STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN MEMORIAL HOSP LYNN CARE	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 5/21/2019 through 5/23/2019. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 5/21/19 through 5/23/19. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 111 at the time of the survey. The survey sample consisted of 33 current Resident reviews and 4 closed record reviews.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F 623		6/9/19

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

Electronically Signed | 06/05/2019

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

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F 623	Continued From page 1 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;	F 623		

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F 623	Continued From page 2 (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by:	F 623		

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F 623	Continued From page 3 Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to notify the Ombudsman of a facility initiated transfer to the hospital for one of 37 residents in the survey sample, Resident #5. The facility staff failed to provide evidence that the Ombudsman was provided with the required written notification of Resident #5's facility initiated transfer to the hospital on 4/3/19. The findings include: Resident #5 was admitted to the facility on 11/11/15 with the diagnoses of but not limited to heart failure, high blood pressure, and Non-Alzheimer's dementia. The most recent MDS (Minimum Data Set), a quarterly Medicare assessment, with an ARD (Assessment reference date) of 5/6/19, coded the resident as scoring a 4 out of 15 on the BIMS (Brief Interview for Mental Status), indicating the Resident had severe cognitive impairment for daily decision-making. A review of the clinical record revealed a nurse's note that was dated 4/3/19 at 5:23 PM, which documented in part, "Nursing staff sounded to a tab/pressure alarm and observed resident laying (sic) face down on the bed matt beside his bed ...laceration noted to the forehead and above the right eyebrow that are bleeding - pressure applied ...Notified doctor (name of) and received verbal order to transfer resident to ER (Emergency Room) ...notified resident representative ...bed hold policy sent with resident." Further review of the clinical record failed to reveal evidence of notification to the Ombudsman	F 623	1. The ombudsman was notified on 5/22/19 of the transfer to the emergency room on 4/3/19 for resident #5. 2. All residents had the potential to be affected. Transfer/Discharge Tool was completed on 6/5/19 for all emergency room transfers since 5/22/18 and no other deficient practices were noted. 3. The transfer/discharge policy was reviewed and no changes are warranted at this time. Social Work staff were re-educated on notifying the ombudsman of any transfers on 6/4/19. 4. The DON is responsible for maintaining compliance. The DON/designee will complete the Transfer/discharge tool for all discharges to ensure compliance is maintained. Any negative findings will be corrected immediately and reported to the facilities monthly QAPI meeting. 5. All corrective action will be completed by 6/9/19.	

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F 623	Continued From page 4 for Resident #5's facility initiated transfer to the hospital on 4/3/19. On 5/22/19 at 1:30 PM, an interview was conducted with ASM (Administrative Staff Member) #1, the Administrator. ASM #1 was asked what information goes with the resident when transferred to the hospital. ASM #1 stated, "The hospital has access to resident's electronic records." When ASM #1 was asked notification to the ombudsman and documentation of the notification. ASM #1 stated she would get them. A review of the April 4, 2019 Ombudsman notifications provided by the facility revealed no evidence of an Ombudsman notification for Resident #5 for the 4/3/19 transfer to the ER. On 5/22/19 at 1:46 PM, a follow up interview with ASM #1 was conducted. ASM #1 was asked who is responsible for the Ombudsman notifications. ASM #1 stated, "The Social Worker." ASM #1 was asked when the Ombudsman is notified of resident transfers. ASM #1 stated, "The Ombudsman is notified when residents go to the ER and return hours later." ASM #1 was asked where the Ombudsman notification for Resident #5's transfer to the hospital on 4/3/19. ASM #1 stated, "He must have been missed since he was gone such a short time." On 5/22/19 at 2:11 PM, ASM #1 provided the Ombudsman notification for Resident #5's transfer to the ER on 4/3/19. However, the notification was not done until 5/22/19 at 1:10 PM, per the fax date stamp on the fax confirmation page. The facility did not notify the Ombudsman of this transfer until after the survey team identified this concern.	F 623		

