RM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/8/19 through 10/18/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000	Disclaimer: This plan of correction is being submitted in compliance with specific regulatory requirements and preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the facts alleged or conclusions set forth on the statement of deficiencies.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid Standard Survey was conducted 10/8/19 through 10/18/19. Five complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care . The Life Safety Code survey/report will follow. The census in this 142 certified bed facility was 111 at the time of the survey. The survey sample consisted of 23 current Resident reviews and 7 closed record reviews.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, and clinical record review, the facility staff failed to provide one of 30 Residents in the survey sample with reasonable accommodation of needs, Resident # 63. The findings included	F 558	1. Resident #63 call bell was placed within reach on 10/10/2019. 2. Audits were completed during Carekeeper Rounds to identify residents with mobility limitations to reach call bell. 3. Staff re-education was provided by the Director of Nursing or designee related to ensuring the call bell is within residents reach. 4.Audits will be completed by the Administrator or designee during Carekeeper Rounds at least 5 times	12/06/2019

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] CDP, LNHA | TITLE: Administrator | (X6) DATE: 12-5-2019

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

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F 558	Continued From page 1 The facility staff failed to ensure that the call bell was within reach for Resident # 63. Resident # 63 was a 47-year-old-female that was originally admitted to the facility on 3/22/18, and had a readmission date of 7/2/19. Diagnoses included but were not limited to, pain in bilateral hands, muscle weakness, vertigo, and paraplegia. The clinical record for Resident # 63 was reviewed on 10/10/19 at 9:46 am. The most recent MDS (minimum data set) assessment for Resident # 63 was a quarterly assessment with an ARD (assessment reference date) of 8/21/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 63 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicated that Resident #63 was cognitively intact. Section G of the MDS assesses functional status. In Section G0110, line E assessed locomotion on unit. Locomotion on the unit assessed how the resident moved between locations in her room and adjacent corridor on the same floor. If in wheelchair, self-sufficiency once in chair. The facility staff documented that Resident # 63 was totally dependent requiring the assistance of two or more persons for locomotion on the unit. The current plan of care for Resident # 63 was reviewed and revised on 9/3/19. The facility staff documented a focus area for Resident # 63 as, "I have a physical functioning deficit related to: mobility impairment, self-care impairment, dx's (diagnoses) of paraplegia, chronic inflammatory demyelinating polyneuropathy, intervertebral disc degeneration-lumbar region, fibromyalgia, morbid	F 558	weekly for 4 weeks. The Administrator will submit the audit results to the Quality Assurance and Performance Improvement Committee. The Administrator is responsible for monitoring and follow-up. 5. 12/06/2019	

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F 558	Continued From page 2 obesity, and anemia." Interventions included but were not limited to, "Call bell within reach." On 10/10/19 at 1:28 pm, the surveyor was in Resident # 63's room conducting a Resident interview. The surveyor observed that Resident # 63 was sitting in her wheelchair that was positioned at the foot of her bed. The surveyor observed the call bell wrapped around the bed rail on the right side at the head of her bed. The surveyor asked Resident # 63 if she needed assistance from the nurse would she be able to reach her call bell. Resident # 63 stated, "No." On 10/10/19 at 1:32 pm, the surveyor and Cna # 1 (certified nursing assistant) observed Resident # 63 sitting in her wheelchair at the foot of her bed, and observed the call bell wrapped around the bed rail on the right side at the head of the bed. Cna # 1 agreed that the call bell was not with reach for Resident # 63. On 10/10/19 at 3:54 pm, the administrator and director of nursing were made aware of the findings as stated above. The administrative team was provided the opportunity to ask questions and/or submit additional information to the survey team to in response to the deficient practice as stated above. No further information was provided to the survey team prior to the exit conference on 10/18/19.	F 558		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination	F 561	1. Resident #47 was informed she was allowed to eat where she prefers on 10/13/2019 and 10/15/2019. 2. Residents who reside in facility are at risk for not being able to eat in their	12/06/2019

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F 561	Continued From page 3 through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, Resident interview, staff interview, and facility document review, the facility staff failed to promote and facilitate resident self-determination for one of 30 residents in the survey sample, Resident # 47. The findings included The facility staff failed to allow Resident # 47 to eat meals in her preferred location, the facility dining room.	F 561	preferred location. 3. Director of Nursing or designee will re-educate the nursing staff by 12/6/19 related to accommodating resident dining location preferences. 4. The Social Work Director or designee will conduct random audits at least 3 times a week for 4 weeks to ensure residents are dining in their preferred 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	

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F 561	Continued From page 4	F 561		

Resident # 47 was admitted to the facility on 5/11/17. Diagnoses included but were not limited to, anxiety disorder, traumatic brain injury and major depressive disorder.

The clinical record for Resident # 47 was reviewed on 10/9/19 at 12:15 pm. The most recent MDS (minimum data set) assessment for Resident # 47 was a quarterly assessment with an ARD (assessment reference date) of 8/5/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 47 had a BIMS score of 15 out of 15, which indicated that Resident # 15 was cognitively intact.

The current plan of care for Resident # 47 was reviewed and revised on 8/19/19. The facility staff documented a focus area for Resident # 47 as, "I sometimes have behaviors which include arguing with other residents using profanity while in the dining room and swiping the table cloth off the table." Interventions included but were not limited to, "Help me maintain my favorite place to sit," and "Offer me something I like as a diversion."

On 10/15/19 at 12:07 pm, the surveyor observed Resident # 47 lying in bed in her room. The surveyor observed that Resident # 47 had a one to one sitter in her room sitting at her bedside. The surveyor interviewed Resident # 47. The surveyor asked Resident # 47 how long she had been in her room with sitters. Resident # 47 stated, "Three days." Resident # 47 stated, "I have been in my room and had girls sitting with me." The surveyor asked Resident # 47 if she wanted to eat her meals in her room. Resident # 47 stated, "I used to love to eat in the dining

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F 561	Continued From page 5	F 561		

room, but they told me I couldn't because there are people in there that are scared of me." The surveyor asked Resident # 47 how not being able to eat in the dining room made her feel. Resident # 47 stated, "Sad."

On 10/15/19 at 12:37 pm, the surveyor observed Resident # 47 eating her lunch in her room with a staff member sitting at her bedside.
The surveyor reviewed the clinical record for Resident # 47. The surveyor reviewed a "SBAR-Change of Condition" note for Resident # 47 that had been documented on 10/12/19 at 8:06 pm. The note was documented as, "Situation: Rsd (resident) # 47 was in the dining room and Resident #29 stated she wanted some ice cream. Resident # 47 stated "Why can't you go get it yourself, you b****" Response: Rsd was removed from the dining and told that she had to finish her supper in her room due to her behavior. Rsd was placed on 1:1 care by staff. Resident # 29 called police."

The surveyor reviewed the clinical record further specifically the progress notes and the plan of care and did not locate any documentation of interventions attempted to offer diversional activities that would allow Resident # 47 to eat meals in the dining room, which was her preferred location.

On 10/16/19 at 5:37 pm, the surveyor informed the director of nursing that there were no interventions documented in the clinical record for Resident # 47 that reflected that the facility staff attempted diversional activities to manage behaviors in order to allow Resident # 47 to eat meals in the dining room, which was her preferred location. The surveyor asked the

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F 561	Continued From page 6 director of nursing if the facility staff had attempted additional interventions to manage behaviors that would allow Resident # 47 to be able to eat meals in her preferred location. The director of nursing had no response to the surveyor's question. The facility staff provided a copy of "Your Resident Rights and Protections under State and Federal Law" which was provided to each resident. The document contained information that included but was not limited to, ..."Quality of Life Self-Determination and Participation: As long as it fits in your care plan, you have the right to make your own schedule, choose the activities you want to participate in, interact with members of your community, and make choices about aspects of your life in the nursing home that are significant to you." ... On 10/17/19 at 4:52 pm, the survey team 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 to the survey team in regard 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 561		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify,	F 580	1. Resident #63 physician was notified of vaginal bleeding on 6/27/2019. Resident #110 physician was notified of Levemir refusals 6/23/2018. 2. Residents that reside in the facility are at risk for this deficient practice.	12/06/2019

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F 580	Continued From page 7 consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in	F 580	3. The Director of Nursing or designee provided re-education to nursing staff related to monitoring for change in resident condition and usage of the interact system; SBAR and stop and watch. 4. The Assistant Director of Nursing or designee will conduct audits to ensure nursing staff continue to document changes in condition and notify the physician through review of nursing notes and the 24-hour report 5 times a week for 8 weeks. The Assistant Director of Nursing will submit audit findings to the Quality Assurance and Performance Improvement Committee. The Director of Nursing is responsible for monitoring and follow-up. 5. 12/06/2019	

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F 580	Continued From page 8	F 580		

§483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on Resident interview, clinical record review, staff interview and during the course of a complaint investigation, it was determined that the facility staff failed to notify the physician of changes for two of 30 Residents in the survey sample, Resident #63 and Resident # 110.

The findings included

1. The facility staff failed to notify the physician that Resident # 63 had vaginal bleeding for more than a month.

Resident # 63 was originally admitted to the facility on 3/22/18, and had a readmission date of 7/2/19. Diagnoses included but were not limited to, anemia, abnormal uterine and vaginal bleeding, paraplegia, and muscle weakness.

The clinical record for Resident # 63 was reviewed on 10/10/19 at 9:46 am. The most recent MDS (minimum data set) assessment for Resident # 63 was a quarterly assessment with an ARD (assessment reference date) of 8/21/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 63 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicated that Resident #63 was cognitively intact. Section G of the MDS assesses functional status. In Section G0110, line I assessed toilet

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F 580	Continued From page 9	F 580		

use. Toilet use assessment included but was not limited to, how the Resident #63 used the toilet room, commode, or bedpan; cleansed self after elimination, and changed pad. The facility staff documented that Resident # 63 was totally dependent requiring the assistance of two or more persons for toilet use. Section G0120 assessed bathing. The facility staff documented that Resident # 63 was totally dependent, requiring the assistance of two or more persons for bathing.

