PRINTED: 11/26/2019 FORM APPROVED OMB NO. 0938-0391

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495143	B. WING			(
NAME OF D	ROVIDER OR SUPPLIER	495143	B. VVING	OTC	REET ADDRESS, CITY, STATE, ZIP CODE	10/	18/2019
NAME OF PI	ROVIDER OR SUPPLIER				7 SPRUCE STREET		
MARTINS	VILLE HEALTH AND RE	IAB			ARTINSVILLE, VA 24112		
(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	survey was conducte The facility was in sul CFR Part 483.73, Re Care Facilities. INITIAL COMMENTS An unannounced Me Survey was conducte Five complaints were survey. Corrections a with 42 CFR Part 483	nergency Preparedness d 10/8/19 through 10/18/19. destantial compliance with 42 quirement for Long-Term dicare/Medicaid Standard d 10/8/19 through 10/18/19. investigated during the are required for compliance B Federal Long Term Care . e survey/report will follow.	F O	000	Disclaimer: This plan of correction is being sub- in compliance with specific regulate requirements and preparation and/ execution of this plan of correction not constitute admission or agreem the provider of the facts alleged or conclusions set forth on the statem of deficiencies.	ory or does nent by	
F 558 SS=D	111 at the time of the consisted of 23 curre closed record reviews Reasonable Accomm CFR(s): 483.10(e)(3) Services in the facility accommodation of repreferences except wendanger the health other residents. This REQUIREMENT by: Based on observation interview, and clinical staff failed to provide	that to reside and receive with reasonable sident needs and when to do so would or safety of the resident or is not met as evidenced on, Resident interview, staff I record review, the facility one of 30 Residents in the easonable accommodation	F5	558	1. Resident #63 call bell was place within reach on 10/10/2019. 2. Audits were completed during Carekeeper Rounds to identify residents with mobility limitations reach call bell. 3. Staff re-education was provided Director of Nursing or designee reto ensuring the call bell is within reach. 4. Audits will be completed by the Administrator or designee during.	to d by the ⊌lated	12/06/2019 VDHOL

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

ADMINISTRATOR

Carekeeper Rounds at least 5 times

(X6) DATE
12-5 2019

Involution of the content and the content and

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

The findings included

Event ID: N52R11

Facility ID: VA0159

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		INCLUSION ATION AND AND AND AND AND AND AND AND AND AN		IULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		495143	B. WING_	8. WING		C 10/18/2019		
NAME OF P	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		s	STREET ADDRESS, CITY, STATE, ZIP CODE	1		
				1	607 SPRUCE STREET			
MARTINSVILLE HEALTH AND REHAB			A	MARTINSVILLE, VA 24112				
(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)		(X5) COMPLETION DATE	
F 558	Continued From page	e 1	F	558	weekly for 4 weeks. The Administ	rator		
	The facility staff failed	to ensure that the call bell			will submit the audit results to the	1		
	was within reach for I	Resident # 63.			Assurance and Performance	addanty		
		47-year-old-female that was			Improvement Committee. The			
		the facility on 3/22/18, and			Administrator is responsible for mo	onitoring		
		ate of 7/2/19. Diagnoses t limited to, pain in bilateral			and follow-up.			
	hands, muscle weak	•			5. 12/06/2019			
	paraplegia.	iooo, vorago, and						
	The clinical record fo	r Resident # 63 was						
		at 9:46 am. The most						
		m data set) assessment for				ĺ		
	•	quarterly assessment with				ĺ		
	an ARD (assessment	reference date) of 8/21/19.						
	Section C of the MDS	_						
	1 -	C0500, the facility staff						
		sident # 63 had a BIMS (brief						
		status) score of 15 out of 15, Resident #63 was cognitively						
		ne MDS assesses functional						
	status. In Section G0							
		ocomotion on the unit						
	assessed how the re	sident moved between						
		and adjacent corridor on the						
		elchair, self-sufficiency once						
		taff documented that						
		tally dependent requiring the						
	on the unit.	more persons for locomotion						
	On the drift.							
	The current plan of c	are for Resident # 63 was						
		on 9/3/19. The facility staff						
		area for Resident # 63 as, "I						
		tioning deficit related to:						
		self-care impairment, dx's						
		legia, chronic inflammatory						
		europathy, intervertebral disc				Ī		
	gegeneration-lumbar	region, fibromyalgia, morbid				I		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (MR) IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495143	B. WING		C 10/18/2019	
	ROVIDER OR SUPPLIER	IAB		STREET ADDRESS, CITY, STATE, ZIP CODE 1807 SPRUCE STREET MARTINSVILLE, VA 24112	10/10/2013	
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 558	obesity, and anemia." were not limited to, "O On 10/10/19 at 1:28 p. Resident # 63's room interview. The survey 63 was sitting in her vipositioned at the foot observed the call bell on the right side at the surveyor asked Resid assistance from the nreach her call bell. Resident her call bell. Resident her call bell. Resident her call on the right side at the surveyor asked Resid assistance from the nreach her call bell. Resident her call bell. Resident her call on the right bed, and observed the bed rail on the right bed. Cna # 1 agreed freach for Resident # 60 On 10/10/19 at 3:54 p. Girector of nursing we findings as stated above as provided the opp and/or submit addition team to in response to stated above.	Interventions included but call bell within reach." Interventions included but call bell within reach." Interventions a Resident or observed that Resident # wheelchair that was of her bed. The surveyor wrapped around the bed rail to head of her bed. The ent # 63 if she needed urse would she be able to esident # 63 stated, "No." Interventions and Cna # sistant) observed Resident ecall bell wrapped around that side at the head of the ent that the call bell was not with 63. Interventions included but # survey or the administrative team ortunity to ask questions and information to the survey or the deficient practice as	F 55	8		
F 561 SS=D	team prior to the exit Self-Determination CFR(s): 483.10(f)(1)-(§483.10(f) Self-determination The resident has the	V°	F 56	1. Resident #47 was informed she allowed to eat where she prefers on 10/13/2019 and 10/15/2019. 2. Residents who reside in facility risk for not being able to eat in the	are at	

		IDENTIFICATION NUMBER:		JLTIPLE CONSTRUCTION DING			(X3) DATE SURVEY COMPLETED	
		495143	B. WING	B. WING		C 10/18/2019		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	10/	18/2019	
					607 SPRUCE STREET			
MARTINSVILLE HEALTH AND REHAB				IARTINSVILLE, VA 24112				
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 561	through support of resont limited to the right (1) through (11) of thi §483.10(f)(1) The resortivities, schedules (waking times), health care services consists assessments, and pla applicable provisions §483.10(f)(2) The resortices about aspect facility that are significable states as the services are significable to the significant significan	sident choice, including but its specified in paragraphs (f) is section. sident has a right to choose (including sleeping and care and providers of health ent with his or her interests, an of care and other of this part. sident has a right to make is of his or her life in the cant to the resident. sident has a right to interact community and participate in both inside and outside the ident has a right to ctivities, including social, unity activities that do not its of other residents in the is not met as evidenced in, clinical record review, taff interview, and facility is a facility staff failed to its in the survey sample,	F	561	preferred location. 3. Director of Nursing or designee re-educate the nursing staff by 12 related to accommodating resider dining location preferences. 4. The Social Work Director or dewill conduct random audits at least times a week for 4 weeks to ensure sidents are dining in their prefer location. Social Work Director will submit the findings of the audits to the Quality Assurance and Performance Improvement Committee. The Administrator is responsible for monitoring and follow-up. 5. 12/06/2019	2/6/19 at signee at 3 re red		
	dining room.	orrad robution, tile lability						

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPL IDENTIFICATION NUMBER: A. BUILDING		FIPLE CONSTRUCTION NG	((X3) DATE SURVEY COMPLETED		
		495143	B. WING_			C 10/18/2019		
	ROVIDER OR SUPPLIER VILLE HEALTH AND REI	HAB		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112				
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION JE ACTION SHOULD BE D TO THE APPROPRIAT JCIENCY)	(X5) COMPLETION DATE		
F 561	Resident # 47 was ac 5/11/17. Diagnoses in to, anxiety disorder, to major depressive discording to the clinical record for reviewed on 10/9/19 recent MDS (minimum Resident # 47 was a an ARD (assessment Section C of the MDS patterns. In Section C documented that Resistent # 15 was concerviewed and revised documented a focus sometimes have behavith other residents undining room and swiptable." Interventions it to, "Help me maintain and "Offer me sometimes of the content of the content in the content of the conten	dmitted to the facility on acluded but were not limited raumatic brain injury and order. Tresident # 47 was at 12:15 pm. The most at 12:15 pm. The most at 12:15 pm. The most at 12:15 pm. The sees at 12:15 pm. The sees at 12:15 pm. The most a				E DAIE		
	Resident # 47 lying in surveyor observed the to one sitter in her room. The surveyor intervies surveyor asked Residuent in her room with stated, "Three days." have been in my room." The surveyor as wanted to eat her me	an bed in her room. The at Resident # 47 had a one om sitting at her bedside. wed Resident # 47. The dent # 47 how long she had an sitters. Resident # 47 Resident # 47 stated, "I an and had girls sitting with asked Resident # 47 if she als in her room. Resident # ove to eat in the dining						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER A. BUILDING		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495143	B. WING_			C 10/18/2019		
	ROVIDER OR SUPPLIER VILLE HEALTH AND RE	HAB		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112				
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	PROVIDER'S PLAN OF CEACH CORRECTIVE ACCURATE CROSS-REFERENCED TO DEFICIEN	THE APPROPRIA			
F 561	room, but they told mare people in there the surveyor asked Resident eat in the dining row #47 stated, "Sad." On 10/15/19 at 12:37 Resident #47 eating staff member sitting at The surveyor reviewed Resident #47. The surveyor reviewed Resident #47. The surveyor reviewed Resident #47. The surveyor Resident #47 in the surveyor reviewed room and Resident #1 ice cream.	ne I couldn't because there hat are scared of me." The dent # 47 how not being able from made her feel. Resident If pm, the surveyor observed her lunch in her room with a at her bedside. Hed the clinical record for urveyor reviewed a condition" note for Resident # cumented on 10/12/19 at as documented as, lent) # 47 was in the dining 129 stated she wanted some # 47 stated "Why can't you a b****" Response: Rsd was hing and told that she had to her room due to her behavior. 11 care by staff. Resident # ed the clinical record further her ess notes and the plan of the any documentation of her to offer diversional hallow Resident # 47 to eat hoom, which was her	F	3				
	attempted diversiona behaviors in order to meals in the dining ro	allow Resident # 47 to eat						

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	ROVIDER OR SUPPLIER	НАВ		STREET ADDRESS, CITY, STATE, ZIP COD 1607 SPRUCE STREET MARTINSVILLE, VA 24112		5710,2013	
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
F 561	behaviors that would able to eat meals in a director of nursing he surveyor's question. The facility staff proven Resident Rights and Federal Law" which a resident. The document that included but was "Quality of Life Self-Determination a fits in your care plantyour own schedule, of to participate in, intercommunity, and make	the facility staff had interventions to manage allow Resident # 47 to be ner preferred location. The ad no response to the ided a copy of "Your Protections under State and was provided to each ent contained information	F 50	61			
F 580 SS=D	with the administrator the regional director surveyor provided the the opportunity to as additional information regard the deficient properties of the surveyor provided to the surveyor provided to the surveyor of the conference on 10/18 Notify of Changes (In CFR(s): 483.10(g)(14) Notificity A facility must immediate the regional surveyor provided the regional surveyor p	njury/Decline/Room, etc.) 4)(i)-(iv)(15)	F 5	1. Resident #63 physicia vaginal bleeding on 6/27 #110 physician was noti refusals 6/23/2018. 2. Residents that reside at risk for this deficient p	/2019. Residen fied of Levemir in the facility ar	t	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING				(X3) DATE SURVEY COMPLETED		
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NAME OF P	ROVIDER OR SUPPLIER		1	CTREET ADDRESS CITY STATE 711	CODE	10/18/2019
	VILLE HEALTH AND REP	H AB	STREET ADDRESS, CITY, STATE, ZIP GODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112			
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F 580	consistent with his or representative(s) where (A) An accident involves a consistent with his or representative(s) where (A) An accident involves a consistent with a significant channel of the consistent of the	her authority, the resident on there is- ving the resident which has the potential for requiring on; ge in the resident's physical, had status (that is, a or mental, or psychosocial reatening conditions or	F	3. The Director of Numprovided re-education related to monitoring resident condition and the interact system; Swatch. 4. The Assistant Director designee will condinursing staff continue changes in condition physician through revand the 24-hour repoweek for 8 weeks. The of Nursing will submit Quality Assurance and Improvement Commit Director of Nursing is monitoring and follow 5. 12/06/2019	to nursing staff for change in dusage of BAR and stop ar actor of Nursing act audits to ensure to document and notify the riew of nursing nor 5 times a e Assistant Direct audit findings to d Performance actee. The responsible for	nd ure otes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		495143	B. WING		C 10/18/2019	
	ROVIDER OR SUPPLIER VILLE HEALTH AND REI	HAB	STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112			
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F 580	§483.5) must disclose its physical configura locations that comprispart, and must specific room changes betweender §483.15(c)(9). This REQUIREMENT by: Based on Resident is review, staff interview complaint investigation the facility staff failed changes for two of 30 sample, Resident #63. The findings included 1. The facility staff that Resident #63 has than a month. Resident #63 was of facility on 3/22/18, and 7/2/19. Diagnoses into, anemia, abnormableeding, paraplegia, The clinical record for reviewed on 10/10/19 recent MDS (minimum Resident #63 was a an ARD (assessment Section C of the MDS patterns. In Section C documented that Resinterview for mental swhich indicated that lintact. Section G of the most section G	e in its admission agreement tion, including the various se the composite distinct y the policies that apply to en its different locations is not met as evidenced interview, clinical record y and during the course of a con, it was determined that to notify the physician of the Residents in the survey and Resident # 110. failed to notify the physician ad vaginal bleeding for more riginally admitted to the ad had a readmission date of cluded but were not limited and muscle weakness. The Resident # 63 was the at 9:46 am. The most medata set) assessment with the reference date) of 8/21/19.	F 580			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495143	B, WING	R WING		С	
	ROVIDER OR SUPPLIER	I	To: Willow	STREET ADDRESS, CITY, STATE, ZIP C 1607 SPRUCE STREET MARTINSVILLE, VA 24112		0/18/2019	
(X4) ID PREFIX TAG			ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 580	limited to, how the Re room, commode, or be elimination, and chardocumented that Res dependent requiring more persons for toili assessed bathing. The that Resident # 63 we requiring the assistar for bathing. On 10/10/19 at 1:28 Resident # 63's room interview. The surveys she had been readmadmission to the facili the surveyor that she was admitted to the bestated, "I was as whill the surveyor reviewed Resident # 63. The some that had been documentation that in to, "Resident alert menstrual was on for pale and states she fill 96.5, 122/70, 73, 16, notified of concern." The surveyor reviewed Condition note for Redocumented on 6/27, was documented as, and had critical low HCT (hematocrit) 16.	sment included but was not esident #63 used the toilet bedpan; cleansed self after ged pad. The facility staff sident # 63 was totally the assistance of two or est use. Section G0120 he facility staff documented as totally dependent, note of two or more persons form, the surveyor was in a conducting a Resident for asked Resident # 63 if sitted to the hospital since her ity. Resident # 63 informed had lost a lot of blood and hospital. Resident # 63 he as that sheet." But the progress notes for surveyor observed a nurse's pocumented on 6/27/19 at 1's note contained had oriented, complained of a month. She appears to be elt weak. VS (vital signs) 98%. MD (medical doctor) had a SBAR- Change of	F	580			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COMPLETED	
		495143	B. WING_			C 10/18/2019	
	ROVIDER OR SUPPLIER	†AB		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112			
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F 580	a month and this was experienced this. Ass 73, 16, 98%, MD notic blood count) which we neurology appointment results. Response: Mouthheld) stated send The surveyor reviewed been documented on nurse's note was doc (Facility name withheld check on rsd (resident with menorrhea with a with menorrhea with a with menorrhea with a month or more, or that Resident # 63 had month or more, or that notified of the vaginal On 10/16/19 at 10:05 interviewed Cna # 2 (The surveyor asked Cexcessive vaginal ble and she has blood clots. Cna With blood clots. Cna On 10/16/19 at 10:33 interviewed the unit murse) and asked if s # 63 had episodes of RN # 1 informed the sunaware that Resident excessive vaginal ble	a not the 1st time she sessment: VS 122/70, 96.5, fied to have CBC (complete as already in place due to int being schedule after ID (physician's name I resident to hospital." ad a nurse's note that had a 6/27/19 at 10:18 pm. The sumented as, "Contacted and ER (emergency room) to ant) condition, Rsd admitted anemia." and the clinical record for a specifically the progress ders, and consultations, and cumentation that reflected ad vaginal bleeding for a at the physician had been I bleeding. am, the surveyor (certified nursing assistant). Cna #2 if Resident # 3 had beding. Cna # 2 stated, "Yes ots." The surveyor asked ed the nursing staff when accessive vaginal bleeding # 2 stated, "Yes."	F5	80			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 580	was pale. RN # 1 state nurse to inform the plasked RN # 1 if she volumes assistants to noticed that Resident vaginal bleeding. RN surveyor asked RN # nursing staff to documbleeding in the clinical physician. RN # 1 state informed RN # 1 that documentation in the # 63 that reflected the bleeding for a month. On 10/17/19 at 3:35 pt. LPN # 1 (licensed preasked LPN # 1 if she 63 had episodes of et. LPN # 1 stated, "Yes. 1 if the certified nursing when Resident # 63 had vaginal bleeding. LPN surveyor asked LPN Resident # 63 was had vaginal bleeding should be the state of the president # 63 was had vaginal bleeding should be the president	ted that she instructed the hysician. The surveyor would expect the certified inform the nurses if they # 63 was having excessive # 1 stated, "Yes." The 1 if she expected the nent episodes of excessive all record and notify the ted, "Yes." The surveyor there was no clinical record for Resident at Resident # 63 had vaginal for more prior to 6/27/19. The surveyor interviewed actical nurse) the surveyor was aware that Resident # xcessive vaginal bleeding. The surveyor asked LPN # ng assistants informed her had episodes of excessive W # 1 stated, "Yes." The # 1 if information that aving episodes of excessive all be documented in the ephysician be notified. LPN	F5	80			
	director of nursing, ar clinical services were as stated above. The administrative team if nursing staff to documbleeding in the clinical physician at the time	they would expect the nent abnormal vaginal of record and notify the the abnormality was noted. we team members agreed					

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 1607 SPRUCE STREET MARTINSVILLE, VA 24112	CODE	1 10/	18/2019
(X4) ID PREFIX TAG	(EACH DEFICIE	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATION) DEFICIENCY)			TION SHOULD B THE APPROPRI		(X5) COMPLETION DATE
F 580	documented in the physician should be abnormality was not was asked for a fact practice regarding in the clinical reconchanges in Resider administrative team opportunity to ask a provide additional indeficient practice at The facility staff preinformation to the spractice for docume but was not limited protocol should be chart with, clear, conurse's decisions, a provided, including should be done at the because passage of accurate recollection. Reference Nettina, S.M. (2013 practice. 10th ed. F. Health/Lippino On 10/18/19 at 10 requested a policy regarding notifying Resident condition. On 10/18/19 at 2:5 a policy or standard the physician of characters.	clinical record and the enotified at the time the beted. The administrative team cility policy and/or standard of documentation abnormalities d and notifying the physician of int condition. The end was also provided the endditional questions and information in response the sistated above. Besented the following survey team as the standard of centation. Information included to,"5. A deviation from documented in the patient's concise statements of the endtions, and reasons for care any apparent deviation. This the time the care is rendered of time may lead to less than on of the specific events." B) Lippincott manual of nursing chiladelphia: Wolters Kluwer out Williams & Wilkins.	F	580			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) AND PLAN OF CORRECTION (X3) DENTIFICATION NUMBER: (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTR	(X3) DATE SURVEY COMPLETED	
495143 B. WING	C 10/18/2019	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 580 Continued From page 13 the administrator, the director of nursing, and the regional director of clinical services the opportunity to ask further questions and provide additional information that would dispute the deficient practice as stated above. The facility staff did not provide the survey team with a policy or standard of practice regarding notifying the physician of changes in resident condition, and no further information regarding this issue was presented to the survey team prior to the exit conference on 10/18/19. 2. The facility staff failed to notify the physician of Resident # 110°s refusal of her bedtime dose of Levemir. Resident # 110 was originally admitted to the facility on 1/18/13, and had a readmission date of 3/18/19. Diagnoses included but were not limited to, type 2 cliabetes mellitus, hypertension, gout, and anxiety. The clinical record for Resident # 110 was reviewed on 10/16/19 at 1:32 pm. The most recent MDS (minimum data set) assessment for Resident # 110 was a quarterly assessment with an ARD (assessment reference date) of 9/18/19. Section C of the MDS assesses cognitive patterns. In Section C5500, the facility staff documented that Resident # 110 had a BIMS (brief interview for mental status) score of 6 out of 15, which indicated that Resident # 110°s cognitive staff documented that Resident # 110°s had received insulin for 7 days during the look-back		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	DING			COMPLETED	
		495143	B. WING			C 10/18/2019		
	ROVIDER OR SUPPLIER	EHAB	,	STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112			10/2013	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	(EACI	ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPE DEFICIENCY)	DRRECTIVE ACTION SHOULD BE COMPRESENCED TO THE APPROPRIATE		
F 580	included but was not Solution Pen-Injects 35 unit subcutaneous bedtime related to the which was initiated and was discontinual. The surveyor review (electronic medicating Resident # 110. The documentation on the that indicated that Finder bedtime dose of 1/2/18, 1/6/18 and 1/2/18, 1/6/18 and 1/2/18. The surveyor review for Resident # 110 and indicated that Resident # 110 and in	physician's orders that bit limited to, "Levemir FlexPen or 100 unit/ml (milliliter) Inject usly every morning and at ype 2 dialbetes mellitus," by the physician on 10/11/17 ed on 8/31/18. wed the January 2018 eMAR on administration record) for a surveyor observed the eMAR for Resident # 110 Resident # 110 had refused of Levemir daily except on 1/15/18. wed the February 2018 eMAR and observed documentation Resident # 110 had refused of Levemir daily except on wed the March 2018 eMAR for observed documentation that lent # 110 had refused her	F 6	80				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495143	8. WING			C 10/18/2019	
	ROVIDER OR SUPPLIER	IAB		STREET ADDRESS, CITY, STATE, ZIP COD 1607 SPRUCE STREET MARTINSVILLE, VA 24112	E	10/10/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 580	administration or refute the eMAR on 5/27/18 The surveyor reviewer Resident # 110 and or indicated that Reside bedtime dose of Leve 6/15/18, 6/18/18 and The surveyor reviewer Resident # 110 and or indicated that Reside bedtime dose of Leve 7/20/18 and 7/27/18. The surveyor reviewer clinical record for Resphysician's orders, prand consultations. The documentation that the notified of Resident # Levemir until 6/23/18 On 10/17/19 at 4:52 and director of nursing, and clinical services were as stated above. The administrative team in nursing staff to notify refusals of medication team members agree be notified of medication administrative team wand/or standard of prephysician of medication administrative team wopportunity to ask administrative team wopportunity to a sk administrative team wopp	sal of bedtime Levemir on 5/28/18 and 5/29/18. In the June 2018 eMAR for beserved documentation that in # 110 had refused her emir daily except on 6/12/18, 6/22/18. In the July 2018 eMAR for observed documentation that in # 110 had refused her emir daily except on 7/4/18, and documentation in the sident # 110 specifically the organization of the sident # 110 specifically the organization had been 110's refusal of bedtime at 8:15 pm. In the administrator, the indicate the physician of Resident in All three administrative and that the physician should the regional director of the findings surveyor asked for a facility policy actice regarding notifying the on refusals. The was also provided the ditional questions and ormation in response to the	F5	680			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDII		PLE CONSTRUCTION G	COMP	COMPLETED	
		495143	B. WING _		C 10/18/2019		
	ROVIDER OR SUPPLIER	······································		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112	10/10/2013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHO		(X5) COMPLETION DATE	
F 580	580 Continued From page 16		F 5	30			
	On 10/18/ 19 at 10:32 requested a policy or regarding notifying th refusal of medication.	standard of practice e physician of Resident					
	a policy or standard of	pm, the surveyor requested of practice regarding notifying dent refusal of medication.					
	the administrator, the regional director of cl opportunity to ask fur additional information practice as stated about The facility staff did no	ther questions and provide n in response to the deficient ove. ot provide the survey team					
	notifying the physicia medication, and no fu	ard of practice regarding n of Resident refusal of arther information regarding nted to the survey team prior e on 10/18/19.					
F 584 SS=D	CFR(s): 483.10(i)(1)- §483.10(i) Safe Envir The resident has a ric comfortable and hom but not limited to rece supports for daily livir The facility must prov	ble/Homelike Environment (7) ronment. ght to a safe, clean, nelike environment, including eiving treatment and ng safely.	F 5	1. Resident #103 received re medication on 6/4/2019. Res PTAC (packaged terminal air was replaced with a new unit 10/9/2019. 2. Residents that reside at fa risk for not having a homelike environment and medication discrepancies.	sident #112 conditioner) on cility are at	12/06/2019	
	homelike environmer	clean, comfortable, and nt, allowing the resident to nal belongings to the extent		Director of Nursing or desi re-educated licensed nursing process to properly complete	staff on the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495143	B. WING _			C 10/18/2019		
	ROVIDER OR SUPPLIER VILLE HEALTH AND REP	HAB	STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112				10,2010	
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 584	(i) This includes ensureceive care and serve physical layout of the independence and do (ii) The facility shall ethe protection of their or theft. §483.10(i)(2) Housek services necessary to and comfortable interfed and complaints and failed to protect loss or theft resulting medication and failing conditioning unit in the	ring that the resident can vices safely and that the facility maximizes resident ones not pose a safety risk, exercise reasonable care for resident's property from loss eeping and maintenance or maintain a sanitary, orderly, rior;	F 5	the Mare-rep the 4. or dis au Made The sui Ada an	ntrolled medication log and note DON/ADON of discrepancies aintenance Director or designed educated staff on identifying a porting debris in PTACs by enter TELs system. Audits will be conducted by the designee for controlled medical screpancies for 8 weeks. Randits will be conducted by the designee for controlled medical screpancies for 8 weeks. Randits will be conducted by the designee for lateral to the designee for	s. ee and tering it in e ADON ation dom ee for 8 weeks. rector will ance		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUIDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED					
		495143	B. WING_			C 10/18/2019				
	ROVIDER OR SUPPLIER	HAB		STREET ADDRESS, CITY, STATE, ZIP CO 1607 SPRUCE STREET MARTINSVILLE, VA 24112	DE.	10/16/2019				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PR		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATI	(X5) COMPLETION E DATE
F 584	F 584 Continued From page 18 1. For Resident #103, facility staff falled to secure from loss or theft		F 5	84						
	3/30/16. Diagnoses i tumor of the rectum, pain, diabetes mellitu complications, chroni traumatic amputation hypertension, anxiety chronic obstructive proposed propos	r, nicotine dependence, almonary disease, and he 14 day Minimum Data assessment reference date scored 15/15 on the brief status and was assessed as um, psychosis, or behavior esident was assessed as pain medication and rentions for pain daily in the sessment. The resident in almost constantly in the 5 essment and that the pain ep. Pain intensity was								
	The Office of Licensure and Certification receive a Facility Reported Incident (FRI) dated 6/4/19 concerning misappropriation of the resident's oxycodone. The FRI investigation revealed the nurse was unable to fill the order for oxycodone on 6/4/19. The facility was unable to discover what happened to the missing 15-16 doses of th medication.									
		ration notes for a physician or "Oxycodone Hcl 15 mg								

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495143	B. WING_		,	C 10/18/2019	
	ROVIDER OR SUPPLIER	HAB		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG			(X5) COMPLETION DATE	
F 584	Continued From page 19		F 5	84			
	tablet give 1 tablet by mouth four times a day for pain *do not change dose unless Blue Ridge Pain Management Associates is contacted" were as follows: 6/1/19 00:48 nursing note awaiting pharmacy arrival 6/1/19 09:43 nursing note awaiting pharmacy						
arrivalcoded 2=refused 6/1/19 12:38 nursing note awaiting pl arrival							
	6/1/19 17:28 nursing note awaiting pharmacy arrival 6/1/19 20:29 nursing note awaiting pharmacy						
	arrivalcoded 2=re 6/2/19 08:59 nursing			11-6-00-14-14-10-1			
	arrival 6/2/19 12:16 nursing arrival	note awaiting pharmacy					
	6/2/19 16:40 nursing arrival	note awaiting pharmacy	i	we have the intervention			
	arrival	note awaiting pharmacy note awaiting pharmacy					
	arrival 6/3/19 20:35 nursing arrival	note awaiting pharmacy					
	4	note awaiting pharmacy					
		13:00 no documentation in notes concerning resident				to year day - glaye de - mana A. a pin min	
	consecutive doses of assessments associa were either 'X' or blar	was documented as '0' on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	9.5%	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495143	B. WING _			C 10/18/2019	
	ROVIDER OR SUPPLIER	1AB		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112		10.10.2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CO		(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 584	The clinical record in physician was notified missing. The surveyor with the director of nut. 8:44 AM. The DON's would not write a represcription to pull do because the doctor with Pain clinic said the prescription and the drug until time for The DON stated the withdrawal. The DON employee statements LPNs stating they had concerning the medic Surveyors discussed resident property with during individual discouncements. Resident #112's Pronditioner) was obshave a fluffy, white starea inside the unit. Resident #112's face date of 5/30/18 and a 7/27/19. The resider diagnoses, which incomoxic brain damage unspecified cirrhosis chronic viral hepatitis and dysphagia. The most recent quaset) with an ARD (asse)19/19 assessed the	cluded no indication that the d that the oxycodone was or discussed the concern ursing (DON) on 10/16/19 at said that the doctor on call lacement prescription or a passes from the stat box vanted to avoid DEA scrutiny. That they would not replace the resident could do without a new prescription to start. The resident showed no signs of a provided hand written a dated 10/16/19 from two discontacted physician offices cation being unavailable.	F 5		RECE DEC 09 VDHVO	ZOIS LC	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		495143	B. WING_			C 10/18/2019	
	ROVIDER OR SUPPLIER	1AB		STREET ADDRESS, CITY, STATE, ZIP 1807 SPRUCE STREET MARTINSVILLE, VA 24112	CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 584	Continued From page	e 21	F 5	584			
	dependent on two or mobility, dressing, per On 10/09/19 at approsurveyor observed Renext to the window are air conditioner) unit. running with the moditemperature turned u "Cooler" setting. The	so coded as being totally more staff members for bed resonal hygiene and bathing. eximately 8:42am, the esident #112 lying in the bed and PTAC (packaged terminal The air conditioning was e turned to "Cool" and the p as far as possible to the surveyor observed a fluffy, he vent/grate area inside the					
	remove the cover from air conditioner) unit in surveyor observed the the vent/grate area in staff member #1 state	ximately 3:55pm, the aintenance staff member #1 m PTAC (packaged terminal Resident #112's room. The e fluffy, white substance on side the unit. Maintenance ed "Whatever it is I hope ddress it immediately."					
	stating in part, that a Resident #112's room The observation of th the vent/grate area of terminal air condition room was discussed (administrator and diff meeting on 10/10/19	ropy of "Work Order #355" new PTAC was installed in a on 10/09/19. e fluffy, white substance on if the PTAC (packaged er) unit in Resident #112's with the administrative staff rector of nursing) during a at approximately 4:30pm.					
	conference on 10/18/	· • ·	_				
F 600	Free from Abuse and	Neglect	F 6	1. Resident #29 and #	63 continue	to 12/06/2019	

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		495143	B. WING			C 10/18/2019		
	ROVIDER OR SUPPLIER	IAB	STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112					
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 600 SS=D	CFR(s): 483.12(a)(1) §483.12 Freedom from Exploitation The resident has the neglect, misappropria and exploitation as de includes but is not limicorporal punishment, any physical or chemitreat the resident's medical statement of the resident's medical statement of the resident's medical statement of the resident of	m Abuse, Neglect, and right to be free from abuse, stion of resident property, efined in this subpart. This sited to freedom from involuntary seclusion and ical restraint not required to edical symptoms. y must- e verbal, mental, sexual, or oral punishment, or is not met as evidenced in clinical record review, staff interview, facility d during the course of a in, the facility staff failed to dents in the survey sample and neglect, Resident #63 : exted to provide appropriate Resident # 63 as evidenced d a history of having e vaginal bleeding. Resident g excessive vaginal bleeding	F 64		reside at facility and are free from a with needs being met. 2. Residents that reside at the facil at risk for this deficient practice. 3. The Director of Nursing or designe-educated staff on abuse and neglect and the reporting practice. 4. The Social Work Director will conduct random audits of nursing releast 3 times weekly to ensure no and neglect concerns are occurring weeks. The Social Work Director with submit findings to the Quality Assurand Performance Improvement Committee. The Administrator is responsible for monitoring and follows. 5. 12/06/2019	ity are gnee notes at abuse g for 8 vill rance		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		IPLE CONS	(X3) DATE SURVEY COMPLETED		
		495143	B. WING			C 10/18/2019	
	ROVIDER OR SUPPLIER VILLE HEALTH AND REI	1AB		1607 SP	ADDRESS, CITY, STATE, ZIP CODE PRUCE STREET INSVILLE, VA 24112		
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		ETION .	
F 600	hemoglobin and hem hospitalized with a dianemia which require is harm. Resident # 63 was or facility on 3/22/18, an 7/2/19. Diagnoses into, anemia, abnormal bleeding, paraplegia, The clinical record for reviewed on 10/10/19 recent MDS (minimum Resident # 63 was a an ARD (assessment Section C of the MDS patterns. In Section C documented that Resinterview for mental swhich indicated that intact. Section G of the status. In Section Go use. Toilet use asses limited to, how the Regroom, commode, or belimination, and charms.	atocrit and being agnosis of menorrhea and ad a blood transfusion. This signally admitted to the dhad a readmission date of cluded but were not limited uterine and vaginal and muscle weakness. Transfer Resident # 63 was at 9:46 am. The most m data set) assessment for quarterly assessment with reference date) of 8/21/19. Sassesses cognitive co500, the facility staff sident # 63 had a BIMS (brief status) score of 15 out of 15, Resident #63 was cognitively the MDS assesses functional 110, line I assessed toilet sment included but was not esident #63 used the toilet bedpan; cleansed self after iged pad. The facility staff	F	600			
	dependent requiring a more persons for tolk assessed bathing. The that Resident # 63 was requiring the assistant for bathing. On 10/10/19 at 1:28 president # 63's room interview. The survey	tident # 63 was totally the assistance of two or the tuse. Section G0120 the facility staff documented as totally dependent, the of two or more persons tom, the surveyor was in the conducting a Resident for asked Resident # 63 if titted to the hospital since her			DEL VDI	CEIVEL 09 2019 VOLC	b

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
		495143	B. WING				C /18/2019	
	ROVIDER OR SUPPLIER	1AB	_	STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112				
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 600	admission to the facilithe surveyor that she was admitted to the histated, "I was as white The surveyor reviews Resident # 63. The surselent # 63. The surselent # 63. The surveyor observed to the important of limited to "Situation of limited to "Situation vaginal area Assoleeding from vaginal blood with clots pressured feels weak Response notifies. New orders to room) ED (emergency transfer)." The surveyor observed been documented on nurse's note contained included but was not and oriented, complate a month. She appear felt weak. VS (vital sing 198%. MD (medical dotted to the surveyor reviews Condition note for Reserveyor reviews Condition note for Reservey	ity. Resident # 63 informed had lost a lot of blood and cospital. Resident # 63 e as that sheet." In the progress notes for curveyor observed a condition" note that had been as 18 at 9:47 am. The note ention that included but was eation: Resident is bleeding cossment: Resident is a area with heavy bright ent. Resident states she as MD (medical doctor) to send to ER (emergency by department) notified of the day of	F	600	DEFICIENCY)			
	and had critical low HHCT (hematocrit) 16. Resident stated her pa month and this was experienced this. Ass 73, 16, 98%, MD noti	"Situation: Lab drawn today IGB (hemoglobin) 5.0 and 0, albumin 2.9 Background: period was on for longer than to not the 1st time she tessment: VS 122/70, 96.5, fied to have CBC (complete as already in place due to						