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F 623	Continued From page 5 On 5/23/19 at 8:23 AM, an interview with OSM (Other staff member) #1, the social worker, was conducted. When OSM #1 was asked who is responsible for notifying the Ombudsman of a resident's discharge or transfer to the ER, she stated, "The social worker department." When OSM #1 was asked if the Ombudsman is notified of a resident's discharge or transfer to the ER, how often she sends the notification, OSM #1 stated, "Weekly, on Thursdays." OSM #1 was asked about the April 4, 2019 Ombudsman notification report which did not reveal Resident #5's name for the ER transfer on 4/3/19 and was if Resident #5 should be included in the Ombudsman report for the first week of April, she said, "Yes." A review of the facility's policy "Transfer/Discharge Process" with a revised date of 4/2019 that documented in part, " ...The Ombudsman will be sent a report of all transfers and discharges on a periodic basis in accordance with CMS (Centers for Medicare Services) regulations ..." On 5/23/19 at 9:56 AM, ASM #1 and ASM #2, the Director of Nursing were made aware of the findings. No further information was provided by the end of the survey.	F 623		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered	F 656		6/14/19

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F 656	Continued From page 6 care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by:	F 656		

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F 656	Continued From page 7 Based on observation, staff interview, clinical record review, and facility documentation review, facility staff failed to implement the Comprehensive Care Plans for two of 37 residents in the survey sample, Residents #58 and #18. 1. The facility staff failed to implement the comprehensive care plan for the administration of oxygen as ordered by the physician to Resident #58. 2. The facility staff failed to implement the comprehensive care plan for the administration of oxygen as ordered by the Physician to Resident #18. The findings include: 1. The facility staff failed to implement the comprehensive care plan for the administration of oxygen as ordered by the physician to Resident #58. Resident #58 was admitted to the facility on 10/19/2017. Resident #58's diagnoses that included, but are not limited to, Congestive Heart Failure(1), Hypertension (elevated blood pressure), Atrial Fibrillation (a condition causing an abnormal beating of the heart), Chronic Obstructive Pulmonary Disease (2), and Chronic Kidney Disease(3). Resident #58's most recent Minimum Data Set (MDS) Assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of 04/08/2019. The Brief Interview for Mental Status (BIMS) coded Resident #58 as a 12, indicating mild impairment. Resident #58 was coded as requiring extensive	F 656	1.Resident # 58 and #18 were immediately checked by DON and oxygen was on correct setting per plan of care on 5/22/19. Nurse in charge of care for resident #58 and #18 was immediately re-educated on following care plan for oxygen administration on 5/22/19. 2. Observation of all residents receiving oxygen administration was completed and no issues of non-compliance were noted on 5/24/19. 3. The policy Oxygen Therapy was reviewed and no changes are warranted at this time. Nursing staff will be re-educated on following the care plan for oxygen administration 6/14/19. 4. DON is responsible for compliance. The DON/Designee will do 5 random observations of oxygen administration on residents with physician orders for oxygen therapy weekly to ensure the plan of care is being followed during administering oxygen. Any negative findings will be corrected immediately and reported to the facilities monthly QAPI meeting. 5. All corrective action will be completed by 6/14/19.	

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assistance of 1 (one) person for bathing, and was coded as independent in all other Activities of Daily Life (ADLs).

During the initial tour of the facility on 05/21/2019 at 12:32p.m., Resident #58 was observed in her room with her oxygen concentrator in use. This surveyor knelt next to the concentrator to obtain an eye-level view of the flow meter on the machine. The meter was observed with its floating indicator hovering between the gauge marks indicating 2.0L (liters of oxygen/minute) and 2.5L. There were no quarter-liter marks on the gauge.

The following day, on 05/22/2019, at 2:03p.m., Resident #58 was again observed in her room, sitting up in her chair receiving oxygen via an oxygen concentrator. Once again, this surveyor knelt next to the machine to obtain an eye-level reading of the flow meter. The indicator was observed hovering between the 2.0L and 2.5L gauge marks.

