patent", and "vital sign significant abnormalitic Resident #49's clinical 05/01/19. It contained dated 03/14/19, which dialysis Monday, Wed Resident #49's "Dialys were reviewed on 05/0 incomplete for the "ret forms. This section cosigns, appearance of a return to facility. The fothe "prior to departure"	ted on 03/14/19. Diagnoses and to anemia, congestive asion, neurogenic bladder, mentia, depression, chronic and disease, respiratory failure, se, atrial fibrillation and disease, respiratory failure, se, atrial fibrillation and disease, respiratory failure, se, atrial fibrillation and disease, respiratory failure, se, atrial fibrillation and disease, atrial fibrillation and disease, atrial fibrillation and disease, atrial fibrillation and disease, atrial fibrillation and disease, atrial fibrillation and disease, atrial fibrillation and disease, atrial fibrillation disease, atrial fibrillat	F	698	2. All residents who take dialysis have the potential to be affected by the same practice.  3. Nurses will be educated regarding the importance of fur completing the dialysis communication form.  4. The DON or designee will audit forms for completion for two residents weekly x 12 week and monthly for six months. If the forms are incomplete, the variance will be investigated, corrected and the nurse will be counseled. Data will be reported to the QAPI team.  5. Corrective action will be complete by 06/07/19.  6. DON or designee	lly ks f	

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		WEDIOAID GLIVICES				<u>OMB N</u>	O. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY IPLETED
		495384	B. WING			0:	C 5/03/2019
	PROVIDER OR SUPPLIER  MARION MANOR HEAD	TH & REHABILITATION		100	REET ADDRESS, CITY, STATE, ZIP CODE D FRANCIS MARION LANE, PO BOX 880 ARION, VA 24354		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ALE E	(X5) COMPLETION DATE
The second secon	section contains info signs, appearance of departure from facility. The concern of the indiscussed with the ameeting on 05/01/19  No further information 2. The facility staff facommunication sheet and the communication sheet. The clinical record of 4/30/19 through 5/3/2 admitted to the facility included but not limited disease (ESRD), voluanemia, hyperphosplarthritis, chronic respediabetes mellitus, dechypothyroidism, periphistory of CVA (cereb Resident #13's quarter (MDS) assessment wereference date (ARD) resident with a BIMS status) as 15/15. Dia O Special Treatments Programs.  Current comprehensing 5/30/18 and revised of focus area that read the contents of t	O4/24/19, and O4/29/19. This rmation on weight, vital f access site and date/time of y.  Incomplete dialysis forms was dministrative team during a at approximately 1625.  In was provided prior to exit. alled to complete the dialysis its for Resident #13.  Resident #13 was reviewed 19. Resident #13 was y9/5/18 with diagnoses, that ad to end stage renal time overload, hypertension, natemia, left shoulder irratory failure, type 2 conditioning, depression, wheral neuropathy, and rovascular accident).  Perly minimum data set ith an assessment of 2/15/19 assessed the (brief interview for mental hysis was marked in Section conditioning in Procedures and the resident is at risk for	F	698			
THE PROPERTY OF THE PROPERTY O	scheduled for Monday	nterventions: Dialysis is  , Wednesday, and Friday.  d send lunch for scheduled	The state of the s				

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AND FLAN OF CORRECTION   IDENTIFICATION NUMBER:			TE SURVEY				
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NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	8	STREET ADDRESS, CITY, STATE, ZIP CODE	05	/03/2019
EBANCIO	MADION MANOR UR			1	00 FRANCIS MARION LANE, PO BOX 880		
FRANCIS	WARION WANUR HEA	LTH & REHABILITATION		1	MARION, VA 24354		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		
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F 698	Continued From pa	ge 74		698			
		in weight and vital signs		090			
	before dialysis and	again once returned.			,		
	part "HD (hemodial) and Friday at freniu	2019 physician orders read in ysis) Monday, Wednesday, s (spelling) and assess for (right) arm dialysis shunt q	The state of the s				
	Reports" for March, The 3/1/19 dialysis documentation of the dialysis site location documented. The 3/8/19 dialysis documentation of vitemperature, pulse, to the facility. The 3/13/19 dialysis weight, vital signs, comarked or access si The 3/18/19 dialysis	ved the "Dialysis Treatment April, and May 2019. treatment report did not have e access site appearance, or weight as ordered treatment report did not have tal signs (Blood pressure, and respiration) upon return treatment report did not have lialysis access location te appearance documented. treatment report did not have		1999			
	documentation of wo or access site appea signature of the nurs from dialysis. The 3/21/19 dialysis include dialysis site appearance, or weightfrom dialysis. The document the access and signature of the The 3/22/19 dialysis include vital signs up return, dialysis accesssessment, time, dialysis it include vital signs up return, dialysis accesses assessment, time, dialysis accessions accession ac	eight, vs. access site location, arance, time, date, and se when the resident returned treatment report did not location, access site location, access site when the resident returned ialysis center failed to se site appearance, time, date nurse. It reatment report did not loon return, weight upon loss site and the site late, and signature of the		THE COLUMN TO TH			
	nurse upon return to The 4/5/19 dialysis t	the facility. reatment report did not		-			

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Event ID: 8XB411

Facility ID: VA0086

If continuation sheet Page 75 of 116



	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495384	B. WING			C 05/03/2019	
	ROVIDER OR SUPPLIER  MARION MANOR HEALT	TH & REHABILITATION		1	TREET ADDRESS, CITY, STATE, ZIP CODE 00 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354	[ 05	03/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E ATE	(X5) COMPLETION DATE
	facility. The 4/15/19 dialysis to include vital signs or vital facility. The 4/19/19 dialysis to include vital signs or vital facility, dialysis accessite appearance. The 4/22/19 dialysis to include vital signs or vital facility, dialysis access appearance, time, data receiving nurse at the The 4/24/19 dialysis to include vital signs or a upon return to the facility, dialysis access appearance, time, data receiving nurse at the The 4/29/19 dialysis to include vital signs or vitality, dialysis access appearance, time, data receiving nurse at the The surveyor informed director of nursing of the treatment reports in the on 5/2/19 at 4:34 p.m. policy on dialysis and The surveyor reviewed contract on 5/3/19. The Dialysis Services Agree Dialysis Unit will conforthan those required by regulations of any local regulatory board, as the from time to time. C. The surveyor time.	reatment report did not veight upon return to the reatment report did not veight upon return to the reatment report did not veight upon return to the site location, or access reatment report did not veight upon return to the site location, access site e and signature of the facility. The eatment report did not recess site appearance lity. The eatment report did not reight upon return to the site location, access site e and signature of the facility.  If the administrator and the he incomplete dialysis e end of the day meeting and requested the facility the dialysis contract.  If the facility's dialysis is e contract titled "Outpatient ement" read in part "5. The rm to standards not less any applicable laws and if, state or federal e same may be amended to establish, modify and deprocedures concerning	·	698			

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1	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING_		COMPLETED	
		495384	B. WNG			l ne	C 5/03/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FRANCIS	MARION MANOR HEALT	H & REHABILITATION		ŧ	00 FRANCIS MARION LANE, PO BOX 880 IARION, VA 24354		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E NTE	(X5) COMPLETION DATE
F 698	public relations, insura scheduling, and hours No further information	personnel staffing, ipment maintenance, a processing, medical atory, billing, collection, ance, cash management, of operation.	F	698			
	Treatment/Srvcs Ment CFR(s): 483.40(b)(1)  §483.40(b) Based on the assessment of a resident that §483.40(b)(1)  A resident who display mental disorder or psy difficulty, or who has a post-traumatic stress of appropriate treatment assessed problem or the practicable mental and This REQUIREMENT by:  Based on staff interview, the facility staff mental health services residents in the survey. The findings included:  The facility staff failed the services/interventions of that expressed having it is assessed to the services of the services o	the comprehensive ent, the facility must ensure so r is diagnosed with chosocial adjustment history of trauma and/or lisorder, receives and services to correct the pattain the highest psychosocial well-being; is not met as evidenced wand clinical record failed to provide adequate finterventions for 1 of 18 sample (Resident #45).	F	742	F742 Providing mental health serve for residents is a priority for team at FMM  1. Resident #45 has a history expressing suicidal ideations when frustrated or homesick. When interviewed, Resident states that the suicidal ideation was not meant and realizes the need to stop expressing frustrations in that manner. Resident #45 currently is being seen by a LCSW for counseling services.  2. All residents who express suicidal ideations have the potential to be affected by the	of #45 n e	
	Resident #45 was adm 7/23/28 with the followi	itted to the facility on ng diagnoses of, but not			same practice.		