F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			(X3) DATE SURVEY COMPLETED		
	495143	B. WING		10	C 9/18/2019		
OVIDER OR SUPPLIER	НАВ		STREET ADDRESS, CITY, STATE, ZIP CO 1607 SPRUCE STREET MARTINSVILLE, VA 24112		10/2013		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF		ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
neurology appointme results. Response: M withheld) stated send The surveyor reviewe been documented on nurse's note was doc (Facility name withheld) the check on rsd (resider with menorrhea with: The surveyor reviewe Resident # 63 further notes, physician's ordid not locate any dot that Resident # 63 ha month or more, or that notified of the vagina. On 10/16/19 at 10:05 interviewed Cna # 2 (excessive vaginal ble and she has blood clots. Cna On 10/16/19 at 10:33 interviewed the unit in nurse) and asked if s # 63 had episodes of RN # 1 informed the unaware that Reside excessive vaginal ble informed her in June	nt being schedule after ID (physician's name is resident to hospital." ed a nurse's note that had a 6/27/19 at 10:18 pm. The sumented as, "Contacted old) ER (emergency room) to not) condition, Rsd admitted anemia." ed the clinical record for a specifically the progress ders, and consultations, and cumentation that reflected ad vaginal bleeding for a set the physician had been a bleeding. from the surveyor (certified nursing assistant). Cna #2 if Resident # 3 had beed the nursing staff when accessive vaginal bleeding # 2 stated, "Yes of a stated, "Yes." from the surveyor asked beed the nursing staff when accessive vaginal bleeding # 2 stated, "Yes." from the surveyor nanager RN # 1 (registered the was aware that Resident fexcessive vaginal bleeding. Surveyor that she had been not # 63 had beginned the nurse had of 2019 that Resident # 63	F 60		REVON	CEIVED 09 2010 OLC		
	OVIDER OR SUPPLIER ILLE HEALTH AND REI SUMMARY ST (EACH DEFICIENC REGULATORY OR) Continued From page neurology appointme results. Response: M withheld) stated send The surveyor reviewe been documented on nurse's note was doc (Facility name withhe check on rsd (resider with menorrhea with The surveyor reviewe Resident # 63 further notes, physician's ord did not locate any do that Resident # 63 ha month or more, or tha notified of the vagina On 10/16/19 at 10:05 interviewed Cna # 2 (Excessive vaginal ble and she has blood cl Cna # 2 if she inform Resident # 63 had ex with blood clots. Cna On 10/16/19 at 10:33 interviewed the unit r urse) and esked if s # 63 had episodes of RN # 1 informed the unaware that Reside excessive vaginal ble informed her in June was pale. RN # 1 sta nurse to inform the p	OVIDER OR SUPPLIER ILLE HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL	OVIDER OR SUPPLIER ILLE HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 25 neurology appointment being schedule after results. Response: MD (physician's name withheld) stated send resident to hospital." The surveyor reviewed a nurse's note that had been documented on 6/27/19 at 10:18 pm. The nurse's note was documented as, "Contacted (Facility name withheld) ER (emergency room) to check on rsd (resident) condition, Rsd admitted with menorrhea with anemia." The surveyor reviewed the clinical record for Resident # 63 further, specifically the progress notes, physician's orders, and consultations, and did not locate any documentation that reflected that Resident # 63 had vaginal bleeding for a month or more, or that the physician had been notified of the vaginal bleeding. On 10/16/19 at 10:05 am, the surveyor interviewed Cna # 2 (certified nursing assistant). The surveyor asked Cna #2 if Resident # 3 had excessive vaginal bleeding, with blood clots. The surveyor asked Cna # 2 stated, "Yes and she has blood clots." The surveyor asked Cna # 2 stated, "Yes." On 10/16/19 at 10:33 am, the surveyor interviewed the unit manager RN # 1 (registered nurse) and asked if she was aware that Resident # 63 had episodes of excessive vaginal bleeding. RN # 1 informed the surveyor that she had been unaware that Resident # 63 had episodes of excessive vaginal bleeding. RN # 1 informed the surveyor that she had been unaware that Resident # 63 had episodes of excessive vaginal bleeding. RN # 1 informed the surveyor that she had been unaware that Resident # 63 was pale. RN # 1 stated that she instructed the nurse to inform the physician. The surveyor	OVIDER OR SUPPLIER ILLE HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 25 neurology appointment being schedule after results. Response: MD (physician's name withheld) stated send resident to hospital." The surveyor reviewed a nurse's note that had been documented on 6/27/19 at 10:18 pm. The nurse's note was documented as, "Contacted (Facility name withheld) ER (emergency room) to check on rad (resident) condition, Rsd admitted with menorrhea with anemia." The surveyor reviewed the clinical record for Resident # 63 had vaginal bleeding for a month or more, or that the physician had been notified of the vaginal bleeding. Cna # 2 stated, "Yes and she has blood clots." The surveyor asked Cna # 2 if she informed the nursing staff when Resident # 63 had excessive vaginal bleeding with blood clots. Cna # 2 stated, "Yes and she has blood clots." The surveyor interviewed the unit manager RN # 1 (registered nurse) and asked if she was aware that Resident # 63 had excessive vaginal bleeding, RN # 1 informed the surveyor that she had been unaware that Resident # 63 had episodes of excessive vaginal bleeding until the nurse had informed her in June of 2019 that Resident # 63 was paie. RN # 1 stated that she instructed the nurse to inform the physician. The surveyor	OVIDER OR SUPPLIER ILLE HEALTH AND REHAB SUMMARY STATEMENT OF PERCENDIES (RACH DEPICENCY WITS THE PROCESTED MATINSVILLE, VA 24112 SUMMARY STATEMENT OF PERCENDIES (RACH DEPICENCY WITS THE PRECEDED BY YILL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 25 Continued From page 25 Continued From page 25 Continued From page 25 (Rach DEPICENCY ACTION SHOULD BE (RACH CORRECTION ACTION ACTION ACTION SHOULD BE (RACH CORRECTION ACTION ACT		

AND PLAN OF CORRECTION DENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING CONSTRUCTION CONSTRUCTION		(X	(X3) DATE SURVEY COMPLETED			
		495143	8. WING_			C 10/18/2019
	ROVIDER OR SUPPLIER	ЕНАВ		STREET ADDRESS, CITY, STATE, 28 1607 SPRUCE STREET MARTINSVILLE, VA 24112	CODE	10/10/2019
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN (X (EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 600	noticed that Reside vaginal bleeding. R surveyor asked RN nursing staff to doc bleeding in the clini physician. RN # 1 st informed RN # 1 th documentation in the # 63 that reflected the bleeding for a month of the following f	on inform the nurses if they int # 63 was having excessive N # 1 stated, "Yes." The # 1 if she expected the ument episodes of excessive cal record and notify the stated, "Yes." The surveyor at there was no in clinical record for Resident that Resident # 63 had vaginal theor more prior to 6/27/19. To pm, the surveyor interviewed practical nurse) the surveyor are was aware that Resident # excessive vaginal bleeding. It is surveyor asked LPN # sing assistants informed her is had episodes of excessive PN # 1 stated, "Yes." The N # 1 if information that having episodes of excessive ould be documented in the sthe physician be notified. LPN thould be." If am, the administrator, the and the regional director of the made aware of the findings in surveyor asked the if they would expect the ument abnormal vaginal cal record and notify the ethe abnormality was noted. It is the time are the time and the expect of the abnormality was noted.	F	600		

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		IDENTIFICATION NUMBER:				COMPLETED		
		495143	B. WING _			C 10/18/2019		
	ROVIDER OR SUPPLIER VILLE HEALTH AND RE	нав		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112				
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F 600	Continued From page	e 27	F 6	600				
	documentation that it to, "Policy: It is inhered each resident at the afforded basic human be free from abuse, it misappropriation of procedure: I. Definition of Res D. Non-action, which psychological, or physame manner as that excessive action. All engage with resident legitimate goal, the hoare and treatment of the surpractice for documentation to the surpractice for documentation to the surpractice for documentation was not limited to protocol should be done at the because passage of accurate recollection. Reference Nettina, S.M. (2013) practice. 10th ed. Phealth/Lippincot. On 10/18/19 at 3:45	n rights, including the right to neglect, mistreatment, and/or property. sident Abuse: results in emotional, visical injury, is viewed in the treatment caused by improper or actions in which employees is must have as their ealthful, proper, and humane of the resident. " ented the following right the following right the resident. " ented the following right to the standard of the specific events." In the surveyor provided the director of nursing, and the standard of the surveyor provided the director of nursing, and the						

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Event ID: N52R11

Facility ID: VA0159

If continuation sheet Page 28 of 188



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1''	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495143	B. WING_				C /18/2019
	ROVIDER OR SUPPLIER	НАВ		1607 SPRU	DDRESS, CITY, STATE, ZIP CODE UCE STREET SVILLE, VA 24112		110/2013
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F 600	Continued From page	e 28	F6	00			
		ther questions and provide in response to the deficient ove.					
		n regarding this issue was ey team prior to the exit 19.					
	•	failed to ensure that e from abuse from another in the nursing facility.	del milmour desde dans de décommendo				
	Resident #29 was readmitted to the facility on 8/17/16 with the following diagnoses of, but not limited to high blood pressure, anxiety disorder, manic depression and psychotic disorder. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/19/19, the resident was coded as having a BIMS (Brief						
	possible score of 15. coded as requiring su for dressing and pers physical help in part of	Status) score of 15 out of a Resident #29 was also opervision of 1 staff member onal hygiene and requiring of the bathing activity from 1					
	through 10/18/19, the following documentat dated and timed for:	ion in the nursing notes					
	called into dining room						
	Assessment: Upon a of Resident #29) scal hair. No other injurie MD (medical doctor)	•					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	IPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED	
		495143	B. WING			C 10/18/2019	
	ROVIDER OR SUPPLIER VILLE HEALTH AND RE	НАВ		STREET ADDRESS, CITY, STATE, 1607 SPRUCE STREET MARTINSVILLE, VA 24112	ZIP CODE		
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F 600	services) and Admininotified. Deputy returned call stating out, whom ever is ha magistrates office to information given to She got in touch with and signed her mom 9/13/19 16:27 (4 head was sore from pulling her hair out. doing ok and has file resident" The surveyor review #29 and the following care plan: " "Focus: I son which include: demachange and to be the Demanding staff to sintervals during the saccusations against objects that are not rake showers unassi Interventions: Attempt interventions: Attempt interventions: Attempt interventions: Ties plained to resigned to me my merordered Help me to avo are upsetting to me Let my physicial interfering with my differ me sometime.	istrator made aware. Police(name of deputy) that he doesn't have to come rmed needs to go to the file charges, This(name of resident). The daughter and she came out to go to the Office the came out to go to the Office the daughter and she came out to go to the Office the came out to go to the Office the daughter and she came out to go to the Office the came out to go to the Offic		800			

L' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF D	ROVIDER OR SUPPLIER	483143	0. 11.10	CT.	DEET ADDRESS OFF STATE 21D CODE	10/	18/2019
	VILLE HEALTH AND REF	HAB		16	REET ADDRESS, CITY, STATE, ZIP CODE 07 SPRUCE STREET ARTINSVILLE, VA 24112		
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F 600	" Please tell me will before you begin " Speak to me unh" The surveyor noted the focus and interventions with a revision date of interventions noted by resident-to-resident at on 9/8/19. The surveyor also not Protective Order data which named Resident victim was to have not resident involved in the expired on 9/11/19 at The survey team interconference room on surveyor asked Reside surveyor what had hat resident on 9/8/19 that obtaining an Emerget another resident that altercation that had of #29 stated, " (not in the altercation on 9 were in the dining roof out of my head. It was pulled out by the root involved in altercation set together in the dinone day she started so not nice and then she things about her son. started. But after she me names, the staff of were told that I would Magistrate's office to	hat you are going to do nurriedly and in a calm voice he date documented for the his were initiated on 3/3/14 f 1/16/17. There were no y the surveyor after the litercation that had occurred ted an "Emergency ed for 9/8/19 at 8:10 pm in nt #29 as being the alleged o contact with the other he altercation. The order 11:59 pm. rviewed Resident #29 in the 10/15/19 at 11:20 am. The litent #29 if she could tell the hippened with another at resulted in this resident hocy Protective Order against was involved in an occurred on 9/8/19. Resident hame of the resident involved b/8/19) came over while we ham and pulled a lot of my hair has a handful of hair and s (Name of resident hi) and I were friends and we hing room for our meals. But having things to me that were he accused me of saying I really don't know how it he pulled my hair and called healled the police and they	F	600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) M IDENTIFICATION NUMBER: A. BUI		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER VILLE HEALTH AND RE	нав		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112				
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F 600	there. I got a Protect away from me but I shallway where my rothings to me as she stopped and told her down that hallway we member being with I hallway from time to The surveyor asked the facility. The resishe (referring to resicould come in my roshe could smother in putting a pillow over because since Frida sitting with her all the happened on Friday surveyor stated that documentation in the about the details of a resident stated, "I havanilla ice cream. Tresident involved in you get it your damn toward me and an ai wheelchair before staten she has had to the time and she has room. The surveyor noted in the nurses' notes at 20:40 (10:40 pm)Altercation with an time in dining room. dining room and go telephoned the sheri 10/12/19 21:32 (9:32 part, "Resident is	tive Order for her to keep still saw her coming down the som is and she would say passed my room, but they that she could not come here I was without a staff fer. I still saw her down the time without anyone with her. It he resident if she felt safe in dent stated, "I really don't. I dent involved in altercation) om, she is a big woman, and he by sitting on my face or it. But I feel better now y, she has had a staff person of time. Did you hear what at supper time?" The she had read the enurses' notes for Friday another altercation. The dasked an aide for some hen (name of other altercation) said, "Why don't self." She came full force de stopped her and the he could get to me. Since have a sitter be with her all is had to eat her meals in her the following documentation timed and dated for 10/12/19	F6					

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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	
		495143	B. WING			C 10/18/2019	
	OVIDER OR SUPPLIER	L.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		16	REET ADDRESS, CITY, STATE, ZIP CODE 07 SPRUCE STREET ARTINSVILLE, VA 24112	10/	10/2019
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 609 SS=D	made aware of the incorders)." The surveyor intervier 10/18/19 at approximation. The surveyor abetween Resident #2 10/12/19. The administration and the resident was not verb Resident was not verb Resident #29). They room with (nare sitting at another table Resident #29). Since that a sitter with in altercation with Resident #29). Since the resident was not verb resident #20 (name of Resident #20) are resolution to this issurveyor prior to the residents." No further information surveyor prior to the residents." Reporting of Alleged CFR(s): 483.12(c)(1) in responsing elect, exploitation, must: §483.12(c)(1) Ensure involving abuse, neglimistreatment, includit source and misapproare reported immedia hours after the allegal	al doctor) on callwas cident with NNO (no new wed the administrator on ately 1 pm in the conference asked about the altercation 9 and another resident on istrator stated that another wally nice to (name of were eating in the dining me of Resident #29) was ad the other resident was e away from (name of that altercation, we have (name of resident involved sident #29) constantly with ever this issue between (name of con't know at this time how but we are actively looking for sue between these 2 In was provided to the exit conference on 10/18/19. Violations (4) se to allegations of abuse, or mistreatment, the facility		600	1. Resident #314 allegation of abut was reported to the appropriate agencies on 10/19/2019. Resident #97 allegation of abuse or reported to the appropriate agenciato/10/17/2019. 2. Residents that reside at the fact at risk for this deficient practice. 3. The Director of Nursing or designed reducated staff on abuse and neglect and the reporting practice. 4. The Social Work Director will	was ies on ility are gnee	12/06/2019

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

Event ID: N52R11

Facility ID: VA0159



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495143	B. WING _			C / 18/2019	
	ROVIDER OR SUPPLIER VILLE HEALTH AND REP	НАВ		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112			
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATÉ	
F 609	serious bodily injury, the events that cause abuse and do not res the administrator of the officials (including to adult protective service for jurisdiction in long accordance with State procedures. §483.12(c)(4) Report investigations to the adesignated represent accordance with State Survey Agency, within incident, and if the all appropriate corrective This REQUIREMENT by: Based on clinical rectacility document revial a complaint investigating the facility staff failed abuse for two of 30 R sample, Resident # 3 The findings included 1. The facility staff of abuse for Resident informed of the allegation to the altimely manner. Resident # 314 was a 10/16/17. Diagnoses	or not later than 24 hours if the allegation do not involve ult in serious bodily injury, to he facility and to other the State Survey Agency and he swhere state law provides herm care facilities) in he law through established the results of all hadministrator or his or her hative and to other officials in he law, including to the State he sworking days of the heged violation is verified he action must be taken. I is not met as evidenced hord review, staff interview, hew, and during the course of hitton it was determined that he to report allegations of he sidents in the survey he and Resident # 97. I failed to report an allegation	F 6	4. conduct random audits of notes at least 3 times week no abuse and neglect conductoring for 8 weeks. The Director will submit findings Quality Assurance and Per Improvement Committee. Administrator is responsible monitoring and follow up. 5. 12/06/2019	kly to ensure eerns are Social Work is to the formance The		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER	1AB		STREET ADDRESS, CITY, STATE, ZIP (1607 SPRUCE STREET MARTINSVILLE, VA 24112	· · · · · · · · · · · · · · · · · · ·		
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F 609	observed a nurse's not documented on 3/30/2 not was documented confusion noted, dau resident stated that he (certified nursing associothes off while chardone on the floor, daistaff to be more tactfor reported incident to Edughters present, stassessment on residuskin noted, daughter father has bad memo DON assured her that claim with other staff this time." On 10/10/19 at 3:54 and administrator we allegation of abuse the Resident # 314's clin requested documentation that read the surveyed documentation that read the surveye	r Resident # 314 was at 9:54 am. The surveyor of that had been 18 at 6:27 pm. The nurse's as, "Resident alert with ghter reported to nurse that e was beat up by two CNAs istants) that took their uging his clothes, all this was ughter stated that she wants all when caring for her dad, DON (director of nursing) with the stated that she knows her early but she was concerned. It she would investigate the but no injuries are noted at the properties and the deep documented in iteal record. The surveyor ation that the allegation had appropriate agencies. The surveyor spoke with stor. The surveyor asked the surveyor aske	F	309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	495143	8. WING_			C 10/18/2019		
NAME OF PROVIDER OR SUPPLIER MARTINSVILLE HEALTH AND REHA	АВ	·	STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112				
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIAT			
314's clinical record that the facility staff on 10/1 administrator informed was no documentation allegation of abuse doc 314's clinical record ha appropriate agencies. That the surveyor had mabuse to the facility on administrator stated, "Comean now." The facility staff later procopy of a "Facility Reput 10/16/19 for Resident of the allegation of abuse. The facility policy on "Indocumentation that incidents and to the appropriate state. The facility policy on "Resident" contained do but was not limited to"4. Notification MUS of all residents involved a. Attending physicia b. Responsible Party 9. The administrator, didesignee MUST notify Service agency and the abuse, neglect, mistress.	es of the allegation of ocumented in Resident # at the surveyor reported to 10/19 at 3:54 pm. The the surveyor that there that supported that the cumented in Resident # ad been reported to the The surveyor reiterated eported an allegation of 10/10/19 at 3:54 pm. The Dh I understand what you rovided the surveyor with a orted Incident" form dated # 314, which documented a reported on 3/30/18. resident Abuse" contained cluded but was not limited tor of the facility will refer to reports of resident abuse a agencies." Resident Abuse - Staff to ocumentation that included in the incident. In the local Adult Protective e local Ombudsman of any atment, and operty immediately of their		609				

NAME OF PROVIDER OR SUPPLIER MARTINSVILLE HEALTH AND REHAB STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	
NAME OF PROVIDER OR SUPPLIER MARTINSVILLE HEALTH AND REHAB STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	18/2019
(***)	(X5) COMPLETION DATE
F 609 Continued From page 36 11. The local law enforcement authorities are to be notified of any instance of resident abuse, mistreatment, neglect, by misappropriation of person property, which is a "criminal act" and in accordance with the Elder Justice Act. 15. The State Board of Nursing is to be notified of all actual incidents of abuse/neglect involving CNAs or Licensed Nurses." On 10/17/19 at 4:52 pm, the survey learn met with the administrator, the director of nursing, and the regional director of clinical services. The surveyor provided the administrative team with the opportunity to ask questions and provide additional information in response to the deficient practice as stated above. No further information regarding this issue was presented to the survey team prior to the exit conference on 10/18/19. 2. For Resident #97, facility staff failed to report altegations involving abuse to the appropriate agency within twenty four hours of learning of the allegation. Resident #97 was admitted to the facility on 4/6/18. Diagnoses included dementia with behavioral disturbance, contractures of hips and knees, repeated falls, attention and concentration deficits and spatial neglect following subarachnoid hemorrhage dysphagia, Alzheimer's disease, hypertension, major depression, and psychosis. On the quarterly Minimum Data Set assessment reference date 8/21/19, the resident was assessed with short and long term memory deficits and severely impaired cognitive skills for daily decision making and as without signs of deliritum, psychosis, or behaviors affecting care.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY				
		495143	B. WING	B. WING		C	
	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112		/18/2019	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE	
F 610 SS=D	transfer, supervision nursing unit in a where assistance of one per wheelchair off the unit of nursing (DON) that made that resident 197 on the leg, then R the resident had a leg asked for the investig DON reported later the resident-resident alter 10/16/19 at 05:44 Ph investigations of this surveyors had report made to the Office of The administrator stathe allegation or investigation again on 10/17/19, the adma Facility Reported In Investigate/Prevent/OCFR(s): 483.12(c)(2) §483.12(c) In response lect, exploitation, must:	ressed as requiring of 2 or more persons for for locomotion on the elchair, and extensive rson for locomotion in a sit. Byor reported to the director to a complaint had been Resident #16 hit Resident #esident #97 yelled out and go xrayed. The surveyor relation of the incident. The mat there was no record of a rocation between the two. On M. Surveyors asked for allegation and others and from the complaints. Licensure and Certification. It is the staff had not reported stigated. The DON stated en made to APS of the eavyors asked about the report a during a summary meeting sinistrator provided copies of recident dated 10/17/19. Correct Alleged Violation—(4) se to allegations of abuse, or mistreatment, the facility evidence that all alleged	F 6	09	10/16/2019. the DON to ensure nee		
		nt further potential abuse, or mistreatment while the		investigations.			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTI			(X3) DATE COMP	SURVEY LETED			
		495143	B. WING_	B. WING		C 10/18/2019	
	ROVIDER OR SUPPLIER	HAB		160	EET ADDRESS, CITY, STATE, ZIP CODE 7 SPRUCE STREET RTINSVILLE, VA 24112	107	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 610	investigation is in pro §483.12(c)(4) Report investigations to the a designated represent accordance with Stat Survey Agency, withi incident, and if the ali appropriate corrective This REQUIREMENT by: Based on clinical rec and facility document that the facility staff fa allegations for one of sample, Resident # 3 The findings included The facility staff failed of abuse that had bed 314. Resident # 314 was a 10/16/17. Diagnoses limited to muscle wea hypertension. The clinical record fo reviewed on 10/9/19 observed a nurse's n documented on 3/30 not was documented confusion noted, dau resident stated that h (certified nursing ass clothes off while char done on the floor, da	the results of all administrator or his or her rative and to other officials in a law, including to the State in 5 working days of the eged violation is verified a action must be taken. It is not met as evidenced ford review, staff interview, it was determined alled to investigate abuse 30 Residents in the survey 14. If to investigate an allegation are reported for Resident #	F 6	310	4. Audits will be conducted by the Administrator or designee of rep (FRI) for complete investigation for 4 weeks. The Administrator is submit the findings to the Quality Assurance and Performance Improvement Committee. The Administrator is responsible monitoring and follow up. 5. 12/06/2019	ortable weekly vill y	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING					SURVEY PLETED		
		495143	B. WING_				C /18/2019
	ROVIDER OR SUPPLIER	ЕНАВ		STREET ADDRESS, C 1607 SPRUCE STRE MARTINSVILLE, V		1 10	10,2013
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(EACH C	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 610	reported incident to daughters present, assessment on resistin noted, daughte father has bad men DON assured her tholaim with other staff this time." On 10/10/19 at 3:54 and administrator wallegation of abuse Resident # 314's clirequested documented record on 3/30/18 h. On 10/11/19 at 8:15 informed the survey documentation that abuse documented record had been involved the survey of the facility administrator documentation that investigated the alled documented in Resithat the surveyor resident in the surveyor that the surveyor that the	DON (director of nursing) with staff went in to do skin dent, skin was clear, broken in stated that she knows her mory but she was concerned. The state would investigate the first but no injuries are noted at the pm, the director of nursing ere made aware of the state had been documented in mical record. The surveyor station that the allegation of in Resident # 314's clinical and been investigated. am, the facility administrator or that she did not locate any reflected that the allegation of in Resident # 314's clinical sestigated. 4 am, the surveyor spoke with ator. The surveyor asked the first she could provide	F	510			
	documented in Resinad been investigat that the surveyor habuse to the facility	ident # 314's clinical record ed. The surveyor reiterated id reported an allegation of on 10/10/19 at 3:54 pm. The , "Oh I understand what you					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIF	PLE CONSTRUCTION 3		(X3) DATE SURVEY COMPLETED	
		495143	B. WING	B. WING		C 18/2019
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(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 610	Continued From page	3 40	F 6	10	i	
	documentation that in to"VIII Investigation of A. The Abuse Coord shall investigate all resident" contained to but was not limited to"10. The State Deprotified immediately to forursing or their desknowledge of any aller resident abuse/negle the investigation must working days." On 10/17/19 at 4:52 point with the administrator the regional director of surveyor provided the	dinator or his/her designee apports of suspected abuse. "Resident Abuse - Staff to documentation that included artment of Health is to be by the administrator, director				
F 622 SS=E	additional information practice as stated about the survive conference on 10/18/ Transfer and Dischar CFR(s): 483.15(c)(1) §483.15(c)(1) Facility (i) The facility must premain in the facility, discharge the resider	in response to the deficient ove. In regarding this issue was rey team prior to the exit regarding this issue was rey team prior to the exit regarding this issue was requirements. If the content is the deficient over the content is the content in the content	F 6	1. Resident # 68, 39, 96 a at facility with current Car 2. Residents with orders transfered to the emerger are at risk for this deficien	C roun (EE	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495143	B. WING		C 10/18/2019	
	ROVIDER OR SUPPLIER	HAB	16	REET ADDRESS, CITY, STATE, ZIP CODE 807 SPRUCE STREET ARTINSVILLE, VA 24112	1 10/10/2013	
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 622	because the resident sufficiently so the res services provided by (C) The safety of indiendangered due to the status of the resident (D) The health of indiotherwise be endang (E) The resident has appropriate notice, to under Medicare or Sident who become admission to a facility resident only allowab or (F) The facility cease (ii) The facility may not resident while the apply 431.230 of this charge notice from 431.220(a)(3) of this discharge or transfer or safety of the reside facility. The facility methat failure to transfer §483.15(c)(2) Docume When the facility transfer	d the resident's needs facility; scharge is appropriate is health has improved ident no longer needs the the facility; viduals in the facility is the clinical or behavioral control or behavioral control or to have paid the resident does not the resident does not the paperwork for third party third party, including the decidity may charge a the facility may charge a the charges under Medicaid; the transfer or discharge the the peal is pending, pursuant to the peal is pending, pursuant to the peal is pending, pursuant to the facility pursuant	F 622	3. Director of Nursing or designed re-educated the licensed nursing sending the Transfer Envelope ar required documentation including Plans with goals to the ER/hospit resident and document in medica noting items that were sent. 4. The Director of Nursing or desi will audit medical record of reside transfered to the ER/hospital to e required documentation including Plan with goals were sent and no medical record weekly for 8 week Director of Nursing will submit fir to the Quality Assurance and Performance Improvement Comm The DON is responsible for monitoring and follow up. 5. 12/06/2019	staff on nd Care al with I record gnee ents nsure Care ted in as. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		PLE CONSTRUCTION		ATE SURVEY DMPLETED
		495143	B. WING _			C 10/18/2019
	ROVIDER OR SUPPLIER	IAB		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112		1011012013
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 622	in paragraphs (c)(1)(i section, the facility more discharge is documedical record and a communicated to the institution or provider. (i) Documentation in the institution or provider. (i) Documentation in the institution or provider. (ii) Documentation in the institution of this section. (B) In the case of parasection, the specific robe met, facility attemphateds, and the service facility to meet the nether (ii) The documentation (2)(i) of this section matching is necessar (A) or (B) of this section (B) A physician when necessary under parasetis section. (iii) Information provide must include a minimation (A) Contact information (C) Advance Directive (D) All special instructiongoing care, as applice) Comprehensive of (F) All other necessar copy of the resident's	p(A) through (F) of this ust ensure that the transfer mented in the resident's perceiving health care the resident's medical record transfer per paragraph (c)(1) agraph (c)(1)(i)(A) of this esident need(s) that cannot to to to meet the resident e available at the receiving ed(s). In required by paragraph (c) (1) on; and transfer or discharge is agraph (c)(1)(i)(C) or (D) of the following: on of the practitioner re of the resident. Intative information including a information, including a	F 6	22		
		tion, as applicable, to ensure				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		ATE SURVEY OMPLETED
		495143	B. WING		!	C
	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP COD 1607 SPRUCE STREET MARTINSVILLE, VA 24112		10/18/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PRÉFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE
F 622	This REQUIREMENT by: Based on staff interv review, the facility stareceiving provider all documentation includ plan when a resident hospital for 4 of 30 re (Resident #68, #39, #The findings included 1. The facility staff receiving provider/fact documentation included plan when Resident #68 was reasolved and the following diaganemia, heart failure, diabetes, dementia and quarterly MDS (Minim (Assessment Referencesident was coded a Interview for Mental Spossible score of 15. coded as requiring sufor dressing, personal assistance of 1 staff receiving holds and timed which read in part, " doctor) (nanobtained orders to se	is not met as evidenced iew and clinical record iff failed to provide the of the required ing a comprehensive care was transferred to the sidents in the survey sample 196 and #63). : failed to provide the iillity of the required ing the comprehensive care 168 was sent to the ER 10/6/19. admitted to the facility on 10/6/19 The resident phoses of, but not limited to high blood pressure, and depression. On the num Data Set) with an ARD ace Date) of 8/23/19, the shaving a BIMS (Brief Status) score of 15 out of a Resident #68 was also pervision of 1 staff member I hygiene and limited member for bathing. cord review on 10/15/19 surveyor noted a nurses' for 10/6/19 at 4;12 pmNotified MD (medical me of medical doctor),	F6			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495143	B. WING_	B. WING		C	
	ROVIDER OR SUPPLIER	HAB		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112		10/18/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION DATE	
F 622	information or the corprovided to the receiving administrator. The surequested copies of the summary/transfer summary/transfe	mentation of what medical mprehensive care plan being ring facility when Resident to the ER on 10/6/19. Eximately 11 am and again eximately 2 pm, the surveyor the discharge mmary for this resident from the grown of (DON) and the surveyor was not provided the exit that had been requested the aperwork that was sent to when the resident went to the administrator stated, "We mentation of the information ted." In was provided to the exit conference on 10/18/19. If alled to provide the cility of the required ling the comprehensive care figg was sent to the ER	F 6		RECEIVED DEC 0 9 2019		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		ATE SURVEY OMPLETED
		495143	B. WING_			C 10/18/2019
	ROVIDER OR SUPPLIER	нав		STREET ADDRESS, CITY, STATE, ZIP COD 1607 SPRUCE STREET MARTINSVILLE, VA 24112		10/10/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 622	of 15. Resident #39 totally dependent on personal hygiene and During the clinical recthrough 10/18/19, the Resident #39 had a r for 7/20/19 13:23 (1:2 was in excruciating doctor) stated to sentroom) for evaluation any documentation of the comprehensive of the receiving facility of transferred to the ER On 10/16/19 at approon 10/18/19 at approon 10/18/19 at approon to the comprehensive of the transferred to the ER On 10/16/19 at approon 10/18/19 at approon 10	was also coded as being 1 staff member for dressing, d bathing. cord review on 10/10/19 e surveyor noted that nurses' note dated and timed 23 pm) which read in part, " pain and he (medical d her out to ER (emergency" The surveyor did not find f what medical information or are plan being provided to when Resident #39 was on 7/20/19. eximately 11 am and again ximately 2 pm, the surveyor he discharge mmary for this resident from	F 6			
	above documented p the receiving facility v ER on 7/20/19. The don't have any docur that you have reques No further information surveyor prior to the 3. The facility staff provider/facility of the including the compre	the surveyor requested the paperwork that was sent to when the resident went to the administrator stated, "We mentation of the information				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495143	B. WING			1	C 18/2019
	ROVIDER OR SUPPLIER	HAB	·	16	TREET ADDRESS, CITY, STATE, ZIP CODE 307 SPRUCE STREET IARTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 622	11/6/18 with the follow limited to coronary are high blood pressure, stroke and depressio (Minimum Data Set) or Reference Date) of 9 having a BIMS (Brief score of 15 out of a president #96 was alsextensive assistance dressing and persona dependent on 1 staff. During the clinical reconstruction of the survey the nurses' notes dated to 12.52 am) which construction of the medical comprehensive care (emergency department of 10/17/19 at 11:45 copies of the medical comprehensive care receiving facility whe transferred to the ED 9/2/19. The surveyor information including plan on 10/15/19, 10 again on 10/17/19 at administrator stated thave any documentary our have requested.	admitted to the facility on wing diagnoses of, but not tery disease, heart failure, renal failure, diabetes, n. On the quarterly MDS with an ARD (Assessment /11/19 coded the resident as Interview for Mental Status) ossible score of 15. The coded as requiring of 1 staff member for all hygiene and being totally member for bathing. Food review on 10/10/19 at for noted documentation in the dand timed for 9/2/19 and the read in part, " Resident test pain @ (at) 0015 (12:15 call bell approximately 3 and to be sent to the ED ent) for further evaluation" For am, the surveyor asked for a linformation including the plan that was sent to the in the resident was per resident request on was requested the medical the comprehensive care /16/19 times (2) and then approximately 10 am. The to the surveyor, "We don't tion of the information that ""	F	622			
		n was provided to the exit conference on 10/18/19.					•

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED
		495143	B. WING			C 10/18/2019
	ROVIDER OR SUPPLIER VILLE HEALTH AND RE	нав		1607 SP	ADDRESS, CITY, STATE, ZIP CODE RUCE STREET NSVILLE, VA 24112	10/10/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 622	4. The facility staff fathe comprehensive of with Resident # 63 uton 6/27/19. Resident # 63 was of facility on 3/22/18, at 7/2/19. Diagnoses included anemia, abnormal ut paraplegia, and must reviewed on 10/10/11 recent MDS (minimus Resident # 63 was a an ARD (assessment Section C of the MD patterns. In Section documented that Resinterview for mental which indicated that intact. On 10/10/19 at 1:28 Resident # 63's room interview. The surveys he had been readmadmission to the facilithe surveyor that she was admitted to the stated, "I was as whith the surveyor review Condition note for Redocumented on 6/27 was documented as	care plan goals were sent pon transfer to the hospital riginally admitted to the and had a readmission date of the but were not limited to, terine and vaginal bleeding, cle weakness. For Resident # 63 was 9 at 9:46 am. The most am data set) assessment for quarterly assessment with at reference date) of 8/21/19. So assesses cognitive C0500, the facility staff status) score of 15 out of 15, Resident #63 was cognitively pm, the surveyor was in a conducting a Resident yor asked Resident #63 if sitted to the hospital since her allity. Resident #63 informed to had lost a lot of blood and hospital. Resident #63		622	VDH/OLC VDH/OLC	RECEIVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		ATE SURVEY OMPLETED
	495143	B. WING_			C 10/18/2019
NAME OF PROVIDER OR SUPPLIER MARTINSVILLE HEALTH AND REHA	АВ		STREET ADDRESS, CITY, STATE, ZIP COI 1607 SPRUCE STREET MARTINSVILLE, VA 24112		10/10/2013
PREFIX (EACH DEFICIENCY				ORRECTION IN SHOULD BE E APPROPRIATE)	(X5) COMPLETION DATE
Resident stated her pea a month and this was experienced this. Assessment: VS 122/7 notified to have CBC (which was already in pappointment being sch Response: MD (physic stated send resident to The surveyor reviewed been documented on urse's note was docu (Facility name withheld check on rsd (resident with menorrhea with a On 10/16/19 at 5:14 pt documentation of infor with Resident # 63 updemergency room on 6/20 with the administrator, the regional director of administrator and direct there was no documer comprehensive care proom on 6/27/19. The administrative team with questions and provide response to the deficie above. No further information	eriod was on for longer than not the 1st time she 70, 96.5, 73, 16, 98%, MD complete blood count) blace due to neurology nedule after results. cian's name withheld) be hospital." If a nurse's note that had 6/27/19 at 10:18 pm. The imented as, "Contacted d) ER (emergency room) to all condition, Rsd admitted nemia." If m, the surveyor requested remation that had been sent for transfer to the 1/27/19. If the director of nursing, and if clinical services. The cotor of nursing agreed that intation that the allan goals were sent with ansfer to the emergency surveyor provided the interpretation in the practice as stated.	F 6	22		