On 10/10/19 at 1:28 pm, the surveyor was in Resident # 63's room conducting a Resident interview. The surveyor asked Resident # 63 if she had been readmitted to the hospital since her admission to the facility. Resident # 63 informed the surveyor that she had lost a lot of blood and was admitted to the hospital. Resident # 63 stated, "I was as white as that sheet."

The surveyor reviewed the progress notes for Resident # 63. The surveyor observed a nurse's note that had been documented on 6/27/19 at 10:59 am. The nurse's note contained documentation that included but was not limited to, ... "Resident alert and oriented, complained of menstrual was on for a month. She appears to be pale and states she felt weak. VS (vital signs) 96.5, 122/70, 73, 16, 98%. MD (medical doctor) notified of concern." ...

The surveyor reviewed a SBAR- Change of Condition note for Resident # 63 that was documented on 6/27/19 at 2:42 pm. The note was documented as, "Situation: Lab drawn today and had critical low HGB (hemoglobin) 5.0 and HCT (hematocrit) 16.0, albumin 2.9 Background: Resident stated her period was on for longer than

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F 580	Continued From page 10	F 580		

a month and this was not the 1st time she experienced this. Assessment: VS 122/70, 96.5, 73, 16, 98%, MD notified to have CBC (complete blood count) which was already in place due to 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. 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."

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 until the nurse had informed her in June of 2019 that Resident # 63

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F 580	Continued From page 11	F 580		

was pale. RN # 1 stated that she instructed the nurse to inform the physician. The surveyor asked RN # 1 if she would expect the certified nursing assistants to inform the nurses if they noticed that Resident # 63 was having excessive vaginal bleeding. RN # 1 stated, "Yes." The surveyor asked RN # 1 if she expected the nursing staff to document episodes of excessive bleeding in the clinical record and notify the physician. RN # 1 stated, "Yes." The surveyor informed RN # 1 that there was no documentation in the clinical record for Resident # 63 that reflected that Resident # 63 had vaginal bleeding for a month or more prior to 6/27/19.

On 10/17/19 at 3:35 pm, the surveyor interviewed LPN # 1 (licensed practical nurse) the surveyor asked LPN # 1 if she was aware that Resident # 63 had episodes of excessive vaginal bleeding. LPN # 1 stated, "Yes." The surveyor asked LPN # 1 if the certified nursing assistants informed her when Resident # 63 had episodes of excessive vaginal bleeding. LPN # 1 stated, "Yes." The surveyor asked LPN # 1 if information that Resident # 63 was having episodes of excessive vaginal bleeding should be documented in the clinical record and the physician be notified. LPN # 1 stated, "Yes it should be."

On 10/17/19 at 4:52 am, the administrator, the director of nursing, and the regional director of clinical services were made aware of the findings as stated above. The surveyor asked the administrative team if they would expect the nursing staff to document abnormal vaginal bleeding in the clinical record and notify the physician at the time the abnormality was noted. All three administrative team members agreed that abnormal vaginal bleeding should be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 12	F 580		

documented in the clinical record and the physician should be notified at the time the abnormality was noted. The administrative team was asked for a facility policy and/or standard of practice regarding documentation abnormalities in the clinical record and notifying the physician of changes in Resident condition. The administrative team was also provided the opportunity to ask additional questions and provide additional information in response the deficient practice as stated above.

The facility staff presented the following information to the survey team as the standard of practice for documentation. Information included but was not limited to, ..."5. A deviation from protocol should be documented in the patient's chart with, clear, concise statements of the nurse's decisions, actions, and reasons for care provided, including any apparent deviation. This should be done at the time the care is rendered because passage of time may lead to less than accurate recollection of the specific events." ...

Reference
Nettina, S.M. (2013) Lippincott manual of nursing practice. 10th ed. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins.

On 10/18/ 19 at 10:32 am, the surveyor requested a policy or standard of practice regarding notifying the physician of changes in Resident condition.

On 10/18/ 19 at 2:52 pm, the surveyor requested a policy or standard of practice regarding notifying the physician of changes in Resident condition.

On 10/18/19 at 3:45 pm, the surveyor provided

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 13	F 580		

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 diabetes 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 C0500, 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 status was severely impaired. Section N assesses medications. In Section N0350, the facility staff documented that Resident # 110 had received insulin for 7 days during the look-back period for the 9/18/19 ARD.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 14	F 580		

Resident # 110 had physician's orders that included but was not limited to, "Levemir FlexPen Solution Pen-Injector 100 unit/ml (milliliter) Inject 35 unit subcutaneously every morning and at bedtime related to type 2 dialbetes mellitus," which was initiated by the physician on 10/11/17 and was discontinued on 8/31/18.

The surveyor reviewed the January 2018 eMAR (electronic medication administration record) for Resident # 110. The surveyor observed documentation on the eMAR for Resident # 110 that indicated that Resident # 110 had refused her bedtime dose of Levemir daily except on 1/2/18, 1/6/18 and 1/15/18.

The surveyor reviewed the February 2018 eMAR for Resident # 110 and observed documentation that indicated that Resident # 110 had refused her bedtime dose of Levemir daily except on 2/22/18.

The surveyor reviewed the March 2018 eMAR for Resident # 110 and observed documentation that indicated that Resident # 110 had refused her bedtime dose of Levemir daily.

The surveyor reviewed the April 2018 eMAR for Resident # 110 and observed documentation that indicated that Resident # 110 had refused her bedtime dose of Levemir daily except on 4/16/18 and 4/17/18.

The surveyor reviewed the May 2018 eMAR for Resident # 110 and observed documentation that indicated that Resident # 110 had refused her bedtime dose of Levemir daily except on 5/2/18 and 5/13/18. The surveyor noted that there was no documentation on the clinical record of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 15	F 580		

administration or refusal of bedtime Levemir on the eMAR on 5/27/18, 5/28/18 and 5/29/18.

The surveyor reviewed the June 2018 eMAR for Resident # 110 and observed documentation that indicated that Resident # 110 had refused her bedtime dose of Levemir daily except on 6/12/18, 6/15/18, 6/18/18 and 6/22/18.

The surveyor reviewed the July 2018 eMAR for Resident # 110 and observed documentation that indicated that Resident # 110 had refused her bedtime dose of Levemir daily except on 7/4/18, 7/20/18 and 7/27/18.

The surveyor reviewed documentation in the clinical record for Resident # 110 specifically the physician's orders, progress notes, nurse's notes, and consultations. The surveyor did not observe documentation that the physician had been notified of Resident # 110's refusal of bedtime Levemir until 6/23/18 at 8:15 pm.

On 10/17/19 at 4:52 am, the administrator, the director of nursing, and the regional director of clinical services were made aware of the findings as stated above. The surveyor asked the administrative team if they would expect the nursing staff to notify the physician of Resident refusals of medication. All three administrative team members agreed that the physician should be notified of medication refusals. The administrative team was asked for a facility policy and/or standard of practice regarding notifying the physician of medication refusals. The administrative team was also provided the opportunity to ask additional questions and provide additional information in response to the deficient practice as stated above.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 16 On 10/18/ 19 at 10:32 am, the surveyor requested a policy or standard of practice regarding notifying the physician of Resident refusal of medication. On 10/18/ 19 at 2:52 pm, the surveyor requested a policy or standard of practice regarding notifying the physician of Resident refusal of medication. On 10/18/19 at 3:45 pm, the surveyor provided the administrator, the director of nursing, and the regional director of clinical services the opportunity to ask further questions and provide additional information in response to 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 Resident refusal of medication, and no further information regarding this issue was presented to the survey team prior to the exit conference on 10/18/19. This is a complaint deficiency.	F 580		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 584	1. Resident #103 received replacement medication on 6/4/2019. Resident #112 PTAC (packaged terminal air conditioner) was replaced with a new unit on 10/9/2019. 2. Residents that reside at facility are at risk for not having a homelike environment and medication discrepancies . 3. Director of Nursing or designee re-educated licensed nursing staff on the process to properly complete the	12/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 17 (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and during the course of a complaint investigation, the facility staff failed to protect the resident's property from loss or theft resulting in unavailability of pain medication and failing to maintain a clean air conditioning unit in the resident's room for 2 of 30 residents in the survey sample (Residents #103 and #112).	F 584	controlled medication log and notify the DON/ADON of discrepancies. Maintenance Director or designee re-educated staff on identifying and reporting debris in PTACs by entering it in the TELs system. 4. Audits will be conducted by the ADON or designee for controlled medication discrepancies for 8 weeks. Random audits will be conducted by the Maintenance Director or designee for debris in PTAC units weekly for 8 weeks. The ADON and Maintenance Director will submit the audit findings to the Quality Assurance and Performance Improvement Committee. The Administrator is responsible for monitoring and follow-up. 5. 12/06/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 18	F 584		

1. For Resident #103, facility staff failed to secure from loss or theft

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 19	F 584		

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 arrival --coded 2=refused
6/1/19 12:38 nursing note awaiting pharmacy arrival
6/1/19 17:28 nursing note awaiting pharmacy arrival
6/1/19 20:29 nursing note awaiting pharmacy arrival-- --coded 2=refused
6/2/19 08:59 nursing note awaiting pharmacy arrival
6/2/19 12:16 nursing note awaiting pharmacy arrival
6/2/19 16:40 nursing note awaiting pharmacy arrival
6/2/19 21:03 nursing note awaiting pharmacy arrival
6/3/19 16:55 nursing note awaiting pharmacy arrival
6/3/19 20:35 nursing note awaiting pharmacy arrival
6/4/19 09:34 nursing note awaiting pharmacy arrival
6/3/19 for 09:00 and 13:00 no documentation in MAR and no nursing notes concerning resident status

This review indicated the resident missed 14 consecutive doses of oxycodone. The pain assessments associated with those 14 doses were either 'X' or blank except for the 6/2 assessment at 21:00 was documented as '0' on the medication administration record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 20	F 584		

The clinical record included no indication that the physician was notified that the oxycodone was missing. The surveyor discussed the concern with the director of nursing (DON) on 10/16/19 at 8:44 AM. The DON said that the doctor on call would not write a replacement prescription or a prescription to pull doses from the stat box because the doctor wanted to avoid DEA scrutiny. The Pain clinic said that they would not replace the prescription and the resident could do without the drug until time for a new prescription to start. The DON stated the resident showed no signs of withdrawal. The DON provided hand written employee statements dated 10/16/19 from two LPNs stating they had contacted physician offices concerning the medication being unavailable.