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STATEMENT	OF DEFICIENCIES	CAN DECOMPENSATION				OMB N	<u>O. 0938-0391</u>
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATI	E SURVEY
		IDEATH IOTHOR HOWBER.	A. BUILD	ING		COM	PLETED
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		495384	B. WNG			1	/03/2019
NAME OF P	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	70072013
FRANCIS	MARION MANOR HEALT	LA & BENADU ITATION		1	100 FRANCIS MARION LANE, PO BOX 880		
		II & KENADILI ATION			MARION, VA 24354		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	L	PROVIDER'S PLAN OF CORRECTION		T
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRECTIVE ACTION SHOULD B	Ε	(X5) COMPLETION
TAG	REGOLATORTORE	SC IDENTIFYING INFORMATION)	TAG	•	CROSS-REFERENCED TO THE APPROPRI	ATE	DATE
					DEFIGIENCY)		
E 740						,,,,,,	
F 742	pugu		F	742	3. Team members will be		
	limited to anemia, high	h blood pressure, diabetes,			educated to contact the reside	ent	
	dementia and anxiety	disorder. On the quarterly			representative, physician and		
	MDS (Minimum Data	Set) with an ARD of 3/27/19			administrator on call when a	uic	
	coded the resident as	having a BIMS (Brief					
	nacerview for Mental S	tatus) score of 12 out of a Resident #45 was also			resident expresses suicidal		]
		tensive assistance of 1 staff			ideations. The notifications		[
	member for dressing	and personal hygiene and			be documented in the record.		
	was totally dependent	on 1 staff member for			Orders will be received from	the	
	bathing.	oss i otali monibei ioi			physician and a plan will be	CATO	
						•	
	The surveyor reviewed	d the clinical record of			initiated to ensure the safety	)Î	
		9. In the "Care Focus"			the resident. The Physician		
	documentation dated	for 2/27/19, the surveyor			and/or Social Worker will fol	low	
	noted under the area	of "Review area(s) of		i	up the next working day to		
	Concern", it read in pa				determine if further interventi		
	o "02/26 nurse ca	alled to res (resident) room			is needed.	OII	
	by CNA (certified nursi	ing assistance), CNA stated			is needed.		
	that the res told her sh	e wanted to kill herself (by			4		
	her to pull herself up in	pat) when she had asked			4. The Assistant Nurse Manag	gers	
	walked in ree was citti	ng on the toilet and noted to	ŀ	ĺ	or designee will review the 24	.	
1 1	be crying"	ig on the tollet and hoted to			hour report for any indication	of	
İ	- : mynng m				residents expressing suicidal	×	
	The Care Focus sign in	n sheet had the following			ideations. An audit will be		
	signatures that were in	attendance: assistant					
-	director of nursing, die	titian, wound care nurse			conducted whenever a residen	.t	
	#1, director of nursing,	activities coordinator and			expresses suicidal ideations to		
	MDS (minimum data s	et) nurse #1.			ensure no variations in the pla	n. I	l
					If a variation occurs, an	,	
	Under the section "Inte				investigation will be conducte	ا ،	1
	Recommendation" of the				and disabliname and conducte	4	
	documentation, the foll				and disciplinary action will be		
I I		rentions were suggested:	1		taken. These audits will be		
	o "freq (frequent \	visual checks made"			ongoing for six months, as		
	The surveyor also note	d the following			and the second s	-	
		or 2/26/19 at 2130 (9 pm)					
		to res room by CNA CNA	'				

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILD	1140_		00	C
NAMEOES	PROVIDER OR SUPPLIER	495384	B. WNG			0	5/03/2019
	MARION MANOR HEALT	'H & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE  100 FRANCIS MARION LANE, PO BOX 880  MARION, VA 24354				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E VTE	(X5) COMPLETION DATE
	stated that res had tol herself (by grabbing had asked her to pull this nurse walked in renoted to be crying upostated she didn't know states, I just want to gkeep doing her therap go home soonNo si for the few minutes I was Resident #45's care plarea or interventions to regards to the resident (twice a day)". On 3/9, note read in part "Excrying/anxious  There was no documented that mental health servithe above documented pm. The surveyor notified to the above documented pm. The surveyor aske physician and mental he #45's suicidal thoughts "When the staff went be the resident said she dithat. This is why the pl  The surveyor was given that the social worker hat 2056 (8:56 pm). It recommended to SW (social worker)	d her she wanted to kill er own throat) when she herself up in bed but when as was sitting on toilet and on questioning res res why she was crying but to home encouraged res to y ad she would be able to ulcidal actions were noted was in the room(sic)"  an did not reflect a focus to be utilized by the staff in thaving suicidal thoughts.  For noted a physician order ligram) po (by mouth) BID fig. the physician progress pisodes of screaming out  antation in the clinical record findings.  The administrative team of findings on 5/1/19 at 4:45 and if the staff notified the eaith services of Resident and the total to the resident, which the total to the resident, and the total to the resident, and the total to the resident and documented for 5/1/19 and as follows:	F	742	needed, and results will be reported to the QAPI team for further interventions.  5. Corrective action will be complete by 06/07/19.  6. Assistant Nurse Manager of designee		

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Event ID: 8XB411

Facility ID: VA0086

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPI F	CONSTRUCTION	OMB NO. 0938-039			
AND PLAN O	CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED		
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		495384	B. WNG			0.5	/03/2019		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		10012013		
FRANCIS	MARION MANOR HEALT	TH & REHABII ITATION		10	00 FRANCIS MARION LANE, PO BOX 880				
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	THE STATE OF THE S	THE REPARENTATION		M	ARION, VA 24354				
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID		PROVIDER'S PLAN OF CORRECTION		(X5)		
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					DEFICIENCY)				
E 749									
F 742	Continued From page		F	742					
	remembers me. SW	explains that in the past she		l					
		d to die and she put her k. She remembers that							
i		hink I said that one time in		l					
		asked if she would really							
		she stated this. She stated							
	no SW asked if she fe	it like harming herself at		.					
	this time. She also no			ı					
		self. SW asked how she							
		she stated she liked it.		l					
	SW to monitor."	•							
	The surveyor was also	given a copy of a							
		for 5/2/19 at 1310 (1:10					-		
Ī	pm) which stated, "Co	nsult with (name of		i			į.		
	counseling services).		7						
	No further information	was provided to the							
	surveyor prior to the e	xit conference on 5/3/19.			·	*			
F 755		edures/Pharmacist/Records	F7	755	F755				
SS=D	CFR(s): 483.45(a)(b)(	1)-(3)			Ensuring the physician ordere	d			
	§483.45 Pharmacy Se	nices			medication is available for				
		de routine and emergency			administration is a priority for	*			
		to its residents, or obtain			the team at FMM				
	them under an agreem	nent described in							
	§483.70(g). The facilit	y may permit unlicensed			1. Resident #13 received no i	11			
Tan January Barana	personnel to administe								
		r the general supervision of			effects from the practice. Follows	iow			
	a licensed nurse.				up blood work done on 5/23/1	,			
	6483 45(a) Procedure	s. A facility must provide			revealed a potassium level of	4.9			
***************************************		es (including procedures			and normal range is 3.5-5.1.				
		te acquiring, receiving,					ĺ		
	dispensing, and admin	istering of all drugs and			2. All residents have the				
-	biologicals) to meet the	e needs of each resident.			potential to be affected by the				
	8483 45/h) Sonice Co	nsultation. The facility			same practice.	`			
	S-00.40(D) DEI NICE CO	nautation. The facility			-				

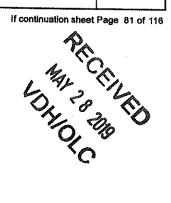
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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	/V2\ 141 0	TIDE	CONSTRUCTION	OWR NO. 0938-039	<u>11</u>
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495384	B. WING			C	
NAME OF PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	05/03/2019	
FRANCIS MARION MANOR HEAL	TH & REHABILITATION		11	00 FRANCIS MARION LANE, PO BOX 880 IARION, VA 24354	,	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IÓ PREFI TAG		PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION ATE DATE	
pharmacist who- §483.45(b)(1) Provide aspects of the provisi the facility.  §483.45(b)(2) Establish receipt and disposition sufficient detail to enait reconciliation; and  §483.45(b)(3) Determ order and that an according is maintained and per This REQUIREMENT by:  Based on staff intervictories, and clinical recipies, and clinical recipies, and clinical recipies, and clinical recipies, and clinical recipies, and clinical recipies, and clinical recipies, and clinical recipies, and clinical recipies, and clinical recipies, and clinical recipies, and clinical recipies, and clinical recipies, and clinical facility staff failed ordered medication Version administration for Resipies.  The clinical record of F4/30/19 through 5/3/19 admitted to the facility included but not limited disease (ESRD), volunt anemia, hyperphosphal arthritis, chronic respins	es consultation on all on of pharmacy services in shes a system of records of a for of all controlled drugs in ble an accurate she that drug records are in bount of all controlled drugs in ble an accurate she that drug records are in bount of all controlled drugs indically reconciled. Is not met as evidenced sew, facility document cord review, the facility staff cian ordered medication inistration for 1 of 18 in a system of the physician ordered medication in the stage are all the cord review are system of the physician shadows a system of the physician ordered medication in the stage are all the order of the stage renaine overload, hypertension, atemia, left shoulder atory failure, type 2 anditioning, depression, eral neuropathy, and	F	755	3. Nursing will be educated notify the physician for follo orders, notify resident, resider representative and nursing leadership. The pharmacy who be notified to send meds or obtain from the back-up pharmacy.  4. Assistant Nurse Managers designee will review up to finnew medications for available per week for 12 weeks and the five monthly for 6 months. It variation is found, an investigation will be initiated corrections made to the processor education given. Audit residual be reported to the QAPI team for further interventions  5. Corrective action will be complete by 06/07/19.  6. Assistant Nurse Manager edesignee	w up ent  ill  or ve lity nen f  and ess ults	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 8XB411