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I		CONSTRUCTION	COMPI	LETEO
		495143	B. WING _			10/	18/2019
	ROVIDER OR SUPPLIER VILLE HEALTH AND RI	EHAB		16	REET ADDRESS, CITY, STATE, ZIP CODE 07 SPRUCE STREET ARTINSVILLE, VA 24112	107	10,2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION S		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 623 SS=D	S483.15(c)(3) Notice Before a facility transesident, the facility (i) Notify the resident representative(s) of the reasons for the language and mann facility must send a representative of the Long-Term Care On (ii) Record the reasons discharge in the resident and (iii) Include in the negargaph (c)(5) of \$483.15(c)(4) Timin (i) Except as specific (c)(8) of this section discharge required made by the facility resident is transferm (ii) Notice must be medangered und this section; (B) The health of incompany to the endangered, und this section; (C) The resident's hallow a more immediate transferd by the resident to the endangered by the resident's hallow a more immediate transering to the endangered by the resident's hallow a more immediate transering to the resident's hallow a more immediate transering to the resident's hallow a more immediate transering to the resident's hallow a more immediate transering the resident by	e before transfer. Isfers or discharges a must- Int and the resident's It and the resident's It the transfer or discharge and move in writing and in a Iter they understand. The Iter copy of the notice to a Iter of the State Inbudsman. Iter or ident's medical record in Iteragraph (c)(2) of this section; Iterities the items described in Ithis section. Iter of the notice. Iter of the notice of transfer or Iter of	F	523	1. State Ombudsman was notified of 11/4/2019 of Resident #68 being transfered to ER on 10/6/2019. State Ombudsman was notified on 8/1/20 Resident #39 being transfered to E 7/20/2019. Resident #63 returned facility where she currently reside. 2. Residents with an order to be transfered to the ER or for involunta facility leave are at risk for the deficing practice. 3. Director of Nursing or designee re-educated the Social Work Direct the State Ombudsman notification requirements. The Director of Nursing re-educated licensed nursing staff on notifying residents and/or responsiting parties of the reason the resident is being sent to the hospital in writing noting in the medical record of the notification. 4. The ADON or designee will audit medical records of resident transfer the ER or involuntary discharges to ensure required documentation of reason resident is being sent to the hospital is noted weekly for 8 week the monthly notification to the State Ombudsman is sent for 2 months. Director of Nursing will submit the findings to the Quality Assurance a Performance Improvement Commit The DON is responsible for	ate 019 of iR on to ary cient tor of sing on ble s and t trs to c is and it trs to c it ing	12/06/2019

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED					
		495143	B. WING_				C 18/2019
	ROVIDER OR SUPPLIER	1AB	STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112				
(X4) ID PREFIX TAG			ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 623	(E) A resident has no days. §483.15(c)(5) Content notice specified in paramust include the follow (i) The reason for traction of the including the name, and telephone number receives such request to obtain an appeal for completing the form a hearing request; (v) The name, address telephone number of Long-Term Care Ombelong-Term Care	ats of the notice. The written ragraph (c)(3) of this section wing: Insfer or discharge; Insfer or discharge; Instead in the resident is reged; It resident's appeal rights, address (mailing and email), and information on how orm and assistance in and submitting the appeal is (mailing and email) and the Office of the State budsman; It residents with intellectual is abilities or related g and email address and the agency responsible for vocacy of individuals with lities established under Part tal Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and the protection and als with a mental disorder or the protection and Advocacy uals Act.	F 6	23	monitoring and follow up. 5. 12/06/2019		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495143	B. WING_			C 10/18/2019		
	ROVIDER OR SUPPLIER	нав		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST 8E PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 623	If the information in teffecting the transfer must update the recias practicable once becomes available. §483.15(c)(8) Notice In the case of facility the administrator of written notification provided to the State Survey (State Long-Term Cathe facility, and the residual to the state survey (State Long-Term Cathe facility, and the residual to the state survey (State Long-Term Cathe facility, and the relocation of the residual to the residual to the state of the state o	the notice changes prior to be or discharge, the facility pients of the notice as soon the updated information In advance of facility closure closure, the individual who is the facility must provide rior to the impending closure agency, the Office of the re Ombudsman, residents of esident representatives, as the transfer and adequate dents, as required at § It is not met as evidenced view and clinical record aff failed to notify the resident upon discharge for the survey sample (Resident discharge of Resident #68 as sent to the ER in 10/6/19.	F	DEFICIEN 523	ICY)			
	had the following dia anemia, heart failure diabetes, dementia a quarterly MDS (Mini (Assessment Refere	ged on 10/6/19 The resident agnoses of, but not limited to be, high blood pressure, and depression. On the mum Data Set) with an ARD ance Date) of 8/23/19, the as having a BIMS (Brief						

NAME OF PROVIDER OR SUPPLIER MARTINSVILLE HEALTH AND REHAB STREET ADDRESS, CITY, STATE, 2P CODE 10/18/2019		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
MARTINSVILLE HEALTH AND REHAB MARTINSVILLE HEALTH AND REHAB MARTINSVILLE HEALTH AND REHAB MARTINSVILLE HEALTH AND REHAB MARTINSVILLE, VA 24112 PREFEX TAG PROVIDER'S PLAN OF CORRECTION MEGULATORY OR ISC IDENTIFYING INFORMATION TAG Continued From page 52 Interview for Mental Status) score of 15 out of a possible score of 15. Resident #68 was also coded as requiring supervision of 1 staff member for dressing, personal hygiene and limited assistance of 1 staff member for bathing. During the clinical record review on 10/15/19 through 10/18/19, the surveyor noted a nurses' note dated and timed for 10/6/19 at 41:2 pm which read in part, **Notified MD (medical doctor)			495143	B. WING_		_	C 10/18/2019
FREEIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 623 Contlinued From page 52 Interview for Mental Status) score of 15 out of a possible score of 15. Resident #68 was also coded as requiring supervision of 1 staff member for dressing, personal hygiene and limited assistance of 1 staff member for bathing. During the clinical record review on 10/15/19 through 10/18/19, the surveyor noted a nurses' note dated and timed for 10/6/19 at 4:12 pm which read in part, "Notified MD (medical doctor) (name of medical doctor), obtained orders to send resident to ER (emergency room) for evaluation" The surveyor did not find any documentation of the Ombudsman being notified of the resident's discharge to the hospital on 10/6/19 at approximately 2 pm, the surveyor requested copies of the Ombudsman notice of discharge for Resident #68 from the director of nursing (DON) and the administrator. The surveyor was not provided the requested information that had been requested as documented above. On 10/18/19 at approximately 3 pm, the surveyor was provided copies of the Ombudsman being notified of discharges but the names of the residents had been blackened out to where the surveyor could not read the residents on this list. No further information was provided to the surveyor prior to the exit conference on 10/18/19. 2. The facility staff failed to notify the Ombudsman of the ER			НАВ		1607 SPRUCE STREET		, 19/19/2019
Interview for Mental Status) score of 15 out of a possible score of 15. Resident #68 was also coded as requiring supervision of 1 staff member for dressing, personal hygiene and limited assistance of 1 staff member for bathing. During the clinical record review on 10/15/19 through 10/18/19, the surveyor noted a nurses' note dated and timed for 10/6/19 at 4:12 pm which read in part, "Notified MD (medical doctor) (name of medical doctor), obtained orders to send resident to ER (emergency room) for evaluation" The surveyor did not find any documentation of the Ombudsman being notified of the resident's discharge to the hospital on 10/6/19. On 10/17/19 at 1:44 pm and again on 10/18/19 at approximately 2 pm, the surveyor requested copies of the Ombudsman notice of discharge for Resident #68 from the director of nursing (DON) and the administrator. The surveyor was not provided the requested information that had been requested as documented above. On 10/18/19 at approximately 3 pm, the surveyor was not provided copies of the Ombudsman being notified of discharges but the names of the residents had been blackened out to where the surveyor could not read the residents on this list. No further information was provided to the surveyor prior to the exit conference on 10/18/19. 2. The facility staff failed to notify the Ombudsman of the discharge of Resident #39 when the resident was sent to the ER	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	X (EACH CORRECT CROSS REFEREN	CTIVE ACTION SHOULD B NCED TO THE APPROPRI	E COMPLETION
Resident #39 was readmitted to the facility on	F 623	Interview for Mental 3 possible score of 15 coded as requiring stor dressing, personal assistance of 1 staff During the clinical rethrough 10/18/19, the note dated and timed which read in part, "doctor)	Resident #68 was also upervision of 1 staff member all hygiene and limited member for bathing. Accord review on 10/15/19 esurveyor noted a nurses' after 10/6/19 at 4:12 pmNotified MD (medical me of medical doctor), and resident to ER or evaluation" The surveyor mentation of the notified of the resident's pital on 10/6/19. Approximation on 10/18/19 at the surveyor requested sman notice of discharge for the director of nursing (DON) or. The surveyor was not ed information that had been ented above. On 10/18/19 at the surveyor was provided alsman being notified of ames of the residents had to where the surveyor could as on this list. And was provided to the exit conference on 10/18/19. Affailed to notify the discharge of Resident #39 as sent to the ER in 7/20/19.	F	523		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495143	B. WING			1	C 18/2019
	ROVIDER OR SUPPLIER	НАВ	•	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1807 SPRUCE STREET MARTINSVILLE, VA 24112	107	10/2015
(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)		(XS) COMPLETION DATE
F 623	7/20/19 for increased following diagnoses of artery disease, high bedepression. On the set (Minimum Data Set) or Reference Date) of 7 coded as having a Bl Mental Status) score of 15. Resident #39 totally dependent on personal hygiene and During the clinical received through 10/18/19, the note dated and timed which read in part, " and he (medical doct ER (emergency room surveyor did not find Ombudsman being ned discharge to the hospital of the Ombudsman than the administrator provided the requester requested as docume approximately 3 pm, copies of the Ombuddischarges but the natal been blackened out to not read the residents.	scharged to the hospital on pain. The resident had the of, but not limited to coronary blood pressure, stroke and significant change MDS with an ARD (Assessment /31/19; the resident was MS (Brief Interview for of 13 out of a possible score was also coded as being 1 staff member for dressing, 1 bathing. Ford review on 10/15/19 as surveyor noted a nurses' for 7/20/19 13:23 (1:23 pm)was in excruciating pain or) stated to send her out to on for evaluation" The any documentation of the obtified of the resident's obtail on 7/20/19. The surveyor requested sman notice of discharge for the director of nursing (DON) of the control of the surveyor was not be dinformation that had been ented above. On 10/18/19 at the surveyor was provided sman being notified of the residents had on where the surveyor could is on this list.	F	623			
		exit conference on 10/18/19. led to notify Resident #63 in					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495143	B. WING_			ı	C /18/2019
	ROVIDER OR SUPPLIER VILLE HEALTH AND RES	HAB		STREET ADDRESS, CITY, STATE, ZI 1607 SPRUCE STREET MARTINSVILLE, VA 24112	P CODE	10,	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		ACTION SHOULD B		(X5) COMPLETION DATE
F 623	writing of reason for the 6/27/19. Resident # 63 was or facility on 3/22/18, and 7/2/19. Diagnoses independing, paraplegia, The clinical record for reviewed on 10/10/19 recent MDS (minimur Resident # 63 was a an ARD (assessment Section C of the MDS patterns. In Section C documented that Resident which indicated that Fintact. On 10/10/19 at 1:28 president # 63's room interview. The surveyshe had been readming admission to the facilithe surveyor that she	iginally admitted to the d had a readmission date of cluded but were not limited uterine and vaginal and muscle weakness. If Resident # 63 was at 9:46 am. The most m data set) assessment for quarterly assessment with reference date) of 8/21/19. Sassesses cognitive 20500, the facility staff sident # 63 had a BIMS (brief status) score of 15 out of 15, Resident #63 was cognitively orm, the surveyor was in conducting a Resident #63 if steed to the hospital since her ity. Resident # 63 informed had lost a lot of blood and pospital. Resident # 63	F	623			
	Condition note for Redocumented on 6/27/was documented as, and had critical low HHCT (hematocrit) 16. Resident stated her parmonth and this was	19 at 2:42 pm. The note "Situation: Lab drawn today IGB (hemoglobin) 5.0 and 0, albumin 2.9 Background: period was on for longer than			VDHVOLC	RECEIVED	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A. BUILDII	IPLE CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		495143	B. WING_			C 10/18/2019
	ROVIDER OR SUPPLIER	1AB		STREET ADDRESS, CITY, STATE, ZIP COL 1607 SPRUCE STREET MARTINSVILLE, VA 24112	DE	10/10/2010
(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 CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 623	73, 16, 98%, MD notion blood count) which we neurology appointmer results. Response: Me withheld) stated send The surveyor reviews been documented on nurse's note was documented on self-acility name withheld check on rsd (resider with menorrhea with Con 10/16/19 at 5:14 with the administrato surveyor requested of that Resident # 63 has reason for transfer to 6/27/19 in writing. On 10/17/19 at 4:52 with the administrator and director administrator and director administrator and director was no document the emergency rocurveyor provided that the opportunity to as additional information practice as stated ab	fied to have CBC (complete as already in place due to nt being schedule after iD (physician's name laresident to hospital." In a da nurse's note that had a 6/27/19 at 10:18 pm. The numented as, "Contacted ld) ER (emergency room) to nt) condition, Rsd admitted anemia." In and director of nursing. The commentation of information and been made aware of the the emergency room on the emergency room on the emergency room on the entry of clinical services. The entry of the reason for transfer on on 6/27/19 in writing. The end administrative team with a questions and provide in in response to the deficient ove.		523		
F 625 SS=E	CFR(s): 483.15(d)(1)	olicy Before/Upon Trnsfr (2) bed-hold policy and return-	F	1. Residents #68, 39, 96 currently reside at facility 2. Residents with an ord transfered to the ER are	er to be	12/06/2019

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDING	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		495143	B. WING			C 18/2019
	ROVIDER OR SUPPLIER VILLE HEALTH AND RE	ЕНАВ	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFILIERCY)	0 8 E	(X5) COMPLETION DATE
F 625	§483.15(d)(1) Notice nursing facility trans the resident goes or nursing facility must the resident or resid specifies- (i) The duration of the any, during which the return and resume refacility; (ii) The reserve bed plan, under § 447.40; (iii) The nursing facility bed-hold periods, who paragraph (e)(1) of the resident to return; and (iv) The information of this section. §483.15(d)(2) Bed-hold the time of transfer of the hospitalization or the facility must provide resident representates specifies the duration described in paragram This REQUIREMENT by: Based on staff interreview, the facility stresident or resident policy when 4 of 30 sample were dischaused (Resident #68, #39, The findings include	e before transfer. Before a fers a resident to a hospital or a therapeutic leave, the provide written information to ent representative that the state bed-hold policy, if e resident is permitted to esidence in the nursing payment policy in the state of this chapter, if any; lity's policies regarding hich must be consistent with this section, permitting a hid specified in paragraph (e)(1) fold notice upon transfer. At of a resident for erapeutic leave, a nursing to the resident and the live written notice which in of the bed-hold policy aph (d)(1) of this section. IT is not met as evidenced view and clinical record taff failed to provide the representative of the bed hold residents in the survey rged to the hospital #96 and #63).	F 625	deficient practice. 3. DON or designee re-educate licensed nursing staff related to the Transfer Envelope including hold policy and documenting in medical record that the require information was sent with resid ER/hospital. 4. The ADON or designee will audit the medical record of transfered to the ER/hospital to the transfer envelop including the policy was sent and documents weekly for 8 weeks. The ADON submit findings to the Quality A and Performance Improvement DON is responsible for monitor follow up. 5. 12/06/2019	sending g the bed the d ent to the residents ensure ed hold ed will ssurance . The	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT	TIPLE CONSTRUCTION			(3) DATE SURVEY COMPLETED	
		495143	B. WING			1	C 18/2019	
	ROVIDER OR SUPPLIER VILLE HEALTH AND REI	HAB		STREET ADDRÉSS, CITY, STATE, ZIP CO 1607 SPRUCE STREET MARTINSVILLE, VA 24112	DE	1 10	10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		ON SHOULD B HE APPROPRI		(X5) COMPLETION DATE	
F 625	and the resident repropolicy when the residhospital on 10/6/19. Resident #68 was rea 9/14/19 and discharghad the following diaganemia, heart failure, diabetes, dementia a quarterly MDS (Minin (Assessment Referencesident was coded a Interview for Mental Spossible score of 15. coded as requiring stor dressing, personal assistance of 1 staff in During the clinical rethrough 10/18/19, the note dated and timed which read in part, " doctor) (nare obtained orders to see (emergency room) for did not find any docu policy being given to representative when to the hospital on 10/16/19 at approximately 3 proportion of 10/18/19 at approximately 3 pm, above documented pm, as well a	esentative of the bed hold ent was discharged to the admitted to the facility on ed on 10/6/19. The resident gnoses of, but not limited to high blood pressure, and depression. On the num Data Set) with an ARD noce Date) of 8/23/19, the is having a BIMS (Brief Status) score of 15 out of a Resident #68 was also appreciation of 1 staff member all hygiene and limited member for bathing. cord review on 10/15/19 es surveyor noted a nurses' of 10/6/19 at 4:12 pmNotified MD (medical me of medical doctor), and resident to ER revaluation" The surveyor mentation of the bed hold the resident was discharged 6/19. Eximately 11 am and again eximately 2 pm, the surveyor he discharge mmary for this resident from g (DON) and the urveyor was not provided the in that had been requested	F	625	VDH/OLC OF THE PROPERTY OF THE	RECEIVED		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI A. BUILDING COMPLET		ETED		
		495143	B. WING_			C		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA 1607 SPRUCE STREET MARTINSVILLE, VA 2411		10/18/2019		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	((EACH CORRECT CROSS-REFERENCE	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE	
F 625	ER on 10/6/19. The don't have any docu that you have reques No further informatis surveyor prior to the 2. The facility state and the resident repolicy when the reserved ER (emergency rook Resident #39 was roughly 1/20/19 for increase following diagnoses artery disease, high depression. On the (Minimum Data Set Reference Date) of coded as having a light Mental Status) scor of 15. Resident #35 totally dependent or personal hygiene at During the clinical rethrough 10/18/19, the clinical read in part, and he (medical do ER (emergency rook surveyor did not find Ombudsman being being given to the representative when to the ER on 7/20/1 On 10/16/19 at app surveyor requested	administrator stated, "We immentation of the information ested." on was provided to the exit conference on 10/18/19. If failed to offer Resident #39 presentative of the bed hold ident was transferred to the m) on 7/20/19. It is admitted to the facility on discharged to the hospital on ed pain. The resident had the exit of, but not limited to coronary is blood pressure, stroke and exignificant change MDS with an ARD (Assessment 7/31/19; the resident was BIMS (Brief Interview for exit of 13 out of a possible score exit was also coded as being in 1 staff member for dressing, and bathing. In the resident was in excruciating pain corol stated to send her out to m) for evaluation" The diany documentation of the notified of the bed hold policy esident and resident in the resident was transferred 9. In the resident from 10/15/19 and	F	525				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI		DISTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495143	B. WING			1	C 18/2019
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	1 10/	10/2019
MARTING	MULE HEALTH AMB BE			1607	SPRUCE STREET		
MARTINS	VILLE HEALTH AND REI	TAB		MARTINSVILLE, VA 24112			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE		T BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD 8				(X5) COMPLETION DATE
F 625	administrator. The sicopy of the bed hold #39's name on the todated. On 10/18/19 administrator stated thave any more docurthat you have requestal ready provided to y No further information surveyor prior to the surveyor	urveyor was provided the policy that had Resident p of this policy but was not at approximately 3 pm, the to the surveyor, "We don't mentation of the information ated other than what we have ou." In was provided to the exit conference on 10/18/19. failed to offer Resident #96 esentative of the bed hold lent was transferred to the n) on 10/10/19. admitted to the facility on wing diagnoses of, but not atery disease, heart failure, renal failure, diabetes, in. On the quarterly MDS with an ARD (Assessment M11/19 coded the resident as a Interview for Mental Status) possible score of 15. so coded as requiring of 1 staff member for all hygiene and being totally member for bathing. cord review on 10/10/19 at for noted documentation in the dand timed for 9/2/19 ich read in part, " Resident est pain @ (at) 0015 (12:15 call bell approximately 3 and to be sent to the ED ent) for further evaluation"	F	625			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495143	B. WING			C 10/18/2019
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA ICIENCY)	
F 625	summary/transfer stated have any more documented to No further information surveyor prior to the 4. The facility staff famotice of bed hold un 6/27/19. Resident # 63 was of facility on 3/22/18, a 7/2/19. Diagnoses in to, anemia, abnormableeding, paraplegian The clinical record for reviewed on 10/10/17 recent MDS (minimum Resident # 63 was an ARD (assessmented Section C of the MD patterns. In Section documented that Resinterview for mental which indicated that intact. On 10/10/19 at 1:28 Resident # 63's rooi interview. The survesshe had been readmarked.	immary for this resident from ag (DON) and the surveyor was provided the policy that had Resident op of this policy but was not at approximately 3 pm, the to the surveyor, "We don't imentation of the information sted other than what we have	F6	25		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495143	B, WING				C 18/2019
	ROVIDER OR SUPPLIER	IAB		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112			
(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 & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 625	the surveyor that she was admitted to the h stated, "I was as whit The surveyor reviewer Condition note for Redocumented on 6/27/was documented as, and had critical low HHCT (hematocrit) 16. Resident stated her parmonth and this was experienced this. Ass 73, 16, 98%, MD notion blood count) which we neurology appointme results. Response: Movemented on nurse's note was documented on 10/16/19 at 5:14 pwith the administrator surveyor requested do that Resident # 63 has bed hold upon transfe 6/27/19. On 10/17/19 at 1:30 purveyor with copy of Policy" form that had handwritten on it. The there was no date do bed hold policy form,	had lost a lot of blood and ospital. Resident # 63 e as that sheet." It d a SBAR- Change of sident # 63 that was 19 at 2:42 pm. The note "Situation: Lab drawn today GB (hemoglobin) 5.0 and 0, albumin 2.9 Background: eriod was on for longer than not the 1st time she essment: VS 122/70, 96.5, fied to have CBC (complete as already in place due to the being schedule after D (physician's name resident to hospital." and a nurse's note that had 6/27/19 at 10:18 pm. The umented as, "Contacted ld) ER (emergency room) to att) condition, Rsd admitted	F	625			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495143	B. WING_				C 18/2019
	ROVIDER OR SUPPLIER	IAB		16	REET ADDRESS, CITY, STATE, ZIP CODE 07 SPRUCE STREET ARTINSVILLE, VA 24112	10/	10/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 625	Resident # 63 upon to room on 6/27/19. On 10/17/19 at 4:52 pwith the administrator the regional director of administrator and director of the regional director of bed hold polyprovided for Resident there was no way to had been offered to be to the emergency roop provided the administrator and director to the emergency roop provided the administrator and ditional information practice as stated about the composition of the provided the administrator and ditional information of the provided the administrator and the provided th	om, the survey team met in, the director of nursing, and of clinical services. The ector of nursing agreed that entation of a date on the licy form that the facility had it #63, and also agreed that verify if a notice of bed hold desident #63 upon transfer im on 6/27/19. The surveyor erative team with the estions and provide in response to the deficient ove.	F	F 625			
F 636 SS=D	Comprehensive Asse CFR(s): 483.20(b)(1) §483.20 Resident Ass The facility must cond a comprehensive, acreproducible assessment functional capacity. §483.20(b) Compreh §483.20(b)(1) Reside A facility must make a assessment of a resignals, life history and resident assessment.	ssments & Timing (2)(i)(iii) sessment duct initially and periodically curate, standardized nent of each resident's ensive Assessments ent Assessment Instrument.	F	336	 The annual MDS assessment for resident # 8 was completed on 10/14/2019. Audits were completed by the M Coordinators for late assessments The Regional Clinical Reimburs Director re-educated the MDS Coordinators of the OBRA required assessment and completion required. Audits will be completed by the Coordinator for timely and complete assessments weekly for 8 weeks. MDS Coordinator will submit finding the Quality Assurance and Perform 	IDS ement d MDS rements. MDS ted The	12/06/2019

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495143	8. WING _			C 10/18/2019	
	ROVIDER OR SUPPLIER VILLE HEALTH AND RE	нав		STREET ADDRESS, CITY, STATE, 2 1607 SPRUCE STREET MARTINSVILLE, VA 24112	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	UMMARY STATEMENT OF DEFICIENCIES ID I DEFICIENCY MUST BE PRECEDED BY FULL PREFIX LATORY OR LSC IDENTIFYING INFORMATION) TAG		(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE	
F 636	(ii) Identification and (iii) Customary routin (iii) Cognitive pattern (iv) Communication. (v) Vision. (vi) Mood and behav (vii) Psychological w (viii) Physical functio (ix) Continence. (x) Disease diagnosi (xi) Dental and nutrit (xii) Skin Conditions. (xii) Activity pursuit. (xiv) Medications. (xv) Special treatmer (xvi) Discharge plant (xvii) Documentation regarding the addition the care areas trighte Minimum Data S (xviii) Documentation assessment. The as include direct observith the resident, as licensed and nonlice members on all shift §483.20(b)(2) When timeframes prescribe chapter, a facility muassessment of a restimeframes specified through (iii) of this seprescribed in §413.3 apply to CAHs. (i) Within 14 calenda excluding readmission.	demographic information e. e. e. e. cior patterns. ell-being. ning and structural problems. s and health conditions. cional status. Ints and procedures. Ining. In of summary information onal assessment performed ggered by the completion of eet (MDS). In of participation in essessment process must vation and communication well as communication with ensed direct care staff	F 63	and Improvement Co DON is responsible f monitoring and follow 5. 12/06/2019	or		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495143	8. WING			C 10/18/2019	
	ROVIDER OR SUPPLIER	HAB		STREET ADDRESS, CITY, STATE, ZIP CO 1607 SPRUCE STREET MARTINSVILLE, VA 24112		10, 10,2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 636	mental condition. (Fo "readmission" means following a temporary or therapeutic leave.) (iii)Not less than once This REQUIREMENT by: Based on clinical received the facility staff failed standardized reproduct ompleting an annual residents in the surversidents in the surversident #8 was admit/6/18. Diagnoses in with diabetic nephrop and hand, anemia, dynamiparesis following or leg, essential hyperwith ulceration of left paraplegia, and other cerebrovascular dise. Minimum Data Set (Nassessment reference scored 10/15 on the listatus and was assessed dirium, psychosis, of Clinical record review revealed the Annual is assessment due 9/10/10/19. The surrecord review revealed the MDS Coordinal assessment had bee and acknowledged the record review revealed completed on 10/14/19	r purposes of this section, a return to the facility absence for hospitalization be every 12 months. Tis not met as evidenced cord review, staff interview, to periodically conduct a licible assessment by I assessment for 1 of 30 by sample (Resident # 8). Initted to the facility on Included diabetes mellitus by sample (Resident # 8). Initted to the facility on Included diabetes mellitus by sample, hemiplegia and by infarct, acquired absence by symbolic dysfunctions, as sequelae of ase. On the quarterly IDS) assessment with the date 6/10/19, the resident by or behaviors affecting care. If on 10/10/19 at 9:07 AM Initial Minimum Data Set IDM 19 had not been completed by over reported the concern ator, who stated that an in initiated but not completed that it was late. Further and that the assessment was	F 63				

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION	COMP	SURVEY	
		495143	B. WING			C /18/2019
	ROVIDER OR SUPPLIER VILLE HEALTH AND RE	нав		STREET ADDRESS, CITY, STATE, ZIP CO 1607 SPRUCE STREET MARTINSVILLE, VA 24112	•	10.2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE BE APPROPRIATE	(X5) COMPLETION DATE
F 636 F 644 SS=D	Coordination of PAS. CFR(s): 483.20(e)(1) §483.20(e) Coordina A facility must coordina readmission scree (PASARR) program of this part to the male avoid duplicative test includes: §483.20(e)(1)Incorpt from the PASARR le PASARR evaluation assessment, care placare. §483.20(e)(2) Referrall residents with new serious mental dison related condition for a significant change This REQUIREMEN	n during on 10/10/19, ARR and Assessments (2)	F 63	36	reside at facility y the Social ARR and rided by the al dership team of nendations of d by the Social gnee to ensure ons are being ressary and weeks. The Social mit findings to the erformance	e
	the facility staff failed residents in the survinecessary services a PASARR, Resident # 1. The facility staff # 9 had restorative in psychiatric services Level II PASARR (prirecord review).	cord review, staff interview is to ensure that two of 30 ey sample received the as outline in the Level II #9 and Resident #74. failed to ensure that Resident ursing and outpatient as recommended in her eadmission screening and ginally admitted to the facility		and follow up. 5. 12/06/2019		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION	(X3	3) DATE :	SURVEY LETED
		495143	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER	495143	B. WING_	STREET ADDRESS, CITY, STATE, ZIP CODE		10/1	18/2019
				1607 SPRUCE STREET			
MARTINS	VILLE HEALTH AND REI	НАВ	MARTINSVILLE, VA 24112				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	2760	LD BE		(X5) COMPLETION DATE
F 644	on 1/27/11, and had a 9/10/18. Diagnoses in to, schizoaffective dis anxiety, and major de The clinical record for on 10/10/19 at 11:10 (minimum data set) a change assessment reference date) of 6/1 assesses cognitive properties that a BIMS score (brown status) of 11 out of 18 Resident # 9's cognitimpaired. On 10/11/19 at 12:06 worker provided the set PASARR for Resident completed on 3/6/18. recommended rehabing grooming needs, non medical equipment, OPT (physical therapy) Psychiatric Consultat Outpatient Psych, Psychiatr	a readmission date of included but were not limited sorder, psychotic disorder, epressive disorder. The Resident # 9 was reviewed am. The most recent MDS issessment was a significant with an ARD (assessment 17/19. Section C of the MDS atterns. In Section C0500, mented that Resident # 9 rief interview for mental 5, which indicated that ive status was moderately In the facility social surveyor with a Level II with a the services of basic incustomized durable DT (occupational therapy), he Restorative Nursing, ions, Crisis Intervention, ychotropic Med ed Case Management. The eclinical record for Resident ocumentation that reflected in received or been offered to outpatient psych services.	F	644	DEC 0 9 2019	RECEIVED	
	on 10/10/19 at 11:10 (minimum data set) a change assessment or reference date) of 6/1 assesses cognitive point the facility staff docur had a BIMS score (br status) of 11 out of 15 Resident # 9's cognit impaired. On 10/11/19 at 12:06 worker provided the se PASARR for Resident completed on 3/6/18. recommended rehabing redical equipment, OPT (physical therapy) Psychiatric Consultat Outpatient Psych, Ps Management, Targete surveyor reviewed the # 9 and did not find d that Resident # 9 had restorative nursing or On 10/16/19 at 5:37 if director of nursing we surveyor did not local Resident # 9 had rec- outpatient psych serve	am. The most recent MDS ssessment was a significant with an ARD (assessment 17/19. Section C of the MDS atterns. In Section C0500, mented that Resident # 9 rief interview for mental 5, which indicated that ive status was moderately pm, the facility social surveyor with a Level II at # 9 that had been The Level II PASARR illitative services of basic recustomized durable DT (occupational therapy), Restorative Nursing, ions, Crisis Intervention, yechotropic Med ed Case Management. The eclinical record for Resident ocumentation that reflected if received or been offered routpatient psych services.			DEC 0.9 2019	RECEIVED	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495143	B. WING_			1	C 18/2019
	ROVIDER OR SUPPLIER	1AB		1607	ET ADDRESS, CITY, STATE, ZIP CODE SPRUCE STREET TINSVILLE, VA 24112	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 644	3/6/18. The administr opportunity to ask que additional information practice as stated about the survive conference on 10/18/2. For Resident #74, incorporate the recompassance of the evaluation report into comprehensive care in Resident #74 was ad 10/26/11. Diagnoses schizophrenia, function gastrostomy, chronic dysphagia, convulsion Parkinson's disease, anxiety, and hyperter Set assessment with 8/31/19, the resident assessed as without or behaviors affecting Clinical record review revealed the PASSA 2013 recommended in DME, PT, OT, psychiatric set through social services through social services through social services in the survices as through social services in the survices and the survival a	ative team was provided the estions and provide in response to the deficient ove. In regarding this issue was ey team prior to the exit 19. If acility staff failed to mendations from the rmination and the PASARR the resident's plan. In the resident's plan. In the facility on included catatonic onal quadriplegia, epilepsy, pain, muscle weakness, ins., lack of falls, ischemia, major depressive disorder, insion. On the Minimum Data assessment reference date scored 15/15 and was signs of delirium, psychosis, in care. In on 10/10/19 at 10:19 AM R II done on admission in rehab for basic grooming, atric services, psychiatric and targeted case inveyor found no orders for ervices or any evidence as of targeted case urveyor was unable to locate early assessments.	F	44			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDII		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495143	B. WING_		10	C /18/2019	
	ROVIDER OR SUPPLIER	HAB		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112		7 1072010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECT) CROSS-REFERENCE	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE	
F 644	Continued From page	e 68	F 6	44			
	needs identified in the During an interview w	s care plans mentioned the e PASARR level II. rith social worker Gwen 1:54 PM, she offered a					
	note dated 8/23/19 th been evaluated 8/29/ note from 8/23/19 sai order for an assessm She said there was lil room on 8/29/19. The recommend a custom social worker discuss targeted case manag to have been met. The that the local Commu- provide that service.	at said the resident had 18; or maybe 8/29/19. The d that there had been an ent of hand for orthotic. kely a visit in the resident's					
E 655	notified of the concer on 10/16/19.	d director of nursing were n during a summary meeting	E	:55 1. Residents #68	and #30 regide at	11/29/2019	
	Planning §483.21(a) Baseline §483.21(a)(1) The far implement a baseline that includes the instreeffective and person- that meet professiona The baseline care pla (i) Be developed with admission.	care Plans cility must develop and care plan for each resident ructions needed to provide centered care of the resident al standards of quality care.	F	facility with Comin place. 2. Audit was con Care Plan and so admissions and past 30 days. 3. Director of Nure-educated licer baseline care place.	and #39 reside at prehensive Care Plans inpleted for Baseline ummary for new readmissions for the irsing or designee insed nursing staff that an must me completed of admission, summary		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495143	B_WING_			(
		450140	U WING			10/	18/2019
NAME OF PE	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MARTINS	/ILLE HEALTH AND REH	IAR		16	607 SPRUCE STREET		
107-11111111111111111111111111111111111	THE THE THE TAND INC.		MARTINSVILLE, VA 24112				
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	-	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI; TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPI DEFICIENCY)			COMPLETION DATE
F 655	Continued From page 69 necessary to properly care for a resident including, but not limited to-		F	provided to resident or respor and noted in medical record.			
	_	led to- l on admission orders.			4. The Director of Nursing or design	nee	
	(B) Physician orders.	on admission orders.			will complete random audits to ensu	ıre	
	(C) Dietary orders.				Baseline Care Plans were complete	d within	
	(D) Therapy services.				48 hours and summary was provide	ed and	
	(E) Social services.				noted as given weekly for 8 weeks.		
	(F) PASARR recomm	endation, if applicable.			Director of Nursing will submit finding		
	0400 044 1/01 71 4				to the Quality Assurance and Perfo	_	
	§483.21(a)(2) The fac	olan in place of the baseline			Improvement Committee. The		
	care plan if the compr				DON is responsible for monitoring		
		n 48 hours of the resident's					
	admission.				and follow up.		
	(ii) Meets the requirer	ments set forth in paragraph			5. 12/06/2019		
		cepting paragraph (b)(2)(i) of					
	this section).						
	resident and their rep	cility must provide the resentative with a summary clan that includes but is not					
	(i) The initial goals of	the resident					
		resident's medications and					
!	dietary instructions.						
	(iii) Any services and						
		acility and personnel acting					
	on behalf of the facilit						
		mation based on the details	-				
		care plan, as necessary.	-				
	by:	is not met as evidenced	-				
		iew and clinical record	1				
	review, the facility sta		İ				
		2 of 30 residents in the					
	survey sample (Resid						
	The findings included	:					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495143	B. WING			C 10/18/2019		
	ROVIDER OR SUPPLIER	HAB		STREET ADDRESS, CITY, STATE, ZIP COI 1607 SPRUCE STREET MARTINSVILLE, VA 24112		3110,2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 655	Continued From page	∍ 70	F 65	55				
		failed to complete the base Resident #68 was readmitted on 9/14/19.						
	9/14/19 after being di 9/11/19 for the reside resident had the follo limited to coronary ar pressure, stroke and significant change MI an ARD (Assessmen 7/31/19; the resident BIMS (Brief Interview 13 out of a possible s was also coded as be	DS (Minimum Data Set) with						
	through 10/18/19, the note dated and timed part, "resident wen coughing up blood.M gave order to send re surveyor did not find baseline care plan be resident was readmit On 10/16/19 at approsurveyor requested a plan that was comple readmitted to the faci director of nursing (D The administrator stated on't have any more information that you what we have alread No further information	a copy of the baseline care sted for Resident #68 was litty on 9/14/19 from the ON) and the administrator. It to the surveyor, "We documentation of the nave requested other than						

1, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			(X3) DATE SURVEY COMPLETED	
		495143	B. WING			C 10/18/2019	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 1607 SPRUCE STREET MARTINSVILLE, VA 24112		10/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 655	2. The facility staff baseline care plan whereadmitted to the number of pains and pains. Resident #39 was ready 7/20/19 after being did 7/20/19. The resident of, but not limited to blood pressure, strok significant change Ml an ARD (Assessment 7/31/19; the resident BIMS (Brief Interview 13 out of a possible swas also coded as be staff member for dress bathing. During the clinical read through 10/18/19, the note dated and timed which read in part, "and he (medical doct ER (emergency room surveyor did not find baseline care plan be when the resident was On 10/18/19 at 10:57 find any documentati being completed whe readmitted to the faci surveyor has asked rinformation to be profiled 18 and 10/17/14 the director of nursing the readmitted to the faci surveyor has asked rinformation to be profiled 18 and 10/17/14 the director of nursing the care plan be when the resident was completed whereadmitted to the faci surveyor has asked rinformation to be profiled 18 and 10/17/14 the director of nursing the care plan be when the resident was asked rinformation to be profiled 18 and 10/17/14 the director of nursing the care plan be when the resident was asked rinformation to be profiled 18 and 10/17/14 the director of nursing the care plan be when the resident was asked rinformation to page 18 and 19/17/14 the director of nursing the care plan be when the resident was a second the care plan be when the resident was a second the care plan be when the resident was a second the care plan be when the resident was a second the care plan be when the resident was a second the care plan be when the resident was a second the care plan be when the resident was a second the care plan be when the resident was a second the care plan be when the resident was a second the care plan be when the resident was a second the care plan be when the resident was a second the care plan be when the resident was a second the care plan be well as a second the care plan be when the resident was a second the care plan be when the resident was a second t	failed to complete the nen Resident #39 was sing facility on 7/22/19 after he hospital on 7/20/19 for admitted to the facility on scharged to the hospital on that the following diagnoses coronary artery disease, high e and depression. On the DS (Minimum Data Set) with the Reference Date) of was coded as having a for Mental Status) score of score of 15. Resident #39 sing totally dependent on 1 sing, personal hygiene and cord review on 10/15/19 a surveyor noted a nurses' of 7/20/19 13:23 (1:23 pm)was in excruciating pain or) stated to send her out to any documentation of the paing completed on 7/22/19 as readmitted to the facility. If am, the surveyor did not on of the baseline care plan on the resident was ality on 7/22/19. The multiple times for this wided to the surveyor on 9 from the administrator and general resident was ality on 7/22/19. The nultiple times for this wided to the surveyor on 9 from the administrator and general resident was ality on 7/22/19. The nultiple times for this wided to the surveyor on 9 from the administrator and general resident was ality on 7/22/19.	F 65	5			
	On 10/18/19 at approadministrator stated to	oximately 3 pm, the to the surveyor, "We don't					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495143	B. WING		C 10/18/2019	
	ROVIDER OR SUPPLIER	HAB		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112	10/10/2019	
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	- 700-	
F 655 F 656 SS=D	have any more docur that you have reques already provided to y No further information surveyor prior to the	nentation of the information ted other than what we have ou."	F 656	1. Resident # 74 and # 73 reside at facility with a Comprehensive Care F	12/06/201	
	§483.21(b) Compreh. §483.21(b)(1) The far implement a compreh care plan for each reresident rights set for §483.10(c)(3), that in objectives and timefra medical, nursing, and needs that are identifiassessment. The cordescribe the following (i) The services that or maintain the reside physical, mental, and required under §483. (ii) Any services that under §483.24, §483 provided due to the runder §483.10, includer treatment under §483.10 includer services provide as a result of recommendations. If findings of the PASAI rationale in the resident's represental	cility must develop and mensive person-centered sident, consistent with the that §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial ided in the comprehensive morehensive care plan must 1 - are to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse 3.10(c)(6). ervices or specialized at the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. In the resident and the		and PASARR. Resident # 108 no longer resides at facility. 2. Audit was conducted by the Socia Services Director of PASARR and the noted recommendations. Audit was conducted by MDS Coordinator of H residents Care Plans. 3. Re-education was provided by the Administrator or designee to the care team staff related to developing a Comprehensive Care Plans and review and follow up of the PASARR recommendations of necessary services appropriate. Re-education was provided by the Regional Clinical Reimbursement Director to the MDS Coordinators Care Plan requirement Hospice residents. 4. Audits will be completed by the Social Services Director or designee that PASARR recommendations are being followed as medically necessary and appropriate and comprehensive care plans are completed at least weekly weeks. The MDS Coordinator will as	the I I I I I I I I I I I I I I I I I I I	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
		495143	8. WING				C /18/2019	
	ROVIDER OR SUPPLIER	HAB	<u>I,.</u>	STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		BE ATE	(X5) COMPLETION DATE		
F 656	(B) The resident's prefuture discharge. Fac whether the resident's community was asserbocal contact agencie entities, for this purpo (C) Discharge plans in plan, as appropriate, requirements set forth section. This REQUIREMENT by: Based on staff intervively, facility staff faimplement a compreficate plan for 3 of 30 I sample resulting in faservices or specialize nursing facility would PASARR recomment to attain highest practhospice care (Reside health (Resident #73) 1. For Resident #74 incorporate the recompassance in the rec	eference and potential for illities must document a desire to return to the seed and any referrals to and/or other appropriate use. In the comprehensive care in accordance with the in in paragraph (c) of this is not met as evidenced itew and clinical record illed to develop and intensive person-centered Residents in the survey illure to provide specialized in rehabilitative services the provide as a result of dations (Resident #74) and ticable well-being related to int #108) and behavioral intended in the paragraph (c) in the resident's plan. In the resident's plan. In the resident's plan. In the resident's plan.	F	656	Hospice resident care plans week 8 weeks. 4. The Social Services Director will submit findings to the Quality Assurance and Performance Improvement Committee. The MDS Coordinator will submit findithe Quality Assurance and Performance Improvement Committee DON is responsible for monit and follow up. 5. 12/06/2019	ngs to		

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		495143	B. WING_	-		C 10/18/2019	
	ROVIDER OR SUPPLIER	1AB		STREET ADDRESS, CITY, STATE, 2 1607 SPRUCE STREET MARTINSVILLE, VA 24112	ZIP CODE		I
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE CROSS-REFERENCED			
F 656	8/31/19, the resident assessed as without or behaviors affecting. Clinical record review revealed the PASSA 2013 recommended in DME, PT, OT, psychioutpatient services, a management. The surprovidence of subsequing the service	scored 15/15 and was signs of delirium, psychosis, o care. on 10/10/19 at 10:19 AM R II done on admission in rehab for basic grooming, atric services, psychiatric and targeted case arveyor found no orders for ervices or any evidence as of targeted case arveyor was unable to locate ent assessments a services were se care plans mentioned the e PASARR level II. with social worker Gwen and 1:54 PM, she offered a part said the resident had 18; or maybe 8/29/19. The did that there had been an leent of hand for orthotic. kely a visit in the resident's	F	656	DEC 0.9 2019 VDH/OLC	RECEIVED	
		d director of nursing were n during a summary meeting			U A	0	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495143	B. WING				18/2019	
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F 656	develop a compreher psychological services. Resident #73's face is date of 8/20/18 and a 1/25/19. The resident diagnoses, which inc. Bipolar Disorder, Ger Major Depressive Dis Chronic Pancreatitis, and Radiculopathy of the most recent quarted with an ARD (ass. 8/28/19 assigned the interview for mental is in section C, cognitive was also coded as be bathing and requiring dressing and personal resident #73's medicactive physician's ord "Deer Oaks may provide Psychiatric S Initial Assessment" for 9/13/19 was present in part, "Patient gave treatment. Patient hapotential side effects. risks vs. benefits of treuture visits: revisit in Upon review, Resident #Resident #Resident #73's medicactive physician's ord "Deer Oaks may provide Psychiatric S Initial Assessment" for 9/13/19 was present in part, "Patient gave treatment. Patient hapotential side effects. risks vs. benefits of treuture visits: revisit in the potential side effects.	the facility staff failed to nsive care plan to include is. sheet listed an admission readmission date of it's diagnosis list indicated luded, but not limited to neralized Anxiety Disorder, sorder, Alcohol Induced Alcoholic Cardiomyopathy it the Lumbosacral Region. Interly MDS (minimum data sessment reference date) of resident a BIMS (brief status) score of 14 out of 15 expatterns. Resident #73 sing totally dependent for extensive assistance for all hygiene. Interly MDS (minimum data sessment reference date) of resident a BIMS (brief status) score of 14 out of 15 expatterns. Resident #73 sing totally dependent for extensive assistance for all hygiene. Interly MDS (minimum data sessment reference date) of resident a BIMS (brief status) score of 14 out of 15 expatterns. Resident #73 extensive assistance for all hygiene. Interly MDS (minimum data sessment reference date) of resident for extensive assistance for all hygiene. Interly MDS (minimum data sessment reference date) of resident for extensive assistance for all hygiene.	F	356				

IMME OF PROMOBER OR SUPPLIER MARTINSVILLE HEALTH AND REHAB MARTINSVILLE HEALTH AND REHAB MARTINSVILLE WA 21112 PREFETX TAG MARTINSVILLE HEALTH AND REHAB MARTINSVILLE HEALTH AND REHAB MARTINSVILLE CONTINUE OF PROMOBERS (ALV. 21112) PROMOBER STREET MARTINSVILLE CONTINUE OF PROMOBERS (ALV. 21112) PROMOBER STREET MARTINSVILLE CONTINUE OF PROMOBERS (ALV. 21112) PROMOBER STREET MARTINSVILLE CONTINUE OF PROMOBERS (ALV. 21112) PROM	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TIPLE NG_	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
MARTINSVILLE HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (RACH DEPOCIENCIES) (RACH DEPOCIENCY MUST as EMBECERDED BY FULL REGULATORY OR LSC IDENTIFYING IMPORMATION) F 656 Continued From page 76 The concern of Resident #73's comprehensive care plan not including psychological services was discussed with the administrative staff (administrator, director of clinical services) during a meeting on 10/17/19 at approximately 5:06pm. No further information was provided prior to exit conference on 10/18/19. 3. For Resident #108's face sheet listed an admission date of #20/19 and a readmission date of 10/07/19. The resident's diagnose, which included, but not limited to Malignant Neoplasm of Euros, Secondary Malignant Neoplasm of Liver and Intrahepatic Bile Duct, Anxiety Disorder, and Schizoaffective Disorder. The most recent admission MDS (minimum data set) with an ARD (assessment reference date) of 9/25/19 assigned the resident at BIMS (brief interview for mental status) score of 15 out of 15 in section C, cognitive patterns. Resident #108's medical record contained an active physiciant's order dated 10/07/19 stating			495143	B. WING				-	
FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 656 Continued From page 76 The concern of Resident #73's comprehensive care plan not including psychological services was discussed with the administrative staff (administrator, director of nursing and regional director of clinical services) during a meeting on 10/17/19 at approximately 5:05pm. No further information was provided prior to exit conference on 10/18/19. 3. For Resident #108, the facility staff failed to develop a comprehensive care plan to include hospice services. Resident #108's face sheet listed an admission date of 10/07/19. The resident's diagnosis list indicated diagnoses, which included, but not limited to Malignant Neoplasm of Pancreas, Secondary Malignant Neoplasm of Pancreas, Secondary Malignant Neoplasm of Ever and Intrahepatic Bile Duct, Anxiety Disorder, and Schizoaffective Disorder. The most recent admission MDS (minimum data set) with an ARD (assessment reference date) of 9/25/19 assigned the resident a BIMS (brief interview for mental status) score of 15 out of 15 in section C, cognitive patterns. Resident #108 was also coded as requiring set-up help only for bathing and staff supervision for dressing and personal hygiene. Resident #108's medical record contained an active physician's order dated 10/07/19 stating			IAB	STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET					
The concern of Resident #73's comprehensive care plan not including psychological services was discussed with the administrative staff (administrator, director of nursing and regional director of clinical services) during a meeting on 10/17/19 at approximately 5:05pm. No further information was provided prior to exit conference on 10/18/19. 3. For Resident #108, the facility staff failed to develop a comprehensive care plan to include hospice services. Resident #108's face sheet listed an admission date of 8/20/19 and a readmission date of 8/20/19 and a readmission date of 10/07/19. The resident's diagnosis list indicated diagnoses, which included, but not limited to Malignant Neoplasm of Pancreas, Secondary Malignant Neoplasm of Bone, Secondary malignant Neoplasm of Bone, Secondary malignant Neoplasm of Liver and Intrahepatic Bile Duct, Anxiety Disorder, and Schizoaffective Disorder. The most recent admission MDS (minimum data set) with an ARD (assessment reference date) of 9/25/19 assigned the resident a BIMS (brief interview for mental status) score of 15 out of 15 in section C, cognitive patterns. Resident #108 was also coded as requiring set-up help only for batting and staff supervision for dressing and personal hygiene. Resident #108's medical record contained an active physician's order dated 10/07/19 stating	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
Hospice."	F 656	The concern of Resider care plan not including was discussed with the (administrator, directed director of clinical sendinector of clinical sendinecto	ent #73's comprehensive g psychological services he administrative staff or of nursing and regional vices) during a meeting on ately 5:05pm. In was provided prior to exit 19. It is the facility staff failed to asive care plan to include sheet listed an admission readmission date of nt's diagnosis list indicated uded, but not limited to of Pancreas, Secondary of Bone, Secondary of Bone, Secondary of Liver and Intrahepatic Bile for, and Schizoaffective ission MDS (minimum data sessment reference date) of resident a BIMS (brief tatus) score of 15 out of 15 apatterns. Resident #108 quiring set-up help only for the provision for dressing and ical record contained an ter dated 10/07/19 stating	F	356				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF PE	ROVIDER OR SUPPLIER	100110		STREET ADDRESS, CITY, STATE, ZIP CODE	10/	/18/2019	
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F 656	F 656 Continued From page 77 Upon review, Resident #108's comprehensive		F 6	56			
	care plan not includin discussed with the ad (administrator and dir 10/16/19 at approximation of the resident's revissating in part, "Patier to: End of life care. In No further information conference on 10/18/	ent #108's comprehensive g hospice services was iministrative staff ector of nursing) on ately 5:15pm. ximately 9:00am, the d the surveyor with a portion ed comprehensive care plan at is on Hospice care related Date Initiated: 10/16/19."					
F 657 SS=E	S483.21(b) (2)(2)(5483.21(b)(2)) Comprehe §483.21(b)(2) A complete (i) Developed within 7 the comprehensive as (ii) Prepared by an intincludes but is not limit (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent practite resident and the ran explanation must medical record if the	ensive Care Plans brehensive care plan must d' days after completion of ssessment. lerdisciplinary team, that sited to resician.	F 6	1. Resident # 29, #47, #63, #9 was reviewed and revised on Resident # 39 and #58 Care I reviewed and revised on 11/29 2. Residents who reside at fact risk for this deficient practice. 3. Re-education was provided Director of Nursing or designe Licensed Nurses to ensure cat being reviewed and revised. 4. The ADON or designee will audit at least 10 random Common weekly for review/revision date for 8 weeks. The ADON will suffindings to the Quality Assurate Performance Improvement Common DON is responsible for	10/15/2019. Plan was 8/2019. Fility are at by the e to the re plans are are Plans es Ubmit nce and		

	ON NUMBER: A. BUII	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER MARTINSVILLE HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112					
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resident's care plan. (F) Other appropriate staff or profess disciplines as determined by the resident or as requested by the resident. (iii)Reviewed and revised by the inte team after each assessment, including comprehensive and quarterly review assessments. This REQUIREMENT is not met as by: Based on clinical record review and interview, the facility staff failed to review the comprehensive care plan residents in the survey sample (Res #39, #58, #78, #63 and #94). The findings included: 1. The facility staff failed to review the comprehensive care plan for Resident #29 was readmitted to the 8/17/16 with the following diagnoses limited to high blood pressure, anxiemanic depression and psychotic disc quarterly MDS (Minimum Data Set) (Assessment Reference Date) of 7/1 resident was coded as having a BIM Interview for Mental Status) score of possible score of 15. Resident #29 coded as requiring supervision of 1 sfor dressing and personal hygiene and physical help in part of the bathing a staff member. During the clinical record review from through 10/18/19, the surveyor noted following documentation in the nursing the clinical record review from through documentation in the nursing the clinical record review from through documentation in the nursing the clinical record review from through documentation in the nursing the clinical record review from through documentation in the nursing the clinical record review from through documentation in the nursing the clinical record review from through documentation in the nursing the clinical record review from through documentation in the nursing the clinical record review from through documentation in the nursing the clinical record review from through documentation in the nursing the clinical record review from through documentation in the nursing the clinical record review from the path the profession and profession	of the sionals in dent's needs rdisciplinary ng both the evidenced staff view and for 6 of 30 sident #29, and revise sident #29. facility on of, but not ty disorder, order. On the with an ARD 9/19, the S (Brief 15 out of a was also staff member and requiring ctivity from 1	F 657	Performance Improvement Commit The DON is responsible for monitoring and follow up. 5. 12/06/2019	tee.			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1''	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	1AB		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112				
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F 657	dated and timed for: "9/8/19 19:33 (7:3: called into dining roor front of wheelchair. A altercation with anoth Background: Bipolar. Assessment: Upon a of Resident #29) scal hair. No other injurie: Response: On call M aware, Own R.P. (res (director of nursing se made aware. Police (name of deputy) retu doesn't have to come needs to go to the ma charges, This inform. (name of resident). S daughter and she car to go to the Office 9/13/19 16:27 (4:27 p head was sore from v pulling her hair out. If doing ok and has filed resident" The surveyor reviewe #29 and the following care plan with a date initiated was 6/8/12 a "Focus: I sometim include: demanding a and to be the first res Demanding staff to st intervals during the sl accusations against se	as pm) Situation: Writer m by aide; resident sitting in hide states resident had an er resident. Anxiety Disorder sesessment (name p is reddened and missing sonoted. ID (medical doctor) made sponsible party), DNS ervices) and Administrator motified. Deputy mred call stating that he ever is harmed agistrates office to file ation given to she got in touch with her me and signed her mom out enter the other resident Resident reported she is discharges against the other was documented in the in which the care plan was and a revision date of 5/3/19: see have behaviors which my showers at shift change ident showered. ay with for hour long mowers. Making false staff. Reporting missing hissing. Trying to sneak and	F6	57				

AND PLAN OF CORRECTION HIMBER		A. BUILDI	FIPLE CONSTRUCTION NG	(X	(X3) DATE SURVEY COMPLETED		
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F 657	o Attempt intervent begin. o Explained to resifirst, but will try to get soon as possible) o Give me my med ordered o Help me to avoid upsetting to me o Let my physician interfering with my da o Make sure I am to Offer me someth o Please refer to mas needed o Please tell me w before you begin o Speak to me unh" The surveyor noted the focus and interventions noted be resident to resident a on 9/8/19. The surveyor also no Protective Order dat which named Reside victim was to have no resident involved in the expired on 9/11/19 at The surveyor did not resident's care plan weach of the above do after the "Emergency place from 9/8/19 three	dent she cannot always be her showered ASAP (as dications as my doctor has distributions or people that are always in the showered ASAP (as dications as my doctor has distributions or people that are always in the show if I my behaviors are ally living not in pain or uncomfortable ing I like as diversion by psychologist/psychiatrist that you are going to do nurriedly and in a calm voice on the date documented for the ns were initiated on 3/3/14 f 1/16/17. There were no you the surveyor after the litercation that had occurred the dan "Emergency ed for 9/8/19 at 8:10 pm in the #29 as being the alleged occurred the contact with the other the altercation. The order 11:59 pm. The note documentation that the was reviewed or revised after cumented altercations or Protective Order" was in		657			

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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	ROVIDER OR SUPPLIER VILLE HEALTH AND R	ЕНАВ		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112				
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F 657	administrator, direct corporate nurse of findings. No further information surveyor prior to the to support that the revised after each cabove or after the "was in place from 9#29. 2. The facility state comprehensive care Resident #39 was roughly 1/20/19 for increase following diagnoses artery disease, high depression. On the (Minimum Data Set Reference Date) of coded as having a Mental Status) scorof 15. Resident #3 totally dependent of personal hygiene and During the clinical rethrough 10/18/19, to Resident #39 care revised to include to that were being moreceiving Effexor 7 depression. On 10/16/19 at apprendict of the composition of the clinical rethrough 10/18/19, to the clinical rethrough 10/18/19, to the clinical rethrough 10/18/19 at apprendiction.	tor of nursing and the regional the above documented on was provided to the exit conference on 10/18/19 care plan was reviewed and of the altercations documented Emergency Protective Order" 1/8/19 to 9/11/19 for Resident wiff failed to review or revise the eplan for Resident #39. The resident #39. The resident had the sof, but not limited to coronary in blood pressure, stroke and exignificant change MDS (1) with an ARD (Assessment 17/31/19; the resident was BIMS (Brief Interview for the of 13 out of a possible score 9 was also coded as being in 1 staff member for dressing,	F	957				

	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 657	requested copies of (CCP) for Resident and revision of the C targeted behaviors to use of the psychotro which was administed depression. The surthe residents CCP, documentation that 10/17/17 and had a documented interve 6/7/19 included the Provide medication and evaluate the eff and Psychotropic m reduction plan as repharmacist." Also during the clinic surveyor noted that "minimal acute appet the L2 vertebral bod inappropriately trans 7/20/19. The reside been reviewed or rereceived the above intervention that had read in part, "Trai (times) 2 person as noted the same interinitiated on Residen documented date of had remained the same intering and the register above documented.	the comprehensive care plan #39 that included the review CCP for the resident's specific hat were associated to the opic medication, Effexor, ared to the resident for veyor was provided copies of The surveyor noted the CCP was initiated on revision date of 6/7/19. The ntions that were revised on following, which read in part, "ons as ordered by physician ectiveness inform MD PRN edication risk/benefit and commended by physician and commended by physician and starting compression fracture at the resident had been sferred by the facility staff on ant's CCP did reflect that it had vised after the resident had documented injury. The did a revision date of 7/23/19 insfer using a hoyer lift X sistance" The surveyor revention that had been	F	657	VDH/OLG DEC US ZUIS	RECEIVED	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED		
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				ı	MARTINSVILLE, VA 24112				
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F 657	Continued From page	e 83	Fé	557					
	No further information	was provided to the							
	No further information was provided to the surveyor prior to the exit conference on 10/18/19.								
	surveyor prior to the t	skit comerence on 10/16/19.							
	Resident #58's Comp to reflect the specific being monitored by the resident was receiving. Resident #58 was add following diagnoses of blood pressure, Alzhe depression and psych quarterly MDS (Minim	failed to review and revise prehensive Care Plan (CCP) targeted behaviors that were the facility staff while the group psychotropic medications. In the facility with an ARD the facility with an ARD face Date) of 8/14/19 coded							
ı	•	g a BIMS (Brief Interview for							
		of 8 out of a possible score							
		was also coded as requiring							
	extensive assistance	of 1 staff member for							
	dressing and persona	ll hygiene.							
	10/17/19, the surveyor specific targeted beha- be monitoring The CO Potential for drug re	elated complications of psychotropic medications							
		ations" had an initiated							
		urveyor noted a revision							
		read, " Observe for side							
		physician: Antipsychotic					i		
		, drowsiness, dry mouth,							
	constipation, blurred	vision,weight gain,							
	edema, postural hypotension, sweating, loss of								
		ntion" The surveyor did							
	not find documentation behaviors that the factors	, •							

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER VILLE HEALTH AND R	EHAB		STREET ADDRESS, CITY, STATE, ZIP (1607 SPRUCE STREET MARTINSVILLE, VA 24112	CODE	10/10/2013
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F 657	monitoring while the psychotropic medicinajor depressive di The surveyor notifie nursing and the reg 10/16/19 at 5:15 pm No further informatic surveyor prior to the 10/18/19. 4. The facility staff comprehensive care include Resident-to-Resident # 47 was admitted to the facil included but were n depressive disorder hypertension. The clinical record for reviewed on 10/9/18 MDS (minimum data Resident # 47 was an ARD (assessment Section C of the ME patterns. In Section documented that Rescore (brief interviewed)	resident was receiving ations for psychosis and	F 6		CY)	
	The surveyor review Resident # 47. The Change of Condition on 9/8/19 at 8:23 pr as " Situation: Resid	ved the progress notes for surveyor reviewed a" SBAR note that was documented note note was documented tent # 47 approached another nt called her son a bastard				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		495143	B. WING				18/2019
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
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	OUR MAR DV OT	ATELIENT OF DEPLOYED ONE		MA	ARTINSVILLE, VA 24112		
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F 657	Continued From page	e 85	F	657			
	child and pulled her hackground: COPD (pulmonary disorder) a injury) Assessment: Language 47 is upset about he bastard child. She hassessment complete Response: MD (medi (director of nursing senotified. Skin check caware that resident wagainst Resident # 47. The surveyor reviewer for Resident # 47. The documentation that the # 47 had been update	pair then resident fell. chronic obstructive anxiety, TBI (traumatic brain Upon assessment Resident er son being called a s no new injury, her skin ed no new bruising cal doctor) notified DNS ervices) administrator, police complete Resident # 47 ras seeking to press charges r, she became upset." ed the current plan of care e surveyor did not locate any ne plan of care for Resident					
	director of nursing we findings as stated above was provided the opp and provide additional the deficient practice. No further information presented to the surviconference on 10/18/5. The facility staff far plan of care to reflect episodes of excessive. Resident # 63 was a originally admitted to had a readmission date.	n regarding this issue was ey team prior to the exit 19. illed to review and revise the that Resident # 63 had e vaginal bleeding. 47-year-old-female that was the facility on 3/22/18, and				VDH/OLC VDH/OLC	RECEIVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	IAB		STREET ADDRESS, CITY, STATE, ZIP COD 1607 SPRUCE STREET MARTINSVILLE, VA 24112	DE	10/18/2019	
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F 657	anemia, abnormal ute paraplegia, and musor The clinical record for reviewed on 10/10/19 recent MDS (minimum Resident # 63 was a can ARD (assessment Section C of the MDS patterns. In Section C documented that Resinterview for mental s which indicated that Fintact. On 10/10/19 at 1:28 p Resident # 63's room interview. The surveyshe had been readmit admission to the facilithe surveyor that she was admitted to the h stated, "I was as white The surveyor reviewe Resident # 63. The su "SBAR-Change in Co documented on 12/23 contained documenta not limited to"Situat from vaginal area Ass bleeding from vaginal area Ass bleeding from vaginal blood with clots prese feels weak Response notifies. New orders to room) ED (emergency transfer)."	Prine and vaginal bleeding, the weakness. Resident # 63 was at 9:46 am. The most of duarterly assessment with reference date) of 8/21/19. It is assesses cognitive (0500), the facility staff (1500), the facilit	F	357			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	IPLE CONSTRUCTION	(X	3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	НАВ		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112		10/18/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		
F 657	been documented on nurse's note contained included but was not and oriented, complated a month. She appear felt weak. VS (vital signs of the surveyor reviewed Condition note for Redocumented on 6/27) was documented as, and had critical low HHCT (hematocrit) 16. Resident stated her paramonth and this was experienced this. Ass 73, 16, 98%, MD notical blood count) which we neurology appointmented results. Response: Month withheld) stated send the surveyor reviewed for Resident # 63. The documented revisions reflected that Resident excessive vaginal bles of care for Resident # 6 to reflect episodes of the administrative te opportunity to ask quitables.	6/27/19 at 10:59 am. The id documentation that limited to "Resident alert ined of menstrual was on for is to be pale and states she gns) 96.5, 122/70, 73, 16, octor) notified of concern." and a SBAR- Change of sident # 63 that was 19 at 2:42 pm. The note "Situation: Lab drawn today IGB (hemoglobin) 5.0 and 0, albumin 2.9 Background: Period was on for longer than into the 1st time she resident: VS 122/70, 96.5, fied to have CBC (complete as already in place due to into being schedule after D (physician's name iresident to hospital." and the current plan of care that in # 63 had episodes of reding. The administrator and the made aware that the plan of 3 should have been revised excessive vaginal bleeding. The administrator g agreed that the plan of 3 should have been revised excessive vaginal bleeding.		657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF PR	ROVIDER OR SUPPLIER	455145	D. WING_	STREET ADDRESS (CITY, STATE, ZIP CODE	10/	18/2019
	/ILLE HEALTH AND REH	HAB		1607 SPRUCE STR	EET		
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F 657	Continued From page	988	F 6	57			
	deficient practice as s	stated above.					}
		n regarding this issue was ey team prior to the exit 19.					
	comprehensive care include the use of a n	led to review and revise the plan for Resident # 94 to seck brace per physician's # 94's noncompliance with					
	Resident # 94 was a 57-year-old-male who was originally admitted to the facility on 1/31/19, and had a readmission date of 7/15/19. Diagnoses included but were not limited to, cervical disc disorder, spinal stenosis, and chronic pain.						
	recent MDS (minimur Resident # 94 was a an ARD (assessment Section C of the MDS patterns. In Section C documented that Res interview for mental s	at 8:48 am. The most m data set) assessment for quarterly assessment with reference date) of 9/13/19. Sassesses cognitive 20500, the facility staff sident # 94 had a BIMS (brief tatus) score of 10 out of 15, Resident # 94's cognitive					
	not limited to, "Hard r	ders that included but were neck brace in place at all e on while in the shower					
	Resident # 94's room	om, the surveyor was in conducting a resident or observed a hard neck 94's nightstand. The					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 657	surveyor asked Reside to be wearing the neck of the surveyor reviewed for Resident # 94. The and documentation the comprehensive care been revised to reflect per physician's orders noncompliance with word of the complement of the comprehensive care not reflect the use of reflect Resident # 94' wearing the neck braid of care for Resident for a neck brace and non-compliant with weadministrative team with a sk questions and documentation in respractice as stated above.	dent # 94 if he was supposed ask brace that was on his # 94 stated that he took the f. If the current plan of care to the surveyor did not observe that reflected that the plan for Resident # 94 had at the use of the neck brace is or Resident # 94's evering the neck brace. If the surveyor set # 1. The surveyor and wed the comprehensive care for the surveyor asked MDS rehensive care plan should the use of a neck brace in and that Resident # 94 did the waring the neck brace. If "Yes," and agreed that the plan for Resident # 94 did not is non-compliance with ce. If the administrator and the made aware that the plan for the surveyor and well as the plan for the deficient # 94 was the plan for the pl	F6	357		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
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		495143	B. WING		10/	18/2019
	ROVIDER OR SUPPLIER VILLE HEALTH AND REM	IAB		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112		_
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F 657	Continued From page	90	F 657			
	presented to the survicenterence on 10/18/	ey team prior to the exit 19.				
F 658 SS=D	CFR(s): 483.21(b)(3)(2)(3)(3)(4)(4)(3)(3)(4)(4)(3)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	chensive Care Plans d or arranged by the facility, inprehensive care plan, standards of quality. is not met as evidenced ord review, staff interview, review, the facility staff consistent with professional for two of 30 Residents in esident # 47 and Resident # alied to document the mazepam on the medication for Resident # 47. 60-year-old-female that was a on 5/11/17. Diagnoses limited to, anxiety, major reaumatic brain injury, and Resident # 47 was at 2:27 pm. The most recent set) assessment for quarterly assessment with reference date) of 8/5/19.	F 65	1.Residents # 47 and # 96 are or receiving care consistent with prestandards. 2. Residents admitted to the facinesiding in the facility with medicorders are at risk for this deficier. 3. Re-education was provided by Director of Nursing or designeer staff to complete the MAR when administering medication and en assessments will not be initiated resident arriving at the facility. 4. The ADON or designee will conduct random audit of admissions for assessment initiate and administration of medical documentation on the MAR at leweekly for 8 weeks. The ADON will submit audit findings to the Quality Assurance and Performal Improvement Committee. The DON is responsible for monitorinand follow up. 5. 12/06/2019	ofessional ity or ation t practice. the o nursing sure prior to the ons and iation ast	