Surveyors discussed the failure to secure resident property with the administrator and DON during individual discussions on 10/16/19.

2. Resident #112's PTAC (packaged terminal air conditioner) was observed by the surveyor to have a fluffy, white substance on the vent/grate area inside the unit.

Resident #112's face sheet listed an admission date of 5/30/18 and a readmission date of 7/27/19. The resident's diagnosis list indicated diagnoses, which included, but not limited to anoxic brain damage, functional quadriplegia, unspecified cirrhosis of liver, hypothyroidism, chronic viral hepatitis C, morbid (severe) obesity and dysphagia.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 9/19/19 assessed the resident with a persistent vegetative state/no discernible consciousness.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 21 Resident #112 was also coded as being totally dependent on two or more staff members for bed mobility, dressing, personal hygiene and bathing. On 10/09/19 at approximately 8:42am, the surveyor observed Resident #112 lying in the bed next to the window and PTAC (packaged terminal air conditioner) unit. The air conditioning was running with the mode turned to "Cool" and the temperature turned up as far as possible to the "Cooler" setting. The surveyor observed a fluffy, white substance on the vent/grate area inside the unit. On 10/09/19 at approximately 3:55pm, the surveyor observed maintenance staff member #1 remove the cover from PTAC (packaged terminal air conditioner) unit in Resident #112's room. The surveyor observed the fluffy, white substance on the vent/grate area inside the unit. Maintenance staff member #1 stated "Whatever it is I hope bleach kills it. I will address it immediately." On 10/10/19 at approximately 4:00pm, the surveyor received a copy of "Work Order #355" stating in part, that a new PTAC was installed in Resident #112's room on 10/09/19. The observation of the fluffy, white substance on the vent/grate area of the PTAC (packaged terminal air conditioner) unit in Resident #112's room was discussed with the administrative staff (administrator and director of nursing) during a meeting on 10/10/19 at approximately 4:30pm. No further information was provided prior to exit conference on 10/18/19.	F 584		
F 600	Free from Abuse and Neglect	F 600	1. Resident #29 and #63 continue to	12/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600 SS=D	Continued From page 22 CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation clinical record review, Resident interview, staff interview, facility document review, and during the course of a complaint investigation, the facility staff failed to ensure two of 30 residents in the survey sample were free from abuse and neglect, Resident #63 and Resident # 29. The findings included: The facility staff neglected to provide appropriate care and services to Resident # 63 as evidenced by, Resident # 63 had a history of having episodes of excessive vaginal bleeding. Resident # 63 had been having excessive vaginal bleeding for over a month. The facility staff failed to document episodes of excessive bleeding and failed to notify the physician that Resident # 63 had been bleeding excessively for over a month, which led to Resident # 63 having a critical	F 600	reside at facility and are free from abuse with needs being met. 2. Residents that reside at the facility are at risk for this deficient practice. 3. The Director of Nursing or designee re-educated staff on abuse and neglect and the reporting practice. 4. The Social Work Director will conduct random audits of nursing notes at least 3 times weekly to ensure no abuse and neglect concerns are occurring for 8 weeks. The Social Work Director will submit findings to the Quality Assurance and Performance Improvement Committee. The Administrator is responsible for monitoring and follow up. 5. 12/06/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 23	F 600		

hemoglobin and hematocrit and being hospitalized with a diagnosis of menorrhea and anemia which required a blood transfusion. This is harm.

Resident # 63 was originally admitted to the facility on 3/22/18, and had a readmission date of 7/2/19. Diagnoses included but were not limited to, anemia, abnormal uterine and vaginal bleeding, paraplegia, and muscle weakness.

The clinical record for Resident # 63 was reviewed on 10/10/19 at 9:46 am. The most recent MDS (minimum data set) assessment for Resident # 63 was a quarterly assessment with an ARD (assessment reference date) of 8/21/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 63 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicated that Resident #63 was cognitively intact. Section G of the MDS assesses functional status. In Section G0110, line I assessed toilet use. Toilet use assessment included but was not limited to, how the Resident #63 used the toilet room, commode, or bedpan; cleansed self after elimination, and changed pad. The facility staff documented that Resident # 63 was totally dependent requiring the assistance of two or more persons for toilet use. Section G0120 assessed bathing. The facility staff documented that Resident # 63 was totally dependent, requiring the assistance of two or more persons for bathing.

On 10/10/19 at 1:28 pm, the surveyor was in Resident # 63's room conducting a Resident interview. The surveyor asked Resident # 63 if she had been readmitted to the hospital since her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 24	F 600		

admission to the facility. Resident # 63 informed the surveyor that she had lost a lot of blood and was admitted to the hospital. Resident # 63 stated, "I was as white as that sheet."

The surveyor reviewed the progress notes for Resident # 63. The surveyor observed a "SBAR-Change in Condition" note that had been documented on 12/23/18 at 9:47 am. The note contained documentation that included but was not limited to ..."Situation: Resident is bleeding from vaginal area Assessment: Resident is bleeding from vaginal area with heavy bright blood with clots present. Resident states she feels weak Response: MD (medical doctor) notifies. New orders to send to ER (emergency room) ED (emergency department) notified of transfer)." ...

The surveyor observed a nurse's note that had been documented on 6/27/19 at 10:59 am. The nurse's note contained documentation that included but was not limited to ..."Resident alert and oriented, complained of menstrual was on for a month. She appears to be pale and states she felt weak. VS (vital signs) 96.5, 122/70, 73, 16, 98%. MD (medical doctor) notified of concern." ...

The surveyor reviewed a SBAR- Change of Condition note for Resident # 63 that was documented on 6/27/19 at 2:42 pm. The note was documented as, "Situation: Lab drawn today and had critical low HGB (hemoglobin) 5.0 and HCT (hematocrit) 16.0, albumin 2.9 Background: Resident stated her period was on for longer than a month and this was not the 1st time she experienced this. Assessment: VS 122/70, 96.5, 73, 16, 98%, MD notified to have CBC (complete blood count) which was already in place due to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 25	F 600		

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. 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."

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 until the nurse had informed her in June of 2019 that Resident # 63 was pale. RN # 1 stated that she instructed the nurse to inform the physician. The surveyor asked RN # 1 if she would expect the certified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 26	F 600		

nursing assistants to inform the nurses if they noticed that Resident # 63 was having excessive vaginal bleeding. RN # 1 stated, "Yes." The surveyor asked RN # 1 if she expected the nursing staff to document episodes of excessive bleeding in the clinical record and notify the physician. RN # 1 stated, "Yes." The surveyor informed RN # 1 that there was no documentation in the clinical record for Resident # 63 that reflected that Resident # 63 had vaginal bleeding for a month or more prior to 6/27/19.

On 10/17/19 at 3:35 pm, the surveyor interviewed LPN # 1 (licensed practical nurse) the surveyor asked LPN # 1 if she was aware that Resident # 63 had episodes of excessive vaginal bleeding. LPN # 1 stated, "Yes." The surveyor asked LPN # 1 if the certified nursing assistants informed her when Resident # 63 had episodes of excessive vaginal bleeding. LPN # 1 stated, "Yes." The surveyor asked LPN # 1 if information that Resident # 63 was having episodes of excessive vaginal bleeding should be documented in the clinical record and the physician be notified. LPN # 1 stated, "Yes it should be."

On 10/17/19 at 4:52 am, the administrator, the director of nursing, and the regional director of clinical services were made aware of the findings as stated above. The surveyor asked the administrative team if they would expect the nursing staff to document abnormal vaginal bleeding in the clinical record and notify the physician at the time the abnormality was noted. All three administrative team members agreed that abnormal vaginal bleeding should have been documented in the clinical record and the physician should have been notified at the time the abnormality was noted.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 27 The facility policy on "Resident Abuse" contained documentation that included but was not limited to, ..."Policy: It is inherent in the nature and dignity of each resident at the facility that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, and/or misappropriation of property. Procedure: I. Definition of Resident Abuse: D. Non-action, which results in emotional, psychological, or physical injury, is viewed in the same manner as that caused by improper or excessive action. All actions in which employees engage with residents must have as their legitimate goal, the healthful, proper, and humane care and treatment of the resident. " ... The facility staff presented the following information to the survey team as the standard of practice for documentation. Information included but was not limited to ..."5. A deviation from protocol should be documented in the patient's chart with, clear, concise statements of the nurse's decisions, actions, and reasons for care provided, including any apparent deviation. This should be done at the time the care is rendered because passage of time may lead to less than accurate recollection of the specific events." ... Reference Nettina, S.M. (2013) Lippincott manual of nursing practice. 10th ed. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins. On 10/18/19 at 3:45 pm, the surveyor provided the administrator, the director of nursing, and the regional director of clinical services the	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 28	F 600		

opportunity to ask further 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.

1. The facility staff failed to ensure that Resident #29 was free from abuse from another resident that resided in the nursing facility.