Facility ID: VA0086



STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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NAME OF P	ROVIDER OR SUPPLIER			,	TREET ADDRESS, CITY, STATE, ZIP CODE	05	/03/2019
FRANCIS	MARION MANOR HEA	LTH & REHABILITATION	,	100 FRANCIS MARION LANE, PO BOX MARION, VA 24354			
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F 755	Continued From pag	ge 81	F	755			
	(MDS) assessment reference date (ARE resident with a BIMS status) as 15/15. Di O Special Treatmen Programs.  Current comprehens 5/30/18 and revised focus area that read volume overload-rec Wednesday, Friday, medications as orde (medication administ The May 2019 physi Resident #53 had or Veltassa Packet 8.4 by mouth one time a Thu (Thursday), Sat supplement. Order of 4/23/19.  The surveyor review medication administr been entered on the 4/23/19 box for adminarked "NA RCS". 4 the medication.  The 4/23/19 08:04 pr Packet 8.4 GM new of from pharmacy Give a day every Tue, Thu There was no documents.	of 2/15/19 assessed the clipies interview for mental alysis was marked in Section its, Procedures and sive care plan initiated on 2/26/19 identified the the resident is at risk for selves dialysis Monday, Interventions: Administer red, refer to MAR tration record).  cian's orders were reviewed. ders dated 4/22/19 for GM (grams) Give 1 packet day every Tue, (Tuesday), (Saturday), Sun (Sunday) for date 4/22/19 Start date  ed the April 2019 electronic ation record. Veltassa had April 2019 eMAR. The inistration of Veltassa was /23/19 was the start date of regress note read "Veltassa order not rec'd (received) 1 packet by mouth one time u, Sat, Sun for supplement." itentation the physician had ne medication was not					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
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	ROVIDER OR SUPPLIER  MARION MANOR HEALT	H & REHABILITATION		1	STREET ADDRESS, CITY, STATE, ZIP CODE 100 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354	Və	/03/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F 755	Continued From page	82 d the administrator and the	F.	755			
	director of nursing of tavailable for administration meeting on 5/3/19 at a asked the director of a their back up. The DC The surveyor requests for Veltassa and Residual potassium level.  The surveyor reviewed 5/3/19. Veltassa (quad/24/19. Resident #13/4/17/19 was 5.9 (norm DON stated the dialys)	the medication Veltassa not ration in the end of the day 4:34 p.m. The surveyor nursing what pharmacy was DN stated "Walgreens." and the pharmacy manifest dient #13's most recent dient #13's most recent dient #13's most recent dient #13's most recent on 15's potassium level obtained all range 3.5-5.1). The is center had drawn the ent #13 received Veltassa				,	
	Drug Regimen is Free CFR(s): 483.45(d)(1)-( §483.45(d) Unnecessas Each resident's drug re unnecessary drugs. A drug when used- §483.45(d)(1) In exces duplicate drug therapy §483.45(d)(2) For exce §483.45(d)(3) Without	xit conference on 5/3/19. from Unnecessary Drugs 6) ary Drugs-General. egimen must be free from n unnecessary drug is any sive dose (including	F 7	57	F757 Ensuring residents are free of a unnecessary medications is a priority for the team at FMM  1. Resident #13 and #53 received no ill effects from the practice. Team members involved will be counseled regarding administering medications as directed by the physician.	The state of the s	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER FRANCIS MARION MANOR HE	ALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE  100 FRANCIS MARION LANE, PO BOX 880  MARION, VA 24354			<u> </u>	/03/2019
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consequences whi reduced or discont stated in paragraph section. This REQUIREME by: Based on staff intereview, the facility residents were free (Resident #13 and The findings included 1. The facility staff orders for accuched Resident #13. The accucheck on 4/2/1 sliding scale insuling sugar (accucheck) The clinical record 4/30/19 through 5/3 admitted to the facilincluded but not limit disease (ESRD), volume and the company of CVA (cere Resident #13's qual (MDS) assessment reference date (AR	e presence of adverse ch indicate the dose should be nued; or combinations of the reasons is (d)(1) through (5) of this of this is not met as evidenced rview and clinical record staff failed to ensure 2 of 18 of an unnecessary medication Resident #53).  ed:  called to follow the physician is with insulin parameters for facility staff failed to obtain an 9 at 6:00 a.m. The amount of was determined by the blood	F 7	of the control of the	<ol> <li>All residents with paramet associated with the medication have the potential to be affect by the same practice. An aud will be conducted to ensure all parameters have been transcrit to the MAR appropriately.</li> <li>Nursing will be re-educated follow physicians orders related to parameters.</li> <li>The Skilled Nurse or design will audit ten medications with parameters three times weekly for twelve weeks and then ten month for six months. The Skilled Nurse will provide education to the team members as needed, if a variance occurs. She will monitor for trends. Audit results will be reported to the QAPI team for further interventions.</li> <li>Corrective action will be complete by 06/07/19.</li> <li>Skilled Nurse or designee</li> </ol>	n ed it l bed d to ed per	

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Event ID: 8XB411

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If continuation the Page 84 of 116

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
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	MARION MANOR HEAL	TH & REHABILITATION		1	100 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354		
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F 757	O Special Treatments Programs.  Current comprehensis 5/30/18 and revised of focus area that read to mellitus type 2. Intervinedication as ordered (medication administriction of their room for act (medication) administriction.	lysis was marked in Section i, Procedures and we care plan initiated in 11/7/18 identified the he resident has diabetes ventions: Diabetes 1 by doctor, see MAR ation record), observe for liveness. Resident requests in day room/social setting to ecuchecks and med	F	757			
	and at bedtime related Mellitus with other dial Start date 3/12/19 D/O The 4/2/19 0600 blood recorded blood sugar. The 4/2/19 0600 blood There was no recordes summary form, on the 4/2/19 progress notes, licensed practical nurs 5/2/19.	betic kidney complication. Date 4/7/12/2019." I sugar box did not have a cor the nurse's initials. I sugar was not obtained. I blood sugar result on the April 2019 eMAR or in the The surveyor informed e #1 of the concern on		THE PROPERTY OF THE PROPERTY O			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			INSTRUCTION	(X3) DATE	SURVEY PLETED
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	ROVIDER OR SUPPLIER	ALTH & REHABILITATION		100	EET ADDRESS, CITY, STATE, ZIP CODE FRANCIS MARION LANE, PO BOX 880 RION, VA 24354	<u>  05</u>	/03/2019
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	asked for the facility No further informa surveyor prior to the surveyor prior to the surveyor prior to the surveyor prior to the surveyor prior to the surveyor prior to the surveyor prior to the facility staff fair ordered parameter Losartan.  The clinical record 4/30/19-5/3/19. Referenced to surveyor the facility 5/22/18 but not limited to suback pain, dement (gastroesophageal hypertension, deprivation of the ference date (AR resident with a BIM status) as 3/15. Referenced to the surveyor the surveyor to the ference date (AR resident with a BIM status) as 3/15. Referenced cardiovascut hypertension, historial tered cardiovascut hypertension, historial for the february 2019 order for Losartan 2 tablet by mouth one surveyor the surveyor to the february 2019 order for Losartan 2 tablet by mouth one surveyor the february 2019 order for Losartan 2 tablet by mouth one surveyor the february 2019 order for Losartan 2 tablet by mouth one surveyor the surveyor the february 2019 order for Losartan 2 tablet by mouth one surveyor the february 2019 order for Losartan 2 tablet by mouth one surveyor the february 2019 order for Losartan 2 tablet by mouth one surveyor the february 2019 order for Losartan 2 tablet by mouth one surveyor the february 2019 order for Losartan 2 tablet by mouth one surveyor the february 2019 order for Losartan 2 tablet by mouth one surveyor the february 2019 order for Losartan 2 tablet by mouth one surveyor the february 2019 order for Losartan 2 tablet by mouth one surveyor the february 2019 order for Losartan 2 tablet by mouth one surveyor the february 2019 order for Losartan 2 tablet by mouth one surveyor the february 2019 order for Losartan 2 tablet by mouth one surveyor the february 2019 order for Losartan 2 tablet by mouth one surveyor the february 2019 order for Losartan 2 tablet by mouth one surveyor the february 2019 order for Losartan 2 tablet by mouth one surveyor 2 tablet by mouth one surveyor 2 tablet by mouth one surveyor 2 tablet by mouth one surveyor 2 tablet by mouth one surveyor 2 ta	ent on 5/2/19 at 4:32 p.m. and by policy on diabetes.  Ition was provided to the se exit conference on 5/3/19.  If failed to hold Resident #53's sedication Losartan on 2/10/19.  Ided to follow the physician is for the administration of the administration of the sident #53 was reviewed esident #53 was admitted to with diagnoses, that included epsis, pneumonia, chronic is a, high cholesterol, GERD reflux disease), anxiety, ession, fatigue, and tiredness.  Interly minimum data set is with an assessment in the properties of the interview for mental esident #53 was not assessed ymptoms of delirium, viors that affected others.  Inside the first was undated is area that the resident had illar status r/t (related to) ry of hyperlipidemia. Ininister medications as ordered	F	757			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	SURVEY LETED
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FRANCIS	MARION MANOR HEALT	H & REHABILITATION		ı	100 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	.ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E TE	(X5) COMPLETION DATE
F 758 SS=E	Continued From page The surveyor reviewe electronic medication 2/10/19 at 0830, Resist the Losartan. The rec Based on the recorder, the medication held. The box that income been administered was the surveyor informed director of nursing of the tat 4:36 p.m.  No further information exit conference on 5/3 Free from Unnec Psyc CFR(s): 483.45(c)(3)(d) §483.45(e) Psychotron (§483.45(c)(3) A psychaffects brain activities processes and behavious but are not limited to a categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic  Based on a comprehe resident, the facility messant of the psychotropic drugs are unless the medication	d the February 2019 administration record. On dent #53 was administered corded BP was 89/60. d BP and the physician Losartan should have been dicated a medication had as checked. d the administrator and the he above concern on 5/1/19 was provided prior to the 1/19. chotropic Meds/PRN Use (e)(1)-(5) bic Drugs. otropic drug is any drug that associated with mental or. These drugs include, drugs in the following  make assessment of a ust ensure that— atts who have not used a not given these drugs is necessary to treat a	F	757	DEFICIENCY)	any 27, vill nts	
	in the clinical record;	agnosed and documented					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FRANCIS	MARION MANOR HEAL	TH & REHABILITATION		10	00 FRANCIS MARION LANE, PO BOX 880		
				M	IARION, VA 24354		
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F 758	drugs receive gradus behavioral interventic contraindicated, in a drugs;  §483.45(e)(3) Reside psychotropic drugs puress that medicating diagnosed specific coin the clinical record;  §483.45(e)(4) PRN of are limited to 14 days;  §483.45(e)(5), if the prescribing practition appropriate for the P beyond 14 days, he rationale in the reside indicate the duration.  §483.45(e)(5) PRN of drugs are limited to renewed unless the appropriateness. This REQUIREMENT by:  Based on staff interview, the facility stresidents were free of psychotropic medical #43, Resident #16, Fand Resident #61).	ents who use psychotropic al dose reductions, and ons, unless clinically in effort to discontinue these ents do not receive pursuant to a PRN order on is necessary to treat a condition that is documented and exact a provided in attending physician or ner believes that it is exert and for the PRN order.  Derders for anti-psychotic ent's medical record and for the PRN order.  Derders for anti-psychotic extending physician or ner evaluates the resident for of that medication.  To is not met as evidenced exiew and clinical record aff failed to ensure 6 of 18 of an unnecessary tion (Resident #13, Resident #27, Resident #54,	F	758	2. All residents receiving a psychotropic medication have potential to be affected by the same practice. An audit will be conducted to ensure all behavious observation summaries are in place to determine if the psychotropic medications being used are needed.  3. Nursing team members will be re-educated to complete the behavior observation weekly summary sheets completely. To care plans will be updated when a medication is started and reviewed on a quarterly basis to ensure identified targeted behaviors and non-pharmacological interventions prior to the use of psychotropic medications are included.  4. The DON or designee will conduct weekly audits of ten records of residents receiving psychotropic medications to ensure the behavior observation weekly summary sheets are	e or g	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	/03/2019
FRANCIS	MARION MANOR HEALT	H & REHABILITATION	100 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E VTE	(X5) COMPLETION DATE
F 758	The clinical record of 4/30/19 through 5/3/19 admitted to the facility included but not limite disease (ESRD), volui anemia, hyperphospharthritis, chronic respii diabetes mellitus, deconypothyroidism, periph history of CVA (cerebron Resident #13's quarte (MDS) assessment wireference date (ARD) resident with a BIMS (status) as 15/15. No sidelirium, psychosis, or others were assessed assessed with zero on Current comprehensive 5/30/18 and revised or Resident #13 uses an to control episodes of depression is contributed disease. His wife is ur home. Interventions: A medications as ordered MAR (medication adm Observe/document side of shift (every shift). Al his feelings when havid depression. He partici	Resident #13 was reviewed 9. Resident #13 was 9/5/18 with diagnoses, that d to end stage renal me overload, hypertension, atemia, left shoulder ratory failure, type 2 conditioning, depression, neral neuropathy, and ovascular accident).  If y minimum data set th an assessment of 2/15/19 assessed the brief interview for mental signs or symptoms of behaviors that affected. Section D Mood was the total severity score.  The care plan initiated an 11/21/18 identified that antidepressant medication depression. His led to end stage renal hable to care for him at administer antidepressant d by physician, refer to inistration record). The effects and effectiveness low him to talk and expressing s/s (signs/symptoms) of pates in therapy from a cutify physician if current	F	758	completed accurately and that care plan has been updated to reflect targeted behaviors and non-pharmacological interventions prior to the use psychotropic medications.  Weekly audits for 12 weeks at then ten monthly for 6 month. If variation is found, an investigation will be initiated corrections made to the proce or education given. Audit reswill be reported to the QAPI team for further interventions.  5. Corrective action will be complete by 06/07/19.  6. DON or designee	of and as. and ess sults	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		E SURVEY IPLETED
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	order for Sertraline one time a day ever (Wednesday), Fri (F. Depressive Disorder Date 10/26/18 and by mouth one time. Thu (Thursday), Sarelated to Major Dej 10/25/18 Start Date. The surveyor review Weekly Summary" if through May 2019. The behavior observer not done the wear of the Februar administration recorned MAR, April 2019 eleand the nurse's programmer of the effects, side effects, interventions. The coplan did not identify non-pharmacological use of the medication. The surveyor inform director of nursing of failure to monitor the targeted behaviors a non-pharmacological plan on 5/3/19 at 3:50.	y physician orders included the 75 mg (milligrams) by mouth by Mon (Monday), Wed Friday) related to Major or Order date 10/25/18 Start Sertraline 75 mg (milligrams) a day every Tue (Tuesday), it (Saturday), Sun (Sunday) pressive Disorder Order date 10/27/18.  In the "Behavior Observation forms from February 2019  In the "Behavior Observation forms from February 2019  In the surveyor for any 2019 electronic medication dis (eMAR), the March 2019  MAR and May 2019 eMAR for sonotes from February 2019 and found no enavior monitoring to include and non-pharmacological current comprehensive care targeted behaviors or all interventions prior to the in.  In the administrator and the fithe above concern with the use of Sertraline, identify and include all interventions on the care	F	758			
	prior to the exit confe						