	F DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING		(X3	(X3) DATE SURVEY COMPLETED		
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F 658	score (brief interview of 15, which indicated cognitively intact. Resident # 47 had or not limited to, "Clonar (milligram) Give 0.5 meeded for anxiety," physician on 8/26/19 9/13/19. The current plan of creviewed and revised documented a focus "Potential for drug relassociated with the umedications related to anti-depressant medi Interventions included "Provide medications evaluate for effectived EMAR (electronic merecord) for Resident # 47 had reneeded) on the follow 9/11/19 and 9/12/19. "Controlled Drug Resident # 47 and obtained in the cognitive of the surveyor reviewed Email of the company of the follow 9/11/19 and 9/12/19. "Controlled Drug Resident # 47 and obtained Email of the cognitive of the company of the controlled Drug Resident # 47 and obtained Email of the cognitive of the cogni	ders that included but were zepam tablet 0.5 mg ng every 12 hours as which was initiated by the and was discontinued on are for Resident # 47 was no 8/19/19. The facility staff area for Resident # 47 as, ated complications se of psychotropic or anti-anxiety medication." d but were not limited to, as ordered by physician and mess." and the September 2019 dication administration # 47. The surveyor observed are MAR that reflected that ceived clonazepam prn (as ving dates: 9/2/19, 9/6/19, The surveyor reviewed the cord" for Clonazepam for aserved documentation that	F6	VDH/OLC	DEC 0 9 2019	
	9/5/19, 9/7/19, and 9/ documented on the S On 10/10/19 at 3:54 p	epam 0.5 mg on 9/4/19, /8/19 that had not been september 2019 eMAR.		6	8 9	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			(X	3) DATE SURVEY COMPLETED
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F 658	the discrepancy in administration of C identified for Reside On 10/15/19 at 10:: informed the survey the nurse that adm the nurse reported Clonazepam being forgotten to docum surveyor asked the nursing staff is expadministration. The "immediately after a "Medication Adminidocumentation that to,"Documentation: 1. The individual medication dose, return the resident's MAR record) immediately being given." On 10/17/19 at 4:5: director of nursing, services were mad practice as stated as	the documentation of lonazepam that had been ent # 47. 22 pm, the director of nursing yor that she had interviewed inistered the medication and that she was used to the scheduled and that she had ent on the eMAR. The director of nursing when ected to document medication administration." and standard of practice for istration" contained to included but was not limited who administers the ecords the administration on (medication administration y following the medication	F 6	58		
	questions and prov response to the de- above. No further informat provided to the sur- conference on 10/1	ride further information in ficient practice as stated ion regarding this issue was vey team prior to the exit				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDI		INSTRUCTION	(X3) DATE COMP	SURVEY
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F 658	standards of practice documenting in the of documenting in the of the commentary and high blood pressure, stroke and depression (Minimum Data Set) Reference Date) of Shaving a BIMS (Brief score of 15 out of a president #96 was all extensive assistance dressing and person dependent on 1 staff During the clinical re 10/17/19 noted the rothe hospital on 9/2/1 resident having ches reviewing the "Admission the most recent as being "09/06/19 1 surveyor reviewed fror "9/7/19 06:38 (6:3 read in part, "Resi (name of nursing fact number) at approx am)" The surveyor ARD of 9/6/19 in which date was "09/06/19" Information. On 10/ surveyor notified the documented findings admission dates for The administrator re	e for Resident #96 when clinical record. radmitted to the facility on wing diagnoses of, but not rery disease, heart failure, renal failure, diabetes, on. On the quarterly MDS with an ARD (Assessment 2/11/19 coded the resident as f Interview for Mental Status) possible score of 15. so coded as requiring a of 1 staff member for all hygiene and being totally f member for bathing. cord review, the surveyor on esident had been admitted to 9 at 6:48 am due to the st pain. The surveyor was ssion Data Collection Form" admission was documented 928 (7:28 pm)". The ne nursing notes documented 38 am)" Admission, which ident readmitted to	F	558			
	pm and stated, "I go	t this from (name of					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
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F 658	hospital) and the discovas 9/7/19 at 5:02 an correct in saying the rescription of provided the facility on 9/7/19." The administrator, "But the nursing assessment of the facility was 9/6/19 reflecting that the nurdocumentation on the Form" was document actually physicially in acceptable for the nurthe nursing notes' betwilding?" The adminurses' should not do arrives in the building and received a copy on ursing documentation Collection" which read and/or readmission to charge shall complete facilitate the beginning plan of care Nurses following information. Data Collection Form Date of admission" Basic Nursing, Essen (Potter and Perry, 20: Used as a Reference Documentation within Is a Vital Aspect of Nursing Practice. A Care Team, Nurses Nurses Nurses Nurses Reference Team, Nurses Nurses Nurses Reference Team, Nurses Nurs	tharge date from the hospital in. So the nurses' notes are resident was admitted to the resident was admitted to the resident was exercised to the resident was the admission to at 19:28 (7:28 pm). This is sing admission in a "Admission Data Collection red before the resident was the nursing facility. Is it right resident in fore the resident is in the nistrator stated, "No, the cument before the resident in." The surveyor requested of the facility's policy on in titled "Admission Data in titled "Admission Data in Data Collection Form to g and/or revisions of the si notes should include the lif not on the Admission in A. Time of admission in a Client's Medical Recordursing Practice, Nursing	F	358		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 658	Timely, Effective Man	ner.	F 65	8		
F 677 SS=D	ADL Care Provided for CFR(s): 483.24(a)(2) §483.24(a)(2) A reside out activities of daily is services to maintain opersonal and oral hygomersonal and discomplaint investigation provide ADL (activities of 30 residents in the 88. The findings included the findings included the facility staff failed 88's hair was washed be anxiety, dementia with and schizophrenia. The clinical record for reviewed on 10/10/19 recent MDS (minimum Resident #88 was a san ARD (assessment Section B of the MDS and vision. In Section	ent who is unable to carry iving receives the necessary good nutrition, grooming, and giene; is not met as evidenced in, clinical record review, uring the course of a son, the facility staff failed to so of daily living) care of one survey sample, Resident #	F 67	1. Resident # 88 hair was washed 10/17/2019. 2. Audits were completed during Carekeeper Rounds to to identify resident in need of personal hygie 3. The Director of Nursing or desi re-educated nursing staff on prov and maintaining residents' person hygiene. 4. Audits will be completed at least a week of residents through Care Rounds by the Director of Nursing designee to identify any resident personal hygiene concerns for 8 weeks. The Director of Nurs submit findings to the Quality Ass and Performance Improvement C The DON is responsible for monitoring and follow up. 5. 12/06/2019	any ene care. gnee iding ial st 5 times keeper g or ing will urance	
	Section B of the MDS and vision. In Section	assesses hearing speech B0700, the facility staff ident # 88 was rarely or				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER VILLE HEALTH AND REI	HAB		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112		10/	10/2013
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F 677	Continued From page	e 96	Fé	77			
	assesses functional s	status. In Section G0120, the ted that Resident # 88 was n one person providing					
	reviewed and revised documented a focus	are for Resident # 88 was f on 10/8/19. The facility staff area for Resident # 88 as, "I ioning deficit related to:					
		side of bed then lays owards foot of bed." d but were not limited to,					
	and mobility.	ssistance w (with)/ADL's		driewen-t-f-france-re-			
	Resident # 88 sitting by facility staff. The s	om, the surveyor observed in her room being fed lunch urveyor observed that nad a greasy appearance.		0 0 1 1 0 0 0 0 0 1 1 1 1 1 1			
	Resident # 88 as she	m, the surveyor observed sat in her room in her eyor observed that Resident asy appearance.					
	services were made a Resident # 88's hair of above. The surveyor documentation for Re	nd regional director of clinical aware of the observations of on the days mentioned					
	shower sheets from to 8/2/19- no documenta 8/6/19- documentatio						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE S COMPL		
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F 677	F 677 Continued From page 97 9/6/19-documentation of bed-bath provided 9/24/19-documentation of bed-bath provided On 10/18/19 at 12:35 pm, the surveyor informed the administrator, director of nursing, and regional director of clinical services that the information provided by the facility did not reflect that Resident # 88 had had her hair washed recently. The administrative team was provided an opportunity to ask questions and provide additional information in response to the deficient practice as stated above. No further information regarding this issue was presented to the survey team prior to the exit conference on 10/18/19. F 684 Quality of Care		F 67			12/06/2010	
SS=G	applies to all treatmet facility residents. Bat assessment of a rest that residents received accordance with propractice, the compressore plan, and the resident facility document failed to follow physicalled to assess and	undamental principle that ent and care provided to sed on the comprehensive ident, the facility must ensure the treatment and care in fessional standards of thensive person-centered esidents' choices. This not met as evidenced eview, clinical record review at review, the facility staffician's orders for 4 of 30 the 440, #103, #47 and #316 and monitor for 2 of 25 residents 163) in the survey sample.		1. Resident # 63 was treated for evaginal bleeding on 6/27/2019. R # 103 received oxycodone on 6/4 Resident # 47 medication administime was changed on 10/17/2019 Resident # 316 no longer resides facility. Resident # 40 received medication 10/15/2019. Resident # 77 received treatment to the identified toe on 10/10/2019. 2. Residents that reside at the fact at risk of this deficient practice. 3. Re-education was provided to nursing staff by the Director of Nudesignee related to ensuring that physician orders are followed and interact system (SBAR and stop as interact system as interact system (SBAR and stop as interact system as interact system as interact system as interact system (SBAR and stop as interact system as	esident /2019. stration at the on on cility are the ursing or d the	12/00/2013	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE COMP	SURVEY LÉTED
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F 684	Resident # 63 for exc which lead to Resider hemoglobin and hem- subsequently admitte diagnosis of menorrha a blood transfusion. Resident # 63 was or facility on 3/22/18, an 7/2/19. Diagnoses ind to, anemia, abnormal bleeding, paraplegia, The clinical record for reviewed on 10/10/19 recent MDS (minimur Resident # 63 was a of an ARD (assessment Section C of the MDS patterns. In Section C documented that Resident which indicated that F intact. Section G of the status. In Section Goffuse. Toilet use assess limited to, how the Re- room, commode, or be elimination, and chan- documented that Residependent requiring to more persons for toile assessed bathing. The	led to assess and monitor ressive vaginal bleeding, int # 63 having a critical atocrit and was do to the hospital with a rea and anemia and required riginally admitted to the do had a readmission date of cluded but were not limited reterine and vaginal and muscle weakness. Resident # 63 was at at 9:46 am. The most in data set) assessment for quarterly assessment with reference date) of 8/21/19. It is assesses cognitive reference date of 15 out of 15, resident # 63 had a BIMS (brief tatus) score of 15 out of 15, resident # 63 was cognitively reference date of the toilet rement included but was not resident # 63 used the toilet redpan; cleansed self after ged pad. The facility staff ident # 63 was totally the assistance of two or retruse. Section G0120 refacility staff documented	F	684	watch) is utilized to identify and more resident changes in condition. 4. Audits will be conducted by the Director of Nursing or designee of motes, 24 hour reports and MAR/TA for changes of condition and to ensphysician orders are followed at least 5 times a week for 8 weeks. T Director of Nursing will submit finding the Quality Assurance and Performance Improvement Commit The DON is responsible for monitoring and follow up. 5. 12/06/2019	nursing R ure he	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	IAB		STREET ADDRESS, CITY, STATE, ZIP CO 1807 SPRUCE STREET MARTINSVILLE, VA 24112		0/16/2019
(X4) ID PREFIX TAG					ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 684	On 10/10/19 at 1:28 p Resident # 63's room interview. The survey she had been readmi admission to the facili the surveyor that she was admitted to the h stated, "I was as white The surveyor reviewe Resident # 63. The st "SBAR-Change in Co documented on 12/23 contained documenta not limited to"Situa from vaginal area Ass bleeding from vaginal blood with clots prese feels weak Response notifies. New orders to room) ED (emergency transfer)." The surveyor observe been documented on nurse's note containe included but was not and oriented, complai a month. She appears felt weak. VS (vital sig 98%. MD (medical do The surveyor reviewe Condition note for Re documented on 6/27/ was documented as, and had critical low H HCT (hematocrit) 16.0	om, the surveyor was in conducting a Resident or asked Resident # 63 if ted to the hospital since her ty. Resident # 63 informed had lost a lot of blood and ospital. Resident # 63 as that sheet." If the progress notes for arveyor observed a notition note that had been with a 18 at 9:47 am. The note tion that included but was ation: Resident is bleeding the sament: Resident is area with heavy bright int. Resident states she is MD (medical doctor) of send to ER (emergency of department) notified of the did a nurse's note that had 6/27/19 at 10:59 am. The did documentation that imited to "Resident alert ned of menstrual was on for is to be pale and states she igns) 96.5, 122/70, 73, 16, ctor) notified of concern."	F 68	34		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	1AB		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112				
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F 684	a month and this was experienced this. Ass 73, 16, 98%, MD noti blood count) which w neurology appointme results. Response: M withheld) stated send The surveyor reviewed been documented on nurse's note was doc (Facility name withher check on rsd (resider with menorrhea with a with menorrhea with a month or more, or the notified of the vaginal On 10/16/19 at 10:05 interviewed Cna # 2 (The surveyor asked Cexcessive vaginal ble and she has blood clots. Cna On 10/16/19 at 10:33 interviewed the unit murse) and asked if s. # 63 had episodes of RN # 1 informed the sunaware that Resider vaginal ble excessive vaginal ble unaware that Resider excessive vaginal ble unaware that Resider excessive vaginal ble excessive vaginal bl	not the 1st time she ressment: VS 122/70, 96.5, fied to have CBC (complete as already in place due to nt being schedule after D (physician's name resident to hospital." Id a nurse's note that had 6/27/19 at 10:18 pm. The umented as, "Contacted Id) ER (emergency room) to ot) condition, Rsd admitted anemia." Id the clinical record for a specifically the progress lers, and consultations, and cumentation that reflected d vaginal bleeding for a at the physician had been bleeding. am, the surveyor certified nursing assistant). Cha #2 if Resident # 3 had eding. Cna # 2 stated, "Yes ots." The surveyor asked ad the nursing staff when cessive vaginal bleeding # 2 stated, "Yes."	F	584				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		4054.42				С	
		495143	B. WING_			10/18/2019	
	VILLE HEALTH AND	REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 1607 SPRUCE STREET MARTINSVILLE, VA 24112	DDE		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)				(X5) COMPLETION DATE	
F 684	was pale. RN # 1 nurse to inform the asked RN # 1 if sh nursing assistants noticed that Resid vaginal bleeding. It is surveyor asked RI nursing staff to do bleeding in the clir physician. RN # 1 informed RN # 1 it documentation in # 63 that reflected bleeding for a more Cn 10/17/19 at 3:3 LPN # 1 (licensed asked LPN # 1 if s 63 had episodes of LPN # 1 stated, "Y 1 if the certified number Resident # 63 was vaginal bleeding. It is surveyor asked LFR Resident # 63 was vaginal bleeding solinical record and # 1 stated, "Yes it it is the control of nursing clinical services was stated above. The clir physician at the tir All three administrative tean nursing staff to do bleeding in the clir physician at the tir All three administrative.	stated that she instructed the ephysician. The surveyor he would expect the certified to inform the nurses if they ent # 63 was having excessive RN # 1 stated, "Yes." The N # 1 if she expected the cument episodes of excessive nical record and notify the stated, "Yes." The surveyor hat there was no the clinical record for Resident that Resident # 63 had vaginal of the or more prior to 6/27/19. 35 pm, the surveyor interviewed practical nurse) the surveyor she was aware that Resident # of excessive vaginal bleeding. Yes." The surveyor asked LPN # ursing assistants informed her 63 had episodes of excessive LPN # 1 stated, "Yes." The PN # 1 if information that is having episodes of excessive hould be documented in the the physician be notified. LPN	F	584			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495143	B. WING_			C 10/18/2019	
	ROVIDER OR SUPPLIER	НАВ		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112		10/10/2015	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(XS) COMPLETION DATE	
F 684	The facility staff pressinformation to the surpractice for document but was not limited to protocol should be dochart with, clear, concurse's decisions, ac provided, including as should be done at the because passage of accurate recollection. Reference Nettina, S.M. (2013) practice. 10th ed. Phi Health/Lippincott On 10/18/19 at 3:45 pthe administrator, the regional director of clopportunity to ask fur additional information practice as stated above the surve conference on 10/18/19. 2. For Resident #103 ensure the resident rebased on the comprefailed to ensure order	inical record and the e been notified at the time noted. ented the following vey team as the standard of tation. Information included o"5. A deviation from ocumented in the patient's cise statements of the tions, and reasons for care my apparent deviation. This e time the care is rendered time may lead to less than of the specific events." Lippincott manual of nursing iladelphia: Wolters Kluwer t Williams & Wilkins. om, the surveyor provided of director of nursing, and the inical services the ther questions and provide in response to the deficient ove. In regarding this issue was ey team prior to the exit 19. B, facility staff failed to exceived treatment and care thensive assessment when it	F€	84			
	Resident #103 was a	dmitted to the facility on					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		495143	B. WING_			C 10/18/2019	
	ROVIDER OR SUPPLIER VILLE HEALTH AND REI	НАВ		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112		10/10/2019	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN X (EACH CORRECTIVE CROSS REFERENCED DEFICE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 684	tumor of the rectum, pain, diabetes mellitu complications, chroni traumatic amputation hypertension, anxiety chronic obstructive pubipolar disorder. On the Set assessment with 9/23/19, the resident interview for mental swithout signs of delirity affecting care. The receiving scheduled pronounced being in pair days prior to the assessmed it difficult to sleassessed as 8/10. The Office of Licensural Facility Reported broncerning misapproproxycodone. The FRI nurse was unable to on 6/4/19. The facility what happened to the medication. On 10/15/19 at 7:37 // generally under contribute was unable to medication. Medication administrorder dated 9/28/18 for tablet give 1 tablet by	ncluded malignant carcinoid major depression, low back s type 2 with ophthalmic c pain, difficulty in walking, of right lower leg, of right lower lo	F	684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495143	B. WING			C	
	ROVIDER OR SUPPLIER	HAB		STREET ADDRESS, CITY, STATE, ZIP CODE 1807 SPRUCE STREET MARTINSVILLE, VA 24112		10/18/2019	-
(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 & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			
F 684	follows: 6/1/19 00:48 nursing arrival 6/1/19 09:43 nursing arrivalcoded 2=refu 6/1/19 12:38 nursing arrival 6/1/19 17:28 nursing arrival 6/1/19 20:29 nursing arrivalcoded 2=re 6/2/19 08:59 nursing arrival 6/2/19 12:16 nursing arrival 6/2/19 16:40 nursing arrival 6/2/19 16:40 nursing arrival	note awaiting pharmacy note awaiting pharmacy sed note awaiting pharmacy note awaiting pharmacy note awaiting pharmacy	F6				
	arrival 6/3/19 20:35 nursing arrival 6/4/19 09:34 nursing arrival 6/3/19 for 09:00 and MAR and no nursing status This review indicated consecutive doses of assessments associa were either 'X' or blar assessment at 21:00 the medication admin	ted with those 14 doses ik except for the 6/2 was documented as '0' on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTR IG	UCTION	(X3) DATE SURVEY COMPLETED	
		495143	B. WING_				18/2019
	ROVIDER OR SUPPLIER	IAB		1607 SPRL	DDRESS, CITY, STATE, ZIP CODE JCE STREET SVILLE, VA 24112	101	18/2019
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL PI		ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE .	(X5) COMPLETION DATE
F 684	physician was notified missing. The surveyor with the director of nu 8:44 AM. The DON's would not write a repl prescription to pull do because the doctor with Pain clinic said the prescription and the drug until time for The DON stated the rewithdrawal. The DON employee statements LPNs stating they had concerning the medical Surveyors discussed medication available to DON during individua. 3. The facility staff fail order with regard to Resident # 47. Resident # 47 was ad 5/11/17. Diagnoses in to, anxiety, major dep brain injury, and hype. The clinical record for reviewed on 10/9/19 and ARD (assessment Section C of the MDS patterns. In Section C documented that Resident Resid	It that the oxycodone was or discussed the concern using (DON) on 10/16/19 at aid that the doctor on call accement prescription or a ses from the stat box anted to avoid DEA scrutiny. In they would not replace the resident could do without a new prescription to start. The esident showed no signs of provided hand written dated 10/16/19 from two discontacted physician offices ation being unavailable. It failure to make pain with the administrator and discussions on 10/16/19. The dot of follow physician's testoril administration for cluded but were not limited ressive disorder, traumatic rension. Resident # 47 was at 2:27 pm. The most recent set) assessment for quarterly assessment with reference date) of 8/5/19.	F	84			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	1, ,	(X3) DATE SURVEY COMPLETED		
		495143	B. WING_			C 10/18/2019		
	ROVIDER OR SUPPLIER	нав		STREET ADDRESS, CITY, STATE, ZIP 1607 SPRUCE STREET MARTINSVILLE, VA 24112		10/10/2019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED			PROVIDER'S PLAN OF ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 684	Continued From page	e 106	Fé	684				
	of 15, which indicated cognitively intact.	d that Resident # 47 was						
	not limited to, "Clona (milligram) give 0.5 n related to anxiety dis- dinner do not give w/ which was initiated b Resident # 47 also had capsule 7.5 mg give bedtime related to insi- by the physician on 9	ng by mouth two times a day order give 2nd dose with in (within) 5 hours of restoril," by the physician on 9/13/19. ad orders for "Restoril 1 capsule by mouth at somnia, which was initiated						
	the September 2019 record for Resident # that Clonazepam 0.5 administered at 1700 mg was scheduled to (9:00 pm). The surve documented adminis with physician's orde specified that clonaze administered within 5	medication administration 47. The surveyor observed mg was scheduled to be 0 (5:00 pm) and Restoril 7.5 be administered at 2100 eyor observed that the tration times did not comply rs. The physician's orders epam was not to be 6 hours of restoril and the tration times reflected a en administration of						
	director of nursing, a	pm, the administrator, nd regional director of clinical aware of the findings as						
		n regarding this issue was by team prior to the exit 119.				a j j j j j j j		
	4. The facility staff fa	iled to administer Xanax to						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		PLE CONSTRUCTION G	(X	(X3) DATE SURVEY COMPLETED	
		495143	B. WING _			C 10/18/2019	
	ROVIDER OR SUPPLIER	HAB		STREET ADDRESS, CITY, STATE, ZIP CO 1607 SPRUCE STREET MARTINSVILLE, VA 24112	DE	10/10/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	(X5) COMPLETION DATE		
F 684	admitted to the facility included but were no bipolar disorder, and The clinical record for reviewed on 10/9/19 had orders for "Alpraby mouth at bedtime anxiety," which was in 9/18/18. The surveyor 2018 medication adm Resident # 316. The documented on the mecord for the 2100 (\$1 mg tablet for Residobserved documenta administration record nurse's notes." The surveyor reviewer # 316 that had been 8:43 pm. The nurse's as, "Alprazolam table related to generalized from pharmacy MD (in On 10/9/19 at 10:46 at the facility "Stat box I observed that 4 table were available in the 4 tablets equaled the have been administed prevent a missed dos	hysician's orders. a 59-year-old-male who was y on 9/18/18. Diagnoses t limited to, anxiety disorder, major depressive disorder. r Resident # 316 was at 9:38 am. Resident # 316 zolam tablet 1 mg (milligram) related to generalized nitiated by the physician on or reviewed the September ninistration record for surveyor observed a "7" nedication administration 2:00 pm) dose of Alprazolam ent # 316. The surveyor tion on the medication that "7" = "Other/see and a nurse's note to Resident documented on 9/19/18 at a note had been documented at 1 mg by mouth at bedtime dianxiety awaiting arrival medical doctor) is aware." am, the surveyor reviewed isting." The surveyor tist of Alprazolam 0.25 mg facility stat box and that the scheduled dose and could red to Resident # 316 to	F 6	84			
		ere made aware of the	and the second) 	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495143	B. WING			C 10/18/2019
	ROVIDER OR SUPPLIER	НАВ		STREET ADDRESS, CITY, STATE, ZIP COD 1607 SPRUCE STREET MARTINSVILLE, VA 24112)E	10/10/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		COMPLETION DATE	
F 684	agreed that the Alpra retrieved from the sta Resident # 316 to promedication. No further information presented to the sunconference on 10/18. This is a complaint displaying the following diagnost an emia, heart failure depression, manic de Schizophrenia. On the Data Set) with an AR Date) of 7/24/19, cod	ove. The administrative team izolam could have been at box and administerd to event a missed dose of an regarding this issue was vey team prior to the exit v19. If failed to follow psychiatric dation for an increase in the ty medication, Clonazepam. If admitted to the facility with the ses of, but not limited to diabetes, anxiety disorder,	F	684		
	was also coded as re of 1 staff member for hygiene and being to member for bathing. Resident #40 asked during the dates of 10 The surveyor intervier 10/15/19 at 10:30 am resident reported to that she sees for her her anxiety medicatic supposed to be done	score of 15. Resident #40 equiring extensive assistance of dressing and personal stally dependent on 1 staff to speak to the surveyor 0/8/19 through 10/18/19. Even the resident on a in the resident's room. The he surveyor that her doctor psychiatrist issues ordered on to be increased. That was a 2 weeks ago and it has not The resident stated, "				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL1 A. BUILDI		ISTRUCTION		SURVEY PLETED
		495143	B. WING				C /18/2019
	ROVIDER OR SUPPLIER VILLE HEALTH AND RE	НАВ		1607 5	T ADDRESS, CITY, STATE, ZIP CODE SPRUCE STREET FINSVILLE, VA 24112	1 10	110/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	•	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	(name of nurse) commorning and tells me issues in getting her and as soon as they done. She keeps tell but nothing gets done sit in this bed and wo helpless and I feel the to help me. So I lay The staff uses me as to me about everything the new changes in a don't mind because a talk to but then the recover what they tell menot doing this like the makes me think they wants then to do for consistently and I get of this. I just feel held in getting my medica with all of the worries surveyor verbalized to concerns. The reside of this to the surveyor the surveyor perform of Resident #40's clir 10/18/19. During this the following docume practitioner with the psychiatric medical get "8/22/19Pt. rebecause she is trying home for Christmas it trouble participating it anxiety r/t (related to	es by my room each that the pharmacy is having anxiety medication increased resolve the issues, it will be ling me this over and over a about this. All I can do is arry about everything. I feel at I cannot get anything done in here and worry about this. a sounding board and talks and that is going on with all staff that has occurred. I everyone needs someone to est of the time, I think back and I think well if they are every are supposed to then what will do what the doctor me. So I worry about this at myself worked up about all pless and I need some help at that I am having. The othe resident that these avestigated and resident the findings of these ent verbalized understanding	F	684			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
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		495143	B, WING		· · · · · · · · · · · · · · · · · · ·		10/	18/2019
NAME OF PR	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
					1607 SPRUCE STREET			
MARTINS	/ILLE HEALTH AND REF	IAB			MARTINSVILLE, VA 24112			j
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	_	PROVIDER'S PLAN OF CORRECT	ION		ave.
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	LD BE		(X5) COMPLETION DATE
F 684	Continued From page	∍ 110	F	684	4			
	doctor recently decrea	ased her Trazodone						
		p as Not as good at all.						
	·	as anxious" Under						
		Anxiety-Currently stating it						
		ants hers Valium back. I						
	suggested Buspar 5 r	mg TID to start and she was						
	agreeable to this plan							
	" "9/13/19Pt (pa	atient) is reporting that "my						
	nerves are real bad" a	and she cannot relax. She						
	reports that it started	about a week after she met						
		rst time. She is reporting						
		now and that nothing seems						
	to make it better. Say	ys the only thing that has						
1		Nalium. Patient reports						
		all. Patient reports mood as						
		of Medications "8/23/19						
		igram) Tablet TID (three						
		ssment/Plan "Anxiety-Pt						
		s gotten much worse since						
		uspar 2 or 3 weeks ago and						
		ouched it. She reports that						
		was helpful for her in the						
	-	iety worsened 3 weeks to a						
		it in June. She was on						
		ars d/t (due to) her "nerves."						
		to 10 mg PO (by mouth) TID						
		ot improve over next 2						
	·	restating low dose benzo						
		Recommendations: "						
	u ·	10 mg PO TID for anxiety						
	" "0/25/10 "I'm n	not good" Pt is reporting that						
		ad. She has been in bed all			1-1-0			
		her anxiety. She shakes						
		ne dealing with people right						
		s really crabby. Patient						
		good at all. Patient reports			1			
		Review of medication: "			*			
	8/23/19 Buspar (1)							

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495143	8. WING		C 10/18/2019
	PROVIDER OR SUPPLIER SVILLE HEALTH AND RI	EHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112	10/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETI
F 684	Assessment/Plan * has gotten worse si Buspar. Is not work decrease Buspar arWill continue to get the patient believes issue and will readd" Recommendation to 5 mg PO TID x (to 5 mg PO BID (two discontinue) Si BID for anxiety" * "10/9/19Pt vand started it last Filittle but not much a she feels like she is and was wondering increased. Patient all. Patient reports of medication * Tablet TID 8/23/19 El9/25/19 Clonazep Assessment/Plan * / vis about the same. helps just a little bit She is asking for an more frequently. It dose to see if this h control since the parmost pressing issue depression in the furth cannot sleep at all a to her Trazodone. It Trazodone is better but the patient was she thinks it will macan try Trazodone for the commendation * Recommendation * Recommendation *	inAnxiety. Pt states anxiety noe she was started on the start Clonazepam at anxiety under control since that is her most pressing tress depression to the future on only; "Decrease Buspar times) 7 days, then decrease fice a day) x 7 days, and then tart Clonazepam 0.25 mg PO as started on Clonazepam diday. She states it "helps a nd not for long." She states sitting on pins and needles if the medication could be reports sleep as Not good at mood as anxious" Review 5/24/19 Trazodone 0.5 50 mg Buspar (1) 5 mg Tablet BID" Anxiety - Pt states her anxiety She says the Clonazepam but not much and not for long. Increased dose or using it old her we can increase the elpsWill get anxiety under tient believes that this is her and will readdress ture. Insomnia - pt says she at night and wants to go back explained to the patient that for insomnia at a lower dose not buying this so I told her if ke her sleep better than we 00 mg PO WHS (at bedtime)	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		STRUCTION	(X3) DATE SURVEY COMPLETED	
		495143	B. WING_				C 18/2019
NAME OF P	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		
MADTINIO				1607 S	PRUCE STREET		
MAKTINS	VILLE HEALTH AND REI	IAB	- 1	MART	INSVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	÷ 112	F	884			
	for insomnia. Increase PO BID for anxiety The surveyor reviewer (POS) and noted the medications: "Buspar 5 mg Giv times a day start date on The surveyor noted sorders that were the forders dates as follow: "Buspar 5 mg Giv a day related to anxiet for this medication was: "Clonazepam 0.5 two times a day - The medication was 10/3/The surveyor reviewer administration record month of October 20: "Clonazepam Tablet (mouth two times a date 1041 (10:41 am)" To Clonazepam 0.5 mg for this medication was 10/3/The surveyor reviewer administration record mouth two times a date 1041 (10:41 am)" To Clonazepam 0.5 mg for this was noted to be correct dosage of Clobegan to investigate a and the director of nupsychiatric recommendatives and the director of nursing of findings on 10/15/19 and for the surveyor notified director of nursing of findings on 10/15/19 and the director of nursing of findings on 10/15/19 and the director of nursing of findings on 10/15/19 and the director of nursing of findings on 10/15/19 and the director of nursing of findings on 10/15/19 and the director of nursing of findings on 10/15/19 and the director of nursing of findings on 10/15/19 and the director of nursing of findings on 10/15/19 and the director of nursing of findings on 10/15/19 and the director of nursing of findings on 10/15/19 and the director of nursing of findings on 10/15/19 and the director of nursing of findings on 10/15/19 and the director of nursing of findings on 10/15/19 and the director of nursing of findings on 10/15/19 and the director of nursing of findings on 10/15/19 and the director of nursing of findings on 10/15/19 and	the Clonazepam to 0.5 mg and the physician order sheets start date for each of these are 10 mg by mouth three ate of 9/13/19 are Give 0.5 tablet by mouth at a f 5/24/19 applemental physician collowing medications with a series of 9/13/19. The order date as 10/3/19. The order date for this are as 10/3/19. The date for this are as 10/3/19. The surveyor also noted that ablet Give 0.25 mg by y Order date 10/15/19 The surveyor also noted that ablet Give 0.25 mg by y D/C Date 10/15/19 The surveyor also noted that ablet Give 0.25 mg by y D/C Date 10/15/19 The surveyor also noted that ablet Give 0.25 mg by y D/C Date 10/15/19 The surveyor also noted that ablet Give 0.25 mg by y D/C Date 10/15/19 The surveyor also noted that ablet Give 0.25 mg by and the dosage of any was started on 10/15/19. The discontinued and started the anazepam after the surveyor and ask the administrator rising questions about the additions that had occurred		104			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495143	B. WING_			C 0/18/2019	
	ROVIDER OR SUPPLIER	IAB		STREET ADDRESS, CITY, STATE, ZIP CO 1607 SPRUCE STREET MARTINSVILLE, VA 24112		0/10/2019	
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 684	the director of nursing approximately 2 week begun and that she wincidents or recomme The assistant director regional corporate nu (DON) came to the suroom and stated that issue concerning the of Resident #40). This pm. The surveyor as practitioner that was in ordered for a resident or discontinue a medit treat this as a regular practitioner had order ADON stated that group that was contrated the nursing facility) stim August 2019. The Practitioner) would or nurses would treat this order into the commould receive this order sordered for the resident would be need the wanted him to recomme resident would be need the contract of the receive the sordered for the resident would be need the contract of the receive the sordered for the resident would be need the contract of the receive the sordered for the resident would be need the facility and order the medical psychiatric group's remedical director would nurses would order the pharmacy and administration of the process of the process would order the pharmacy and administration of the process would order the pharmacy and administration of the process would order the pharmacy and administration of the process would order the pharmacy and administration of the process would order the pharmacy and administration of the process would order the pharmacy and administration of the process would order the pharmacy and administration of the process would order the pharmacy and administration of the process would order the pharmacy and administration of the process would order the pharmacy and administration of the process would order the pharmacy and administration of the pharmacy and administrat	for the facility until as before this survey had as not aware of these indations for this resident. If of nursing (ADON) and as and director of nursing arveyor in the conference they wanted to discuss the medication for	F6	984			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		495143	B. WING			1	18/2019
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
MADTING	VILLE HEALTH AND REI	LAB		1	607 SPRUCE STREET		
MAKTING	AILLE MEACHN AND KEI	TAB		N	MARTINSVILLE, VA 24112		
(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 APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	recommended for the stated, "I believe that would be an appropri occur." The surveyor period that all of this is Resident #40 to have recommended for her she was verbalizing to practitioner in the about The ADON did not requestion. The ADON The recommended of medications were fax responded and asked and faxed back to him response from the do he stated no new ordshe had called or faxed clarification to this simpractitioner had record Clonazepam due to the increased anxiety that had remained in bed this anxiety she was estated, "The doctor stidin't ask him further for this resident." The surveyor again of documented findings the administrator, directly regional corporate nu No further information surveyor prior to the 6. For Resident #77, assess and treat an agreat toe.	am to have. The ADON 48 hours for this to occur ate time period for this to asked what was the time process occurred for and get the medications r to have for the anxiety that to the psychiatric nurse ove documented findings. spond to the surveyor's responded later and stated, manges in the resident's ed to the doctor. Then he diquestions that I answered in several times. The final actor was on 9/30/19 which eers." The surveyor asked if ed and asked for a lice the psychiatric nurse mended an increase in the resident verbalizing at was to the point that she one whole weekend due to experiencing. The ADON lated no new orders. So I aff he wanted anything else discussed the above on 10/18/19 at 4:15 pm with ector of nursing and the rse.	F	684			
	date of 8/21/14 and a		1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		495143	B. WING			C 10/18/2019	
	ROVIDER OR SUPPLIER	1AB		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112		10,10,2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECT!' CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIAT FICIENCY)		
F 684	5/15/15. The resident diagnoses, which incled a Diabetes Mellitus we have the art Failure. The most recent quart set) with an ARD (assequent	t's diagnosis list indicated uded, but not limited to Type ith Diabetic Neuropathy, ential Hypertension, and terly MDS (minimum data sessment reference date) of resident a BIMS (brief tatus) score of 15 out of 15 e patterns. Resident #77 sing independent in bathing sion only in dressing and esident #77 on 10/10/19 at an, the resident stated her and there is a place on it that black. Resident stated she is month ago and no one ident also stated "the nurses es but they never look at my with LPN #1 on 10/10/19 at an regarding resident's right asked LPN #1 if Resident er right foot, LPN #1 stated reported but she would to an area on the loce.	F	884			
		esident #77 dated 10/10/19					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495143	B. WING			C 10/18/2019	
	ROVIDER OR SUPPLIER	1AB	•	STREET ADDRESS, CITY, STAT 1607 SPRUCE STREET MARTINSVILLE, VA 2411			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION IVE ACTION SHOULD BI CED TO THE APPROPRIA FICIENCY)		
F 684	15:30 written by LPN nurse assessed pt an great toe 0.3 x 0.2 cm c/o of numbness r/t nepedal pulses. NP noto R extremity Surveyor reviewed Restrategity Check" asserecord dated 10/05/15 statement "Skin clear assessed". Surveyor requested a of the facility policy "Swhich stated in part, "complete a total body resident weekly, paying skin tears, bruises, st pressure ulcers, lesionareas and skin turgor the Skin Assessment of the resident's skin of the resid	#1 stating in part, "this id noted black area to R n, skin cool and color wnl. Pt europathy, and noted weak stified and new order for ABI esident #77's "Weekly Skin ssment in the medical which is checked for the no change of condition and was provided with a copy skin Assessment - Weekly" A Licensed Nurse will assessment on each ng particular attention to any asis ulcers, rashes, ns, abrasions, reddened problems. The purpose of is to evaluate the condition on a regular basis". ck of assessment and on Resident #77's right sed with the administrative irector of nursing and inical services) on 10/17/19 ipm.	F6				
	Free of Accident Haza CFR(s): 483.25(d)(1)(§483.25(d) Accidents The facility must ensu	•	F 6	securely on 1 # 13 oxygen of securely on 1	ders were stored 0/8/2019. Resid cylinders were st 0/8/2019. Reside er resides at facil	ored ent	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495143	B. WING		C 10/18/2019	
	ROVIDER OR SUPPLIER	нав	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 689	§483.25(d)(1) The reas free of accident has free of accident has supervision and assist accidents. This REQUIREMENT by: Based on clinical recresident interview and the facility staff failed for 7 of 30 residents aroom in the nursing fa#63, #68, #314, #13. The findings included 1. The facility staff failed for 7 of 30 residents aroom in the nursing fa#63, #68, #314, #13. The findings included in Resident fathe floor and hitting has the floor and hitting has the lift. As a result of experienced pain to the transferred to the emdiagnosed with mech contusion, contusion This is harm. Resident # 9 was a 6 originally admitted to had a readmission daincluded but were not disorder, psychotic didepressive disorder. The clinical record for on 10/10/19 at 11:10 (minimum data set) as	sident environment remains azards as is possible; and esident receives adequate stance devices to prevent. It is not met as evidenced cord review, staff interview, d facility document review, to prevent accident hazards and in (1) oxygen storage acility (Resident #29, #9, and #97). It: illed to ensure that Resident roperly while in the lift, which #9 sliding out of the lift onto her head on the foot rest of the fall, Resident #9 the head and back and was hergency room and was	F 689	Resident # 68 oxygen storage bag tank were securely affixed to the wheelchair on 10/17/2019. Resider and # 9 are safely transfered via lift 6/6/2019. Resident # 97 resides on level 4/18/2019. Resident # 29 cur resides at facility and is free from a from another resident. 2. Residents that reside at facility a risk deficient practice. 3. Re-education was provided by the Director of Nursing to nursing staff proper storage of oxygen cylinders, monitoring residents for aggressive behaviors, reporting signs of aggression immediately, proper storage of lifts, monitoring residents for abnormal wandering patterns and appropriate fall interventions. 4. Audits will be conducted by the End of Nursing or designee for oxygen cylinder storage, signs of aggressive behaviors, proper use of lift, appropriate intervention, and excessive was weekly for 8 weeks. The Director of Nursing will submit findings a report to the Quality Assigned Performance Improvement Committee. The DON is responsible for monitoring and follows. 12/06/2019	ats # 63 con lower rently buse re at ne on roper Director re priate ndering	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495143	B. WING				C 18/2019	
	ROVIDER OR SUPPLIER	HAB		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112				
(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 APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 689	reference date) of 6/1 assesses cognitive pointhe facility staff docur had a BIMS score (bring status) of 11 out of 15 Resident # 9's cognitimpaired. Section Gofunctional status. In Staff documented that dependent on staff reto assist with transfer and revised on 10/10 documented a focus risk for falls related to of falls, decreased mincontinence, require assistance for transfer but were not limited to Move lift with two per The surveyor observe Condition" note that wat 11:55 pm. The note that included but was Called to room by aid floor, resident slide of transfer. Assessment of) mid and lower bac notice resident head lift." The surveyor reviewed discharge instructions 4/1/19. The surveyor the discharge instructions the discharge inst	atterns. In Section C of the MDS atterns. In Section C0500, mented that Resident # 9 rief interview for mental 5, which indicated that ive status was moderately of the MDS assesses Section G0110, the facility of the RDS assesses Section G0110, the facility of the MDS assesses Section G0110, the facility of the Resident was totally equiring two or more persons inc. Resident # 9 was reviewed /19. The facility staff area for Resident # 9 as "At increase of Resident # 9 as "At increase in the resident in the Maxie in the resident in the Maxie in the resident was at all times." The da "SBAR-Change of was documented on 4/1/19 as included documentation in the resident was laying on the reside	F	689				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		495143	B. WING_			C 10/18/2019
	ROVIDER OR SUPPLIER	HAB	,	STREET ADDRESS, 1607 SPRUCE STR MARTINSVILLE,		10/10/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 689	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	e 119 contusion to lumbar hip, and	F6	89		
	the "Fall Investigation 4/1/19. The surveyor the fall investigation to observed a handwritte where 2-3 assists used handwritten check may of Hoyer lift in correct observed a handwritte On 10/10/19 at 2:51 pLPN # 2 (licensed preasked LPN # 2 if she SBAR-Change of Coninvestigation that was Resident #9. LPN # 2 asked LPN # 2 to exphappened with Residinformed the surveyon ursing assistant) had with the lift and the lift at the bottom, which cout of the lift pad onto "She hit her head on back and head pain, a surveyor asked LPN assisted with the lift to 4/1/19. LPN #2 inform	om, the surveyor interviewed actical nurse). The surveyor had documented the ndition note and fall adocumented on 4/1/19 for a stated, "Yes." The surveyor olain the events that ent # 9 on 4/1/19. LPN # 2 or that a CNA (certified dogotten Resident # 9 up to pad was not criss crossed caused Resident # 9 to slide to the floor. LPN # 2 stated, the lift." "She complained of and we sent her out." The # 2 if two staff members had ransfer for Resident # 9 on need the surveyor that the one during the transfer on				