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 Interview for Mental Status) score of 15 out of a possible score of 15. Resident #29 was also coded as requiring supervision of 1 staff member for dressing and personal hygiene and requiring physical help in part of the bathing activity from 1 staff member.
During the clinical record review from 10/8/19 through 10/18/19, the surveyor noted the following documentation in the nursing notes dated and timed for:
" " ...9/8/19 19:33 (7:33 pm) Situation: Writer called into dining room by aide; resident sitting in front of wheelchair. Aide states resident had an altercation with another resident.
Background: Bipolar, Anxiety Disorder
Assessment: Upon assessment _____ (name of Resident #29) scalp is reddened and missing hair. No other injuries noted. Response: On call MD (medical doctor) made aware, Own R.P. (responsible party), DNS (director of nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 29 services) and Administrator made aware. Police notified. Deputy _____ (name of deputy) returned call stating that he doesn't have to come out, whom ever is harmed needs to go to the magistrates office to file charges, This information given to _____ (name of resident). She got in touch with her daughter and she came and signed her mom out to go to the Office ... " 9/13/19 16:27 (4:27 pm) Resident stated her head was sore from where the other resident pulling her hair out. Resident reported she is doing ok and has filed charges against the other resident ..." The surveyor reviewed the care plan for Resident #29 and the following was documented in the care plan: " " ...Focus: I sometimes have behaviors which include: demanding my showers at shift change and to be the first resident showered. Demanding staff to stay with for hour long intervals during the showers. Making false accusations against staff. Reporting missing objects that are not missing. Trying to sneak and take showers unassisted ... Interventions: Attempt interventions before my behaviors begin. " Explained to resident she cannot always be first, but will try to get her showered ASAP (as soon as possible) " Give me my medications as my doctor has ordered " Help me to avoid situations or people that are upsetting to me " Let my physician know if I my behaviors are interfering with my daily living " Make sure I am not in pain or uncomfortable " Offer me something I like as diversion " Please refer to my psychologist/psychiatrist as needed	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 30	F 600		

" Please tell me what you are going to do before you begin
" Speak to me unhurriedly and in a calm voice ..."
The surveyor noted the date documented for the focus and interventions were initiated on 3/3/14 with a revision date of 1/16/17. There were no interventions noted by the surveyor after the resident-to-resident altercation that had occurred on 9/8/19.
The surveyor also noted an "Emergency Protective Order" dated for 9/8/19 at 8:10 pm in which named Resident #29 as being the alleged victim was to have no contact with the other resident involved in the altercation. The order expired on 9/11/19 at 11:59 pm.
The survey team interviewed Resident #29 in the conference room on 10/15/19 at 11:20 am. The surveyor asked Resident #29 if she could tell the surveyor what had happened with another resident on 9/8/19 that resulted in this resident obtaining an Emergency Protective Order against another resident that was involved in an altercation that had occurred on 9/8/19. Resident #29 stated, "_____ (name of the resident involved in the altercation on 9/8/19) came over while we were in the dining room and pulled a lot of my hair out of my head. It was a handful of hair and pulled out by the roots. ____ (Name of resident involved in altercation) and I were friends and we set together in the dining room for our meals. But one day she started saying things to me that were not nice and then she accused me of saying things about her son. I really don't know how it started. But after she pulled my hair and called me names, the staff called the police and they were told that I would have to go to the Magistrate's office to press charges against her. So I called my daughter and she took me down

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 31	F 600		

there. I got a Protective Order for her to keep away from me but I still saw her coming down the hallway where my room is and she would say things to me as she passed my room, but they stopped and told her that she could not come down that hallway where I was without a staff member being with her. I still saw her down the hallway from time to time without anyone with her.
The surveyor asked the resident if she felt safe in the facility. The resident stated, "I really don't. She (referring to resident involved in altercation) could come in my room, she is a big woman, and she could smother me by sitting on my face or putting a pillow over it. But I feel better now because since Friday, she has had a staff person sitting with her all the time. Did you hear what happened on Friday at supper time?" The surveyor stated that she had read the documentation in the nurses' notes for Friday about the details of another altercation. The resident stated, "I had asked an aide for some vanilla ice cream. Then ____ (name of other resident involved in altercation) said, "Why don't you get it your damn self." She came full force toward me and an aide stopped her and the wheelchair before she could get to me. Since then she has had to have a sitter be with her all the time and she has had to eat her meals in her room.
The surveyor noted the following documentation in the nurses' notes timed and dated for 10/12/19 at 20:40 (10:40 pm) which read in part, " ...Altercation with another resident during meal time in dining room. Resident asked to come out dining room and go back to room. This resident telephoned the sheriff department ..." For 10/12/19 21:32 (9:32 pm) the nurses' note read in part, " ...Resident is her own responsible party, but she states she called her daughter anyway.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 32 ____ (name of medical doctor) on call ...was made aware of the incident with NNO (no new orders)." The surveyor interviewed the administrator on 10/18/19 at approximately 1 pm in the conference room. The surveyor asked about the altercation between Resident #29 and another resident on 10/12/19. The administrator stated that another resident was not verbally nice to _____ (name of Resident #29). They were eating in the dining room with _____ (name of Resident #29) was sitting at one table and the other resident was sitting at another table away from _____ (name of Resident #29). Since that altercation, we have had a sitter with _____ (name of resident involved in altercation with Resident #29) constantly with her until we can resolve this issue between _____ (name of Resident #29) and _____ (name of other resident). We don't know at this time how this will be resolved but we are actively looking for a resolution to this issue between these 2 residents." No further information was provided to the surveyor prior to the exit conference on 10/18/19.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in	F 609	1. Resident #314 allegation of abuse was reported to the appropriate agencies on 10/19/2019. Resident #97 allegation of abuse was reported to the appropriate agencies on 10/17/2019. 2. Residents that reside at the facility are at risk for this deficient practice. 3. The Director of Nursing or designee re-educated staff on abuse and neglect and the reporting practice. 4.The Social Work Director will	12/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 33 serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, facility document review, and during the course of a complaint investigation it was determined that the facility staff failed to report allegations of abuse for two of 30 Residents in the survey sample, Resident # 314 and Resident # 97. The findings included 1. The facility staff failed to report an allegation of abuse for Resident # 314. Upon being informed of the allegation of abuse made by Resident # 314, the facility staff failed to report the allegation to the appropriate agencies within a timely manner. Resident # 314 was admitted to the facility on 10/16/17. Diagnoses included but were not limited to muscle weakness, chronic pain, and hypertension.	F 609	4. conduct random audits of nursing notes at least 3 times weekly to ensure no abuse and neglect concerns are occurring for 8 weeks. The Social Work Director will submit findings to the Quality Assurance and Performance Improvement Committee. The Administrator is responsible for monitoring and follow up. 5. 12/06/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 34	F 609		

The clinical record for Resident # 314 was reviewed on 10/9/19 at 9:54 am. The surveyor observed a nurse's note that had been documented on 3/30/18 at 6:27 pm. The nurse's not was documented as, "Resident alert with confusion noted, daughter reported to nurse that resident stated that he was beat up by two CNAs (certified nursing assistants) that took their clothes off while changing his clothes, all this was done on the floor, daughter stated that she wants staff to be more tactful when caring for her dad, reported incident to DON (director of nursing) with daughters present, staff went in to do skin assessment on resident, skin was clear, broken skin noted, daughter stated that she knows her father has bad memory but she was concerned. DON assured her that she would investigate the claim with other staff but no injuries are noted at this time."

On 10/10/19 at 3:54 pm, the director of nursing and administrator were made aware of the allegation of abuse that had been documented in Resident # 314's clinical record. The surveyor requested documentation that the allegation had been reported to the appropriate agencies.

On 10/11/19 at 8:15 am, the facility administrator informed the surveyor that she did not locate any documentation that reflected that the allegation of abuse documented in Resident # 314's clinical record had been reported to the appropriate agencies.

On 10/16/19 at 11:54 am, the surveyor spoke with the facility administrator. The surveyor asked the facility administrator if she could provide documentation that the facility staff had notified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 35	F 609		

the appropriate agencies of the allegation of abuse that had been documented in Resident # 314's clinical record that the surveyor reported to the facility staff on 10/10/19 at 3:54pm. The administrator informed the surveyor that there was no documentation that supported that the allegation of abuse documented in Resident # 314's clinical record had been reported to the appropriate agencies. The surveyor reiterated that the surveyor had reported an allegation of abuse to the facility on 10/10/19 at 3:54 pm. The administrator stated, "Oh I understand what you mean now."

The facility staff later provided the surveyor with a copy of a "Facility Reported Incident" form dated 10/16/19 for Resident # 314, which documented the allegation of abuse reported on 3/30/18.

The facility policy on "resident Abuse" contained documentation that included but was not limited to ..."4. Discipline:
c. The abuse coordinator of the facility will refer any or all incidents and reports of resident abuse to the appropriate state agencies." ...

The facility policy on "Resident Abuse - Staff to Resident" contained documentation that included but was not limited to
..."4. Notification MUST be made to the following of all residents involved in the incident.
a. Attending physician
b. Responsible Party
9. The administrator, director of nursing, or their designee MUST notify the local Adult Protective Service agency and the local Ombudsman of any abuse, neglect, mistreatment, and misappropriation of property immediately of their knowledge of the alleged incident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 36	F 609		

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 team 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 allegations 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 with 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 delirium, psychosis, or behaviors affecting care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 37 The resident was assessed as requiring extensive assistance of 2 or more persons for transfer, supervision for locomotion on the nursing unit in a wheelchair, and extensive assistance of one person for locomotion in a wheelchair off the unit. On 10/8/19, the surveyor reported to the director of nursing (DON) that a complaint had been made that resident Resident # 16 hit Resident # 97 on the leg, then Resident #97 yelled out and the resident had a leg xrayed. The surveyor asked for the investigation of the incident. The DON reported later that there was no record of a resident-resident altercation between the two. On 10/16/19 at 05:44 PM Surveyors asked for investigations of this allegation and others surveyors had reported from the complaints made to the Office of Licensure and Certification. The administrator stated staff had not reported the allegation or investigated. The DON stated that no report had been made to APS of the allegation. After surveyors asked about the report of investigation again during a summary meeting on 10/17/19, the administrator provided copies of a Facility Reported Incident dated 10/17/19.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the	F 610	1. Allegation of abuse for resident #314 investigation was initiated on 10/16/2019. 2. An audit was completed by the DON of Facility Reported Incidents to ensure investigations are completed. 3. The Administrator or designee re-educated nursing leadership on completing abuse allegation investigations.	12/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 38 investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and facility document review, it was determined that the facility staff failed to investigate abuse allegations for one of 30 Residents in the survey sample, Resident # 314. The findings included The facility staff failed to investigate an allegation of abuse that had been reported for Resident # 314. Resident # 314 was admitted to the facility on 10/16/17. Diagnoses included but were not limited to muscle weakness, chronic pain, and hypertension. The clinical record for Resident # 314 was reviewed on 10/9/19 at 9:54 am. The surveyor observed a nurse's note that had been documented on 3/30/18 at 6:27 pm. The nurse's not was documented as, "Resident alert with confusion noted, daughter reported to nurse that resident stated that he was beat up by two CNAs (certified nursing assistants) that took their clothes off while changing his clothes, all this was done on the floor, daughter stated that she wants staff to be more tactful when caring for her dad,	F 610	4. Audits will be conducted by the Administrator or designee of reportable (FRI) for complete investigation weekly for 4 weeks. The Administrator will submit the findings to the Quality Assurance and Performance Improvement Committee. The Administrator is responsible for monitoring and follow up. 5. 12/06/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 39	F 610		

reported incident to DON (director of nursing) with daughters present, staff went in to do skin assessment on resident, skin was clear, broken skin noted, daughter stated that she knows her father has bad memory but she was concerned. DON assured her that she would investigate the claim with other staff but no injuries are noted at this time."