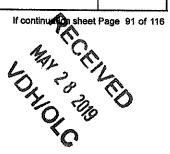
PRINTED: 05/16/2019 FORM APPROVED OMB NO. 0938-0391

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	ROVIDER OR SUPPLIER  MARION MANOR HEAI	LTH & REHABILITATION		1	TREET ADDRESS, CITY, STATE, ZIP CODE 00 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354		
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F 758	Continued From pag	ge 90	F	758			
		ailed to monitor the use of sed for anxiety) for Resident					
	4/30/19 through 5/3/ admitted to the facili that included but not thrombosis), hyponal leukocytosis, periphe (coronary artery dise ischemic attack), BP hypertrophy), acute is constipation, hyperte Resident #43's quart (MDS) assessment v reference date (ARD resident with a BIMS status) as 00/15. Re signs or symptoms of	bronchitis, atrial fibrillation, ension, and pacemaker. terly minimum data set					
er en en en en en en en en en en en en en	assessed the resider of 9.  Resident #43's currer (undated) identified to resident uses psychological psychological and anx Administer psychotropy physician, observe effectiveness, consumedical doctor) to cowhen clinically approdiscuss with MD, famof medication. Review	nt with a total severity score  Int comprehensive care plan the focus area that read the otropic chotic medication r/t (related		TO THE PARTY OF TH			·

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 8XB411

Facility ID: VA0086



	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  MARION MANOR HEALT	H & REHABILITATION	······································	1	TREET ADDRESS, CITY, STATE, ZIP CODE 00 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354	j UR	5/03/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E VTE	(X5) COMPLETION DATE
	The current comprehe identified the issue of process of CVA. Intermedications as ordered (medications as ordered (medications as ordered (medications as ordered (medications as ordered (medications as ordered (medications as ordered (medications as ordered (medications as ordered (medications as ordered (medications) as ordered (medications) as ordered (signs/symptoms) as ad mood.  Resident #43's May 20 included Ativan tablet tablet by mouth at bed date 1/26/19 start date Lactate Concentrate 0 three times a day for a Haloperidol Lactate Comouth at bedtime for a date 1/21/19, start date 1/21/19, star	ve prn (as needed) any sychotropic medications.  Ansive care plan also mood problem r/t disease ventions: Administer d, refer to MAR ation record), encourage roughts and feelings, and to MD prn mood patterns, of depression, anxiety, and time for agitation (order 1/26/19) and Haloperidol .25 ml (milliliter) by mouth gitation and anxiety and procentrate 0.25 ml by gitation and anxiety (order ed 1/21/19).  Insive care plan did not iors for the use of Haldol acological interventions for of each, and weekly notropic medications per ion Weekly Summary. Is done from January that one was done 3/7/19.  The administrator and the se concern with the lack of d care plan without	F	758			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  IG		ATE SURVEY DMPLETED
		495384	B. WING_			С
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		05/03/2019
FRANCIS	MARION MANOR HE	ALTH & REHABILITATION		100 FRANCIS MARION LANE, PO BOX 88 MARION, VA 24354	0	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 758	exit conference on 3. The facility fails the behavioral mode in the	tion was provided prior to the 5/3/19.  Indicate the facility on the second resident #16.  Treadmitted to the facility on collowing diagnoses of, but not diabetes, stroke, dementia, inxiety disorder, depression and in the quarterly MDS (Minimum ARD (Assessment Reference coded the resident as having a new for Mental Status) score of 15. Resident #16 was also extensive assistance of 1-2 dressing, personal hygiene and ally dependent on 1 staff grecord review on Resident #16, the following on the weekly	F 7	58		
	(medical doctor) or psychoactive med box under this only diagnosis.  " 4/5/19 and 3/2 diagnosis for each The box under this listed. There were two medications.  " 3/22/19 " B 7. Paranoia (des by the staff but the behavior.  " 3/15/19 and 3/	ing sheets:  12/19 "2. Current MD  der and diagnosis for each (medication) ordered" The has Klonopin listed without a  9/19 "Current MD order and psychoactive med ordered" only has Klonopin and Paxil no diagnosis listed with these  Behaviors and Side effects cribe below)" was marked re was no description of this  1/19 "2. Current MD  der and diagnosis for each				