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		495143	B. WING			C 10/18/2019		
	ROVIDER OR SUPPLIER VILLE HEALTH AND RE	НАВ		STREET ADDRESS, CITY, STATE, ZIP COD 1607 SPRUCE STREET MARTINSVILLE, VA 24112				
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PI REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE		
F 689	CNA # 4. The surve provided care for Re 4 stated, "Yes." The describe the events from the lift on 4/1/1 morning they had a used that before." "I girl didn't come back different." "I was und cross." "I started to go On 10/17/19 at 4:52 director of nursing, a clinical services were as stated above. No further information presented to the surconference on 10/18 2. The facility staff fainterventions for fall 314, which led to co fall on 7/3/18 in which transferred to the hor fractured hip and brack admitted to the facili included but were not unsteadiness on feet. The clinical record for reviewed on 10/9/19 MDS (minimum data Resident # 314 was an ARD (assessment)	am, the surveyor interviewed yor asked CNA # 4 if she esident # 9 on 4/1/19. CNA # surveyor asked CNA # 4 to that led to Resident # 9's fall 9. CNA #4 stated, "That different lift pad." "I had never asked for assistance, but the c." "The lift I usually use was aware that you had to criss get her up, and she slid out." am, the administrator, the and the regional director of the made aware of the findings on regarding this issue was vey team prior to the exit	F 68	39				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		4054.40	D. MILLO				2
	<u> </u>	495143	B. WING			10/	18/2019
MARTINSVILLE HEALTH AND REHAB				160	REET ADDRESS, CITY, STATE, ZIP CODE 07 SPRUCE STREET ARTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(ÉACH 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)	_	(X5) COMPLETION DATE
F 689	Tommidde Crom page	e 121 e facility staff documented	F	689			
	that Resident # 314's severely impaired.	· ·					
	general note for Resid	m, the surveyor observed a dent # 314 that had been 6/17 at 6:56 pm. The general					
	note contained documents as not limited to"I	nentation that included but Resident is alert and					
	place or time." "Resid	ly, resident is not oriented to lent is a high fall risk." wetter due to Lasix."					
	at 12:35 pm. The note	vas documented on 10/26/17 e was documented as,					
	CNA assigned to him tear on the right elboy	sitting on the floor by the . He sustained a large skin w and a smaller skin tear on					
	normal saline, triple a	Areas were cleaned with intibiotic ointment applied, rm. Resident tolerated					
		(vital signs) T (temperature) respirations) 18 B/P (blood					
		surveyor observed a focus 14 was initiated by facility					
	environment, use of r initiated on 10/26/19	isk for falls related to: new nedication." Interventions were as follows: "Assess for					
	size, assess need for to have wheelchair lo	heelchair is of appropriate foot rests, assess for need cked/unlocked for safety,					
		nt or personal items or private reacher," "Keep nd free of clutter," "Observe					

AND PLAN OF CORRECTION (2)		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER: A. BUILDING			ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495143	B. WING _			į.	C 18/2019
NAME OF PR	ROVIDER OR SUPPLIER	I		STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 10/	10/2019
MARTINS	/ILLE HEALTH AND RE	HAB			7 SPRUCE STREET RTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 689	for side effects of meto new room and room. The surveyor reviewed Investigation" from Red 10/26/17 that was confall investigation contincluded but was not"3. What is the reside surveyor observed has A&O x1 (alert and ori (Indicate what may his surveyor observed has Confused and got our assistance." The surveyor observed matt beside bed" was The surveyor observed Resident # 314 that he 10/26/19 at 11:04 amd documented as, "MD assessment for ARD date)/14 day: Resident times. However, he express his needs to that in the last two we depression, feeling by trouble concentration total severity score is mental status) score.	dications," and Orientation mmate." and the facility "Fall esident # 314's fall on impleted on 10/27/17. The ained documentation that limited to, dent's cognition? (The andwritten documentation) ented times one), confused. ave caused the incident (The andwritten documentation) to of the bed without and an intervention of "Fall initiated on 10/27/17. and a general note for inad been documented on intervention. The general note was S (minimum data set) (assessment reference in the salert and oriented at experiences episodes of it well. Resident needs for and completed ADLs in intervention. He is able to the staff. Resident stated beeks he has experienced and about himself, and on watching television. The 06. BIMS (brief interview for is 02."		689			
	· ·	vas documented on 12/12/17					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	DING			(X3) DATE SURVEY COMPLETED	
		495143	B. WING				C 18/2019	
	ROVIDER OR SUPPLIER VILLE HEALTH AND REI	HAB		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(EA	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD E SS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 689	at 10:35 am. The note "MDS assessment fo Resident was in bed worker) entered the roriented. He is able to staff. Resident has she memory problems. Rinterview. During the sated that he has exp weeks depression, truitiredness, feeling bac concentrating on react Total severity score is BIMS of 05." The surveyor observed Resident # 314 that vat 11:28 am, the note "Resident has a fall tham. He was attemption unattended and fell in noted to right elbow a (medical doctor) order elbow, neuro checks unsupervised fall. Rewithheld) notified of in The surveyor reviewed Investigation from R 12/14/17 that was co fall investigation contincluded but was not "3. What is the resident was the resident passistance required."	e was documented as, r ARD/Medicare 60 day: resting when SW (social com. Resident was alert and coexpress his needs to the nort term and long term esident agreed to do the mood interview, resident cerienced in the last two couble falling asleep, about himself, and trouble ding/watching television. So 05. Resident received a labout himself on 12/14/17 was documented on 12/14/17 was documented as, his am (morning) @ (at) 7:30 high to toilet himself on the bathroom, skin tear and c/o pain, notified MD are given for xray of right in place due to a responsible party) (name incident."	F	889				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER: A. BUILDING		ULTIPLE CONSTRUCTION LDING			(X3) DATE SURVEY COMPLETED	
		495143	B. WING			1	C /18/2019	
NAME OF PE	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	10/	10/2019	
MARTINS	VILLE HEALTH AND REF	HAB			607 SPRUCE STREET MARTINSVILLE, VA 24112			
(X4) ID PREFIX TAG				x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 689	(Handwritten) correct Indicate what may ha (handwritten) Reside had one shoe on and toilet self unattended. The surveyor noted the added to the plan of the 12/14/17 as "Ensure when he is up ambulated to the plan of the surveyor observed Resident # 314 that wat 9:22 am. The note "Resident calling out resident's room. Resident's room air the doo noted on the fitted shright elbow. A nickel shis outer left wrist and size of a nickel was not blood on it. Rsd (rethe bed but he has maway from his bed. Rewithin normal limits) (room air). Daughter withheld) was called the facility matter. Tx (treatment order to left wrist and (tolerated) well. Residus chair. No c/o (con Resident's MD was monitor.	as implemented after the fall? It footwear ave caused the incident int states he doesn't know he It one shoe off attempting to " that an intervention was care for Resident # 314 on Resident has on both shoes ating." ed a nurse's note that for was documented on 12/31/17 was documented as, for help and staff rushed to ident was found sitting is with his feet up against or. Scant amount of blood heet to his bed and on his size skin tear was noted to d a scabbed area about the hoted to have a scant amount esident) stated he fell out of hemory loss and he was far ROM WNL (range of motion witals 132/100-56-18-97% RA of resident (daughter's name and a message was left for in regards to a non-urgent th) rendered per standing I wright elbow and tol dent assisted by two staff to inplaints of) pain at this time. hotified. Will continue to	F	689				
	The surveyor reviews	ed the facility "Fall						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER: A. BUILDING		TIPLE CONSTRUCTION NG	(X	(X3) DATE SURVEY COMPLETED	
		495143	B. WING _			C 10/18/2019	
	ROVIDER OR SUPPLIER	IAB		STREET ADDRESS, CITY, STATE, 2 1607 SPRUCE STREET MARTINSVILLE, VA 24112	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X (EACH CORRECTIVE CROSS-REFERENCED		(X5) COMPLETION DATE	
F 689	Investigation" from Re 12/31/17 that was confall investigation containcluded but was not"3. What is the resid (Handwritten) Alert wi 12. Was the call bell i mark beside) YES Can resident use it? (beside) NO (handwrit What intervention was (Handwritten) nonskid slipping Indicate what may had (handwritten) ambula. The surveyor noted the added to the plan of confusion of 12/31/17 as "Footwest" Encourage resident in needed" on 1/1/18. The surveyor observed documented on 4/12/10 that was noted shedroom door, stated scooted to the door, copain to left back, notif x-ray to back. Encourassistance when he reminded resident of The surveyor reviewed Investigation" from Re 4/12/18 that was come	esident # 314's fall on impleted on 12/31/17. The ained documentation that limited to, dent's cognition? With confusion in place (handwritten check it Handwritten check mark it ten) Resident confused is implemented after the fall? It footwear given to prevent we caused the incident it ting unassisted." In at an intervention was eare for Resident # 314 on ar to prevent slipping," and to call for assistance when it is all the nurse's did as, Resident is alert with ears washed out today, an hear some better, withing on the floor at the fell in the bathroom and denies hitting his head, c/o ited MD, family MD ordered age resident to ask for needs to go to the bathroom, urinal at his bedside."	F6	689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIP IDENTIFICATION NUMBER: A. BUILDING) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		495143	B. WING_			C 10/18/2019		
	ROVIDER OR SUPPLIER VILLE HEALTH AND REH	IAB		STREET ADDRESS, CITY, STATE, ZIP CO 1607 SPRUCE STREET MARTINSVILLE, VA 24112	DE			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BI HE APPROPRIA		(X5) COMPLETION DATE	
F 689	included but was not"3. What is the resid (Handwritten) Alert, c What intervention wa (Handwritten) encour-assessed and placed Indicate what may ha (handwritten) tired an himself." The surveyor noted the added to the plan of containing the surveyor observed Resident # 314 that wat 11:17 am. The note "Resident was found tub in resident's bathrattempting to use the backwards. Resident to the back of head. In Neuro checks in place spoke with (daughter Resident resting in be light in reach. Will continue to the surveyor reviewed Investigation on tained included but was not"3. What is the reside (Handwritten) confused wassessed, placed in the surveyor medical assessed, placed in the surveyor medical assessed.	limited to, dent's cognition? confusion implemented after the fall? age resident to use call light distance between the incident distance and intervention was care for Resident # 314 on the resident to utilize call and an urse's note for the was documented on 5/18/18 as was documented as, by nursing staff in the bath froom. Resident was bathroom and fell had small blanchable area for c/o pain from resident. The common the common that the side of the facility "Fall desident # 314's fall on the pleted on 5/18/18. The fall and documentation that dimited to, dent's cognition?	F 6	89				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPL IDENTIFICATION NUMBER: A. BUILDING			NSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495143	B. WING_				C 10/18/2019	
	ROVIDER OR SUPPLIER	НАВ		1607	ET ADDRESS, CITY, STATE, ZIP CODE SPRUCE STREET TINSVILLE, VA 24112		10/10/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION DATE	
F 689	Continued From page (handwritten) unstead		F	89				
	The surveyor noted to	hat an intervention was care for Resident # 314 on						
	Condition note for Re documented on 6/27/ was documented as, bathroom and hit hea	ed a SBAR-Change of sident # 314 that was 118 at 6:59 am. The note "Situation: Resident fell in ad on wall Background: of hearing Assessment:						
	Resident has skinned tear on right hand, re Response: Sending r	d up head on back and skin sident is awake and alert resident to ER (emergency e sure everything is ok. MD						
	6/27/18/18 that was of fall investigation cont included but was not "3. What is the resid (Handwritten) confusion what intervention was (Handwritten) educated	esident # 314's fall on completed on 6/27/18. The ained documentation that limited to, dent's cognition? ed/alert s implemented after the fall? ion live caused the incident						
	The surveyor noted the added to the plan of 66/28/18 as "Educate with toileting during e The surveyor observe Condition note for Re	hat an intervention was care for Resident # 314 on resident to ask for assist early morning hours." ed a SBAR-Change of esident # 314 that was 8 at 9:50 pm. The note was						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) M IDENTIFICATION NUMBER: A. BUI		IPLE CO	(X3) DATE SURVEY COMPLETED			
		495143	B. WING			1	C /18/2019	
	ROVIDER OR SUPPLIER	НАВ	,	STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 689	documented as, "Sit floor in room Backgr systolic and diastolic unsteadiness on fee hyperplasia without chronic kidney diseawithout behavioral dhypertension, chron disease Assessmen Resident is very hardry. Noted to have seyebrow, laceration right elbow. Also c/orotated outward and movement and touc PEARL (pupils equa Response: (Physicia order to send to ER name withheld) notifimedical services) not The surveyor observed that was docur to (name withheld) refacility name withheld) refacility name withheld) restingation from that was completed investigation contain included but was no"3. What is the rest (Handwritten) alert reward without the rest (Handwritten) sent to the formal without the rest (Handwritten) sent to the rest of the rest (Handwritten) sent to the rest of t	uation: Found resident on round: unspecified combined or congestive heart failure, it, benign prostatic lower urinary tract symptoms, ise, vascular dementia isturbance, essential ic obstructive pulmonary it: Resident alert, yelling out. d of hearing. Skin warm and imall hematoma above left to right forehead, skin tear to iright hip/leg pain, right leg shortened. C/O pain upon the VS 97.4, 57, 20, 164/82, all and reactive to light) an's name withheld) new for eval. RP (daughter's fied. EMS (emergency offied." Inved a nurse's not for Resident imented on 7/4/18 at 3:03 am. Inented as, "Called ER spoke esident is being transferred to held) with DX (diagnosis) right in bleed. DON (director of light) are decident # 314's fall on 7/3/18 on 7/4/18. The fall need documentation that the limited to, sident's cognition? normally confused as implemented after the fall?	F	589				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	DING			(X3) DATE SURVEY COMPLETED		
		495143	B. WING				C 10/18/2019		
	ROVIDER OR SUPPLIER VILLE HEALTH AND RE	EHAB	STREET ADDRESS, CITY, STATE, ZIP COD 1607 SPRUCE STREET MARTINSVILLE, VA 24112		SPRUCE STREET	·			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE		
F 689	(handwritten) reside and sleepy and lost On 10/10/19 at 1:15 MDS coordinator respecifically nurse's for Resident # 314. of the falls and interfalls with the MDS cothe MDS coordinated documentation that status was severely often ambulated unagait. After review of clinical record the Mthe interventions imfollowing falls were cognitive status and On 10/17/19 at 4:54 director of nursing, a services were information opportunity to ask quaditional information. No further information opportunity to the surconference on 10/18. This is a complaint of 3. The facility staff falls was appropriated a transfer, which respected to the surconference on 10/18. Resident # 63 was appropriated a transfer, which respected to the surconference on 10/18.	nt was ambulating while tired balance." pm, the surveyor and the viewed the clinical record for notes, MDS, and plan of care The surveyor reviewed each ventions put in place after the coordinator. The surveyor and r also reviewed Resident # 314's cognitive impaired; Resident # 314 assisted with an unsteady the documentation in the IDS coordinator agreed that plemented for Resident # 314 not appropriate due to his level of confusion. pm, the administrator, and regional director of clinical ned of the incident as stated trative team was provided the uestions and provide in.	F	689					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER: A. BUILDING			RUCTION	(X3) DATE SURVEY COMPLETED	
		495143	8. WING			C 10/18/2019	
	ROVIDER OR SUPPLIER	HAB		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112			1072010
(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)		(X5) COMPLETION DATE
F 689	Continued From page	e 130	F	889			
		ate of 7/2/19. Diagnoses t limited to, paraplegia, and					
	recent MDS (minimur Resident # 63 was a an ARD (assessment Section C of the MDS patterns. In Section C documented that Resinterview for mental swhich indicated that Fintact. Section G of the status. In Section G of transfer status. The fire Resident # 63 was to assistance of two or remainded that Fintact in the fire plan of care for Find revised on 9/3/13 documented a focus "At risk for falls relate Dx's (diagnoses) of compelinating polyne paraplegia, and due to Interventions included "Transfer using the Hippersons assisting," and fall 6/5/19." The surveyor observed Resident # 63 that has 6/5/19 at 3:06 pm. The documented as, "Residor during transport overturning. She was	at 9:46 am. The most in data set) assessment for quarterly assessment with reference date) of 8/21/19. Sassesses cognitive 20:500, the facility staff sident # 63 had a BIMS (brief status) score of 15 out of 15, Resident #63 was cognitively ne MDS assesses functional 110, line B assessed acility staff documented that stally dependent requiring the more persons for transfers. Resident # 63 was reviewed 9. The facility staff area for Resident # 63 as, d to: Use of medication, hronic inflammatory suropathy, morbid obesity, so fear of falling." It but were not limited to, over lift w/at least 2-staff and "Education provided after and been documented on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION NG	((X3) DATE SURVEY COMPLETED	
		495143	B. WING			C 10/18/2019	
	ROVIDER OR SUPPLIER	IAB		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIAT		
F 689	the room. Resident w while the CNAs were of nursing) and unit m incident. Statements the situation." On 10/10/19 at 3:30 pto see the facility inversion of the floor. On 10/15/19 at 11:04 a hand written statement director of nursing on documented as, "Had withheld) concerning the floor. Had CNAs at the rapy, administration that as they went to not tilted and they has to re-inactment revealed Resident # 63's weigh had her feet on one so the other side which coside that had her upp On 10/16/19 at 10:32 interviewed CNA # 2. 2 if she was providing 6/5/19 when she was 2 stated, "Yes." The so describe the events the ing lowered to the were getting her out of the side was provided to the were getting her out of the side was provided to the were getting her out of the side was provided to the were getting her out of the side was provided to the were getting her out of the side was provided to the were getting her out of the side was provided to the were getting her out of the side was provided to the was getting her out of the side was provided to the was getting her out of the side was provided to the was getting her out of the side was provided to the was getting her out of the side was provided to the was getting her out of the side was provided to the was getting her out of the side was provided to the was getting her out of the side was provided to the was getting her out of the side was provided to	as still on part of the bed holding her. DON (director transper came to witness the will be written in regards to the will be written in regards to the part of the incident on the singular of the incident on the singular of the incident on the sident # 63 being lowered the sident # 63 being lowered the sident was written by the 6/5/19. The statement was a continued the transfer with the sident incompact of the sident was the sident with the sident was the sident with the sident was the sident was the sident with the sident was the sident wa	F	689			
	On 10/17/19 at 4:54 p	om, the surveyor reviewed ngs of Resident # 63's fall on					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDII		(X3) DATE SURVEY COMPLETED				
			495143	B. WING _				C 18/2019
	PROVIDER OR SU		1AB		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112			10/20/3
(X4) I PREF TAG	X (EAC)	H DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	•	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 6	And regional No further is team prior of tea	the admir al director of the exit ity staff fainder was 68's whee 68 was a dmitted to mission dat were no pulmonar record for 10/17/19 (minimum 68 was a D (assess ection C of atterns. In mented that interview of indicated intact. See interview of intact. See interview of interview of intact. See interview of intact. See interview of interview of intact. See interview of interview of intact. See interview of intact. Se	inistrator, director of nursing, of clinical services. In was provided to the survey conference to 10/18/19. Iled to ensure that a portable properly secured on elichair. 62-year-old-male who was the facility on 3/18/19, and ate of 10/8/19. Diagnoses tilmited to, chronic y disorder and shortness of at 2:52 pm. The most in data set) assessment for quarterly review assessment ment reference date) of the MDS assesses Section C0500, the facility to the Resident # 68 had a BIMS for mental status) of 15 out that Resident # 68 was cition O of the MDS assesses recedures, and programs. In accility staff documented that ceived oxygen therapy is during the look back	F	589			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	0	(X3) DATE SURVEY COMPLETED		
		495143	B. WING			C 10/18/2019		
	ROVIDER OR SUPPLIER	HAB		STREET ADDRESS, CITY, STATE, 1607 SPRUCE STREET MARTINSVILLE, VA 24112	ZIP CODE	10/10/2013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE O TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE		
F 689	On 10/9/19 at 11:25 a Resident # 68 sitting i wheelchair. The surve oxygen cylinder that w back of Resident # 68 observed that the bot holder that held the or secured to the wheeld On 10/17/19 at 2:52 p Resident # 68 sitting i room. The surveyor or cylinder held in a blact of Resident # 68's wh observed that the bot holder were not secure The manufacturer's in (wheelchair) Oxygen documentation that in to,"Application Instruct 1. Place the oxygen 2. With the cylinder backrest, hang the to handles and secure the wheelchair frame. 3. To secure and pot holder, tighten all four On 10/17/19 at 4:52 p director of nursing, an services were made a stated above. On 10/18/19 at 12:02 informed the surveyor team had reviewed the	in, the surveyor observed in the hallway in his ayor observed a portable was in a nylon holder on the its wheelchair. The surveyor tom straps of the nylon aygen cylinder were not chair frame. In, the surveyor observed in his wheelchair in his bserved a portable oxygen as a portable oxygen as a portable oxygen as the nylon holder on the back eelchair. The surveyor tom straps of the nylon ared to the wheelchair frame. In the structions for "W/C Tank Holder" contained actuded but was not limited attions: In cylinder in the sleeve. If a cylinder in the sleeve. If a cylinder in the push the bottom straps to the postraps on the push the bottom straps to the assistion the oxygen tank are straps as desired." In the administrator, and regional director of clinical aware of the findings as a pm, the director of nursing a that the administrative the oxygen tank holder for a reed that the straps were	F	589				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495143	B. WING_			C 10/18/2019		
	ROVIDER OR SUPPLIER	1AB		STREET ADDRESS, CITY, STATE, ZII 1607 SPRUCE STREET MARTINSVILLE, VA 24112	CODE	10/10/2013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN (K (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIA			
F 689	Resident # 68. No further information presented to the surviconference on 10/18/5. The facility staff Resident #29 was free resident that resided. Resident #29 was reason and the facility staff Resident #29 was reason and the facility staff Resident #29 was reason and the facility of	regarding this issue was ey team prior to the exit 19. failed to ensure that e from abuse from another in the nursing facility. admitted to the facility on wing diagnoses of, but not pressure, anxiety disorder, dipsychotic disorder. On the num Data Set) with an ARD face Date) of 7/19/19, the shaving a BIMS (Brief Status) score of 15 out of a Resident #29 was also prervision of 1 staff member onal hygiene and requiring of the bathing activity from 1 cord review from 10/8/19 e surveyor noted the ion in the nursing notes (7:33 pm) Situation: Writer m by aide; resident sitting in Aide states resident had an er resident.		389				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495143	B. WING				С	
NAME OF P	ROVIDER OR SUPPLIER	100110			PERFECT ADDRESS CITY OFFEET AND CODE	11	0/18/2019	
I I I I I I I I I I I I I I I I I I I	NOTIDEN ON GOFFEIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
MARTINS	VILLE HEALTH AND REI	HAB			1607 SPRUCE STREET			
			MARTINSVILLE, VA 24112		MARTINSVILLE, VA 24112			
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO		(X5)	
PREFIX TAG	-	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE	
					DEFICIENCY)			
			TV.		1			
F 689	Continued From page	e 135	F	689	Q			
		hat he doesn't have to come	•	-				
		rmed needs to go to the						
	magistrates office to							
		(name of resident).						
		her daughter and she came						
	_	out to go to the Office						
		:27 pm) Resident stated her						
		where the other resident						
		Resident reported she is						
		d charges against the other						
	resident"	a onargos agamot tro otro						
		ed the care plan for Resident						
		was documented in the						
,	care plan:	, mad addamonida in the						
		netimes have behaviors						
		nding my showers at shift						
		first resident showered.						
	Demanding staff to st							
	_	howers. Making false					1	
1	-	staff. Reporting missing						
		nissing. Trying to sneak and						
	take showers unassis							
	Interventions:							
Ţ	Attempt interventions	before my behaviors begin.						
4	" Explained to resi	ident she cannot always be						
	first, but will try to get	her showered ASAP (as						
	soon as possible)							
	" Give me my med	dications as my doctor has						
	ordered							
	" Help me to avoi	d situations or people that						
	are upsetting to me							
		know if I my behaviors are						
	interfering with my da							
		not in pain or uncomfortable						
		ing I like as diversion						
	" Please refer to n	ny psychologist/psychiatrist						
	as needed							
		hat you are going to do						
	before you begin							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	IPLE CONSTRUCTION	(X:	(X3) DATE SURVEY COMPLETED	
		495143	B. WING _			C 10/18/2019	
	ROVIDER OR SUPPLIER	IAB		STREET ADDRESS, CITY, STATE 1607 SPRUCE STREET MARTINSVILLE, VA 24112	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE D TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE	
F 689	"Speak to me unh" The surveyor noted the focus and interventions with a revision date of interventions noted by resident-to-resident at on 9/8/19. The surveyor also not Protective Order" date which named Resident victim was to have not resident involved in the expired on 9/11/19 at the surveyor asked Resident involved in the surveyor what had have resident on 9/8/19 that obtaining an Emerger another resident that altercation that had on #29 stated, " (note the altercation on 9 were in the dining root out of my head. It was pulled out by the root involved in altercation set together in the dinone day she started so not nice and then she things about her son. started. But after she me names, the staff of were told that I would Magistrate's office to	ne date documented for the as were initiated on 3/3/14 ff 1/16/17. There were no yethe surveyor after the litercation that had occurred ted an "Emergency ed for 9/8/19 at 8:10 pm in at #29 as being the alleged contact with the other ne altercation. The order 11:59 pm. Inviewed Resident #29 in the 10/15/19 at 11:20 am. The lent #29 if she could tell the appened with another at resulted in this resident may Protective Order against was involved in an occurred on 9/8/19. Resident ham of the resident involved (18/19) came over while we am and pulled a lot of my hair as a handful of hair and so in an occurred on 9/8/19. Resident has a handful of hair and so in an order friends and we have friends and we have friends and we have friends and we have accused me of saying I really don't know how it apulled my hair and called the police and they	F	589			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1''	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495143	B. WING				C /18/2019	
	ROVIDER OR SUPPLIER	IAB		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EA	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD SS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE	
F 689	away from me but I si hallway where my roo things to me as she p stopped and told her down that hallway wh member being with he hallway from time to to the surveyor asked to the facility. The resides She (referring to reside could come in my roo she could smother moutting a pillow over it because since Friday sitting with her all the happened on Friday surveyor stated that sedocumentation in the about the details of air resident stated, "I had vanilla ice cream. The resident involved in a you get it your damn toward me and an aid wheelchair before she then she has had to he the time and she has room. The surveyor noted the time and go be telephoned the sherif 10/12/19 21:32 (9:32)	ive Order for her to keep ill saw her coming down the om is and she would say assed my room, but they that she could not come ere I was without a staff er. I still saw her down the ime without anyone with her. The resident if she felt safe in ent stated, "I really don't. Ident involved in altercation) in, she is a big woman, and is by sitting on my face or it. But I feel better now it, she has had a staff person time. Did you hear what at supper time?" The inhe had read the inurses' notes for Friday nother altercation. The if asked an aide for some en (name of other latercation) said, "Why don't is self." She came full force le stopped her and the exact a sitter be with her all had to eat her meals in her interesident during meal Resident asked to come out ack to room. This resident	F	889				

	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495143	B. WING _			C 0/18/2019	
	ROVIDER OR SUPPLIER	НАВ		STREET ADDRESS, CITY, STATE, ZIP COE 1607 SPRUCE STREET MARTINSVILLE, VA 24112		0/10/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
F 689	Continued From page	e 138	F 6	89			
	(name of medic made aware of the in orders)." The surveyor intervie 10/18/19 at approxim room. The surveyor between Resident #2 10/12/19. The admir resident was not vert Resident #29). They room with (naisiting at one table ar sitting at another table Resident #29). Since had a sitter with in altercation with Reher until we can reso (name of Resident #2 other resident). We determine the interval of the inter	alled her daughter anyway. Ital doctor) on callwas cident with NNO (no new wed the administrator on lately 1 pm in the conference asked about the altercation and another resident on listrator stated that another lately nice to (name of listrator stated that another lately nice to (name of listrator stated that another lately nice to (name of listrator stated that another lately nice to (name of listrator stated that another lately nice to (name of listrator stated that another lately nice to (name of listrator stated that another lately nice to (name of listrator stated that another lately nice to (name of listrator stated that another lately nice to (name of listrator stated that another listrator stated that another lately nice to (name of listrator st					
	6. For Resident #13 the environment rem hazards by securing resident's room.	n was provided to the exit conference on 10/18/19. facility staff failed to ensure nained free of accident oxygen tanks stored in the mitted to the facility on					
	2/23/12. Diagnoses in pulmonary disease, of difficulty walking, che schizoaffective disordialure, hypertension, obesity. On the quar	included chronic obstructive cutaneous abscess of back, est pain, depression, angina, der, lymphedema, heart type 2 diabetes, and morbid terly Minimum Data Set essment reference date					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED			
		495143	B. WING _			C 10/18/2019		
	ROVIDER OR SUPPLIER	1AB		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112				
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 689	9/23/19, the resident interview for mental s without signs of deliri affecting others. The using oxygen in the 1 assessment. During initial tour on two unsecured full ox stands in the resident tanks stood in the flor conditioning unit and The resident was in the enough to the bed that the resident if the resident received prevent accidents by non-ambulatory residents. Resident #97 was ad 4/6/18. Diagnoses in behavioral disturbance, repeated falls deficits and spatial nesubarachnoid hemoral Alzheimer's disease, depression, and psychinimum Data Set as reference date 8/21/1	scored 10/15 on the brief status and was assessed as um, psychosis, or behaviors resident was assessed as 4 days prior to the 10/8/19, surveyors observed ygen tanks without rack or it's room. The full oxygen or between the resident's air the resident's wheelchair, sed and the tanks were close at they could be bumped by ident chose to sit with legs a of the bed facing the director of nursing were in during a summary meeting PM. If a cility staff failed to ensure adequate supervision to ensuring the ent did not have access to mitted to the facility on cluded dementia with a contractures of hips and attention and concentration eglect following thage dysphagia, hypertension, major shosis. On the quarterly sesssment with assessment	F	389				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495143	B. WING _				10/2040	
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO	DE	10/	18/2019	
MARTINS	/ILLE HEALTH AND RE	HAB		1607 SPRUCE STREET MARTINSVILLE, VA 24112				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BI		(X5) COMPLETION DATE	
F 689	daily decision making delirium, psychosis, or the resident was assextensive assistance transfer, supervision nursing unit in a where assistance of one per wheelchair off the unit of the assistance of one per wheelchair off the unit of the transfer, supervision nursing unit in a where assistance of one per wheelchair off the unit of the transfer of the unit of the stair of the bottom of the stair of the bottom of the stair of the fall, the resident of the fall, the resident of the surveyor ware unit of the surveyor were undependent resident of the surveyor ware undependent resident of the surveyor was unable to offer a explained that the resident of the facifalling down stairs. The resident was unabout the incident.	impaired cognitive skills for and as without signs of or behaviors affecting care. Sessed as requiring of 2 or more persons for for locomotion on the elchair, and extensive rson for locomotion in a sit. Incident (FRI) dated 4/14/19 To was found on the floor at rewell near the laundry area. Sessed in Emergency rened to the facility. Prior to was ambulatory with ag, and seeking exit. After was moved to a ground level and was placed.	F6	89				
	9. Facility staff failed	to ensure the environment						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	S	IDENTIFICATION NUMBER:		JULTIPLE CONSTRUCTION			SURVEY LETED
		495143	B. WING_			C 10/18/2019	
NAME OF PROVIDER OR SU		нав		STREET ADDRESS, 1607 SPRUCE STR MARTINSVILLE,		101	10,2010
PREFIX (EACH	DEFICIENC	TATEMENT OF DEFICIENCIES THE MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRECTION I CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
partially dep stored free-creating a partially dep stored free-creating a partially the oxygen empty oxyg. There were and empty is surveyor mark while to the duration of the feet of the compression of the feet of the compression of the feet o	ee of accolleted oxystanding sotential file at 4:56 P storage ren tanks open spaportable coved the survey 9 at 3:45 e administ of the sugement 3.25(k) Pain Manmust ensive pridents' go IREMEN' bbservation incolor pain material pain materia	ident hazards by when agen storage tanks were in the oxygen storage room are hazard. I'M, the surveyor inspected from the room contained 6 standing loose in the floor. The room contained 6 standing loose in the storage from the empty tank rack from the empty tanks to the storage for was present. I'M during a summary strator and director of nursing afety concern. No oxygen to be improperly stored for arvey.	F6	97 1. Resider medicatio 2. Resider are at risk 3. Director re-educate to properly medicatio of discrep monitoring 4. Audits of Director of discrepan Medicatio pain for 4	ant #103 received replace on on 6/4/2019. The prescribed pain medical for the deficient practice of Nursing or designees and log and notify the DON prancies and general for increased pain. The provided by the of Nursing or designee for increased pain. The Donard increases in respect to the Quality it a report to the Quality	ication e. rocess d I/ADON r	