On 10/10/19 at 3:54 pm, the director of nursing and administrator were made aware of the allegation of abuse that had been documented in Resident # 314's clinical record. The surveyor requested documentation that the allegation of abuse documented in Resident # 314's clinical record on 3/30/18 had been investigated.

On 10/11/19 at 8:15 am, the facility administrator informed the surveyor that she did not locate any documentation that reflected that the allegation of abuse documented in Resident # 314's clinical record had been investigated.

On 10/16/19 at 11:54 am, the surveyor spoke with the facility administrator. The surveyor asked the facility administrator if she could provide documentation that the facility staff had investigated the allegation of abuse that had been documented in Resident # 314's clinical record that the surveyor reported to the facility staff on 10/10/19 at 3:54pm. The administrator informed the surveyor that there was no documentation that supported that the allegation of abuse documented in Resident # 314's clinical record had been investigated. The surveyor reiterated that the surveyor had reported an allegation of abuse to the facility on 10/10/19 at 3:54 pm. The administrator stated, "Oh I understand what you mean now."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 40 The facility policy on "Resident Abuse" contained documentation that included but was not limited to ..."VIII Investigation of Abuse A. The Abuse Coordinator or his/her designee shall investigate all reports of suspected abuse. The facility policy on "Resident Abuse - Staff to Resident" contained documentation that included but was not limited to ..."10. The State Department of Health is to be notified immediately by the administrator, director of nursing or their designee of the facility's knowledge of any alleged incident of staff to resident abuse/neglect, and a written follow-up of the investigation must be sent within five (5) working days." ... On 10/17/19 at 4:52 pm, the survey team 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.	F 610		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the	F 622	1. Resident # 68, 39, 96 and 63 resident 12/06/2019 at facility with current Care Plans. 2. Residents with orders to be transfered to the emergency room (ER) are at risk for this deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	1607 SPRUCE STREET MARTINSVILLE, VA 24112

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F 622	Continued From page 41 resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified	F 622	3. Director of Nursing or designee re-educated the licensed nursing staff on sending the Transfer Envelope and required documentation including Care Plans with goals to the ER/hospital with resident and document in medical record noting items that were sent. 4. The Director of Nursing or designee will audit medical record of residents transfered to the ER/hospital to ensure required documentation including Care Plan with goals were sent and noted in medical record weekly for 8 weeks. The Director of Nursing will submit findings to the Quality Assurance and Performance Improvement Committee. The DON is responsible for monitoring and follow up. 5. 12/06/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 42 in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 43 This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to provide the receiving provider all of the required documentation including a comprehensive care plan when a resident was transferred to the hospital for 4 of 30 residents in the survey sample (Resident #68, #39, #96 and #63). The findings included: 1. The facility staff failed to provide the receiving provider/facility of the required documentation including the comprehensive care plan when Resident #68 was sent to the ER (emergency room) on 10/6/19. Resident #68 was readmitted to the facility on 9/14/19 and discharged on 10/6/19 The resident had the following diagnoses of, but not limited to anemia, heart failure, high blood pressure, diabetes, dementia and depression. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/23/19, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #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	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 44	F 622		

did not find any documentation of what medical information or the comprehensive care plan being provided to the receiving facility when Resident #68 was transferred to the ER on 10/6/19.

On 10/16/19 at approximately 11 am and again on 10/18/19 at approximately 2 pm, the surveyor requested copies of the discharge summary/transfer summary for this resident 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 requested the above documented paperwork that was sent to the receiving facility when the resident went to the ER on 10/6/19. The administrator stated, "We don't have any documentation of the information that you have requested."

No further information was provided to the surveyor prior to the exit conference on 10/18/19.

2. The facility staff failed to provide the receiving provider/facility of the required documentation including the comprehensive care plan when Resident #39 was sent to the ER (emergency room) on 7/20/19.

Resident #39 was readmitted to the facility on 7/22/19 after being discharged to the hospital on 7/20/19 for increased pain. The resident had the following diagnoses of, but not limited to coronary artery disease, high blood pressure, stroke and depression. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/31/19; the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 13 out of a possible score

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 45	F 622		

of 15. Resident #39 was also coded as being totally dependent on 1 staff member for dressing, personal hygiene and bathing.

During the clinical record review on 10/10/19 through 10/18/19, the surveyor noted that Resident #39 had a nurses' note dated and timed for 7/20/19 13:23 (1:23 pm) which read in part, " ...was in excruciating pain and he (medical doctor) stated to send her out to ER (emergency room) for evaluation ..." The surveyor did not find any documentation of what medical information or the comprehensive care plan being provided to the receiving facility when Resident #39 was transferred to the ER on 7/20/19.

On 10/16/19 at approximately 11 am and again on 10/18/19 at approximately 2 pm, the surveyor requested copies of the discharge summary/transfer summary for this resident 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 requested the above documented paperwork that was sent to the receiving facility when the resident went to the ER on 7/20/19. The administrator stated, "We don't have any documentation of the information that you have requested."

No further information was provided to the surveyor prior to the exit conference on 10/18/19.

3. The facility staff failed to provide the receiving provider/facility of the required documentation including the comprehensive care plan when Resident #96 was sent to the ER (emergency room) on 9/2/19.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 46	F 622		

Resident #96 was readmitted to the facility on 11/6/18 with the following diagnoses of, but not limited to coronary artery disease, heart failure, high blood pressure, renal failure, diabetes, stroke and depression. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 9/11/19 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #96 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and being totally dependent on 1 staff member for bathing.

During the clinical record review on 10/10/19 at 03:12 pm, the surveyor noted documentation in the nurses' notes dated and timed for 9/2/19 00:52 (12:52 am) which read in part, " ... Resident c/o (complains of) chest pain @ (at) 0015 (12:15 am) ...Resident rang call bell approximately 3 minutes and requested to be sent to the ED (emergency department) for further evaluation ..."

On 10/17/19 at 11:45 am, the surveyor asked for copies of the medical information including the comprehensive care plan that was sent to the receiving facility when the resident was transferred to the ED per resident request on 9/2/19. The surveyor was requested the medical information including the comprehensive care plan on 10/15/19, 10/16/19 times (2) and then again on 10/17/19 at approximately 10 am. The administrator stated to the surveyor, "We don't have any documentation of the information that you have requested."

No further information was provided to the surveyor prior to the exit conference on 10/18/19.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 47	F 622		

4. The facility staff failed to ensure that a copy of the comprehensive care plan goals were sent with Resident # 63 upon transfer to the hospital on 6/27/19.

Resident # 63 was originally admitted to the facility on 3/22/18, and had a readmission date of 7/2/19.

Diagnoses included but were not limited to, anemia, abnormal uterine and vaginal bleeding, paraplegia, and muscle weakness.

The clinical record for Resident # 63 was reviewed on 10/10/19 at 9:46 am. The most recent MDS (minimum data set) assessment for Resident # 63 was a quarterly assessment with an ARD (assessment reference date) of 8/21/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 63 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicated that Resident #63 was cognitively intact.

On 10/10/19 at 1:28 pm, the surveyor was in Resident # 63's room conducting a Resident interview. The surveyor asked Resident # 63 if she had been readmitted to the hospital since her admission to the facility. Resident # 63 informed the surveyor that she had lost a lot of blood and was admitted to the hospital. Resident # 63 stated, "I was as white as that sheet."

The surveyor reviewed a SBAR- Change of Condition note for Resident # 63 that was documented on 6/27/19 at 2:42 pm. The note was documented as, "Situation: Lab drawn today and had critical low HGB (hemoglobin) 5.0 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 48	F 622		

HCT (hematocrit) 16.0, albumin 2.9 Background: Resident stated her period was on for longer than a month and this was not the 1st time she experienced this.
Assessment: VS 122/70, 96.5, 73, 16, 98%, MD notified to have CBC (complete blood count) which was already in place due to 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."

On 10/16/19 at 5:14 pm, the surveyor requested documentation of information that had been sent with Resident # 63 upon transfer to the emergency room on 6/27/19.

On 10/17/19 at 4:52 pm, the survey team met with the administrator, the director of nursing, and the regional director of clinical services. The administrator and director of nursing agreed that there was no documentation that the comprehensive care plan goals were sent with Resident # 63 upon transfer to the emergency room on 6/27/19. 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	F 623	1. State Ombudsman was notified on 11/4/2019 of Resident #68 being transfered to ER on 10/6/2019. State Ombudsman was notified on 8/1/2019 of Resident #39 being transfered to ER on 7/20/2019. Resident #63 returned to facility where she currently reside. 2. Residents with an order to be transfered to the ER or for involuntary facility leave are at risk for the deficient practice. 3. Director of Nursing or designee re-educated the Social Work Director of the State Ombudsman notification requirements. The Director of Nursing re-educated licensed nursing staff on notifying residents and/or responsible parties of the reason the resident is being sent to the hospital in writing and noting in the medical record of the notification. 4. The ADON or designee will audit medical records of resident transfers to the ER or involuntary discharges to ensure required documentation of reason resident is being sent to the hospital is noted weekly for 8 weeks and the monthly notification to the State Ombudsman is sent for 2 months. The Director of Nursing will submit the findings to the Quality Assurance and Performance Improvement Committee. The DON is responsible for	12/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	1607 SPRUCE STREET MARTINSVILLE, VA 24112

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F 623	Continued From page 50 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.	F 623	monitoring and follow up. 5. 12/06/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	1607 SPRUCE STREET MARTINSVILLE, VA 24112

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F 623	Continued From page 51	F 623		

If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to notify the Ombudsman and/or resident upon discharge for 3 of 30 residents in the survey sample (Resident #68, #39, and #63).