A review of Resident #58's Physician Orders revealed the following order: "O2 (oxygen) at 2 LPM (liters per minute) via NC (nasal cannula) every shift; Day 0:700 - 19:00 (7pm), Night 19:00 - 0:700"

The order had a start date of 10/20/2017 and an End Date of "Open Ended".

A review of Resident #58's Comprehensive Care Plan revealed the following under "[Resident Name] is at Risk for Respiratory Distress": Administer oxygen as ordered.

A review of the facility policy entitled "Oxygen

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Therapy" revealed the following under the heading "Statement of Policy/Procedure":

A. Oxygen Administration
1. A Physician's Order is required for the Administration of Oxygen
2. Initial set-up of needed equipment at appropriate liter flow will be done by the nurse
3. The nurse will regulate oxygen flow

On 05/22/2019 at 4:57p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked if she was familiar with setting up oxygen for a resident, LPN #2 replied that she was. LPN #2 was asked how the nurse setting up an oxygen concentrator adjusts the flow rate to the level prescribed by the doctor. LPN #2 stated that the oxygen concentrators have a flow meter on the front with a dial for adjustment. She stated that the nurse adjusts the dial until the floating ball in the flow meter is hovering at the gauge mark indicating the proper flow rate, when viewed from eye level.

The Administrator ASM (Administrative Staff Member) #1 and Director of Nursing ASM #2 were informed of the findings at the end of day meeting on 05/23/2019. No further documentation was provided.

1. Heart failure is a condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. The weakening of the heart's pumping ability causes blood and fluid to back up

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F 656	Continued From page 10 into the lungs, the buildup of fluid in the feet, ankles and legs - called edema, and tiredness and shortness of breath. - https://medlineplus.gov/heartfailure.html 2. COPD (chronic obstructive pulmonary disease) makes it hard for you to breathe. The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it. - https://medlineplus.gov/copd.html 3. Chronic kidney disease (CKD) means that your kidneys are damaged and can't filter blood as they should. This damage can cause wastes to build up in your body. It can also cause other problems that can harm your health. Diabetes and high blood pressure are the most common causes of CKD. - https://medlineplus.gov/chronickidneydisease.html 2. The facility staff failed to implement the comprehensive care plan for the administration of oxygen as ordered by the Physician to Resident #18. Resident #18 was admitted to the facility on 12/09/2017. Resident #18's diagnoses included, but were not limited to, Hypertension (high blood pressure), Congestive Heart Failure (1), and Chronic Obstructive Pulmonary Disease (2). Resident #18's most recent Minimum Data Set (MDS) Assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of	F 656		

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F 656	Continued From page 11 02/26/2019. The Brief Interview for Mental Status (BIMS) coded Resident #18 as a 15, indicating no impairment. Resident #18 was coded as requiring extensive assistance of 1 person for bathing, and was coded as independent in all other Activities of Daily Life (ADLs). During the initial tour of the facility on 05/21/2019 at 12:46p.m., Resident #18 was observed in her room with her oxygen concentrator in use. This surveyor knelt next to the concentrator to obtain an eye-level view of the flow meter on the machine. The meter was observed with its floating indicator hovering between the gauge marks indicating 2.5L and 3.0L. There were no quarter-liter marks on the gauge. A review of Resident #18's Physician Orders revealed the following order: "May titrate Oxygen 2L-2.5L/min via NC (nasal cannula), Special Instructions: Keep O2 sats above 94%, every shift; Day 0:700 - 19:00 (7pm), Night 19:00 - 0:700" The order had a start date of 05/21/2019 and an End Date of "Open Ended". A review of Resident #18s Comprehensive Care Plan revealed the following under "[Resident Name] is at Risk for Respiratory Distress": Administer oxygen as ordered. A review of the facility policy entitled "Oxygen Therapy" revealed the following under the heading "Statement of Policy/Procedure": A. Oxygen Administration 1. A Physician's Order is required for the Administration of Oxygen	F 656		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 12 2. Initial set-up of needed equipment at appropriate liter flow will be done by the nurse 3. The nurse will regulate oxygen flow On 05/22/2019 at 4:57p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked if she was familiar with setting up oxygen for a resident, LPN #2 replied that she was. LPN #2 was asked how the nurse setting up an oxygen concentrator adjusts the flow rate to the level prescribed by the doctor. LPN #2 stated that the oxygen concentrators have a flow meter on the front with a dial for adjustment. She stated that the nurse adjusts the dial until the floating ball in the flow meter is hovering at the gauge mark indicating the proper flow rate, when viewed from eye level. The Administrator ASM (Administrative Staff Member) #1 and Director of Nursing ASM #2 were informed of the findings at the end of day meeting on 05/23/2019. No further documentation was provided. 1. Heart failure is a condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. The weakening of the heart's pumping ability causes blood and fluid to back up into the lungs, the buildup of fluid in the feet, ankles and legs - called edema, and tiredness and shortness of breath. - https://medlineplus.gov/heartfailure.html 2. COPD (chronic obstructive pulmonary disease)	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	05/23/2019