NAME OF PROVIDER OR SUPPLIER MARTINSVILLE HEALTH AND REHAB STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 697 Continued From page 142 F 697 Continued From page 142 Resident #103 was admitted to the facility on 3/30/16. Diagnoses included malignant carcinoid tumor of the rectum, major depression, low back pain, diabetes mellitus type 2 with ophthalmic		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
MARTINSVILLE HEALTH AND REHAB (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 697 Continued From page 142 F 697 Continued From page 142 F 697 Resident #103 was admitted to the facility on 3/30/16. Diagnoses included malignant carcinoid tumor of the rectum, major depression, low back STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) AND PREFIX TAG PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) AND PREFIX TAG PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) AND PREFIX TAG PREFIX TAG PROVIDER'S PRUCE STREET MARTINSVILLE, VA 24112 PROVIDER'S PRUCE STREET MARTINSVILLE, VA 24112 PROVIDER'S PRUCE STREET MARTINSVILLE, VA 24112 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112 PREFIX TAG PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112 PREFIX TAG PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG STREET ADDRESS, CITY, STATE ARTICLE STATE MARTINSVILLE, VA 24112 PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG STREET ADDRESS, CITY AS A STATE TO THE APPROPRIATE DEFICIENCY TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			495143	B. WING			_	
F 697 Continued From page 142 The findings included: Resident #103 was admitted to the facility on 3/30/16. Diagnoses included malignant carcinoid tumor of the rectum, major depression, low back PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PREFIX CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PREFIX			НАВ		1607 SPRUCE STREET		10/2013	
Committee. The DON is responsible for monitoring and follow-up. Resident #103 was admitted to the facility on 3/30/16. Diagnoses included malignant carcinoid tumor of the rectum, major depression, low back Committee. The DON is responsible for monitoring and follow-up. 5. 12/06/2019	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	COMPLETION	
complications, chronic pain, difficulty in walking, traumatic amputation of right lower leg, hypertension, anxiety, nicotine dependence, chronic obstructive pulmonary disease, and bipolar disorder. On the 14 day Minimum Data Set assessment with assessment reference date 9/23/19, the resident scored 15/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behavior affecting care. The resident was assessed as receiving scheduled pain medication and non-medication interventions for pain daily in the 5 days prior to the assessment. The resident reported being in pain almost constantly in the 5 days prior to the assessment and that the pain made it difficult to sleep. Pain intensity was assessed as 8/10. The Office of Licensure and Certification received a Facility Reported Incident (FRI) dated 6/4/19 concerning misappropriation of the resident's oxycodone. The FRI investigation revealed the nurse was unable to fill the order for oxycodone on 6/4/19. The facility was unable to discover what happened to the missing 15-16 doses of the medication. Medication administration notes for a physician order dated 9/28/18 for "Oxycodone Hcl 15 mg tablet give 1 tablet by mouth four times a day for pain "do not change dose unless Blue Ridge Pain Management Associates is contacted" were as	F 697	The findings included Resident #103 was a 3/30/16. Diagnoses it tumor of the rectum, pain, diabetes mellitu complications, chronit traumatic amputation hypertension, anxiety chronic obstructive pubipolar disorder. On the Set assessment with 9/23/19, the resident interview for mental swithout signs of delirical affecting care. The receiving scheduled phonemedication interview for mental swithout signs of delirical affecting care. The receiving scheduled phonemedication interview for mental swithout signs of delirical affecting care. The receiving scheduled phonemedication interview for mental swithout signs of delirical affecting care. The receiving scheduled phonemedication in the following scheduled phonemedication to the set of the set	dmitted to the facility on included malignant carcinoid major depression, low back is type 2 with ophthalmic ic pain, difficulty in walking, of right lower leg, or, nicotine dependence, ulmonary disease, and the 14 day Minimum Data assessment reference date scored 15/15 on the brief status and was assessed as um, psychosis, or behavior esident was assessed as pain medication and ventions for pain daily in the sessment. The resident in almost constantly in the 5 essment and that the pain ep. Pain intensity was an additional for the resident's investigation revealed the fill the order for oxycodone y was unable to discover a missing 15-16 doses of the ation notes for a physician for "Oxycodone Hcl 15 mg or mouth four times a day for dose unless Blue Ridge Pain	F 697	Committee. The DON is responsible for monitoring			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION IG	-	(X3) DATE SURVEY COMPLETED		
		495143	B. WING_			C 10/18/2019		
	ROVIDER OR SUPPLIER	НАВ		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112				
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F 697	follows: 6/1/19 00:48 nursing arrival 6/1/19 09:43 nursing arrivalcoded 2=ref 6/1/19 12:38 nursing arrival 6/1/19 17:28 nursing arrival 6/1/19 20:29 nursing arrivalcoded 2=ref 6/2/19 08:59 nursing arrival 6/2/19 12:16 nursing arrival 6/2/19 12:16 nursing arrival 6/2/19 16:40 nursing arrival 6/2/19 21:03 nursing arrival 6/3/19 20:35 nursing arrival 6/3/19 20:35 nursing arrival 6/3/19 09:34 nursing arrival 6/3/19 for 09:00 and MAR and no nursing status	note awaiting pharmacy note awaiting pharmacy used note awaiting pharmacy note awaiting pharmacy	F6		<u>a</u>			
	consecutive doses of assessments associtive either 'X' or blat assessment at 21:00 the medication admits a second assessment at 21:00 the medication admits a second assessment at 21:00 the medication at 21:00 the 21:00 the medication at 21:00 the	f oxycodone. The pain ated with those 14 doses nk except for the 6/2) was documented as '0' on						
		DON) on 10/16/19 at 8:44		1 1 1 1 1 1 1				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A BUILDIN		PLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495143	B. WING_	B. WING		C 10/18/2019	
	ROVIDER OR SUPPLIER VILLE HEALTH AND REI	HAB		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PR REGULATORY OR LSC IDENTIFYING INFORMATION) T			PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
F 697	AM. The DON said to not write a replacement prescription to pull do because the doctor with Pain clinic said to the prescription and to the drug until time for The DON stated the withdrawal. The DON employee statements LPNs stating they had concerning the medical with surveyors and to During that meeting, that some of the residues not give them the Surveyors discussed medication was availant DON during individialysis	that the doctor on call would ent prescription or a sees from the stat box vanted to avoid DEA scrutiny. The resident could do without a new prescription to start. The sident showed no signs of a provided hand written a dated 10/16/19 from two docontacted physician offices eation being unavailable. The medical director met alked about several issues. The medical director stated dents dislike him because he are pills they want.	F			12/06/2019	
	require dialysis receive with professional star comprehensive personal the residents' goals at This REQUIREMENT by: Based clinical record the facility staff failed complete communications.	ure that residents who we such services, consistent adards of practice, the on-centered care plan, and and preferences. The is not met as evidenced are review and staff interview, to ensure adequate and tion between the nursing is facility for 1 of 30 residents		completion on 10/17/2019 2. Residents receiving dia for deficient practice. 3. Re-education was provided birector of Nursing or designed nursing staff related and obtaining a completed communication sheet from provider. 4. Audit will be completed of Nursing or designee to the state of the s	ded by the ignee to the ted to completing dialysis in the dialysis by the Director	g	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		JILTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495143	B. WING			C 10/18/2019	
	ROVIDER OR SUPPLIER VILLE HEALTH AND RE	НАВ		STREET ADDRESS, CITY, STATE, ZIP COD 1607 SPRUCE STREET MARTINSVILLE, VA 24112		10/10/2013	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 698	in the survey sample The findings included The facility staff failed complete communicate facility and the dialys Resident #68 was re 9/14/19 and discharg had the following dia anemia, heart failure diabetes, dementia a quarterly MDS (Minir (Assessment Referencesident was coded a Interview for Mental spossible score of 15. coded as requiring stor dressing, personal assistance of 1 staff During the clinical reading the surveyor communication Form The surveyor noted the information that the document before and center portion was not communicate back to dialysis or any medicinesident while receiving and the region above documented find approximately 2 pm.	d to ensure adequate and ation between the nursing is facility for Resident #68. admitted to the facility on god on 10/6/19. The resident gnoses of, but not limited to high blood pressure, and depression. On the num Data Set) with an ARD noce Date) of 8/23/19, the as having a BIMS (Brief Status) score of 15 out of a Resident #68 was also supervision of 1 staff member all hygiene and limited member for bathing. cord review on 10/16/19 at or reviewed the "Dialysis on" from 9/3/19 to 10/15/19, that the communication is out completely with either the facility was supposed to diafter dialysis or the dialysis of completely filled out to the facility aspects of sations that were given to the	F 69	communication sheets corrected. The audit finding submitted to the Quality As Performance Improvemen The DON is responsible for monitoring and follow up. 5. 12/06/2019	ngs will be ssurance and t Committee.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION AND ADOD		JLTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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NAME OF B	DOWNER OR OURDUIED	455145			10/18	/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
MARTINS	VILLE HEALTH AND REA	AB	'	1607 SPRUCE STREET			
				MARTINSVILLE, VA 24112			
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE C	(X5) COMPLETION DATE	
F 698		e 146 exit conference on 10/18/19.	F 698				
F 726			F 726				
	/ i		F /20	1. Nurses and CNAs providing car	e to 1	12/06/2019	
SS=D	OFN(8). 403.33(a)(3)	(4)(6)		residents # 9 and # 63 completed			
	\$402.25 Nurning Con	dana.		,	tanaisa		
	§483.35 Nursing Sen	sufficient nursing staff with		mechanical lift training and compe			
		etencies and skills sets to		2. Audit of employee personnel file	-	i	
		elated services to assure		completed by the Director of Nursi	ng to		
		tain or maintain the highest		ensure competencies/ lift training			
		mental, and psychosocial		of nursing staff are completed.			
		sident, as determined by	:	3. Re-education was provided by	the		
		and individual plans of care					
	and considering the n			Director of Nursing or designee or		ľ	
	_	ity's resident population in		mechanical lift transfers and clinic	al		
		acility assessment required		competencies.			
	at §483.70(e).	dollary descention required		4. The Director of Nursing or design audits new employee personnel file.			
	§483.35(a)(3) The fac	cility must ensure that		completed orientation competence			
		the specific competencies					
		ary to care for residents'		within the first 30 days of employn			
	needs, as identified th			weekly for 8 weeks. The Director of	of		
		scribed in the plan of care.		Nursing will submit findings to the	Quality		
		,		Assurance Committee. The Admir	•		
	§483.35(a)(4) Providi	ng care includes but is not	1	is responsible for monitoring and f			
		evaluating, planning and		5. 12/06/2019	Silow up.		
	implementing residen	t care plans and responding		5. 12/06/2019			
	to resident's needs.						
			*				
	§483.35(c) Proficienc	·					
	_	ure that nurse aides are able	1				
	to demonstrate comp	•					
		to care for residents'					
	needs, as identified th						
		scribed in the plan of care.			1		
		is not met as evidenced			-		
	by:				-		
	Based on clinical rec						
	interview, the facility s	staff failed to assure that					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	HAB		STREET ADDRESS, CITY, STATE, ZIP COI 1607 SPRUCE STREET MARTINSVILLE, VA 24112		0/18/2019	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 726	Continued From page	e 147	F 7	26			
	nursing staff had the and skill sets to provi services to assure re-	appropriate competencies de nursing and related sident safety for two of 30 by sample, Resident #9 and					
	The findings included	:		-			
	that nursing staff had competencies related following falls from the and Resident # 63. Resident # 9 was origon 1/27/11. Resident readmission date of 9 but were not limited to	I to safety with the Hoyer lift e Hoyer lift for Resident # 9 ginally admitted to the facility					
	on 10/10/19 at 11:10 (minimum data set) a change assessment or reference date) of 6/1 assesses cognitive the facility staff document data BIMS score (broatatus) of 11 out of 15 Resident # 9's cogniti impaired. Section Go functional status. In Staff documented that dependent on staff reto assist with transfer	Section G0110, the facility t Resident was totally equiring two or more persons es. Resident # 9 was reviewed					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		()	(X3) DATE SURVEY COMPLETED		
		495143	B. WING _			C 10/18/2019		
	ROVIDER OR SUPPLIER VILLE HEALTH AND RE	НАВ		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112				
(X4) ID PREFIX TAG	((EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE		ID PREFI) TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	ULD BE COMPLETION		
F 726	risk for falls related to falls, decreased mincontinence, require assistance for transful but were not limited. Move lift with two per On 10/11/19 at 9:19 CNA # 4. The survey provided care for Refundamental that the survey provided that before." If girl didn't come back different. "I was una cross." If started to girl didn't come back different. "I was una cross." If started to girl didn't come back different. "I was una cross." If started to girl didn't come back different. "I was una cross." If started to girl didn't come back different. "I was una cross." If started to girl didn't come back different. "I was una cross." If started to girl didn't come back different. "I was una cross." If started to girl didn't come back different. "I was una cross." If started to girl didn't come back different. "I was una cross." If started to girl didn't come back different. "I was una cross." If started to girl didn't come back different. "I was una cross." If started to girl didn't come back different. "I was una cross." If started to girl didn't come back different. "I was una cross." If started to girl didn't come back different. "I was una cross." If started to girl didn't come back different. "I was una cross." I started to girl didn't come back different. "I was una cross." I started to girl didn't come back different. "I was una cross." I started to girl didn't come back different. "I was una cross." I started to girl didn't come back different. "I was una cross." "I started to girl didn't come back different." "I was una cross." "I started to girl didn't come back different." "I was una cross." "I started to girl didn't come back different." "I was una cross." "I started to girl didn't come back different." "I was una cross." "I started to girl didn't come back different." "I wa	area for Resident # 9 as "At or Use of medication, history hobility, bladder/bowel as maxi lift w(with)/staff ers." Interventions included to, "Transfer using the Maxie rson assistance at all times." am, the surveyor interviewed yor asked CNA # 4 if she sident # 9 on 4/1/19. CNA # surveyor asked CNA # 4 to that led to Resident # 4's fall 9. CNA #4 stated, "That different lift pad." "I had never asked for assistance, but the the transfer using the was aware that you had to criss get her up, and she slid out." 47-year-old-female that was be the facility on 3/22/18, and ate of 7/2/19. Diagnoses of limited to, paraplegia, and or Resident # 63 was 9 at 9:46 am. The most am data set) assessment with the reference date) of 8/21/19. S assesses cognitive CO500, the facility staff sident # 63 had a BIMS (brief status) score of 15 out of 15, Resident #63 was cognitively he MDS assesses functional 2010, line B assessed facility staff documented that	F7	726				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
7		495143	B. WING			C 0/18/2019	
	PROVIDER OR SUPPLIER	НАВ	160	REET ADDRESS, CITY, STATE, ZIP CODE 07 SPRUCE STREET ARTINSVILLE, VA 24112		0/10/2013	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 726	Resident # 63 was to assistance of two or The plan of care for and revised on 9/3/1 documented a focus "At risk for falls related Dx's (diagnoses) of demyelinating polyne paraplegia, and due Interventions include "Transfer using the Epersons assisting," a fall 6/5/19." The surveyor observe Resident # 63 that he 6/5/19 at 3:06 pm. The documented as, "Refloor during transport overturning. She was There were 3 CNAs the room. Resident while the CNAs were of nursing) and unit resident. Statements the situation." On 10/15/19 at 11:04 a hand written statent director of nursing or documented as, "Hawithheld) concerning the floor. Has CNAs therapy, administration that as they went to relinate the reveale in the situation of the situa	otally dependent requiring the more persons for transfers. Resident # 63 was reviewed 9. The facility staff area for Resident # 63 as, and to: Use of medication, chronic inflammatory europathy, morbid obesity, to fear of falling." d but were not limited to, Hoyer lift w/at least 2-staff and "Education provided after ed a nurse's note for ad been documented on	F 726				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIP IDENTIFICATION NUMBER: A. BUILDING		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495143 B. WING			C 10/18/2019	
	ROVIDER OR SUPPLIER VILLE HEALTH AND REH	1AB		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 726	had her feet on one s the other side which of side that had her upport On 10/16/19 at 10:32 interviewed CNA # 2. 2 if she was providing 6/6/19 when she was 2 stated, "Yes." The s describe the events the being lowered to the f were getting her out of chair." "They didn't ha and the lift tilted, so w The surveyor asked of trained to use the lift, been, but not with per On 10/16/19 at 4:15 p director of nursing we incidents as stated ab requested to see door that the CNA involved Resident # 9 sliding fr CNAs involved in the Resident # 63 being le properly trained on sa Hoyer lift prior to the i The facility staff failed for the CNAs involved involved Resident # 9 Resident # 63 being le further information reg further information reg	ide and her upper body on caused the lift to tilt to the er body on it." am, the surveyor The surveyor asked CNA # g care to Resident # 63 on lowered to the floor. CNA # surveyor asked CNA # 2 to nat led to Resident # 63 floor. CNA # 2 stated, "We of bed and putting her in the ave her positioned properly, we lowered her to the floor." CNA # 2 if she had been CNA # 2 if she had been CNA # 2 stated, "I have ople that are her size." om, the administrator and are made aware of the pove and the surveyor numentation of competencies in the incident with rom the lift and the three incident which led to owered to the floor, were afe transfers while using the incident. It to produce competencies in the incidents that of alling from the lift and owered to the floor. No garding this issue was ey team prior to the exit	F 7:	26		
F 740 SS=D		rvices	F 74	1. Resident #9 was seen by Deer Behavioral Health Services on 11/	1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495143	B. WING	B. WING		C	
NAME OF PROVIDER OR SUPPLIER MARTINSVILLE HEALTH AND REHAB		AAB	-, I	16	TREET ADDRESS, CITY, STATE, ZIP CODE 507 SPRUCE STREET ARTINSVILLE, VA 24112		18/2019
PRÉFIX (EACH DE	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	_	(X5) COMPLETION DATE
Each resident provide the ne services to att practicable ph well-being, in a assessment a encompasses mental well-be limited to, the and substance This REQUIRI by: Based on resclinical record complaint inversare that the sample receives services to ma well-being, Resident # 63 The findings in 1. The facilit # 9 had a follo services in a till Resident # 9 von 1/27/11, with Diagnoses incomplaint inversarial properties of the clinical record to the control of the clinical record to the control of the clinical record to the	evioral himust recessary ain or no sysical, accordant plan a residence of a residence of a set behaviorate of a set behaviorate of a resident a resident a resident a resident a resident a realuded be disorder.	ealth services. eceive and the facility must y behavioral health care and naintain the highest mental, and psychosocial ance with the comprehensive of care. Behavioral health ent's whole emotional and nich includes, but is not tion and treatment of mental sorders. is not met as evidenced terview, staff interview, and during the course of a in, the facility staff failed to 0 residents in the survey avioral health care and the highest practicable 4 9, Resident # 17, and failed to ensure that Resident sit with behavioral health	F	740	Resident # 17 was seen by Deer O Behavioral Health Services on 11/6/ Resident # 63 was seen by Deer O Behavior Health Services on 11/6/2 2. Residents requiring Behavior heservices are at risk for this deficient practice. 3. Re-education was provided to the nursing staff by the DON or designe ensure residents receive behavior health services and follow up visits ordered. 4. Audits will be completed by the Director of Nursing or designee to expect the services as ordered weekly for 8	aks 2019. akth e ee to as ensure alth eeks. findings	

PRINTED: 11/26/2019 FORM APPROVED

OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495143 B. WING 10/18/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1607 SPRUCE STREET MARTINSVILLE HEALTH AND REHAB** MARTINSVILLE, VA 24112 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION DATE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 152 F 740 ARD (assessment reference date) of 6/17/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 9 had a BIMS score (brief interview for mental status) of 11 out of 15, which indicated that Resident # 9's cognitive status was moderately impaired. Resident # 9 had current orders that included but were not limited to, "Deer Oaks may provide psychological services and/or med management associates may provide psychiatric services," which was initiated by the physician on 2/12/19. The plan of care for Resident # 9 was reviewed and revised on 10/10/19. The facility staff documented a focus area for Resident # 9 as, "I sometimes have behaviors which include Hx (history) of suicidal words such as "I want to kill myself." Interventions included but were not limited to, "Please refer me to my psychologist/psychiatrist as needed." On 10/17/19 at 3:23 pm, the surveyor observed a "Psychiatric Initial Assessment" in the clinical record for Resident # 9. The surveyor observed documentation on the psychiatric initial assessment form that included but was not limited to ... "Future Visits: Revisit in 2 weeks." ... On 10/17/19 at 4:00 pm, the surveyor interviewed the assistant director of nursing. The surveyor asked the assistant director of nursing why Resident # 9 had not been see by the behavioral health provider when the consult stated that Resident # 9 was to be revisited in 2 weeks and now 3 weeks and 3 days later Resident # 9 still had not seen the behavioral health provider. The

assistant director of nursing informed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUIL		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495143	B. WING_		[,	C 10/18/2019	
	ROVIDER OR SUPPLIER	НАВ	•	STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112		10/10/2013	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF COI X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 740	surveyor that the behable to see all of the and if he is unable to in he will see the resi when he visits the factor of nursing agreed that been seen in 2 weeks psychiatric initial assorting to make a seen in 2 weeks psychiatric initial assorting to make a seen in 2 weeks psychological Structure of Comparts of Savailable a profession following psychological Comake available clinic psychological service Medicare Part B (or of Provider)," On 10/17/19 at 4:54 provided to form the surve services were made stated above. No further information provided to the surve conference on 10/18/12. The facility staff # 17 received behavior Resident # 17 was or facility on 11/24/09, a of 12/4/10. Diagnose	avioral health provider is not residents when he comes in see the resident when he is dent on the following week cility. The assistant director at Resident # 9 should have as as documented on the essment. Services Agreement" included included but was not limited Services. Provider will make had clinician to perform the had services: consultations. Provider will all staff to provide on-site as to residents covered by other insurance accepted by other insurance accepted by the insurance accepted by the findings as an aregarding this issue was by team prior to the exit oral health services. In regarding this issue was by team prior to the exit oral health services. In regarding this issue was by team prior to the exit oral health services.		740			

PRINTED: 11/26/2019 FORM APPROVED

OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING _ С 495143 B. WING 10/18/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1607 SPRUCE STREET** MARTINSVILLE HEALTH AND REHAB MARTINSVILLE, VA 24112 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 740 Continued From page 154 F 740 reviewed on 10/9/19 at 11:49 am. The most recent MDS (minimum data set) assessment for Resident # 17 was a quarterly assessment with an ARD (assessment reference date) of 6/28/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 17 had a BIMS score (brief interview for mental status) of 13 out of 15, which indicated that Resident # 17 was cognitively intact. Resident # 17 had current orders that included but were not limited to, "Deer Oaks may provide psychological services and/or med management associates may provide psychiatric services." which was initiated by the physician on 2/11/19. The current plan of care for Resident # 17 was reviewed and revised on 10/4/19. The facility staff documented a focus area for Resident # 17 as, "Potential for drug related complications associated with use of psychotropic medications related to: Anti-depressant medication." Interventions included but were not limited to. "Refer to psychologist/psychiatrist for medication and behavior intervention recommendations PRN (as needed)." On 10/15/19 at 10:44 am, the surveyor observed a "Med Management Note" from the previous behavioral health provider that was dated 11/1/18 in the clinical record for Resident # 17. The surveyor observed documentation on the med management not that included but was not limited to ... "Next Follow up Date: 11/30/2018." ... The surveyor reviewed the clinical record further and did not locate any additional documentation that reflected that Resident # 17 had received behavioral health services since 11/1/18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	495143	B, WING			C	
NAME OF PROVIDER OR SUPPLIER MARTINSVILLE HEALTH AND REH			STREET ADDRESS, CITY, STATE, ZIP COD 1607 SPRUCE STREET MARTINSVILLE, VA 24112	· · · · · · · · · · · · · · · · · · ·	0/18/2019	
PREFIX (EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
director of nursing we surveyor did not locate clinical record for Res behavioral health serve since 11/1/18. The surveyor had seen Resadministrative team if provider had seen Resadministrator stated si report to the survey te On 10/17/19 at 2:37 p provided the surveyor Resident # 17 had not behavioral health provided health served on 10/17/19 at 4:52 p director of nursing, an services were made a stated above. No further information presented to the surveyor conference on 10/18/13. The facility staff for # 63 had a follow up we services in a timely made in a diagnose included be bipolar disorder, anxied depressive disorder. The clinical record for reviewed on 10/10/19	m, the administrator and re informed that the e any documentation in the sident # 17 that reflected that vices had been provided received asked the the new behavior health sident # 17. The the would look into it and the sam. In the director of nursing with information that the been seen by the new vider and had not received vices since 11/1/18. In the administrator, and regional director of clinical aware of the findings as a regarding this issue was every team prior to the exit 19. ailled to ensure that Resident visit with behavioral health anner. Iginally admitted to the facility a readmission date of 7/2/19. Let were not limited to, ety disorder, and major	F 7	40			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495143	8. WING			С	
NAME OF PROVIDER OR SUPPLIER MARTINSVILLE HEALTH AND REHA		нав	-	STREET ADDRESS, CITY, STATE, ZIP 1607 SPRUCE STREET MARTINSVILLE, VA 24112	CODE	10/18/2019	
(X4) ID PREFIX TAG			ID PREF TAG		THE APPROPRIA		
F 740	an ARD (assessment Section C of the MDS patterns. In Section C documented that Resinterview for mental s which indicated that Fintact. Resident # 63 had cubut were not limited to psychological service associates may proviwhich was initiated by On 10/10/19 at 1:37 p. Resident # 63's room interview. Resident # stated, "I just wanna gasked Resident # 63 health services at the informed the surveyor something for her depit stopped. Resident # that she had talked to ago and has not talke surveyor asked Resident # 60 no 10/17/19 at 2:34 p. "Psychiatric Initial Asservices. Resident # 10 no 10/17/19 at 2:34 p. "Psychiatric Initial Asservices in The psychiatric initial documentation that in to"Future visits Resurveyor reviewed the surveyor reviewed the	quarterly assessment with reference date) of 8/21/19. Sassesses cognitive c0500, the facility staff sident # 63 had a BIMS (brief tatus) score of 15 out of 15, Resident #63 was cognitively be rent orders that included on "Deer Oaks may provide and/or med management de psychiatric services," by the physician on 2/12/19. The surveyor was in conducting a resident 63 became tearful and go home." The surveyor if she received behavioral facility. Resident #63 or that the facility was doing pression but all of a sudden, as for a person a couple weeks of to anyone since. The lent # 63 if she wanted to m behavioral health 63 stated, "Yes." The surveyor observed a sessment" in the clinical 63 that was dated 9/18/19. assessment contained cluded but was not limited visit in 2 weeks." The eclinical record further and	F	740			
	to"Future visits Re surveyor reviewed the did not locate any doo	visit in 2 weeks." The					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495143	B. WING		C 10/18/2019	
	ROVIDER OR SUPPLIER VILLE HEALTH AND REH	НАВ		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112	10/10/2013	
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 740	services since 9/18/19 On 10/17/19 at 4:00 p the assistant director asked the assistant d Resident # 63 had no health provider when Resident # 63 was to now 4 later Resident b behavioral health provident behavioral health provident the residents when he unable to see the resi see the resident on th visits the facility. The	om, the surveyor interviewed of nursing. The surveyor irector of nursing why ot been see by the behavioral the consult stated that be revisited in 2 weeks and # 63 still had not seen the vider. The assistant director ne surveyor that the vider is not able to see all of e comes in and if he is ident when he is in he will ne following week when he assistant director of nursing # 63 should have been ocumented on the	F 7-	40		
F 744 SS=D	services were made a stated above. No further information provided to the survey conference on 10/18/ This is a complaint de Treatment/Service for CFR(s): 483.40(b)(3) A residuagnosed with demeappropriate treatment	nd regional director of clinical aware of the findings as in regarding this issue was by team prior to the exit 19. efficiency. In Dementia ent who displays or is not and services the it and services to attain or ghest practicable physical,	F 74	 Resident # 58 Care Plan was revito include treatment and services for dementia care. Resident # 11 Care was revised to include resident cerdementia care. Residents with diagnosis of demare at risk for deficient practice. 	or Plan itered	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE (A. BUILDING		CONSTRUCTION		LETED			
		495143	B. WING _			10/	C 18/2019
	ROVIDER OR SUPPLIER VILLE HEALTH AND REI	НАВ		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112			16/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE	
F 744	by: Based on clinical recinterview, the facility residents in the survey and services for dem and #11) The findings included 1. The facility staff #58 received treatmed care. There was no president's Demential a staff to compare to whas a staff to compare to whas essed or reasses sudden change or worthe resident's condition. Resident #58 was ad following diagnoses of blood pressure, Alzhed depression and psychologour pression and presonate the resident as having Mental Status) score of 15. Resident #58 extensive assistance dressing and personal puring the clinical recomprehensive care #58. The surveyor maseline for the facility the resident was exported worsening of the resident was exported worsening of the resident was exported.	ris not met as evidenced cord review and staff staff failed to ensure 2 of 30 by sample received treatment entia care. (Resident #58 I: failed to ensure Resident ent and services for dementia progression rate of the and Alzheimer's disease for then the resident was est to know if there was a prsening from the baseline of on. mitted to the facility with the of, but not limited to high eimer's disease, dementia, thotic disorder. On the num Data Set) with an ARD noce Date) of 8/14/19 coded g a BIMS (Brief Interview for of 8 out of a possible score was also coded as requiring of 1 staff member for al hygiene.	F7	744	3. Re-education was provided by the Administrator to the interdisciplinar for residents with a dementia diagrensure a resident centered demendance plans are in place. 4. Audits will be completed by the of Nursing or designee to ensure movement a diagnosis have a recentered dementia care plan week weeks. The Director of Nursing was submit findings to the Quality Assuand Performance Improvement Control The DON is responsible for monitoring and follow up. 5. 12/06/2019	ry team nosis to tia care Director esidents sident tly for vill urance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING		ļ	(X3) DATE SURVEY COMPLETED	
l <u></u>		495143	B. WING_			C 10/18/2019	
	ROVIDER OR SUPPLIER VILLE HEALTH AND REF	нав		STREET ADDRESS, CITY, STATE, ZIP 1607 SPRUCE STREET MARTINSVILLE, VA 24112	CODE		
(X4) ID PREFIX TAG			ID PREFII TAG	,	CTION SHOULD BE THE APPROPRIAT	1	
F 744	The surveyor notified nursing and the regio above documented fit approximately 2 pm. of these findings, they any information to the findings. No further information surveyor prior to the 2. The facility staff fair care for Resident # 11 dementia care to enswell-being. Resident # 11 was on facility on 7/11/17, wit 11/29/17. Diagnoses to, dementia, anxiety, disorders. The clinical record for reviewed on 10/9/19 arecent MDS assessm quarterly assessment Section C of the MDS patterns. In Section C documented that Resident # 11 had According to the care Section V0200, the fasses the section V0200, the fasses the section V0200, the fasses and section V0200, the fasses are section V0200.	the resident's condition. If the administrator, director of conal corporate nurse of the indings on 10/18/19 at After this group was notified by did not verbalize or provide the exit conference on 10/18/19. Illed to ensure that the plan of 1 included resident centered sure the highest practicable or included but were not limited to the exit a readmission date of included but were not limited to psychosis, and delusional or Resident # 11 was at 11:57 am. The most ment for Resident # 11 was at twith an ARD of 8/26/19. Sassesses cognitive control of the ental status of 15 out of 15, Resident # 11 was cognitively and an ARD of 3/20/19. Sa area assessments in accility staff documented that the mentia would be addressed.		744			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING		(X3) DATE SURVEY COMPLETED	
		495143	B. WING_		C 40/49/2049	
	ROVIDER OR SUPPLIER	НАВ		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112	10/18/2019	
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 744	The current plan of careviewed and revised staff documented a form as "Impaired neurolog seizure disorder, demobserve any documented for Resident # 11 that needs and support or interventions to manawith dementia. On 10/15/19 at 11:32 the plan of care for Resident # 17 centered dementia care for Resident # 17 centered dementia care terred interventions associated with demential contered interventions associated with demential contents as stated about the form of the survey of the facility must provide	are for Resident # 11 was on 10/11/19. The facility ocus area for Resident # 11 gical status related to tentia." The surveyor did not intation on the plan of care included dementia care person centered ge behaviors associated am, the surveyor reviewed esident # 11 with the MDS e agreed that the plan of I did not include person are needs or person is to manage behaviors entia. am, the administrator and re made aware of the ove. a regarding this issue was every team prior to the exit 19. aredures/Pharmacist/Records 1)-(3) ervices de routine and emergency to its residents, or obtain ment described in ity may permit unlicensed	F 75	44	ility s are at	
	director of nursing we findings as stated about the survice conference on 10/18/Pharmacy Srvcs/Proc CFR(s): 483.45(a)(b)(§483.45 Pharmacy Set facility must providrugs and biologicals them under an agreer §483.70(g). The facility personnel to administration	re made aware of the ove. regarding this issue was ey team prior to the exit 19. redures/Pharmacist/Records 1)-(3) ervices ide routine and emergency to its residents, or obtain ment described in ity may permit unlicensed er drugs if State law	F 75	 Resident # 47 received medicat 9/27/2019. Residents who reside at the fact that receive prescribed medication risk for this deficient practice. 	illity s are at	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	5.5		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495143	B. WING _			C 10/18/2019	
NAME OF P	ROVIDER OR SUPPLIER	 .		ST	REET ADDRESS, CITY, STATE, ZIP CODE	107	10/2019
					07 SPRUCE STREET		
MARTINS	/ILLE HEALTH AND REH	IAB		M	ARTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 755	§483.45(a) Procedure pharmaceutical service that assure the accura dispensing, and administration biologicals) to meet the \$483.45(b) Service Comust employ or obtain pharmacist whospharmacist whospharmacist whospharmacist whospharmacist of the provision the facility. §483.45(b)(1) Provide aspects of the provision the facility. §483.45(b)(2) Establist receipt and disposition sufficient detail to enareconciliation; and sufficient detail to enareconciliation; and sufficient data and per This REQUIREMENT by: Based on clinical receipt and facility document to ensure that medical of 30 Residents in the 47. The findings included The facility staff failed was available for admit 47.	es. A facility must provide the concluding procedures attended and including procedures attended and including procedures and including of all drugs and included and included and including and inclu	F 7	555	Audits will be conducted by the Director of Nursing or designee of medication carts to ensure medica are available weekly for 8 weeks. 4. The Director of Nursing will subfindings to the Quality Assurance a Performance Improvement Committee DON is responsible for monitor and follow up. 5. 12/06/2019	mit and ttee.	
	5/11/17. Diagnoses in	cluded but were not limited ressive disorder, traumatic		- Andrews			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU (DENTIFICATION NUMBER: A. BUIL		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495143	B. WING_			C 10/18/2019	
	ROVIDER OR SUPPLIER	НАВ	•	STREET ADDRESS, CITY, STATE, ZIP COO 1607 SPRUCE STREET MARTINSVILLE, VA 24112	Æ	10/10/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 755	MDS (minimum data Resident # 47 was a an ARD (assessment Section C of the MDS patterns. In Section C documented that Resident # 47 had or 15, which indicated cognitively intact. Resident # 47 had or not limited to, "Clonal (milligram) give 0.5 m related to anxiety discidinner do not give w/ which was initiated by which was initiated by the current plan of conceive well and revised documented a focus "Potential for drug relassociated with the cumedications." Interversimited to, "Medication and evaluate for effect on 10/10/19 at 2:52 the September 2019 record for Resident # a "7" documented on administration record	ertension. r Resident # 47 was at 2:27 pm. The most recent set) assessment for quarterly assessment with the reference date) of 8/5/19. Sassesses cognitive 20500, the facility staff sident # 47 had a BIMS for mental status) of 15 out did that Resident # 47 was ders that included but was repart tablet 0.5 mg mg by mouth two times a day porder give 2nd dose with in (within) 5 hours of restoril," by the physician on 9/13/19. The physician on 9/13/19. The facility staff area for Resident # 47 was at a on 9/9/19. The facility staff area for Resident # 47 as, at at a complications se of psychotropic of anti-anxiety medication, cation, hypnotic intions included but was not in as a ordered by physician ctiveness."	F7	55			
		6/19. According to the chart					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495143	B. WING _			C 10/18/2019	
	ROVIDER OR SUPPLIER	1AB		STREET ADDRESS, CITY, STATE, ZIP COD 1607 SPRUCE STREET MARTINSVILLE, VA 24112		10/10/2013	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 755	codes listed on the marecord, "7" means "of The surveyor reviewed Resident # 47. The structure and the nurse's note was ""Clonazepam tablet mg by mouth two time disorder give 2nd dos w/n (within) 5 hours of pharmacy notified." The surveyor observed documented on 9/26/note was documented mg (milligram) give 0 day related to anxiety dinner do not give w/n to be sent." The surveyor observed documented on 9/26/note was documented mg (milligram) give 0 day related to anxiety dinner do not give w/n md and pharm aware On 10/10/19 at 3:54 g director of nursing we findings as stated above. No further information	edication administration her/see nurses notes." ad the nurse's notes for curveyor observed a nurse's ented on 9/25/19 at 5:55pm. adocumented as, 0.5 mg (milligram) give 0.5 as a day related to anxiety se with dinner do not give if restoril unavailable ad a nurse's note that was 19 at 9:11 am. The nurse's das, "Clonazepam tablet 0.5 5 mg by mouth two times a disorder give 2nd dose with in (within) 5 hours of restoril ad a nurse's note that was 19 at 4:27 pm. The nurse's das, "Clonazepam tablet 0.5 5 mg by mouth two times a disorder give 2nd dose with in (within) 5 hours of restoril	F 7	55			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495143	B. WING			C /18/2019
	ROVIDER OR SUPPLIER VILLE HEALTH AND REM	1AB		STREET ADDRESS, CITY, STATE, ZIP CODE 1807 SPRUCE STREET MARTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 756 SS=D	CFR(s): 483.45(c)(1)(1)(1)(1)(2)(1)(2)(1)(2)(2)(1)(1)(2)(2)(1)(1)(2)(2)(1)(2)(2)(1)(2)(2)(2)(1)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)	imen Review. Ing regimen of each resident east once a month by a series once a month by a series of each review ical chart. In armacist must report any tending physician and the ctor and director of nursing, set be acted upon. In the acted upon is to each of the pharmacist is to each of the pharmacist is to edocumented on a cort that is sent to the individual of nursing and lists, at a cort in the relevant drug, it is name, the relevant drug, it is pharmacist identified. In it is cord that the identified reviewed and what, if any, in to address it. If there is to medication, the attending ument his or her rationale in	F 756	1. Resident # 88 pharmacy recommendation was completed 11/6/2019. 2. An audit was completed of the pharmacy recommendations for 30 days to ensure recommendate addressed. 3. Re-education was conducted Director of Nursing or designee of licensed nursing staff to ensure recommendations are completed 4. Audits will be completed by the of Nursing or designee of pharm ensure recommendations continus completed timely monthly for 2 of The Director of Nursing will submit findings to the Quality Assurance Performance Improvement Commendations up. 5. 12/06/2019	the last ions were by the o oharmacy f. e Director acy to ue to be months. hit a e and mittee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	2.2 (0.000)	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
		495143	B. WING			l '	2
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1607 SPRUCE STREET MARTINSVILLE, VA 24112	DDE	<u> 10/</u>	18/2019
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE OF CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE OF CORRECTION OF CORRE			(X5) COMPLETION DATE
F 756	This REQUIREMENT by: Based on clinical recinterview, the facility spharmacy recommentimely manner for one survey sample, Resident sample, Resi	is not met as evidenced ord review, and staff staff failed to ensure that a dation was acted upon in a e of 30 Residents in the lent # 88. It to act upon a pharmacy timely manner for Resident Imitted to the facility on acluded but were not limited with behavioral disturbance, Resident # 88 was at 11:28 am. The most an data set) assessment for quarterly assessment with reference date) of 9/10/19. assesses hearing speech B0700, the facility staff ident # 88 was rarely or am, the surveyor observed dation in the clinical record ted 9/25/19. The pharmacy tained documentation that limited to," The resident inxiolytic clonazepam 1 mg uth) qhs (every hour of clease evaluate the current dose reduction." The	F	756			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495143	B. WING _			C /18/2019
NAME OF PROVIDER OF		1AB		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112		10,2019
	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTI (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		OULD BE	(X5) COMPLETION DATE		
recomme there we recomme rounds. (licenses LPN # not been pharmal by the percommen 10/9/19 not get on 10/9/19 recommen psych of the provided deficier. No furth provided conference of F 773 Lab Sn SS=D CFR(s) §483.5 (i) Proviorderect practition of the provided conference	as a handwritt nendation that "The surveyor do practical nual why the pha in addressed. It is a surveyor doctor didn't accepted to all of the rewind to all of the rewind to all of the rewind the total of the surveyor of of the	not been addressed and ten note on the pharmacy stated, "Place on psych or interviewed LPN # 1 rse). The surveyor asked rmacy recommendation had LPN # 1 stated that the dation would be addressed when he came in on the next or asked LPN # 1 why the ddress the pharmacy le he was in the facility on led that the psych doctor did sidents while in the facility Resident #17's pharmacy led be addressed by the lek. The administrator and leave made aware of the delay pharmacy recommendation in the administrative team was an interview to ask questions and formation in response to the stated above. The regarding this issue was by team prior to the exit [19]. Order/Notify of Results (i)(ii)	F 7		d labs on orders are at	12/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	MULTIPLE CONSTRUCTION HLDING		(X3) DATE COMP	SURVEY LETED
		495143	B. WING_			C 10/18/2019	
NAME OF PR	OVIDER OR SUPPLIER		Ĭ	STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
MARTINSV	ILLE HEALTH AND REF	1AR	1	1607	SPRUCE STREET		
				MAR	TINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
F 773	nurse specialist of lab outside of clinical refewith facility policies an notification of a practiphysician's orders. This REQUIREMENT by: Based on clinical recand during the course investigation, the facilias ordered for 2 of 30 sample (Resident #23 tha Valproic Acid Level Resident #23's face s date of 1/23/15. The indicated diagnoses, Ilmited to Bipolar Discourse, Major Depre Disease, Type 1 Diab Disease, and Chronic The most recent quarset) with an ARD of 7 a BIMS (brief interview 15 out of 15 in section Resident #23 was als extensive assistance dressing, personal hy for bathing.	e ordering physician, urse practitioner, or clinical poratory results that fall prence ranges in accordance and procedures for tioner or per the ordering is not met as evidenced ordereiew, staff interview of a complaint lity staff failed to obtain labs presidents in the survey and #77). : the facility staff failed to obtain as ordered for 8/15/18. theet listed an admission resident's diagnosis list which included, but not order, Generalized Anxiety essive Disorder, Parkinson's lettes, Peripheral Vascular is Kidney Disease Stage 3. terly MDS (minimum data /16/19 assigned the resident who for mental status) score of an C, cognitive patterns. To coded as requiring of one staff member for giene and total dependence	F 7] 	4. Audits will be completed by the Director of Nursing or designee to abs are completed as ordered 2 ti week for 8 weeks. The Director of will submit findings to the Quality Assurance and Performance Improcommittee. The DON is responsite monitoring and follow up. 5. 12/06/2019	mes a Nursing ovemen	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495143	B. WING			C 10/18/2019	
	ROVIDER OR SUPPLIER	1AB		16	REET ADDRESS, CITY, STATE, ZIP CODE 07 SPRUCE STREET ARTINSVILLE, VA 24112	10/	16/2019
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 773	Acid Level with Start Date of 8/16/18. The results in the resident valproic acid level obt 8/16/18. The concern of the m was discussed with the 10/17/19 at approxim of nursing stated she the valporic acid level. No further information exit conference on 10/2. For Resident #77 obtain the following la (Thyroid-stimulating hetabolic Panel) and TSH Hormone) on 9/14/19. Resident #77's face state of 8/21/14 and a 5/15/15. The resident diagnoses, which incl 2 Diabetes Mellitus we Essential Hypertensic Hypothyroidism, and The most recent quarter) with an ARD of 9 a BIMS (brief intervier 15 out of 15 in section Resident #77 was also	Date of 8/15/18 and End surveyor could not locate surveyor could not locate shall be surveyor could not locate shall be director and active 5:00pm. The director could not find the results for shall be director could not find the results for shall be shall be director could not find the results for shall be s	F	7773			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495143	B. WING _		C	
	ROVIDER OR SUPPLIER VILLE HEALTH AND REH	IAB		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112	10/18/2019	
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 773	every 6 months Jan, dated 6/22/18 to obta Jan/July". The survey in the resident's medi (Thyroid-stimulating F Metabolic Panel) obta A "MD/Nursing Comm resident's medical recipart, "Fasting Lipid Pa July. Do you want to response stated "OK, surveyor could not loc record for a FLP (Fas (Thyroid-stimulating F the 9/13/19 physician). The concern of the mi with the administrative director of nursing) duat approximately 5:00	ed 2/05/19 to obtain a "BMP duly" and a physician's order in a "TSH q 6 months for could not locate results cal record for a TSH dormone) or BMP (Basic sined in July 2019. Intuitions" document in the cord dated 9/13/19 stated in draw now". Physician get next lab day." The cate results in the medical ting Lipid Panel) or a TSH dormone) obtained following is order. Issing labs was discussed a staff (administrator and uring a meeting on 10/16/19 pm.	F 7			
SS=D	CFR(s): 483.55(b)(1)- §483.55 Dental Service The facility must assist	(5)	F 79	10/28/2019. 2. Residents who reside at facility a risk for dental concerns. 3. Re-education was provided by the	re at	
į	outside resource, in a	ovide or obtain from an occordance with §483.70(g) ng dental services to meet		Administrator to the Social Work Director to ensure residents with de concerns receive timely dental care required. 4.Audits will be completed by the S Work Director for dental concerns	as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTII IDENTIFICATION NUMBER: A. BUILDIN		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		495143	B. WING			C 10/18/2019			
	ROVIDER OR SUPPLIER	HAB		STREET ADDRESS, CITY, STATE, ZIP CO 1607 SPRUCE STREET MARTINSVILLE, VA 24112	DE	107	0/2013		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 791	under the State plan) (ii) Emergency dental §483.55(b)(2) Must, it assist the resident- (i) In making appointr (ii) By arranging for tr dental services locati §483.55(b)(3) Must p residents with lost or dental services. If a ra 3 days, the facility may what they did to ensure and drink adequately services and the extered to the delay; §483.55(b)(4) Must h circumstances when dentures is the facility charge a resident for dentures determined policy to be the facility §483.55(b)(5) Must a eligible and wish to p reimbursement of den medical expense und This REQUIREMENT by: Based on resident in clinical record review	sident: vices (to the extent covered; and services; f necessary or if requested, ments; and ansportation to and from the ons; romptly, within 3 days, refer damaged dentures for eferral does not occur within ust provide documentation of are the resident could still eat while awaiting dental muating circumstances that ave a policy identifying those the loss or damage of a's responsibility and may not the loss or damage of in accordance with facility y's responsibility; and ssist residents who are articipate to apply for ntal services as an incurred fer the State plan. is not met as evidenced terview, staff interview, and the facility staff failed to set omeet resident needs for	F 79	The Social Work Director findings to the Quality Assemble Performance Improvement The Administrator is respondent and follow up. 5. 12/06/2019	surance a nt Commit onsible fo	nd ttee.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION AND ADDROG		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495143	B. WING _			C 10/18/2019	
	ROVIDER OR SUPPLIER VILLE HEALTH AND RE	НАВ		STREET ADDRESS, CITY, STATE, ZIP COI 1607 SPRUCE STREET MARTINSVILLE, VA 24112		10/10/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 791	The findings included The facility staff failer appointment for Resisthat her dentures we Resident # 17 was or facility on 11/24/09, a of 12/4/10. Diagnose limited to, dysphagia disease (GERD) and The clinical record for reviewed on 10/9/19 recent MDS (minimu Resident # 17 was a an ARD (assessmen Section C of the MDS patterns. In Section C documented that Rescore (brief interview	d to set up a dental ident # 17 after she voiced re ill fitting. riginally admitted to the and had a readmission date as included but were not a gastro-esophageal reflux bypokalemia. President # 17 was at 11:49 am. The most m data set) assessment for quarterly assessment with t reference date) of 6/28/19.	F 7				
	reviewed and revised documented a focus "At risk for dental proof her natural teeth woiced that her uppershe has difficulty chebut were not limited that needed." On 10/8/19 at 1:52 p Resident # 17's room interview. The surveyshe had any dental process.	are for Resident # 17 was d on 10/4/19. The facility staff area for Resident # 17 as, ablems related to: missing all wears dentures. Resident or denture is loosely fitting and awing." Interventions included to, "Refer for dental services m, the surveyor was in or conducting a resident yor asked Resident # 17 if or that her top dentures did					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495143	B. WING			C 10/18/2019	
	ROVIDER OR SUPPLIER VILLE HEALTH AND REP	łAB	STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112				
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 791	not fit well. The surveyor reviewer Resident # 17 and ob Condition" note that h 9/20/19 at 6:14 pm. T documentation that in to, "Situation: Resider fitting upper denture a foods, beans." The clinical record further not observe any docu a dental referral had a Resident # 17's loose. On 10/15/19 at 2:08 pthe facility social worker if she with dental services for restated that she was redental services and the residents that have decommunicate with nuresidents to be sent of surveyor asked the seaware that Resident # dentures were ill fitting difficulty chewing. The "Honestly, I can't say. On 10/15/19 at 3:11 pthe informed the surveyor manager and that the the nurses and Resid 17 will be put on the I dentist. On 10/16/19 at 5:14 pthe information of the surveyor and that the the nurses and Resid 17 will be put on the I dentist.	and the clinical record for served a "SBAR-Change of served a "SBAR-Change of served a "SBAR-Change of served a "SBAR-Change of served and been documented on the note contained scluded but was not limited at voiced having a loosely and having difficulty chewing surveyor reviewed the for Resident # 17 and did amentation that reflected that been made to evaluate sty fitting dentures. The surveyor interviewed the serves responsible for setting up seidents. The social worker as possible for setting up set the test of setting up set the serves and would rese to get orders for the serves to get orders for the serves to the dentist. The social worker if she was fall that she was having a social worker stated,	F 79				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495143	B. WING			C 18/2019
	ROVIDER OR SUPPLIER	HAB	1	STREET ADDRESS, CITY, STATE, ZIP CODE 607 SPRUCE STREET MARTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 791	presented to the surv	ove. n regarding this issue was vey team prior to the exit	F 791			
F 825 SS=D	CFR(s): 483.65(a)(1) §483.65 Specialized §483.65(a) Provision If specialized rehabili not limited to physica pathology, occupatio therapy, and rehabilit illness and intellectua lesser intensity as se required in the reside care, the facility musi §483.65(a)(1) Provid §483.65(a)(2) In according the required seresource that is a pro- rehabilitative service participating in any fe programs pursuant to the Act. This REQUIREMENT by: Based on clinical recreview, resident inter during the course of was determined that provide specialized re-	rehabilitative services. In of services. In of services. Itative services such as but all therapy, speech-language anal therapy, respiratory stative services for mental all disability or services of a set forth at §483.120(c), are sent's comprehensive plan of tenter the required services; or or ordance with §483.70(g), ervices from an outside	F 825	1. Resident # 63 Prafos (pressur relief ankle foot orthosis) were or 2. Residents who reside in facility specialized equipment orders are for deficient practice. 3. Re-education was provided by the Regional Clinical Director or to licensed nursing staff and ther to ensure equipment is being proordered. 4. Audit will be completed by the Director or designee that special rehabilitative equipment is provided ordered weekly for 8 weeks. The Director will submit findings to the Assurance and Performance Improvement Committee. The Administrator is responsible for monitoring and follow up. 5. 12/06/2019	rdered. y with e at risk the designee rapy staff ovided as Rehab lized ded as Rehab	