The findings included:

1. The facility staff failed to notify the Ombudsman of the discharge of Resident #68 when the resident was sent to the ER (emergency room) on 10/6/19.

Resident #68 was readmitted to the facility on 9/14/19 and discharged on 10/6/19 The resident had the following diagnoses of, but not limited to anemia, heart failure, high blood pressure, diabetes, dementia and depression. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/23/19, the resident was coded as having a BIMS (Brief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	1607 SPRUCE STREET MARTINSVILLE, VA 24112

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F 623	Continued From page 52	F 623		

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 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 (emergency room) on 7/20/19.

Resident #39 was readmitted to the facility on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	1607 SPRUCE STREET MARTINSVILLE, VA 24112

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F 623	Continued From page 53	F 623		

7/22/19 after being discharged to the hospital on 7/20/19 for increased pain. The resident had the following diagnoses of, but not limited to coronary artery disease, high blood pressure, stroke and depression. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/31/19; the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 13 out of a possible score of 15. Resident #39 was also coded as being totally dependent on 1 staff member for dressing, personal hygiene and bathing.

During the clinical record review on 10/15/19 through 10/18/19, the surveyor noted a nurses' note dated and timed for 7/20/19 13:23 (1:23 pm) which read in part, " ...was in excruciating pain and he (medical doctor) stated to send her out 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 7/20/19.

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 #39 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.
3. The facility staff failed to notify Resident # 63 in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 54	F 623		

writing of reason for transfer to the hospital on 6/27/19.

Resident # 63 was originally admitted to the facility on 3/22/18, and had a readmission date of 7/2/19. Diagnoses included but were not limited to, anemia, abnormal uterine and vaginal bleeding, paraplegia, and muscle weakness.

The clinical record for Resident # 63 was reviewed on 10/10/19 at 9:46 am. The most recent MDS (minimum data set) assessment for Resident # 63 was a quarterly assessment with an ARD (assessment reference date) of 8/21/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 63 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicated that Resident #63 was cognitively intact.

On 10/10/19 at 1:28 pm, the surveyor was in Resident # 63's room conducting a Resident interview. The surveyor asked Resident # 63 if she had been readmitted to the hospital since her admission to the facility. Resident # 63 informed the surveyor that she had lost a lot of blood and was admitted to the hospital. Resident # 63 stated, "I was as white as that sheet."

The surveyor reviewed a SBAR- Change of Condition note for Resident # 63 that was documented on 6/27/19 at 2:42 pm. The note was documented as, "Situation: Lab drawn today and had critical low HGB (hemoglobin) 5.0 and HCT (hematocrit) 16.0, albumin 2.9 Background: Resident stated her period was on for longer than a month and this was not the 1st time she experienced this. Assessment: VS 122/70, 96.5,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 55 73, 16, 98%, MD notified to have CBC (complete blood count) which was already in place due to 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." On 10/16/19 at 5:14 pm, the survey team met with the administrator and director of nursing. The surveyor requested documentation of information that Resident # 63 had been made aware of the reason for transfer to the emergency room on 6/27/19 in writing. On 10/17/19 at 4:52 pm, the survey team met with the administrator, the director of nursing, and the regional director of clinical services. The administrator and director of nursing agreed that there was no documentation that Resident # 63 had been made aware of the reason for transfer to the emergency room on 6/27/19 in writing. 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.	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return-	F 625	1. Residents #68, 39, 96, and 63 currently reside at facility. 2. Residents with an order to be transfered to the ER are at risk of	12/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 56 §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to provide the resident or resident representative of the bed hold policy when 4 of 30 residents in the survey sample were discharged to the hospital (Resident #68, #39, #96 and #63). The findings included: 1. The facility staff failed to offer Resident #68	F 625	deficient practice. 3. DON or designee re-educated licensed nursing staff related to sending the Transfer Envelope including the bed hold policy and documenting in the medical record that the required information was sent with resident to the ER/hospital. 4. The ADON or designee will audit the medical record of residents transfered to the ER/hospital to ensure the transfer envelop including bed hold policy was sent and documented weekly for 8 weeks. The ADON will submit findings to the Quality Assurance and Performance Improvement. The DON is responsible for monitoring and follow up. 5. 12/06/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 57	F 625		

and the resident representative of the bed hold policy when the resident was discharged to the hospital on 10/6/19.
Resident #68 was readmitted to the facility on 9/14/19 and discharged on 10/6/19. The resident had the following diagnoses of, but not limited to anemia, heart failure, high blood pressure, diabetes, dementia and depression. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/23/19, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #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 bed hold policy being given to the resident and resident representative when the resident was discharged to the hospital on 10/6/19.
On 10/16/19 at approximately 11 am and again on 10/18/19 at approximately 2 pm, the surveyor requested copies of the discharge summary/transfer summary for this resident 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 requested the above documented paperwork that was sent to the receiving facility when the resident went to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 58	F 625		

ER on 10/6/19. The administrator stated, "We don't have any documentation of the information that you have requested."
No further information was provided to the surveyor prior to the exit conference on 10/18/19.

2. The facility staff failed to offer Resident #39 and the resident representative of the bed hold policy when the resident was transferred to the ER (emergency room) on 7/20/19.
Resident #39 was readmitted to the facility on 7/22/19 after being discharged to the hospital on 7/20/19 for increased pain. The resident had the following diagnoses of, but not limited to coronary artery disease, high blood pressure, stroke and depression. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/31/19; the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 13 out of a possible score of 15. Resident #39 was also coded as being totally dependent on 1 staff member for dressing, personal hygiene and bathing.

During the clinical record review on 10/15/19 through 10/18/19, the surveyor noted a nurses' note dated and timed for 7/20/19 13:23 (1:23 pm) which read in part, " ...was in excruciating pain and he (medical doctor) stated to send her out to ER (emergency room) for evaluation ..." The surveyor did not find any documentation of the Ombudsman being notified of the bed hold policy being given to the resident and resident representative when the resident was transferred to the ER on 7/20/19.
On 10/16/19 at approximately 11 am, the surveyor requested copies of the discharge summary/transfer summary for this resident from the director of nursing (DON) and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 59	F 625		

administrator. The surveyor was provided the copy of the bed hold policy that had Resident #39's name on the top of this policy but was not dated. On 10/18/19 at approximately 3 pm, the administrator stated to the surveyor, "We don't have any more documentation of the information that you have requested other than what we have already provided to you."
No further information was provided to the surveyor prior to the exit conference on 10/18/19.

3. The facility staff failed to offer Resident #96 and the resident representative of the bed hold policy when the resident was transferred to the ER (emergency room) on 10/10/19.
Resident #96 was readmitted to the facility on 11/6/18 with the following diagnoses of, but not limited to coronary artery disease, heart failure, high blood pressure, renal failure, diabetes, stroke and depression. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 9/11/19 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #96 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and being totally dependent on 1 staff member for bathing.

During the clinical record review on 10/10/19 at 03:12 pm, the surveyor noted documentation in the nurses' notes dated and timed for 9/2/19 00:52 (12:52 am) which read in part, " ... Resident c/o (complains of) chest pain @ (at) 0015 (12:15 am) ...Resident rang call bell approximately 3 minutes and requested to be sent to the ED (emergency department) for further evaluation ..."
On 10/16/19 at approximately 11 am, the surveyor requested copies of the discharge

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 60	F 625		

summary/transfer summary for this resident from the director of nursing (DON) and the administrator. The surveyor was provided the copy of the bed hold policy that had Resident #96's name on the top of this policy but was not dated. On 10/18/19 at approximately 3 pm, the administrator stated to the surveyor, "We don't have any more documentation of the information that you have requested other than what we have already provided to you."
No further information was provided to the surveyor prior to the exit conference on 10/18/19.
4. The facility staff failed to offer Resident # 63 a notice of bed hold upon transfer to the hospital on 6/27/19.

Resident # 63 was originally admitted to the facility on 3/22/18, and had a readmission date of 7/2/19. Diagnoses included but were not limited to, anemia, abnormal uterine and vaginal bleeding, paraplegia, and muscle weakness.

The clinical record for Resident # 63 was reviewed on 10/10/19 at 9:46 am. The most recent MDS (minimum data set) assessment for Resident # 63 was a quarterly assessment with an ARD (assessment reference date) of 8/21/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 63 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicated that Resident #63 was cognitively intact.

On 10/10/19 at 1:28 pm, the surveyor was in Resident # 63's room conducting a Resident interview. The surveyor asked Resident # 63 if she had been readmitted to the hospital since her admission to the facility. Resident # 63 informed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 61	F 625		

the surveyor that she had lost a lot of blood and was admitted to the hospital. Resident # 63 stated, "I was as white as that sheet."

The surveyor reviewed a SBAR- Change of Condition note for Resident # 63 that was documented on 6/27/19 at 2:42 pm. The note was documented as, "Situation: Lab drawn today and had critical low HGB (hemoglobin) 5.0 and HCT (hematocrit) 16.0, albumin 2.9 Background: Resident stated her period was on for longer than a month and this was not the 1st time she experienced this. Assessment: VS 122/70, 96.5, 73, 16, 98%, MD notified to have CBC (complete blood count) which was already in place due to 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."

On 10/16/19 at 5:14 pm, the survey team met with the administrator and director of nursing. The surveyor requested documentation of information that Resident # 63 had been offered a notice of bed hold upon transfer to the emergency room on 6/27/19.