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F 656	Continued From page 13 makes it hard for you to breathe. The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it. - https://medlineplus.gov/copd.html	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to follow professional standards of practice for one of 37 residents in the survey sample, Resident #5. The facility staff failed to clarify the physician orders for iron (1) administration for Resident #5. The findings include: Resident #5 was admitted to the facility on 11/11/15 with diagnoses that included but were not limited to: iron deficiency anemia (2), thrombocytopenia (3), congestive heart failure (4) and pulmonary embolism (5). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/6/19, coded the	F 658	1. Resident #5's Ferrous Sulfate order was clarified on 5/22/19. 2. An audit of all residents receiving Ferrous sulfate was completed on 5/24/19 and no issues of non-compliance was noted. 3. The policy on "Order clarification" was reviewed on 6/3/19 and no changes are warranted at this time. Nursing staff will be re-educated on process for clarification of physician order by 6/14/19. 4. DON is responsible for compliance. The DON/Designee will audit all new orders of Ferrous Sulfate to ensure compliance is maintained. Any negative findings will be corrected immediately and reported to the facilities monthly QAPI meeting. 5. All corrective action will be completed by 6/14/19.	6/14/19

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F 658	Continued From page 14 resident as having scored 4 out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely cognitively impaired. Resident #5's care plan dated 12/8/18, revision date of 5/2/19, documented "(name of Resident #5) has a diagnosis of anemia and takes medication daily. Approach: administer medication as ordered." Physician order report (POR) dated 5/2/19 documented, "Ferrous sulfate (6) tablet, delayed release, 324 mg (milligrams) [65 mg iron], amount 1 tablet, oral, once a day, DX (diagnosis): iron deficiency anemia." The May 2019 medication administration record (MAR) documented, "Ferrous sulfate tablet, delayed release, 324 mg (milligrams) [65 mg iron], amount 1 tablet, oral, once a day, DX (diagnosis): iron deficiency anemia.", as being administered daily from 5/3/19 through 5/22/19. On 05/22/19 at approximately 8:00 a.m., LPN (licensed practical nurse) #1 was observed preparing and administering medication to Resident #5. LPN #1 was observed preparing the medications on a brown medication cart. LPN #1 viewed Resident #5's electronic MAR, opened a draw from which she pulled a clear pill pack labeled "Ferrous sulfate 325 mg", LPN #1 then placed the pill into a small plastic cup and gave it Resident #5 who then took took the pill. LPN #1 then documented on the MAR, "Ferrous sulfate tablet, delayed release, 324 mg (milligrams) [65 mg iron], amount 1 tablet, oral, once a day, DX (diagnosis): iron deficiency anemia." had been administered.	F 658		