STATEMENT OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		495384	B. WING				C (03/0040
	OVIDER OR SUPPLIER	TH & REHABILITATION		10	REET ADDRESS, CITY, STATE, ZIP CODE 0 FRANCIS MARION LANE, PO BOX 880 ARION, VA 24354	<u>  va</u>	/03/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E NTE	(X5) COMPLETION DATE
t T t F M S 4 c 种 F S li d b M ti S	box under this only hadiagnosis.  The surveyor reviewer administration record The resident was record (milligram) two times Paxil 30 mg two times disorder and Quetiap dementia with behavior of the surveyor notified nursing) of the above 5/2/19 at approximate the medications."  The surveyor notified the above documente on in the conference on in the conference on the behavioral more than the behavioral more than the behavioral more than the terministry of the followinited to renal failure til abetes, arthritis, Statolood pressure and defends (MDS (Minimum Data)	addication) ordered" The as Klonopin listed without a bed the MAR (medication of the MAR (medication of the MAR (medication of the MAR (medication of a day for dementia/agitation, of a day for major depressive ine 25 mg at bedtime for oral disturbance.  The DON (director of documented findings on one of the MAR of	F	758			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	(X3) DATE SURVEY COMPLETED
	c
495384 B. WING	05/03/2019
NAME OF PROVIDER OR SUPPLIER  FRANCIS MARION MANOR HEALTH & REHABILITATION  STREET ADDRESS, CITY, STATE, ZIP  100 FRANCIS MARION LANE, PO I  MARION, VA 24354	PCODE
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACT OF TAG PROVIDER'S PLAN OF TAG PR	CTION SHOULD BE COMPLETION O THE APPROPRIATE DATE
dressing and personal hygiene and was totally dependent on 1 staff member for bathing.  During the clinical record review on 5/1 to 5/3/19, the surveyor noted the following on the weekly behavioral monitoring sheets:  "For the dates of 4/23/19, 4/17/19, 4/9/19, 4/1/19, 3/26/19, 3/19/19, 3/12/19 and 3/4/19 "2. Current MD (medical doctor) order and diagnosis for each psychoactive med (medication) ordered" The box under this only has Zoloft 100 mg (milligram) q (every) day listed without a diagnosis."  "Also for the above dates, Under Section "B. Behaviors and Side Effects" Other has been marked but the staff did not describe what Other was.  The surveyor reviewed the MAR (medication administration record) for March and April 2019. The resident was receiving Zoloft 100 mg (milligram) one time a day for depression.  The surveyor notified the DON (director of nursing) of the above documented findings on 5/2/19 at approximately 11 am. The DON stated, "No they didn't put a diagnosis in that section of the medications."  The surveyor notified the administrative team of the above documented findings on 5/3/19 at 3:52 pm in the conference room.  5. The facility staff failed to document accurately on the behavioral monitor sheets for Resident #54.  Resident #54 was admilited to the facility on	

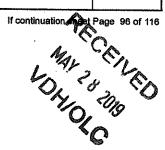
PRINTED: 05/16/2019 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	•	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495384	B. WING		<u>.</u>		C
	ROVIDER OR SUPPLIER	TH & REHABILITATION		1	STREET ADDRESS, CITY, STATE, ZIP CODE 100 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354	<u>  05</u>	/03/2019
(X4) ID PREFIX TAG			1	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		E NTE	(X5) COMPLETION DATE
	limited to dementia, a psychotic disorder and the quarterly MDS (M ARD of 4/5/19, the red a BIMS (Brief Intervier of 11 out of a possible was also coded as red of 2 staff members for and being totally dependent of the surveyor noted the behavioral sheets:  "For the dates of 4 3/30/19, 3/23/19, 3/162. Current MD (mediagnosis for each psy (medication) ordered has Zoloft 50 mg (milliagonal and April 2019. The pfollowing for Resident "Zoloft 50 mg one"	ving diagnoses of, but not nxiety disorder, depression, d high blood pressure. On inimum Data Set) with an sident was coded as having w for Mental Status) score a score of 15. Resident #54 quiring extensive assistance of dressing, personal hygiene endent on 1 staff member for sord review on 5/1 to 5/3/19, a following on the weekly 1/20/19, 4/13/19, 4/5/19, 1/19, 3/8/19 and 3/2/19 " dical doctor) order and ychoactive med" The box under this only gram) daily and Seroquel by listed without a 1/20/19 without a	F	758			
	nursing) of the above of 5/2/19 at approximatel	he DON (director of documented findings on y 11 am. The DON stated, lagnosis in that section of	The same of the sa			· ·	

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Event ID: 8X8411

Facility ID: VA0086



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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		495384	B. WING			ł	С
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	05	03/2019
FRANCIS	MARION MANOR HEAL	FH & REHABILITATION		100 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE .	(X5) COMPLETION DATE
F 758	Continued From page	96	F	758		ę	
	The surveyor notified the above documente pm in the conference	the administrative team of ed findings on 5/3/19 at 3:52 room.					
	6. For Resident #61 t	exit conference on 5/3/19. he facility staff failed to d side effects related to				į	
	06/27/17. Diagnoses anemia, coronary arte heart failure, gastroes diabetes mellitus, hyp	mitted to the facility on included but not limited to ary disease, congestive ophageal reflux disease, erlipidemia, arthritis, lent, hemiplegia, anxiety		17-1-1-1		i i	
	an ARD (assessment	(minimum data set) with reference date) of 04/13/19 s 15 of 15 in section C, is an annual MDS.		***************************************			
	was reviewed and coruses anti-anxiety metimes. She is at risk for to the use of medication to this care plan include "Observe/document/readverse reaction of ar unsteady gait, tardive ([extra-pyramidal symmuscles, shaking), free difficulty swallowing, consider the authority of the control of the contro	eport PRN (as needed) any nti-anxiety medication: dyskinesia, EPS ptoms] shuffling gait, rigid quent falls. Refusal to eat, lry mouth, depression, lal isolation, blurred vision,		T PRODUCTION OF THE PROPERTY O		To the state of th	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 8XB411

Facility ID: VA0086

If continuation sheet Page 97 of 116



STATEMENT	OF DEFICIENCIES	AN DOORDEDON DO LED OUT				OMR M	<u>0. 0938-0391</u>
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY	
			A. BUILDI	ING_		COM	PLETED
		405004	7 11414				С
MANTOTO	700.000.00	495384	B. WNG			05	/03/2019
NAME OF I	PROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE		
FRANCIS	MARION MANOR HEALT	TH & REHABILITATION		1	00 FRANCIS MARION LANE, PO BOX 880		
				A	MARION, VA 24354		:
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	E	COMPLETION DATE
					DEFICIENCY)	ue	DAIL .
				-			
F 758	Continued From page	97	F:	758			
	behavior symptoms n	ot usual to the person".	1				
		•					
		l record was reviewed on					
	05/02/19. It contained	signed physician's order	Ì				
	summary for the moni	h of April 2019, which read					
	mouth at hedtime reia	blet 1 mg Give 1 tablet by ted to anxiety disorder,					
	unspecified" and "Par	exetine HCI F/C 20 mg					
	tablet Give by mouth of	one time a day related to					
	major depressive diso	rder, recurrent,					
	unspecified".			İ			
	Basistand NO44						
	contained "Behavior C	record was reviewed and					
		surveyor could only locate				,	
	one weekly form for th	e month of April 2014.				İ	
	Surveyor spoke with the	ne DON (director of					
	nursing) regarding the	missing behavior					
		DON could not locate the		ĺ	,		
	forms.				•		
	The concern of not made	mikanian Alam Manistratur		l			
	hebavior or side effect	nitoring the Resident's s of the medication was					
		ninistrative team during a		·			
	meeting on 05/02/19 a	t approximately 1625.		j	Faco		
	•				F760		
		was provided prior to exit.			Ensuring the residents are free		
F 760	Residents are Free of	Significant Med Errors	F 7	60	from significant medication	- 1	
SS=D	CFR(s): 483.45(f)(2)			l	errors is a priority for the team	at	1
	The facility must ensur	e that its			FMM		
		s are free of any significant				ļ	
Ī	medication errors.	any organicalit			1. Resident #13 received no il	. 1	1
		is not met as evidenced			effects from the practice. The	·	ļ
	by:				nurse reconsible for mile		1
	Based on staff intervie				nurse responsible for missing t	ne	
ļ		failed to ensure 1 of 18		'	blood sugar level and medication	on	
	residents was free of a	significant medication			will be counseled.		
						- 1	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		T	·····		OMB NO	<u>0. 0938-0391</u>	
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		495384	B. WING			1	C /03/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	0012013
EDANCIO	MADION MANOO HEAL			Ι.	00 FRANCIS MARION LANE, PO BOX 880		
FRANCIS	MARION MANOR HEALT	H & REHABILITATION			MARION, VA 24354		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	,				·
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E VTE	(X5) COMPLETION DATE
F 760	Continued From page	98	_	760	2. All residents receiving a		
	error (Resident #13).			100	sliding scale insulin dose hav	e	
	The findings included				the potential to be affected by same practice. Nursing will he	the e	:
	orders for accuchecks	to follow the physician with insulin parameters for nical record did not have			re-educated to follow the slid scale orders for residents	_	
	evidence Resident #1	3 was administered sliding			receiving insulin on a sliding- scale basis and document on t	1	
	scale insulin five times 3/28/19 and 4/2/19).	s (3/5/19, 3/14/19, 3/23/19,			MAR.	ne	
	4/30/19 through 5/3/19 admitted to the facility included but not limite disease (ESRD), volui anemia, hyperphosphiarthritis, chronic respir	9/5/18 with diagnoses, that d to end stage renal me overload, hypertension, atemia, left shoulder ratory failure, type 2			3. Nursing will be re-educated follow the sliding-scale orders for residents receiving insuling a sliding-scale basis and document on the MAR.	:	
į	hypothyroidism, periph history of CVA (cerebr	onditioning, depression, neral neuropathy, and ovascular accident).			4. The Skilled Nurse or design will audit records of ten reside	nts	
	resident with a BIMS ( status) as 15/15. Dialy O Special Treatments, Programs.	th an assessment of 2/15/19 assessed the brief interview for mental ysis was marked in Section Procedures and			who receive sliding scale insulthree times weekly for twelve weeks and then ten residents monthly for six months. The Skilled Nurse will provide education to the team member as needed, if a variance occurs She will address and monitor for the state of	S .	
	focus area that read the mellitus type 2. Intervenedication as ordered (medication administration side effects and effects)	n 11/7/18 identified the ne resident has diabetes entions: Diabetes by doctor, see MAR ation record), observe for veness. Resident requests in day room/social setting to		THE PROPERTY OF THE PROPERTY O	trends. Audit results will be reported to the QAPI team for further interventions.	or	