On 10/17/19 at 1:30 pm, the facility provided the surveyor with copy of a "Notice of Bed Hold Policy" form that had Resident # 63's name handwritten on it. The surveyor observed that there was no date documented on the notice of bed hold policy form, and the surveyor was unable to verify that the form was provided to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 62 Resident # 63 upon transfer to the emergency room on 6/27/19. On 10/17/19 at 4:52 pm, the survey team met with the administrator, the director of nursing, and the regional director of clinical services. The administrator and director of nursing agreed that there was no documentation of a date on the notice of bed hold policy form that the facility had provided for Resident # 63, and also agreed that there was no way to verify if a notice of bed hold had been offered to Resident # 63 upon transfer to the emergency room on 6/27/19. 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.	F 625		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:	F 636	1. The annual MDS assessment for resident # 8 was completed on 10/14/2019. 2. Audits were completed by the MDS Coordinators for late assessments. 3. The Regional Clinical Reimbursement Director re-educated the MDS Coordinators of the OBRA required MDS assessment and completion requirements. 4. Audits will be completed by the MDS Coordinator for timely and completed assessments weekly for 8 weeks. The MDS Coordinator will submit findings to the Quality Assurance and Performance	12/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 636	Continued From page 63 (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or	F 636	and Improvement Committee. The DON is responsible for monitoring and follow up. 5. 12/06/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 636	Continued From page 64	F 636		

mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)
(iii)Not less than once every 12 months.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview, the facility staff failed to periodically conduct a standardized reproducible assessment by completing an annual assessment for 1 of 30 residents in the survey sample (Resident # 8).

Resident #8 was admitted to the facility on 11/6/18. Diagnoses included diabetes mellitus with diabetic nephropathy, contracture of left wrist and hand, anemia, dysphagia, hemiplegia and hemiparesis following infarct, acquired absence or leg, essential hypertension, atherosclerosis with ulceration of left heel, symbolic dysfunctions, paraplegia, and other sequelae of cerebrovascular disease. On the quarterly Minimum Data Set (MDS) assessment with assessment reference date 6/10/19, the resident scored 10/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care.

Clinical record review on 10/10/19 at 9:07 AM revealed the Annual Minimum Data Set assessment due 9/10/19 had not been completed by 10/10/19. The surveyor reported the concern to the MDS Coordinator, who stated that an assessment had been initiated but not completed and acknowledged that it was late. Further record review revealed that the assessment was completed on 10/14/19.

The administrator and director of nursing were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 636	Continued From page 65 notified of the concern during on 10/10/19,	F 636		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview the facility staff failed to ensure that two of 30 residents in the survey sample received the necessary services as outline in the Level II PASARR, Resident #9 and Resident #74. 1. The facility staff failed to ensure that Resident # 9 had restorative nursing and outpatient psychiatric services as recommended in her Level II PASARR (preadmission screening and record review). Resident # 9 was originally admitted to the facility	F 644	1. Resident # 9 and # 74 reside at facility with PASARR. 2. Audit was conducted by the Social Services Director of PASARR and recommendations. 3. Re-education was provided by the Administrator to the Social Services Director and leadership team of PASARR and the recommendations of necessary services. 4. Audits will be completed by the Social Services Director or designee to ensure PASARR recommendations are being followed as medically necessary and appropriate weekly for 8 weeks. The Social Services Director will submit findings to the Quality Assurance and Performance Improvement Committee. The Administrator is responsible for monitoring and follow up. 5. 12/06/2019	12/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 644	Continued From page 66	F 644		

on 1/27/11, and had a readmission date of 9/10/18. Diagnoses included but were not limited to, schizoaffective disorder, psychotic disorder, anxiety, and major depressive disorder.

The clinical record for Resident # 9 was reviewed on 10/10/19 at 11:10 am. The most recent MDS (minimum data set) assessment was a significant change assessment with an 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.

On 10/11/19 at 12:06 pm, the facility social worker provided the surveyor with a Level II PASARR for Resident # 9 that had been completed on 3/6/18. The Level II PASARR recommended rehabilitative services of basic grooming needs, non-customized durable medical equipment, OT (occupational therapy), PT (physical therapy), Restorative Nursing, Psychiatric Consultations, Crisis Intervention, Outpatient Psych, Psychotropic Med Management, Targeted Case Management. The surveyor reviewed the clinical record for Resident # 9 and did not find documentation that reflected that Resident # 9 had received or been offered restorative nursing or outpatient psych services.

On 10/16/19 at 5:37 pm, the administrator and director of nursing were made aware that the surveyor did not locate documentation that Resident # 9 had received restorative therapy and outpatient psych services as recommended in the Level II PASARR that had been completed on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 644	Continued From page 67	F 644		

3/6/18. 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 #74, facility staff failed to incorporate the recommendations from the PASARR level II determination and the PASARR evaluation report into the resident's comprehensive care plan.

Resident #74 was admitted to the facility on 10/26/11. Diagnoses included catatonic schizophrenia, functional quadriplegia, epilepsy, gastrostomy, chronic pain, muscle weakness, dysphagia, convulsions, lack of falls, ischemia, Parkinson's disease, major depressive disorder, anxiety, and hypertension. On the Minimum Data Set assessment with assessment reference date 8/31/19, the resident scored 15/15 and was assessed as without signs of delirium, psychosis, or behaviors affecting care.

Clinical record review on 10/10/19 at 10:19 AM revealed the PASSAR II done on admission in 2013 recommended rehab for basic grooming, DME, PT, OT, psychiatric services, psychiatric outpatient services, and targeted case management. The surveyor found no orders for PT, OT, psychiatric services or any evidence through social services of targeted case management. The surveyor was unable to locate evidence of subsequent assessments determining that those services were unnecessary.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 644	Continued From page 68 None of the resident's care plans mentioned the needs identified in the PASARR level II. During an interview with social worker Gwen Martin on 10/15/19 at 1:54 PM, she offered a note dated 8/23/19 that said the resident had been evaluated 8/29/18; or maybe 8/29/19. The note from 8/23/19 said that there had been an order for an assessment of hand for orthotic. She said there was likely a visit in the resident's room on 8/29/19. The assessor did not recommend a custom orthotic. The surveyor and social worker discussed the recommendation for targeted case management which did not appear to have been met. The social worker speculated that the local Community Services Board might provide that service. The surveyor noted that the psychiatric services recommended had not been provided. The administrator and director of nursing were notified of the concern during a summary meeting on 10/16/19.	F 644		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information	F 655	1. Residents #68 and #39 reside at facility with Comprehensive Care Plans in place. 2. Audit was completed for Baseline Care Plan and summary for new admissions and readmissions for the past 30 days. 3. Director of Nursing or designee re-educated licensed nursing staff that baseline care plan must me completed within 48 hours of admission, summary	11/29/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 69 necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to complete a baseline care plan for 2 of 30 residents in the survey sample (Resident #68 and #39). The findings included:	F 655	provided to resident or responsible party and noted in medical record. 4. The Director of Nursing or designee will complete random audits to ensure Baseline Care Plans were completed within 48 hours and summary was provided and noted as given weekly for 8 weeks. The Director of Nursing will submit findings to the Quality Assurance and Performance Improvement Committee. The DON is responsible for monitoring and follow up. 5. 12/06/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 70 1. The facility staff failed to complete the base line care plan when Resident #68 was readmitted to the nursing facility on 9/14/19. Resident #68 was readmitted to the facility on 9/14/19 after being discharged to the hospital on 9/11/19 for the resident coughing up blood. The resident had the following diagnoses of, but not limited to coronary artery disease, high blood pressure, stroke and depression. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/31/19; the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 13 out of a possible score of 15. Resident #68 was also coded as being totally dependent on 1 staff member for dressing, personal hygiene and bathing. During the clinical record review on 10/15/19 through 10/18/19, the surveyor noted a nurses' note dated and timed for 9/11/19 which read in part, " ...resident went to therapy and began coughing up blood.MD (medical doctor) on call gave order to send resident to the hospital." The surveyor did not find any documentation of the baseline care plan being completed when the resident was readmitted to the facility on 9/14/19. On 10/16/19 at approximately 11 am, the surveyor requested a copy of the baseline care plan that was completed for Resident #68 was readmitted to the facility on 9/14/19 from the director of nursing (DON) and the administrator. The administrator stated to the surveyor, "We don't have any more documentation of the information that you have requested other than what we have already provided to you." No further information was provided to the surveyor prior to the exit conference on 10/18/19.	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 71	F 655		

2. The facility staff failed to complete the baseline care plan when Resident #39 was readmitted to the nursing facility on 7/22/19 after being discharged to the hospital on 7/20/19 for increased pain.
Resident #39 was readmitted to the facility on 7/22/19 after being discharged to the hospital on 7/2019. The resident had the following diagnoses of, but not limited to coronary artery disease, high blood pressure, stroke and depression. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/31/19; the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 13 out of a possible score of 15. Resident #39 was also coded as being totally dependent on 1 staff member for dressing, personal hygiene and bathing.

During the clinical record review on 10/15/19 through 10/18/19, the surveyor noted a nurses' note dated and timed for 7/20/19 13:23 (1:23 pm) which read in part, " ...was in excruciating pain and he (medical doctor) stated to send her out to ER (emergency room) for evaluation ..." The surveyor did not find any documentation of the baseline care plan being completed on 7/22/19 when the resident was readmitted to the facility.
On 10/18/19 at 10:57 am, the surveyor did not find any documentation of the baseline care plan being completed when the resident was readmitted to the facility on 7/22/19. The surveyor has asked multiple times for this information to be provided to the surveyor on 10/16/18 and 10/17/19 from the administrator and the director of nursing.
On 10/18/19 at approximately 3 pm, the administrator stated to the surveyor, "We don't

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 72 have any more documentation of the information that you have requested other than what we have already provided to you." No further information was provided to the surveyor prior to the exit conference on 10/18/19.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656	1. Resident # 74 and # 73 reside at facility with a Comprehensive Care Plan and PASARR. Resident # 108 no longer resides at the facility. 2. Audit was conducted by the Social Services Director of PASARR and the noted recommendations. Audit was conducted by MDS Coordinator of Hospice residents Care Plans. 3. Re-education was provided by the Administrator or designee to the care plan team staff related to developing a Comprehensive Care Plans and review and follow up of the PASARR and the recommendations of necessary services as appropriate. Re-education was provided by the Regional Clinical Reimbursement Director to the MDS Coordinators Care Plan requirements for 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 for 8 weeks. The MDS Coordinator will audit	12/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 73 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, facility staff failed to develop and implement a comprehensive person-centered care plan for 3 of 30 Residents in the survey sample resulting in failure to provide specialized services or specialized rehabilitative services the nursing facility would provide as a result of PASARR recommendations (Resident #74) and to attain highest practicable well-being related to hospice care (Resident #108)and behavioral health (Resident #73). 1. For Resident #74, facility staff failed to incorporate the recommendations from the PASARR level II determination and the PASARR evaluation report into the resident's comprehensive care plan. Resident #74 was admitted to the facility on 10/26/11. Diagnoses included catatonic schizophrenia, functional quadriplegia, epilepsy, gastrostomy, chronic pain, muscle weakness, dysphagia, convulsions, lack of falls, ischemia, Parkinson's disease, major depressive disorder, anxiety, and hypertension. On the Minimum Data Set assessment with assessment reference date	F 656	Hospice resident care plans weekly for 8 weeks. 4.The Social Services Director will submit findings to the Quality Assurance and Performance Improvement Committee. The MDS Coordinator will submit findings to the Quality Assurance and Performance Improvement Committee. The DON is responsible for monitoring and follow up. 5. 12/06/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 74	F 656		

8/31/19, the resident scored 15/15 and was assessed as without signs of delirium, psychosis, or behaviors affecting care.