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F 658	Continued From page 15 On 05/22/19 at approximately 1:29 p.m., an interview was conducted with LPN #1. LPN #1 was asked what dose of iron Resident #5 was given. LPN #1 replied, "I gave him 325 mg." LPN #1 was then asked what dose of iron Resident #5 was ordered to receive. LPN #1 replied, "I don't know let me check." LPN #1 then reviewed Resident #5's POR. LPN #1 replied, "324 mg, I thought it was 325 mg I have never personally heard of 324 mg of iron." LPN #1 was asked about the process staff follows if they are not sure of a physician medication order. LPN #1 replied, "If there is a question about an order you can always call the pharmacist or doctor and clarify." LPN #1 was asked if this order for Resident #5 should be clarified. LPN #1 replied, "Yes, (name of ASM [administrative staff member] #3, MD [medical doctor]) is right here I can clarify it with him now." LPN #1 then asked ASM #3 did you mean to write an order for 324 mg of iron or 325 mg. ASM #3 replied, "They are equivalent doses, but I can clarify." On 05/23/19 at approximately 9:05 a.m., an interview was conducted with ASM #2, the Director of Nursing. When asked if a nurse should give a dosage of a medication that, she is not familiar with, ASM #1 replied, "If you are talking about the iron, yes the order should have been clarified. I talked to the pharmacy and they said the doses were interchangeable." On 5/22/19 at approximately 5:15 p.m., ASM #1, the Administrator and ASM #2, the Director of Nursing were made aware of the findings. The facility policy titled: "Order Clarification" dated 5/23/19 documented, "Orders that are incomplete, illegible, or unclear must be clarified	F 658		

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F 658	Continued From page 16 with the ordering health care professional or a physician prior to carrying out the order." No further information was provided prior to exit. 1. Iron is a mineral that our bodies need for many functions. For example, iron is part of hemoglobin, a protein which carries oxygen from our lungs throughout our bodies. It helps our muscles store and use oxygen. Iron is also part of many other proteins and enzymes. Your body needs the right amount of iron. If you have too little iron, you may develop iron deficiency anemia. Causes of low iron levels include blood loss, poor diet, or an inability to absorb enough iron from foods. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=iron&_ga=2.183194918.1419770610.1558705372-578281844.1558705372 2. Iron deficiency anemia is a type of anemia that occurs when there is not enough iron to make the hemoglobin in red blood cells. The main causes of iron deficiency anemia in adults are bleeding and conditions that block iron absorption in the intestines. This information was obtained from the website: https://www.uptodate.com/contents/anemia-caused-by-low-iron-in-adults-beyond-the-basics?search=iron&source=search_result&selectedTitle=4~145&usage_type=default&display_rank=3#H1 3. A disorder in which there is an abnormally low amount of platelets. Platelets are parts of the blood that help blood to clot. This condition is	F 658		

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F 658	Continued From page 17 sometimes associated with abnormal bleeding. This information was obtained from the website: https://medlineplus.gov/ency/article/000586.htm. 4. A condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. This information was obtained from the website: https://medlineplus.gov/heartfailure.html 5. A pulmonary embolism (PE) is a sudden blockage in a lung artery. It usually happens when a when a blood clot breaks loose and travels through the bloodstream to the lungs. PE is a serious condition that can cause: permanent damage to the lungs, low oxygen levels in your blood and damage to other organs in your body from not getting enough oxygen. PE can be life-threatening, especially if a clot is large, or if there are many clots. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=pulmonary+embolism 6. Iron (ferrous fumarate, ferrous gluconate, ferrous sulfate) is used to treat or prevent anemia (a lower than normal number of red blood cells) when the amount of iron taken in from the diet is not enough. Iron is a mineral that is available as a dietary supplement. It works by helping the body to produce red blood cells. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682778.html	F 658		