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495143	B. WING _			C	
	ROVIDER OR SUPPLIER	<u>.</u>		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112	<u>\</u>	10/18/2019	
(X4) ID PREFIX TAG	DECIN ATOMY OR LOCALITY WILL IN HER THE TOWN		ID PREFI) TAG	X (EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 825	The findings included The facility staff failed with Prafos (pressure avoid ankle contractu Resident # 63 was or facility on 3/22/18, an 7/2/19. Diagnoses incto, anemia, Guillian B and muscle weakness The clinical record for reviewed on 10/10/19 recent MDS (minimum Resident # 63 was a can ARD (assessment Section C of the MDS patterns. In Section C documented that Resinterview for mental s	to provide Resident # 63 relief ankle foot orthosis) to re. iginally admitted to the d had a readmission date of cluded but were not limited arre syndrome, paraplegia, s. Resident # 63 was at 9:46 am. The most n data set) assessment for quarterly assessment with reference date) of 8/21/19.	F	325			
	not limited to, "PRAFC contracture," which w on 9/23/19. The surverecord for Resident # medication administration that treatment administration and documentation the for PRAFOs at night thad been carried out. On 10/10/19 at 1:43 president # 63's room	on record and did not locate at reflected that the order o avoid ankle contracture om, the surveyor was in conducting a resident or asked Resident # 63 if					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING		(X3)	(X3) DATE SURVEY COMPLETED					
		495143	B. WING			C 10/18/2019		
	ROVIDER OR SUPPLIER VILLE HEALTH AND R	ЕНАВ		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112				
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 825	informed the survey therapy and therapy wished that she coulon of the director of rehal order written on 9/2 avoid ankle contract the director of rehal documentation in the that the order for Ple contracture had been rehab informed the the doctor that wroth night for clarification size she needed class to order. The survey rehab to provide do the physician for class provided the survey handwritten documedirector of rehab had on 10/9/19 and 10/1 type of boot to orded director of rehab if the presented to the survey for the sur	y was going well but she ald get therapy on her legs. 5 pm, the surveyor interviewed by the surveyor reviewed the 3/19 for PRAFOs at night to sture. The surveyor informed by that there was no ne clinical record that reflected RAFOs at night to avoid ankle en carried out. The director of surveyor that she had called the order for PRAFOs at the because of Resident # 63's arification on the type of boot beyor asked the director of coumentation of follow up with	F8	25				
	up in the clinical red order that order had director of rehab sta On 10/17/19 at 4:52	ntation of clarification or follow cord for Resident # 63 and the did not been carried out. The lated, "I understand." 2 pm, the administrator, and regional director of clinical						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495143	B. WING			1	18/2019
	ROVIDER OR SUPPLIER	HAB		16	TREET ADDRESS, CITY, STATE, ZIP CODE 807 SPRUCE STREET NARTINSVILLE, VA 24112	10/	10/2019
(X4) ID PREFIX TAG	REFIX (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)		(X5) COMPLETION DATE
F 825	services were made a had an order for PRA contracture that was not been carried out. was provided the oppand provide additionathe deficient practice. No further information presented to the survice conference on 10/18/	aware that Resident # 63 FOs at night to avoid ankle initiated on 9/23/19 that had The administrative team portunity to ask questions all information in response to as stated above. The regarding this issue was ey team prior to the exit 19. Deficiency.		825			
	This is a complaint deficiency. Rehab Services Physician Order/Qualified Pers CFR(s): 483.65(b) §483.65(b) Qualifications Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, facility staff failed to have a written order of a physician to provide Physical Therapy services for 1 of 30 residents in the survey sample (Resident #97). Resident #97 was admitted to the facility on 4/6/18. Diagnoses included dementia with behavioral disturbance, contractures of hips and knees, repeated falls, attention and concentration deficits and spatial neglect following subarachnoid hemorrhage dysphagia, Alzheimer's disease, hypertension, major depression, and psychosis. On the quarterly Minimum Data Set assessment with assessment		F	826	 Resident # 77 had on order for services on 8/16/2019. Residents who reside in the facility and have orders for the services are at risk for this deficie practice. Re-education was completed by Regional Clinical Director or design the Therapy staff related to ensurrequired orders are obtained and on the medical record. Audits will be completed by the Director that a referral/order is obtained to the Rehab Director will submit fint to the Quality Assurance and Performance Improvement Common The Administrator is responsible from the find the	erapy nt the gnee to ing present Rehab tained weeks. idings	44.7.5

	PF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495143	B. WING		10	C /1 8/2019	
	ROVIDER OR SUPPLIER	1AB	STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		SHOULD BE	(XS) COMPLETION DATE	
F 826	deficits and severely daily decision making delirium, psychosis, of the resident was assextensive assistance transfer, supervision nursing unit in a whereassistance of one per wheelchair off the underside that X-ray results data for a resident with the name as Resident #5 facility was named or form. A note on the former to eval and treat and for OT to eval and treat services 5 X week for Therapy notes indicate provided to the resident was assistance of the services of the services of the residual treatment of the services of the se	and long term memory impaired cognitive skills for and as without signs of or behaviors affecting care, sessed as requiring of 2 or more persons for for locomotion on the elchair, and extensive rson for locomotion in a sit. Teview, the surveyor noted ed 8/14/19 in the chart were a same first initial and last 17. A different long term care in the header on the results form said "PT, OT eval and the ers were written on 8/16/19 at as indicated as of 8/16/19 d treat as indicated as of en 8/19/19 for Occupational Il Therapy were started for 14 weeks in each service, ted these services were ent.	F 82	26			
	unit manager. When that therapy had bee order on those result	resident's results with the the surveyor discovered in started in response to the started in response to the started in of nursing and noted this					
-	CFR(s): 483.20(f)(5), §483.20(f)(5) Reside	nt-identifiable information.	F 84	assessment completed by nurse with no areas noted	the licensed to the inner thi	12/06/2019 gh.	
	(i) A facility may not r	elease information that is		Resident # 77 record was registered dietitian and the	•		

PRINTED: 11/26/2019

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING A. BUILDING		(X3) DATE SURVEY COMPLETED					
		495143	B. WING	Ī	- 111 1 - 1	0	
NAME OF B	ROVIDER OR SUPPLIER	455145	1		STREET ADDRESS, CITY, STATE, ZIP CODE	10/	18/2019
NAME OF P	ROVIDER OR SUPPLIER						
MARTINS	VILLE HEALTH AND REP	1AB			607 SPRUCE STREET		
				ħ	MARTINSVILLE, VA 24112		
(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)		(X5) COMPLETION DATE
F 842	resident-identifiable to (ii) The facility may re resident-identifiable to accordance with a co agrees not to use or cexcept to the extent to do so. §483.70(i) Medical re §483.70(i)(1) In accordance with a region of the extent to do so. §483.70(i)(1) In accordance must maintain medical that are-(i) Complete; (ii) Accurately docum (iii) Readily accessible (iv) Systematically organished information contain regardless of the form records, except when (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, paroperations, as permit with 45 CFR 164.506 (iv) For public health neglect, or domestic activities, judicial and law enforcement purpurposes, research permedical examiners, for a serious threat to he by and in compliance.	the public. Islease information that is of an agent only in intract under which the agent disclose the information in the facility itself is permitted. Is and practices, the facility all records on each resident in the resident's records, in or storage method of the interesident permitted by applicable law; Is the public. Is the public. Is an agent only in the agent disclose the information in the resident's records, in or storage method of the interesident permitted by applicable law; Is the public in the permitted by applicable law; Is the public in the agent disclose the information in the resident permitted by applicable law; Is the public in the agent disclose the information in the permitted by applicable law; Is the public information that is an agent disclose the information in the permitted by applicable law;	F	842	weight was struck-out. 2. Residents that reside at facility at risk for deficient practice. 3. Re-education was provided by the or designee to the nursing staff regarding accurate documentation and maintaining a commedical record. 4. Audits will be completed by the lost of Nursing or designee of 3 medical records per week to ensure medical records remain accurate and complete for 8 weeks. The Director Nursing will submit findings to the Quality Assurance and Performance Improvement Co. The Administrator is responsible for monitoring and follow up. 5. 12/06/2019	ne DON complete Director al al	
	§483.70(i)(3) The fac	ility must safeguard medical					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1, ,	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495143	B. WING_			C 10/18/2019	
	ROVIDER OR SUPPLIER	EHAB		STREET ADDRESS, CITY, STATE, ZIP COD 1607 SPRUCE STREET MARTINSVILLE, VA 24112			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ([EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 842	record information a unauthorized use. §483.70(i)(4) Medica for- (i) The period of time (ii) Five years from the there is no requirem (iii) For a minor, 3 yelegal age under State §483.70(i)(5) The medical formal (ii) A record of the record	gainst loss, destruction, or al records must be retained a required by State law; or he date of discharge when ent in State law; or ears after a resident reaches he law. edical record must contain- tion to identify the resident; esident's assessments; sive plan of care and services by preadmission screening evaluations and flucted by the State; he's, and other licensed hess notes; and hology and other diagnostic required under §483.50. It is not met as evidenced he staff failed to ensure an ord for two of 30 residents in Resident # 63 and Resident # and failed to document an open his right inner thigh on	F8	42			
		originally admitted to the and had a readmission date of		T + + + + + + + + + + + + + + + + + + +			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	DINSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495143	B. WING			C 10/18/2019	
	ROVIDER OR SUPPLIER	НАВ	STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 842	to, anemia, abnormal bleeding, paraplegia, The clinical record for reviewed on 10/10/19 recent MDS (minimu Resident # 63 was a an ARD (assessmen Section C of the MDS patterns. In Section C documented that Resinterview for mentals which indicated that intact. Section M of the conditions. In Section documented that Resident # 63 had on not limited to, "Apply right inner thigh 2 x (Mon (Monday), Fri (Inneeded for if dressin missing," which was 9/11/19. The current plan of creviewed and revised documented a focus "Pressure ulcer, at rivequired in bed mobils Braden score 18 or included but were not assessments to be continuous continuous missing to be continuous to be continuous missing to b	acluded but were not limited al uterine and vaginal and muscle weakness. The Resident # 63 was 9 at 9:46 am. The most am data set) assessment for a quarterly assessment with at reference date) of 8/21/19. Sassesses cognitive C0500, the facility staff asident # 63 had a BIMS (brief status) score of 15 out of 15, Resident #63 was cognitively the MDS assesses skin and M0150, the facility staff asident # 63 was at risk for a ulcers. The reference date of 8/21/19. Sassesses cognitive was cognitively the MDS assesses skin and M0150, the facility staff asident # 63 was at risk for a ulcers. The reference date of 8/21/19. The facility staff area for Resident # 63 was at risk for a ulcers. The reference date of 8/21/19. The facility staff area for Resident # 63 was at risk due to: Assistance as area for Resident # 63 as, isk due to: Assistance allity, bowel incontinence, < (less)." Interventions	F 842				
	Resident # 63's room						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
		495143	B. WING		C 10/18/2019	
	ROVIDER OR SUPPLIER	HAB	1607	EET ADDRESS, CITY, STATE, ZIP CODE SPRUCE STREET RTINSVILLE, VA 24112	10/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 842	which the facility staff Resident # 63 stated, legs where my diaper to heal it up and it wo they put ABD (abdom to make it comfortabl The surveyor reviewe Check" for Resident it documentation on the dated 9/12/19 "Skin of assessed." The surveyor observe weekly skin integrity of clear, no change of of The surveyor observe weekly skin integrity of clear, no change of of The surveyor observe weekly skin integrity of clear, no change of of The surveyor observe weekly skin integrity clear, no change of of The surveyor observe weekly skin integrity clear, no change of of The surveyor noted to checks that were con accurately reflect the treatment to Residen The facility policy on Condition Record" intincluded but was notPolicy To document the presimpairment/new skin Pressure when first of	eas or skin conditions in had to provide treatment. "I have one between my is." "They have been trying on't heal like it should, so sinal) pads and ointment on it is for me." I de the "Weekly Skin Integrity of the surveyor observed to weekly skin integrity check elear, no change of condition and documentation on the check dated 9/19/19 "Skin condition assessed." I de documentation on the check dated 9/26/19 "Skin condition assessed." I de documentation on the check dated 10/3/19 "Skin condition assessed." I de documentation on the check dated 10/3/19 "Skin condition assessed." I de documentation on the check dated 10/11/19 "Skin condition assessed." I de documentation on the check dated 10/11/19 "Skin condition assessed." I de documentation on the check dated 10/11/19 "Skin condition assessed." I de documentation on the check dated 10/11/19 "Skin condition assessed." I de documentation on the check dated 10/11/19 "Skin condition assessed." I de documentation on the check dated 10/11/19 "Skin condition assessed." I de documentation on the check dated 10/11/19 "Skin condition assessed." I de documentation on the check dated 10/11/19 "Skin condition assessed." I de documentation on the check dated 10/11/19 "Skin condition assessed." I de documentation on the check dated 10/3/19 "Skin condition assessed." I de documentation on the check dated 10/3/19 "Skin condition assessed." I de documentation on the check dated 10/3/19 "Skin condition assessed." I de documentation on the check dated 10/3/19 "Skin condition assessed." I de documentation on the check dated 10/3/19 "Skin condition assessed." I de documentation on the check dated 10/3/19 "Skin condition assessed." I de documentation on the check dated 10/3/19 "Skin condition assessed." I de documentation on the check dated 10/3/19 "Skin condition assessed." I de documentation on the check dated 10/3/19 "Skin condition assessed." I de documentation on the check dated 10/3/19 "Skin condition assessed." I de documentation on the check dated 10/3	F 842			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/26/2019 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLI		A. BUILDING		COMPLETED		
	495143	B. WING		C 10/18/2019		
NAME OF PROVIDER OR SUPPLIER MARTINSVILLE HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112			
(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETION		
On 10/17/19 at 4:5 director of nursing services were made currently had an owhich required one skin condition was weekly skin integrinursing agreed that been documenting 63's right thigh on administrative tear to ask questions a	act." 22 pm, the administrator, and regional director of clinical de aware that Resident # 63 pen area to her right inner thigh going treatment and that the not being documented on the ty checks. The director of at the facility staff should have the open area to Resident # the weekly skin checks. The m was provided the opportunity nd provide additional	F 842				
presented to the s conference on 10/2. For Resident # address a significate 9/05/19. Resident #77's fact date of 8/21/14 and 5/15/15. The resident gardeness, which 2 Diabetes with Dia	urvey team prior to the exit 18/19. 77 the facility staff failed to ant weight loss documented on the sheet listed an admission d a readmission date of dent's diagnosis list indicated included, but not limited to Type labetic Neuropathy, al Reflux Disease, flajor Depressive Disorder, Irritable Bowel Syndrome. Juarterly MDS (minimum data lassessment reference date) of the resident a BIMS (brief al status) score of 15 out of 15					
	CORRECTION ROVIDER OR SUPPLIER VILLE HEALTH AND F SUMMARY (EACH DEFICIE REGULATORY OF Continued From parashes abrasions of On 10/17/19 at 4:5 director of nursing services were made currently had an owe which required on skin condition was weekly skin integrinursing agreed that been documenting 63's right thigh on administrative tear to ask questions a information in respansion to the seconference on 10/2. For Resident # address a signification of the seconference on 10/2. For Resident # address a signification of the seconference on 10/2. For Resident # address a signification of the seconference on 10/2. For Resident # address a signification of the seconference on 10/2. For Resident # address a signification of the seconference on 10/2. For Resident # address a signification of the seconference on 10/2. For Resident # address a signification of the seconference on 10/2. For Resident # address a signification of the seconference on 10/2. For Resident # address a signification of the seconference on 10/2. For Resident # address a signification of the seconference on 10/2. For Resident # address a signification of the seconference on 10/2. For Resident # address a signification of the seconference on 10/2. For Resident # address a signification of the seconference on 10/2. For Resident # address a signification of the seconference on 10/2. For Resident # address a signification of the seconference on 10/2. For Resident # address a signification of the seconference on 10/2. For Resident # address a signification of the seconference on 10/2. For Resident # address a signification of the seconference on 10/2. For Resident # address a signification of the seconference on 10/2. For Resident # address a signification of the seconference on 10/2. For Resident # address a signification of the seconference on 10/2. For Resident # address a signification of the seconference on 10/2. For Resident # address a signification of the seconference on 10/2. For Resident # address a signification of the seconference on 10/2.	A95143 ROVIDER OR SUPPLIER VILLE HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 182 rashes abrasions ect." On 10/17/19 at 4:52 pm, the administrator, director of nursing, and regional director of clinical services were made aware that Resident # 63 currently had an open area to her right inner thigh which required ongoing treatment and that the skin condition was not being documented on the weekly skin integrity checks. The director of nursing agreed that the facility staff should have been documenting the open area to Resident # 63's right thigh on the weekly skin checks. The administrative team was provided the opportunity to ask questions and provide additional information in response to the deficient practice as stated above. No further information regarding this issue was presented to the survey team prior to the exit conference on 10/18/19. 2. For Resident #77 the facility staff failed to address a significant weight loss documented on	ROVIDER OR SUPPLIER **JULLE HEALTH AND REHAB** **SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) **Continued From page 182 rashes abrasions ect." **On 10/17/19 at 4:52 pm, the administrator, director of nursing, and regional director of clinical services were made aware that Resident # 63 currently had an open area to her right inner thigh which required ongoing treatment and that the skin condition was not being documented on the weekly skin integrity checks. The director of nursing agreed that the facility staff should have been documenting the open area to Resident # 63's right thigh on the weekly skin checks. The administrative team was provided the opportunity to ask questions and provide additional information in response to the deficient practice as stated above. No further information regarding this issue was presented to the survey team prior to the exit conference on 10/18/19. 2. For Resident #77 the facility staff failed to address a significant weight loss documented on 9/05/19. Resident #77's face sheet listed an admission date of 8/21/14 and a readmission date of 5/15/15. The resident's diagnosis list indicated diagnoses, which included, but not limited to Type 2 Diabetes with Diabetic Neuropathy, Gastro-Esophageal Reflux Disease, Hypothyroidism, Major Depressive Disorder, Heart Failure and Irritable Bowel Syndrome. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 9/04/19 assigned the resident a BIMS (brief interview for mental status) score of 15 out of 15	ROUIDER OR SUPPLIER WILLE HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 182 rashes abrasions ect." On 10/17/19 at 4:52 pm, the administrator, director of nursing, and regional director of clinical services were made aware that Resident # 63 currently had an open area to her right inner thigh which required ongoing treatment and that the skin condition was not being documented on the weekly skin integrity checks. The director of nursing agreed that the facility staff should have been documenting the open area to Resident # 63's right thigh on the weekly skin checks. The administrative team was provided the opportunity to ask questions and provide additional information in response to the deficient practice as stated above. No further information regarding this issue was presented to the survey team prior to the exit conference on 10/18/19. 2. For Resident #77 he facility staff failed to address a significant weight loss documented on 9/05/19. Resident #77's face sheet listed an admission date of \$2/15/15. The resident's diagnosis list indicated diagnoses, which included, but not limited to Type 2 Diabetes with Diabetic Neuropathy, Gastro-Esophageal Reflux Disease, Hypothyroidism, Major Depressive Disorder, Heart Failure and Irritable Bowel Syndrome. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 9/04/19 assigned the resident a BIMS (brief interview for mental status) score of 15 to ut of 15		

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		4054.40			С			
		495143	B. WING			10/	18/2019	
NAME OF PROVIDER OR SUPPLIER MARTINSVILLE HEALTH AND REHAB		1AB		10	TREET ADDRESS, CITY, STATE, ZIP CODE 607 SPRUCE STREET IARTINSVILLE, VA 24112			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST 8E PRECEDED BY FULL PREFIX (EACH CORRECE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCE REGULATORY OR LSC IDENTIFYING INFORMATION)				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	BE COMPLETION		
F 842	and requiring supervise personal hygiene and Resident #77's weigh documented as 179.0 documented on 9/05/ of 10.84%. The surve medical record and documentation addre Resident #77's weigh documented as 178.0 The concern of Resided discussed with the dimeeting on 10/16/19 The director of nursing notes for Resident #79/05/19 is believed to (registered dietitian) director of nursing the dietitian) forgot to stri document. No further information conference on 10/18/QAPI/QAA Improvem CFR(s): 483.75(g)(2) S483.75(g) Quality as \$483.75(g)(2) The quassurance committee (ii) Develop and imple action to correct iden	sion only in dressing, I eating. It obtained on 8/02/19 is It and the following weight It is 159.6, which is a loss eyor reviewed the resident's id not find any ssing this weight loss. It obtained on 9/26/19 is It obtained on 9/26/19 is It is It is a loss rector of nursing during a at approximately 5:56pm. It is stated the weight meeting It is stated the weight on It is an error and the RD It is on stated, the RD (registered It is out. The It is not the weight and It is was provided prior to exit It is It is seessment and assurance. It is obtained on 8/02/19 is It is obtained on 9/26/19 is		842	1. The facility has QAPI/QAA Come 2. The deficiencies and Plan of Communication 3. Re-education was provided by the Regional Clinical Director to the interdisciplinary team of the Quality Assurance and Performance Impro	rection ittee. ne vement	12/06/2019	
		riew and facility document ff failed to provide a quality			4. Audits will be conducted by the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATÉ SURVEY COMPLETED	
		495143	B. WING_	B. WING		10/	18/2019
NAME OF PROVIDER OR SUPPLIER MARTINSVILLE HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112				
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		CH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880 SS=D	assurance program to facility. The findings included The facility staff failed (quality assurance) p the facility as evidence from the previous 6/4 reasonable accommon needs/preferences, s confidentiality of recomprehensive care revision, services prostandards, quality of review, resident recomprehensive care revision Prevention & CFR(s): 483.80(a)(1) §483.80 Infection Confidentiality must estainfection prevention a designed to provide a comfortable environmediseases and infection program. The facility must estain and control program.	portinued From page 184 surance program to meet the needs of the cility. The findings included: The facility staff failed to ensure an effective QA suality assurance) program to meet the needs of the facility as evidenced by repeated deficiencies of the previous 6/4/18 survey in the areas of asonable accommodations of seeds/preferences, self determinstion, sunfidentiality of records, develop and implement somprehensive care plan, care plan timing and vision, services provided to meet professional andards, quality of care, dialysis, drug regimen view, resident records, free of accidendent azzards/surpervision and infection control. FR(s): 483.80(a)(1)(2)(4)(e)(f) 183.80 Infection Control the facility must establish and maintain an fection prevention and control program the provided a safe, sanitary and comfortable environment and to help prevent the evelopment and transmission of communicable seases and infections.			Regional Clinical Director to ensure the facility is maintaining an effective Quality Assurance and Performance Improvement program to include PIP an SMART weekly for 8 weeks. 5. The Regional Clinical Director will submit findings the Quality Assurance and Performance Improvement Committee. The Administrator is responsible for monitoring and follow up 5. 12/06/2019		
	a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals				3 times a week for 8 weeks. The E of Nursing will submit findings to the Quality Assurance Committee. The Administrator is responsible for meand follow up. 5. 12/06/2019	ne e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495143 B. WING			C 10/18/2019			
NAME OF PROVIDER OR SUPPLIER MARTINSVILLE HEALTH AND REHAB			•	STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PR		ID PREFI TAG		(EACH CORRECTIVE ACTION SHOUL	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 880	conducted according accepted national sta \$483.80(a)(2) Written procedures for the probut are not limited to: (i) A system of surveil possible communicabin infections before they persons in the facility; (ii) When and to whor communicable disease reported; (iii) Standard and trant to be followed to prev (iv) When and how iscresident; including bu (A) The type and dura depending upon the involved, and (B) A requirement that least restrictive possilicircumstances. (v) The circumstances must prohibit employed disease or infected sk contact with residents contact will transmit the (vi) The hand hygiene by staff involved in directions.	der a contractual pon the facility assessment to §483.70(e) and following indards; standards, policies, and ogram, which must include, llance designed to identify ble diseases or can spread to other in possible incidents of se or infections should be assission-based precautions tent spread of infections; blation should be used for a t not limited to: ation of the isolation, infectious agent or organism the isolation should be the ble for the resident under the sunder which the facility ses with a communicable tin lesions from direct to or their food, if direct the disease; and procedures to be followed rect resident contact.	F	880				
	identified under the facorrective actions take §483.80(e) Linens.							

AND PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495143	B. WING_		•	C 10/18/2019	
1	ROVIDER OR SUPPLIER VILLE HEALTH AND REI	НАВ	·	STREET ADDRESS, CITY, STA 1607 SPRUCE STREET MARTINSVILLE, VA 2411			
(X4) ID PREFIX TAG	((EACH DEFICIENCY MUST BE PRECEDED BY FULL PR		ID PREFII TAG	PROVIDER'S ((EACH CORREC CROSS-REFEREN D			
F 880	Continued From page	e 186	F	380			
		lle, store, process, and stoprevent the spread of					
	IPCP and update the This REQUIREMENT by: Based on observation document review, the	view. Ict an annual review of its ir program, as necessary. I is not met as evidenced in, staff interview, and facility a facility staff failed to follow elines on one of three facility					
	The findings included	ı					
	The facility staff failed control policy for han	d to follow the infection dwashing.					
	surveyor observed co Resident # 88's door CNA # 3 (certified nu Resident # 88's room gloves on, as she pro Resident # 88.	om, during initial tour the ontact precaution signage on . The surveyor observed that rsing assistant) was in a, with isolation gown and ovided feeding assistance to					
	CNA # 3 as she exite Resident # 88's meal CNA # 3 as she carri- hands and placed the surveyor observed th sanitize her hands. C another Resident's ro- over bed table, and ri- her room and placed surveyor asked CNA	m, the surveyor observed d Resident # 88's room with tray. The surveyor observed ed the tray with her bare e tray on the food cart. The lat CNA # 3 did not wash or INA # 3 entered room loom, handled items on her emoved her meal tray from it on the food cart. The # 3 how facility staff was neal trays of Resident's on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495143	495143 B. WING		1	19/2040		
NAME OF PROVIDER OR SUPPLIER MARTINSVILLE HEALTH AND REHAB			90, 1	1607 S	T ADDRESS, CITY, STATE, ZIP CODE PRUCE STREET INSVILLE, VA 24112	10/	18/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 880	contact precautions. It is supposed to have platexplained to CNA # 3 handling a meal tray is precautions with her handling a meal tray is precautions with her hands. CNA # 3 staying." The facility policy on Control Consideration that included but was "Procedures 5. Soiled dishware with precautions, including equipment such as glidisposable aprons." On 10/10/19 at 3:54 procedures of nursing well and the procedures of nursing well	CNA # 3 stated, "They are stic ware." The surveyor the observation of her from a room on contact pare hands, and entering om and handling items on thout washing or sanitizing stated, I see what you are "Meal Distribution: Infection as" contained documentation not limited to, Il be handled using universal g personal protective oves, goggles, and on, the administrator and are made aware of the stated above. In regarding this issue was ey team prior to the exit		380				