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STATEMENT OF DEFI AND PLAN OF CORR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SUI		
		495384	B. WING				С
NAME OF PROVIDE	D OD SLIDDI ICO	430304	D. VVIING			05	/03/2019
	ON MANOR HEALT	TH & REHABILITATION		11	TREET ADDRESS, CITY, STATE, ZIP CODE 00 FRANCIS MARION LANE, PO BOX 880 IARION, VA 24354		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E VTE	(X5) COMPLETION DATE
Residuate Residu	reviewed. The posolution 100 ung scale: 1-200=2 unit 250=4 units 300=6 units 350=8 units 400=10 units, substituted the diametric surveyor reviewed cation administration box for the 5/19 at 0600 was surveyor reviewed surveyor surveyor reviewed surveyor reviewed surveyor reviewed surveyor reviewed surveyor reviewed surveyor reviewed surveyor reviewed sur	ration.  2019 physician's orders obysician ordered Insulin nit/ml (milliliter) Inject as per ocutaneously before meals to Type 2 Diabetes betic kidney complication. Date 03/12/2019.  If the March 2019 electronic tion record (eMAR). The results of the blood sugar is blank as well as the staff's of the March 2019 blood dent #13's blood sugar on 18 174. Based on the esident #13 should have inits of insulin but the reveal insulin was 19. There was not a 18/5/19.	F	760	<ul><li>5. Corrective action will be complete by 06/07/19.</li><li>6. Skilled Nurse or designee</li></ul>		

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Event ID: 8XB411

Facility ID: VA0086 If contin

If continuation sheet Page 100 of 116

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STATEMENT	OF DEFICIENCIES	V4) DDO (DEDIC) (DD) (ED)				OWR V	<u>IO. 0938-0391</u>	
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		E CONSTRUCTION		E SURVEY MPLETED	
		495384	B. WING				C 5/03/2019	
NAME OF P	ROVIDER OR SUPPLIER		•	s	TREET ADDRESS, CITY, STATE, ZIP CODE	į vi	010312019	
FRANCIS	MARION MANOR HEALT	"U P. DELIADII ITATION		1	00 FRANCIS MARION LANE, PO BOX 880			
		TH & REHABILITATION		Ŀ	ARION, VA 24354			
(X4) ID PREFIX	ID SUMMARY STATEMENT OF DEFICIENCIES FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S		PROVIDER'S PLAN OF CORRECTION	F CORRECTION (X5)		
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA	E NTE	COMPLETION DATE	
					DEFICIENCY)			
F 760	Continued From page	100	_	700				
	and at bedtime related		-	760				
	Mellitus with other dia	betic kidney complication.			·			
	Start date 3/12/19 D/0	Date 4/7/12/2019.						
	The 3/14/19 0600 bloc	od sugar box did not have a						
	recorded blood sugar	or the nurse's initials.						
	The 3/23/19 0600 bloc	od sugar box did not have a						
	recorded blood sugar	or the nurse's initials.  Indicate the state of the state						
f	recorded blood sugar	or the nurse's initials						
	The 4/2/19 0600 blood	sugar box did not have a						
	recorded blood sugar	or the nurse's initials.						
	The 3/14/19 blood sug	ar obtained from the blood						
	sugar summary report	was done at 6:11 a.m. with						
	a result of 160. Reside							
	was not a progress no	0600 on 3/14/19. There		ĺ				
1	Resident #13 should h	ave been administered 1						
	unit of sliding scale ins				•			
	The 3/23/19 0600 bloo	d sugar found on the blood						
	sugar summary report	was 160. Resident #13						
	was not administered t	he sliding scale insulin.	1					
	There were 2 progress	notes written 3/23/19-one						
	note addressed Reside	5 p.m.). Neither progress ent #13's diabetic needs.						
	Resident #13 should ha	ave been administered 1						
	unit of sliding scale ins							
	The 3/28/19 0600 bloo	d sugar was found on the						
	blood sugar summary f	orm and was documented						
	as 156. Based on the s	sliding scale insulin,						
	Resident #13 should ha	ave been administered 1						
	unit. There was no evid							
	received silding scale it 3/28/19 was not found i	nsulin. A progress note for in the clinical record						
			1					
1.	The 4/2/19 0600 blood	sugar was not obtained.	1					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495384	B. WING			1	C (03/2040	
	ROVIDER OR SUPPLIER  MARION MANOR HEALT	H & REHABILITATION		10	TREET ADDRESS, CITY, STATE, ZIP CODE 00 FRANCIS MARION LANE, PO BOX 880 1ARION, VA 24354	<u> </u>	/03/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOUL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(X5) COMPLETION DATE	
F 812 SS=E	summary form, on the 4/2/19 progress notes  The surveyor informed director of nursing of the diabetic management asked for the facility possible. No further information surveyor prior to the effood Procurement, Stoc CFR(s): 483.60(i)(1)(2)  §483.60(i) Food safety. The facility must -  §483.60(i)(1) - Procure approved or considered state or local authorities (i) This may include for	d blood sugar result on the April 2019 eMAR or in the I the administrator and the he above issue with on 5/2/19 at 4:32 p.m. and olicy on diabetes.  was provided to the xit conference on 5/3/19. ore/Prepare/Serve-Sanitary ) requirements.		760	F812 Labeling opened spices with expiration date is important to the team at FMM  1. Dietary team members obtained a Julian calendar who	0		
	facilities from using progardens, subject to cor safe growing and food- (iii) This provision does from consuming foods §483.60(i)(2) - Store, p serve food in accordan standards for food serv This REQUIREMENT by: Based on observation	not prohibit or prevent oduce grown in facility inpliance with applicable handling practices. In not preclude residents not procured by the facility.  repare, distribute and ce with professional rice safety. It is not met as evidenced and staff interview, the related and date opened food			will translate the codes on the labels for the spices. Expirate dates were then placed on ever spice.  2. All residents have the potential to be affected by the same practice.	ion ery		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION .	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		495384	B. WING			C 05/03/2019		
	PROVIDER OR SUPPLIER  MARION MANOR HEALT	TH & REHABILITATION		1	TREET ADDRESS, CITY, STATE, ZIP CODE 00 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354	1 08	103/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 812	kitchen that were open opened and a label of The surveyor toured the graph of the following was not labeled with an expiration ounces of Ground Cin Garlic Powder and Let Upon return to the kitch stated, "The manager and this code at the beautiful to a date him from the company that they go by the cody what is the expiration of stated, "I didn't know what is the expiration of the surveyor informed."	to ensure food items in the ned included a date when ithe package contents.  The kitchen on 4/30/19 at discribes director (FSD), and to be opened but not stion or use by date: 18 namon, Black Pepper, and Pepper.  Then at 10:45 am, the FSD has called the company of the container can are. He is getting it sent to a surveyor asked if the on the container then date or use by date. FSD what this code was used	F	812	3. Team members were reeducated regarding the use of Julian calendar. Upon receiv spices, an orange date tag will placed on incoming spices withe Julian date decoded with date listed on the product. Information on how to decode the dates is listed in the kitches area, near the spice holder for easy access. Going forward swill be educated on the improprocess for labeling and datin spices.  4. The Registered Dietitian or designee will audit weekly for twelve weeks and then month for six months to ensure all spices are labeled with an expiration date.  5. Corrective action will be complete by 06/07/19.	ing I be th the e en ttaff eved g		
F 842 SS=D	meeting on 5/1/19 at 4 5/3/19 at 3:52 p.m.  No further information surveyor prior to the expesident Records - Ide CFR(s): 483.20(f)(5), 4	:45 p.m. and again on was provided to the kit conference on 5/3/19, entifiable Information	F8	342	6. Registered Dietitian or designee  F842 Having resident records with identifiable information is a priority for the team at FMM			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		495384	B. WING			0.5	C 5/03/2019	
	ROVIDER OR SUPPLIER  MARION MANOR HEALT	H & REHABILITATION		1	TREET ADDRESS, CITY, STATE, ZIP CODE 00 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354	1 00	103/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E NTE	(X5) COMPLETION DATE	
	(i) A facility may not re resident-identifiable to (ii) The facility may rel resident-identifiable to accordance with a coragrees not to use or dexcept to the extent the todo so.  §483.70(i) Medical red §483.70(i)(1) In accordance with a red (i) Complete; (ii) Accurately docume (iii) Readily accessible (iv) Systematically org §483.70(i)(2) The facilial information container regardless of the form records, except when (i) To the individual, or representative where properties, as permitted with 45 CFR 164.506; (iv) For public health a neglect, or domestic viactivities, judicial and a law enforcement purpopurposes, research purposes, research purpodical examiners, fur	elease information that is the public. ease information that is an agent only in intract under which the agent isclose the information is facility itself is permitted.  Fords. Idance with accepted and practices, the facility is records on each resident.  Inted; and anized.  Ity must keep confidential and in the resident's records, or storage method of the release istheir resident is remitted by applicable law; ment, or health care and by and in compliance.  Intediction is the resident of the release istheir resident is remitted by applicable law; ment, or health care and by and in compliance.  Intediction is reporting of abuse, otherwise, reporting of abuse, otherwise, reporting of abuse, otherwise, or to coroners, iteral directors, and to avert ith or safety as permitted.	F	842	1. Incorrect coding "vitals outside of range" of Hydrocodone did not cause il effects for resident #28. The staff persons responsible for accurate coding of the MAR of 2/26/19 and on 2/28/19 will be re-educated on accurate use of codes on the MAR.  2. All residents receiving PRI pain medications have the potential to be affected by the same practice. An audit will be conducted for all PRN pain medications given in the mont of May, to ensure proper coding for 10 PRN pain medications.  4. The DON or designee will conduct an audit to ensure proceeding for 10 PRN pain medications. The audit will be medications. The audit will be medications. The audit will be medications. The audit will be	on e f N oe h ng.		