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F 695	Continued From page 18	F 695		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 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 and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation review, facility staff failed to administer oxygen per the physician's orders for two of 37 residents in the survey sample, Residents #58 and #18. 1. The facility staff failed to administer oxygen to Resident #58 at the physician ordered flow rate of 2 LPM (liters per minute) via NC (nasal cannula), during separate observations the oxygen flowmeter was observed set at a flow rate between 2.0LPM and 2.5LPM. 2. The facility staff failed to administer oxygen to Resident #18 at the physician ordered flow rate of 2L (liters)-2.5L/min via NC (nasal cannula), the oxygen flowmeter was observed set at a flow rate between 2.5LPM (liters per minute) and 3.0LPM. The Findings Include: 1. The facility staff failed to administer oxygen to Resident #58 at the physician ordered flow rate of 2 LPM (liters per minute) via NC (nasal cannula),	F 695	1.Resident # 58 and #18 were immediately checked by DON and oxygen was on correct setting per physician order on 5/22/19. Nurse in charge of care for resident #58 and #18 was immediately re-educated on following care plan for oxygen administration on 5/22/19. 2. Observation of all residents receiving oxygen administration was completed and no issues of non-compliance were noted on 5/24/19. 3. The policy Oxygen Therapy was reviewed and no changes are warranted at this time. Nursing staff will be re-educated on following the care plan for oxygen administration by 6/14/19. 4. DON is responsible for compliance. The DON/Designee will do 5 random observations of oxygen administration on residents with physician orders for oxygen therapy weekly to ensure the plan of care is being followed during administering oxygen. Any negative findings will be corrected immediately and reported to the facilities monthly QAPI meeting.	6/14/19

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F 695	Continued From page 19 during separate observations the oxygen flow meter was observed set at a flow rate between 2.0L and 2.5LPM. Resident #58 was admitted to the facility on 10/19/2017. Resident #58's diagnoses included, but were not limited to, Congestive Heart Failure (1), Hypertension (elevated blood pressure), Atrial Fibrillation (a condition causing an abnormal beating of the heart), Chronic Obstructive Pulmonary Disease (2), and Chronic Kidney Disease (3). Resident #58's most recent Minimum Data Set (MDS) Assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of 04/08/2019. The Brief Interview for Mental Status (BIMS) coded Resident #58 as a 12, indicating mild impairment. Resident #58 was coded as requiring extensive assistance of 1 person for bathing, and was coded as independent in all other Activities of Daily Life (ADLs). During the initial tour of the facility on 05/21/2019 at 12:32p.m., Resident #58 was observed in her room with her oxygen concentrator in use. This surveyor knelt next to the concentrator to obtain an eye-level view of the flow meter on the machine. The meter was observed with its floating indicator hovering between the gauge marks indicating 2.0L (liters of oxygen/minute) and 2.5L. There were no quarter-liter marks on the gauge. The following day, on 05/22/2019, at 2:03p.m., Resident #58 was again observed in her room, sitting up in her chair receiving oxygen via an oxygen concentrator. Once again, this surveyor knelt next to the machine to obtain an eye-level reading of the flow meter. The indicator was	F 695	5. All corrective action will be completed by 6/14/19.	

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F 695	Continued From page 20 observed hovering between the 2.0L and 2.5L gauge marks. A review of Resident #58's Physician Orders revealed the following order: "O2 (oxygen) at 2 LPM (liters per minute) via NC (nasal cannula) every shift; Day 0:700 - 19:00 (7pm), Night 19:00 - 0:700" The order had a start date of 10/20/2017 and an End Date of "Open Ended". A review of Resident #58's Comprehensive Care Plan revealed the following under "[Resident Name] is at Risk for Respiratory Distress": Administer oxygen as ordered. A review of the facility policy entitled "Oxygen Therapy" revealed the following under the heading "Statement of Policy/Procedure": A. Oxygen Administration 1. A Physician's Order is required for the Administration of Oxygen 2. Initial set-up of needed equipment at appropriate liter flow will be done by the nurse 3. The nurse will regulate oxygen flow On 05/22/2019 at 4:57p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked if she was familiar with setting up oxygen for a resident. LPN #2 replied that she was. LPN #2 was asked how the nurse setting up a concentrator adjusts the flow rate to the level prescribed by the doctor. LPN #2 stated that the oxygen concentrators have a flow meter on the front with a dial for adjustment. She stated that the nurse adjusts the dial until the floating ball in the flow meter is hovering at the gauge mark	F 695		

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F 695	Continued From page 21 indicating the proper flow rate, when viewed from eye level. According to Fundamentals of Nursing, Perry and Potter, 6th edition, page 1122, "Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration." The Administrator ASM (Administrative Staff Member) #1 and Director of Nursing ASM #2 were informed of the findings at the end of day meeting on 05/23/2019. No further documentation was provided. 1. Heart failure is a condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. The weakening of the heart's pumping ability causes blood and fluid to back up into the lungs, the buildup of fluid in the feet, ankles and legs - called edema, and tiredness and shortness of breath. - https://medlineplus.gov/heartfailure.html 2. COPD (chronic obstructive pulmonary disease) makes it hard for you to breathe. The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs.	F 695		

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F 695	Continued From page 22 This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it. - https://medlineplus.gov/copd.html 3. Chronic kidney disease (CKD) means that your kidneys are damaged and can't filter blood as they should. This damage can cause wastes to build up in your body. It can also cause other problems that can harm your health. Diabetes and high blood pressure are the most common causes of CKD. - https://medlineplus.gov/chronickidneydisease.html 2. The facility staff failed to administer oxygen to Resident #18 at the physician ordered flow rate of 2L (liters)-2.5L/min via NC (nasal cannula), the oxygen flowmeter was observed set at a flow rate between 2.5LPM (liters per minute) and 3.0LPM. Resident #18 was admitted to the facility on 12/09/2017. Resident #18's diagnoses included, but were not limited to, Hypertension (high blood pressure), Congestive Heart Failure (1), and Chronic Obstructive Pulmonary Disease (2). Resident #18's most recent Minimum Data Set (MDS) Assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of 02/26/2019. The Brief Interview for Mental Status (BIMS) coded Resident #18 as a 15, indicating no impairment. Resident #18 was coded as requiring extensive assistance of 1 person for bathing, and was coded as independent in all other Activities of Daily Life (ADLs). During the initial tour of the facility on 05/21/2019 at 12:46p.m., Resident #18 was observed in her room with her oxygen concentrator in use. This	F 695		

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F 695	Continued From page 23	F 695		

surveyor knelt next to the concentrator to obtain an eye-level view of the flow meter on the machine. The meter was observed with its floating indicator hovering between the gauge marks indicating 2.5LPM and 3.0LPM. There were no quarter-liter marks on the gauge.

A review of Resident #18's Physician Orders revealed the following order: "May titrate Oxygen 2L-2.5L/min via NC (nasal cannula), Special Instructions: Keep O2 sats [saturation] above 94%, every shift; Day 0:700 - 19:00 (7pm), Night 19:00 - 0:700"

The order had a start date of 05/21/2019 and an End Date of "Open Ended".

A review of Resident #18s Comprehensive Care Plan revealed the following under "[Resident Name] is at Risk for Respiratory Distress": Administer oxygen as ordered.

A review of the facility policy entitled "Oxygen Therapy" revealed the following under the heading "Statement of Policy/Procedure":

A. Oxygen Administration
1. A Physician's Order is required for the Administration of Oxygen
2. Initial set-up of needed equipment at appropriate liter flow will be done by the nurse
3. The nurse will regulate oxygen flow

On 05/22/2019 at 4:57p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked if she was familiar with setting up oxygen for a resident. LPN #2 replied that she was. LPN #2 was asked how the nurse setting up a concentrator adjusts the flow rate to the level

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WARREN MEMORIAL HOSP LYNN CARE	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 24 prescribed by the doctor. LPN #2 stated that the oxygen concentrators have a flow meter on the front with a dial for adjustment. She stated that the nurse adjusts the dial until the floating ball in the flow meter is hovering at the gauge mark indicating the proper flow rate, when viewed from eye level. The Administrator ASM (Administrative Staff Member) #1 and Director of Nursing ASM #2 were informed of the findings at the end of day meeting on 05/23/2019. No further documentation was provided. 1. Heart failure is a condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. The weakening of the heart's pumping ability causes blood and fluid to back up into the lungs, the buildup of fluid in the feet, ankles and legs - called edema, and tiredness and shortness of breath. - https://medlineplus.gov/heartfailure.html 2. COPD (chronic obstructive pulmonary disease) makes it hard for you to breathe. The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it. - https://medlineplus.gov/copd.html	F 695		