PRINTED: 05/16/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				•			С	
MANGOGE	200,4050,000,000	495384	B. WING			05	5/03/2019	
	PROVIDER OR SUPPLIER  MARION MANOR HEAL	TH & REHABILITATION		1	TREET ADDRESS, CITY, STATE, ZIP CODE 00 FRANCIS MARION LANE, PO BOX 880 IARION, VA 24354			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(X5) COMPLETION DATE	
F 842	§483.70(i)(3) The factorecord information agunauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requirement (iii) For a minor, 3 year legal age under State (iii) For a minor, 3 year legal age under State (iii) A record of the resection (iii) A record of the resection (iv) The results of any and resident review edeterminations conductly (v) Physician's, nurse professional's progress (vi) Laboratory, radioloservices reports as real this REQUIREMENT by:  Based on staff intervity review, the facility staff failed the MAR (medication month of February 20).  Resident #28 was real	ility must safeguard medical painst loss, destruction, or a records must be retained required by State law; or e date of discharge when and in State law; or ears after a resident reaches law.  dical record must containate to identify the resident; sident's assessments; we plan of care and services repreadmission screening valuations and cted by the State; s, and other licensed so notes; and ones; and ones; and ones; and ones; and one of the diagnostic quired under §483.50.  is not met as evidenced ew and clinical record ff failed to ensure that 1 of record (Resident #28).	F	842	done weekly X 12 weeks and monthly X 6 months. Data with the reported to the QAPI team further recommendations.  5. Corrective action will be complete by 06/07/19.  6. DON or designee.	for		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 8XB411

Facility ID: VA0086

If continuation sheet Page 105 of 116



	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495384	B. WNG				C /03/2019
	ROVIDER OR SUPPLIER  MARION MANOR HEALT	FH & REHABILITATION		1	TREET ADDRESS, CITY, STATE, ZIP CODE 00 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E TE	(X5) COMPLETION DATE
F 842	limited to atrial fibrillar disease, high blood p diabetes and arthritis. MDS (Minimum Data (Assessment Referent resident was coded a Interview for Mental Spossible score of 15. coded as only requiring and limited assistance bathing.  The surveyor conduct clinical record, which February 2019. During order for "Hydrocodor mouth every 8 hours a 2/26/19, the surveyor code of "4". According "Vitals Outside of Para On 2/28/19, the MAR According to the MAR Progress Notes." The documentation concerprogress notes.  The surveyor notified the above documented pm. The surveyor asknursing) were these the surveyor asknursing) were these these	tion, coronary artery ressure, renal failure, On the significant change Set) with an ARD rec Date) of 3/3/19; the shaving a BIMS (Brief Status) score of 15 out of a Resident #28 was also ng supervision with dressing of for personal hygiene and red a review of the resident's included the MAR for noted on MAR as having a ground the MAR key, "4" is for ameters for Administration." had been coded with a "9" receively of the with a "9" receively of the many rening this medication in the stee administrative team of defindings on 5/3/19 at 3:52 red the DON (director of the appropriate codes that ON stated, "Those were	F	842	F880		
F 880 SS=E		xit conference on 5/3/19. Control	F 8	80	Following established infection control procedures is important to the team at FMM	n t	

STATEMENIT	OE DEFICIENCIES		<u> </u>			OMB N	<u>O. 0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495384	B. WNG			1	C 5/03/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	103/2019
FRANCIS	MARION MANOR HEALT	H & REHABILITATION	100 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354		00 FRANCIS MARION LANE, PO BOX 880		
(X4) ID	SHMMARY STA	ATEMENT OF DEFICIENCIES					
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E VTE	(X5) COMPLETION DATE
F 880	Continued From page	106	F	880	3		
	§483.80 Infection Con	itrol					
	The facility must estat		İ		1. Residents #53, #27, #45 h	ave	
	infection prevention a	nd control program			not received any ill effects from		
	designed to provide a	safe, sanitary and			the practice. The team memb		
	comfortable environme	ent and to help prevent the					
		smission of communicable			not washing their hands after		
	diseases and infection				caring for #53 was counseled	•	
					Team members caring for		
	§483.80(a) Infection p	revention and control			resident #27 were counseled	to	
	program.				keep tubing off the floor and		
	The facility must estab	lish an infection prevention			use proper techniques when	•••	
	and control program (I	PCP) that must include, at					
	a minimum, the followi	ing elements:			cleaning a wound. The nurse		
	8483 80(a)(1) A system	n for preventing, identifying,			was counseled to properly sto		
		, and controlling infections	-		the nebulizer mask and tubing	g for 📑	
		eases for all residents,			resident #45.	1	
		rs, and other individuals					
1	providing services und		ŀ		2. All residents have the		
		on the facility assessment			potential to be affected by the		
		o §483.70(e) and following					
	accepted national stan	dards;		İ	same practices. Team membe	rs	
	\$400 00/a\/0\ \ALiu	standards wellster t			were re-educated regarding		
		standards, policies, and gram, which must include,			following standard infection		
	but are not limited to:	yranı, wilicii must inciúde,			prevention and control		
I .		ance designed to identify			procedures.		
	possible communicable				*		
	infections before they				3. Team members were re-		ľ
	persons in the facility;	•				1	
	(ii) When and to whom	possible incidents of			educated regarding following		
	communicable disease	or infections should be			standard infection prevention	and	
	reported;				control procedures. Team		
	(iii) Standard and trans	mission-based precautions			members are charged with		
		nt spread of infections;					
		ation should be used for a			•		
	resident; including but I						j
	(A) The type and durati	on of the isolation,		1			

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	(X2) MULTIPLE CONSTRUCTION			ONE NO. 0938-0391	
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD				(X3) DATE SURVEY COMPLETED	
			7. 50,00					
		495384	B. WING			1	C	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	05	/03/2019	
				į.				
FRANCIS	MARION MANOR HEALT	'H & REHABILITATION		1	00 FRANCIS MARION LANE, PO BOX 880			
	SI SI SI SI SI SI SI SI SI SI SI SI SI S				MARION, VA 24354			
' (X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	e ate	(X5) COMPLETION DATE	
F 880	Continued From page	. 107		000				
. 555			F-6	880	mountaing for combilance W	ith		
		nfectious agent or organism			infection prevention procedur	'Ac		
	involved, and	t the isolation should be the			P-0 tolland procedur	ψō.		
		ole for the resident under the			A An audit of wine			
	circumstances.	ne for the resident under the			4. An audit of using appropri	ate		
		under which the facility			infection prevention/control			
		es with a communicable			techniques during wound care	;		
	disease or infected sk				will be conducted twice week	lv		
		or their food, if direct			for twelve weeks and then three	•,		
	contact will transmit th				times monthly for six months,	1		
		procedures to be followed			the Infaction Description 2.	by		
	by staff involved in dire	ect resident contact.			the Infection Prevention Nurse	or or		
					designee. If variances occur,	he		
		m for recording incidents			nurse will be counseled at that	•		
	identified under the fac				time. An audit of appropriate			
	corrective actions take	eri by the facility.			storage of nebulizer supplies,			
	§483.80(e) Linens.				positioning of foley tubing and	1		
	Personnel must handle	e, store, process, and			proper handwashing will be do	<u> </u>		
	transport linens so as	to prevent the spread of			three times are 11 C	ne		
	infection.	,		ĺ	three times weekly for twelve			
					weeks and then ten times a			
	§483.80(f) Annual revi				month for six months by the			
		t an annual review of its			Assistant Nurse Manager or	ļ	l	
	IPCP and update their	program, as necessary.			designee. If variances are four	vd		
. ]	4	is not met as evidenced			the appropriate team member	ru,		
1	by: Based on observation	, facility document review,			will be counseled. Audits will			
		ew, the facility staff failed			managed 4 DOM 6	oe		
		fection control procedures			reported to DON for trending a	nd		
		Resident #53, Resident #27,			recommendation for additional	Ī		
	and Resident #45).	•			education, modification of			
***************************************	·				protocols/policy, and / or			
ŀ	The findings included:				disciplinary action. Results of	.		
					the audits will be presented to t	.		
	1. The facility staff fail				OADI Carried to t	ne		
	control procedures for				QAPI team for further	-		
	surveyor observed state	. •			recommendations.			
	uioves and then not be	rforming hand washing or	1	į.	Sight and a second and a second and a second and a second and a second and a second and a second and a second	~~~~~		

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F	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
			A. BUILD	NG_		l	COMPLETED	
		495384	B. WING				C 5/03/2019	
NAME OF P	ROVIDER OR SUPPLIER			i	TREET ADDRESS, CITY, STATE, ZIP CODE		10012013	
FRANCIS	MARION MANOR HEALT	H & REHABILITATION			00 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E TE	(X5) COMPLETION DATE	
	4/30/19-5/3/19. Reside the facility 5/22/18 with but not limited to seps back pain, dementia, it (gastroesophageal ref hypertension, depress Resident #53's quarte (MDS) assessment wireference date (ARD) resident with a BIMS (status) as 3/15. Reside with any signs or symposychosis, or behavior Resident #53 required one person for toilet us assessed to be freque and bowel.  Current comprehensive but identified a focus a ADL (activities of daily performance deficit r/t impaired balance, fatig pain as well. Intervent extensive by 1 staff for area for incontinence with the resident has in dementia, impaired mod (urinary tract infection) chronic kidney disease peri-area with each incobed, offer bedpan or Bill	Resident #53 was reviewed lent #53 was admitted to in diagnoses, that included is, pneumonia, chronic nigh cholesterol, GERD lux disease), anxiety, ion, fatigue, and tiredness.  Ity minimum data set than assessment of 4/5/19 assessed the brief interview for mental lent #53 was not assessed of the others.  Extensive assistance of se. Resident #53 was not ladder living) self-care (related to) dementia, ue-has chronic intractable ions: She requires toileting. A second focus was also undated and read continence of bladder-billity. She has risk for UTI and dx (diagnosis) of Interventions: Clean ontinence episode. If in SC (bedside commode), or sable diapers. Change principle in the property of the	F	B80	5. Corrective action will be complete by 06/07/19.  6. Infection Prevention Nurse and Assistant Nurse Managers designee.	or		

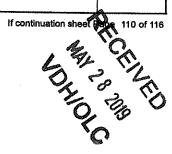
PRINTED: 05/16/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED	
		495384	B. WING	-			С	
NAME OF PROV	/IDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE	05	/03/2019	
FRANCIS MA	RION MANOR HEALT	H & REHABILITATION		1	100 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	D BE COMPLET		
The ceasing will know an an an an an an an an an an an an an	ertified nursing assis m. C.N.A. #1 entered ithout knocking on the door, and stated to the surveyed then apologized. Indicated prior to glow as pulled on both side id-bed. When C.N.A. Inveyor observed the continent of urine. Our placed a clean bridled brief and failed in the then apologized it bed. C.N.A. #1 has bed. C.N.A. #1 has bed. C.N.A. #1 has bed. C.N.A. #1 has bed. C.N.A. #1 has bed. C.N.A. #1 has bed. C.N.A. #1 has bed. C.N.A. #1 has bed. C.N.A. #1 has bed. C.N.A. #1 has bed. C.N.A. #1 has bed. C.N.A. #1 has bed. C.N.A. #1 has bed. C.N.A. #1 put the soiled moved the transcant blaced the liner with a gloves, walked down then C.N.A. #1 left the then went into the caper in the charger, a computer on wheels) and went to the break of clocked out.  The surveyor informed in of the above observed as surveyor observed as a converger of the above observed as a converger observed as	d incontinence care with tant #1 on 5/2/19 at 7:01 at the resident's room ne door. When the surveyor C.N.A. #1 turned around eyor she forgot to knock C.N.A. #1 closed the door gloves. No handwashing e use. The privacy curtain les of the bed to about A. #1 removed the brief, the resident had been C.N.A. #1 removed the brief of on Resident #53. C.N.A. was after removing the to provide incontinence C.N.A. #1 then covered the aket and raised the head of all not changed or removed Resident #53's brief.  The do brief in the trashcan and bag, tied it up, and a clean one. She removed when the hall to the soiled away the trash bag. No hygiene was observed a resident's room. C.N.A. Elean utility, placed her and then rolled the COW to the day room. C.N.A. #1 room, got her lunch bag	F	8880				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 8XB411

Facility ID: VA0086



	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495384	B. WING			0.5	C 5/03/2019	
	ROVIDER OR SUPPLIER  MARION MANOR HEAL	TH & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE  100 FRANCIS MARION LANE, PO BOX 880  MARION, VA 24354				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 880	C.N.A. #2 had donned the brief, which was a trashcan. C.N.A. #2 resident. No inconting Certified nursing assisted. C.N.A. #2. C.N.A. #3 washing or hand hygidonning gloves. C.N pull-up, pants, socks observed a pad and a wheelchair. A gait be resident, then assisted both c.n.a.s, and ther wheelchair. Resident C.N.A. #2 took the traremoved her gloves. observe handwashing C.N.A. #2's gloves were moved her gloves a resident's hair and the combing hair and left pushed the resident to the transport of the conversing with the resident to the transport of the surveyor interview assistant #2 on 5/2/19 care provided and obsurveyor. C.N.A. #2 then went to the surveyor informed director of nursing (Do on 5/2/19 at 4:34 p.m.	to provide incontinent care. d gloves on and removed soiled and placed in put a clean pull-up on the ence care was provided. stant #3 came to assist applied gloves. No hand ene observed prior to A. #3 assisted with the and shoes. The surveyor a towel in Resident #53's It was placed around the d to the side of the bed by a transferred to the a #53's top was changed. Is hout to the buggy and The surveyor did not g or hand hygiene after ene removed. C.N.A. #3 and then combed the en washed her hands after the room. C.N.A. #2 the hallway. Mouth care d washing after care, to the roommate and was e over the bed table and asident. Before C.N.A. #2 s were washed.  wed certified nursing at 10:00 a.m. about the servations made by the	F.	880				

STATEMENT OF DEFICIENCIES (X: AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495384	B. WNG			ŀ	C	
	ROVIDER OR SUPPLIER  MARION MANOR HEAL	TH & REHABILITATION		1	TREET ADDRESS, CITY, STATE, ZIP CODE 00 FRANCIS MARION LANE, PO BOX 880 1ARION, VA 24354	<u> </u>	(03/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION TE DATE			
	The surveyor reques handwashing and per handwashing and per the surveyor reviews sheet on 5/3/19. The Perineal care involves the patient's external skin. Gloves must be because of the risk or Patients who are incompared in the perineal Card 1. Perform hand hyging 2. Introduce yourself 10. b. Using a clean wipe from the perineal back). Repeat this properties of the pusing a new washold and dry the area thore 18. Discard supplies, hand hygiene."  The facility policy title reviewed 5/3/19. The 2. Hands must be we alcohol hand gel used a before and after ha patients or their surrountering the patient's patient's room) d. after contact with a taking a pulse, blood e. after having contact	ploves. The DON stated yes. ted the policy on rineal care.  ed the Perineal Care skill e skill sheet read "Overview: a thorough cleansing of genitalia and surrounding e worn during perineal care of contracting an infection. Interest of urine or stool at perineal care. Perineal ed with soap and water.  eleme and don gloves. It to the patient. It washcloth or perineal wipe, arm to the rectum (front to rocess on the opposite side, the or perineal wipe. C. Rinse bughly. It is not a proposite side, the or perineal wipe. C. Rinse bughly. The present of the patient was a policy read in part: I shed with soap and water or the policy read in part: I shed with soap and water or the pressure, before the patient's skin (i.e., when pressure, lifting a patient) at with body fluids or the patients, non-intact skin the pressure, non-intact skin the pressure of the patient of the	F	380				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		495384	B. WING		····		С
NAME OF D	ROVIDER OR SUPPLIER	730307	D. 111110	Т.		0.5	/03/2019
	MARION MANOR HEALT	TH & REHABILITATION		1	STREET ADDRESS, CITY, STATE, ZIP CODE 100 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CO CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
	clean body site h. after contact with ir medical equipment)  4. Glove usage b. Remove gloves afte c. Gloves should be c a contaminated body d. Do not wear the sai patients  No further information exit conference on 5/3 2a. The facility staff fa catheter tubing off the Resident #27 was adn 5/18/17 with the follow limited to renal failure, diabetes, arthritis, Stat blood pressure and de MDS (Minimum Data S the resident's BIMS (B Status) score of 15 our Resident #27 was also extensive assistance of dressing and personal dependent on 1 staff in	a contaminated site to a sanimate objects (i.e., er caring for the patient shanged when moving from site to a clean body site me pair of gloves between was provided prior to the 1/19. Itel to keep the Foley floor for Resident #27. Initted to the facility on sing diagnoses of, but not neurogenic bladder, ge 3 pressure ulcer, high pression. On the quarterly Set) with an ARD of 3/3/19, rief Interview for Mental to fa possible score of 15. In coded as requiring of 1 staff member for hygiene and was totally	F	880			
	catheter tubing was lyi (registered nurse) #1 v resident's room by the the side of the bed and tubing lying the floor. S Foley catheter bag on						

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495384	B. WING				C	
NAME OF F	PROVIDER OR SUPPLIER			T 8	STREET ADDRESS, CITY, STATE, ZIP CODE	1 05	3/03/2019	
FRANCIS	MARION MANOR HEAL	TH & REHABILITATION		1	00 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E ATE	(X5) COMPLETION DATE	
F 880	"The Foley catheter to the floor."  The surveyor notified the above documenter pm and again on 5/3/conference room.  No further information surveyor prior to the experimental surveyor prior t	the administrative team of ad findings on 5/1/19 at 4:45 19 at 3:52 pm in the awas provided to the exit conference on 5/3/19.  Alied to follow infection ing a dressing change ent #27.  Mitted to the facility on wing diagnoses of, but not in neurogenic bladder, in neurogenic	F	880				
	the above documented	d findings on 5/2/19 at the conference room.						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURV	
		495384	B. WING			ı	C
	ROVIDER OR SUPPLIER  MARION MANOR HEALT	TH & REHABILITATION		1	STREET ADDRESS, CITY, STATE, ZIP CODE 00 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354	1 09	/03/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E NTE	(X5) COMPLETION DATE
F 880		I wound care nurse came	F	880			
	notified the wound ca control issue that was	e room and the surveyor re nurse of the infection s observed by the surveyor. e stated, "I just got so					
	No further information surveyor prior to the e	was provided to the exit conference on 5/3/19.			· ·		
	3. The facility staff fai control guidelines in re nebulizer mask when Resident #45.	egards to the storage of the	And the second s				THE PARTY OF THE P
	1/22/19 with the follow limited to anemia, high dementia and anxiety MDS (Minimum Data : (Assessment Referenthe resident as having Mental Status) score of	ce Date) of 3/19/19 coded a BIMS (Brief Interview for of 12 out of a possible score was also coded as requiring of 1 staff member for giene and is totally		The state of the s			
Average de la constant de la constan	4/30/19 at approximate noted that the resident	of the resident's room on ely 11 am, the surveyor i's nebulizer mask was lying The mask was out in the a plastic bag.					
	received a copy of the storage of a nebulizer	surveyor requested and facility's policy on the mask when not in use. sposable Nebulizers"	,			THE PARTY OF THE P	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DAT	X3) DATE SURVEY COMPLETED	
		495384	B. WNG			1	C	
	ROVIDER OR SUPPLIER  MARION MANOR HEALT	TH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE  100 FRANCIS MARION LANE, PO BOX 88  MARION, VA 24354		00 FRANCIS MARION LANE, PO BOX 880	<u> </u>	i/03/2019	
(X4) ID PREFIX TAG			ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	CTION SHOULD BE O THE APPROPRIATE		
F 880	with water and air dry cloth. Reassemble ar bag"  The surveyor notified the above documente pm in the conference  No further information	Rinse all parts thoroughly or hand dry with a lint free and store in clean equipment the administrative team of d finding on 5/3/19 at 3:52 room.	F	880	DEFICIENCY)			