Clinical record review on 10/10/19 at 10:19 AM revealed the PASSAR II done on admission in 2013 recommended rehab for basic grooming, DME, PT, OT, psychiatric services, psychiatric outpatient services, and targeted case management. The surveyor found no orders for PT, OT, psychiatric services or any evidence through social services of targeted case management. The surveyor was unable to locate evidence of subsequent assessments determining that those services were unnecessary.

None of the resident's care plans mentioned the needs identified in the PASARR level II.

During an interview with social worker Gwen Martin on 10/15/19 at 1:54 PM, she offered a note dated 8/23/19 that said the resident had been evaluated 8/29/18; or maybe 8/29/19. The note from 8/23/19 said that there had been an order for an assessment of hand for orthotic. She said there was likely a visit in the resident's room on 8/29/19. The assessor did not recommend a custom orthotic. The surveyor and social worker discussed the recommendation for targeted case management which did not appear to have been met. The social worker speculated that the local Community Services Board might provide that service. The surveyor noted that the psychiatric services recommended had not been provided.

The administrator and director of nursing were notified of the concern during a summary meeting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 75	F 656		

on 10/16/19.
2. For Resident #73, the facility staff failed to develop a comprehensive care plan to include psychological services.

Resident #73's face sheet listed an admission date of 8/20/18 and a readmission date of 1/25/19. The resident's diagnosis list indicated diagnoses, which included, but not limited to Bipolar Disorder, Generalized Anxiety Disorder, Major Depressive Disorder, Alcohol Induced Chronic Pancreatitis, Alcoholic Cardiomyopathy and Radiculopathy of the Lumbosacral Region.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 8/28/19 assigned the resident a BIMS (brief interview for mental status) score of 14 out of 15 in section C, cognitive patterns. Resident #73 was also coded as being totally dependent for bathing and requiring extensive assistance for dressing and personal hygiene.

Resident #73's medical record contained an active physician's order dated 2/12/19 stating "Deer Oaks may provide Psychological Services and/or Med Management Associate Services may provide Psychiatric Services." A "Psychiatric Initial Assessment" for the date of service of 9/13/19 was present in the medical record stating in part, "Patient gave verbal consent for treatment. Patient has been made aware of potential side effects. Patient understands the risks vs. benefits of treatment with psychotropics. Future visits: revisit in 2 weeks."

Upon review, Resident #73's current comprehensive care plan did not include the provision of psychological services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 76	F 656		

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 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 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 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 "Admit to full services of Commonwealth Hospice."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 77 Upon review, Resident #108's comprehensive care plan did not include hospice services. The concern of Resident #108's comprehensive care plan not including hospice services was discussed with the administrative staff (administrator and director of nursing) on 10/16/19 at approximately 5:15pm. On 10/17/19 at approximately 9:00am, the administrator provided the surveyor with a portion of the resident's revised comprehensive care plan stating in part, "Patient is on Hospice care related to: End of life care. Date Initiated: 10/16/19." No further information was provided prior to exit conference on 10/18/19.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined	F 657	1. Resident # 29, #47, #63, #94 Care Plan was reviewed and revised on 10/15/2019. Resident # 39 and #58 Care Plan was reviewed and revised on 11/29/2019. 2. Residents who reside at facility are at risk for this deficient practice. 3. Re-education was provided by the Director of Nursing or designee to the Licensed Nurses to ensure care plans are being reviewed and revised. 4. The ADON or designee will audit at least 10 random Care Plans weekly for review/revision dates for 8 weeks. The ADON will submit findings to the Quality Assurance and Performance Improvement Committee. The DON is responsible for	12/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 78 not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed to review and revise the comprehensive care plan for 6 of 30 residents in the survey sample (Resident #29, #39, #58, #78, #63 and #94). The findings included: 1. The facility staff failed to review and revise the comprehensive care plan for Resident #29. 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 Interview for Mental Status) score of 15 out of a possible score of 15. Resident #29 was also coded as requiring supervision of 1 staff member for dressing and personal hygiene and requiring physical help in part of the bathing activity from 1 staff member. During the clinical record review from 10/8/19 through 10/18/19, the surveyor noted the following documentation in the nursing notes	F 657	Performance Improvement Committee. The DON is responsible for monitoring and follow up. 5. 12/06/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 79 dated and timed for: " ...9/8/19 19:33 (7:33 pm) Situation: Writer called into dining room by aide; resident sitting in front of wheelchair. Aide states resident had an altercation with another resident. Background: Bipolar, Anxiety Disorder Assessment: Upon assessment _____ (name of Resident #29) scalp is reddened and missing hair. No other injuries noted. Response: On call MD (medical doctor) made aware, Own R.P. (responsible party), DNS (director of nursing services) and Administrator made aware. Police notified. Deputy _____ (name of deputy) returned call stating that he doesn't have to come out, whom ever is harmed needs to go to the magistrates office to file charges, This information given to _____ (name of resident). She got in touch with her daughter and she came and signed her mom out to go to the Office ... 9/13/19 16:27 (4:27 pm) Resident stated her head was sore from where the other resident pulling her hair out. Resident reported she is doing ok and has filed charges against the other resident ..." The surveyor reviewed the care plan for Resident #29 and the following was documented in the care plan with a date in which the care plan was initiated was 6/8/12 and a revision date of 5/3/19: " ...Focus: I sometimes have behaviors which include: demanding my showers at shift change and to be the first resident showered. Demanding staff to stay with for hour long intervals during the showers. Making false accusations against staff. Reporting missing objects that are not missing. Trying to sneak and take showers unassisted ... Interventions:	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 80 o Attempt interventions before my behaviors begin. o Explained to resident she cannot always be first, but will try to get her showered ASAP (as soon as possible) o Give me my medications as my doctor has ordered o Help me to avoid situations or people that are upsetting to me o Let my physician know if I my behaviors are interfering with my daily living o Make sure I am not in pain or uncomfortable o Offer me something I like as diversion o Please refer to my psychologist/psychiatrist as needed o Please tell me what you are going to do before you begin o Speak to me unhurriedly and in a calm voice ..." The surveyor noted the date documented for the focus and interventions were initiated on 3/3/14 with a revision date of 1/16/17. There were no interventions noted by the surveyor after the resident to resident altercation that had occurred on 9/8/19. The surveyor also noted an "Emergency Protective Order" dated for 9/8/19 at 8:10 pm in which named Resident #29 as being the alleged victim was to have no contact with the other resident involved in the altercation. The order expired on 9/11/19 at 11:59 pm. The surveyor did not note documentation that the resident's care plan was reviewed or revised after each of the above documented altercations or after the "Emergency Protective Order" was in place from 9/8/19 through 9/11/19. On 10/15/19 at 3:34 pm, the surveyor notified the	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 81	F 657		

administrator, director of nursing and the regional corporate nurse of the above documented findings.

No further information was provided to the surveyor prior to the exit conference on 10/18/19 to support that the care plan was reviewed and revised after each of the altercations documented above or after the "Emergency Protective Order" was in place from 9/8/19 to 9/11/19 for Resident #29.

2. The facility staff failed to review or revise the comprehensive care plan for Resident #39.

Resident #39 was readmitted to the facility on 7/22/19 after being discharged to the hospital on 7/20/19 for increased pain. The resident had the following diagnoses of, but not limited to coronary artery disease, high blood pressure, stroke and depression. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/31/19; the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 13 out of a possible score of 15. Resident #39 was also coded as being totally dependent on 1 staff member for dressing, personal hygiene and bathing.

During the clinical record review on 10/10/19 through 10/18/19, the surveyor noted that Resident #39 care plan was not reviewed or revised to include the specific targeted behaviors that were being monitored while the resident was receiving Effexor 75 mg (milligram) each day for depression.

On 10/16/19 at approximately 11 am and again on 10/18/19 at approximately 2 pm, the surveyor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 82	F 657		

requested copies of the comprehensive care plan (CCP) for Resident #39 that included the review and revision of the CCP for the resident's specific targeted behaviors that were associated to the use of the psychotropic medication, Effexor, which was administered to the resident for depression. The surveyor was provided copies of the residents CCP. The surveyor noted documentation that the CCP was initiated on 10/17/17 and had a revision date of 6/7/19. The documented interventions that were revised on 6/7/19 included the following, which read in part, " ... Provide medications as ordered by physician and evaluate the effectiveness inform MD PRN and Psychotropic medication risk/benefit and reduction plan as recommended by physician and pharmacist."

Also during the clinical record review, the surveyor noted that the resident had sustained a "minimal acute appearing compression fracture at the L2 vertebral body" after the resident had been inappropriately transferred by the facility staff on 7/20/19. The resident's CCP did reflect that it had been reviewed or revised after the resident had received the above documented injury. The intervention that had a revision date of 7/23/19 read in part, " ...Transfer using a hoyer lift X (times) 2 person assistance ..." The surveyor noted the same intervention that had been initiated on Resident #39's CCP had a documented date of "6/7/19". This intervention had remained the same when revised on 7/23/19.

The surveyor notified the administrator, director of nursing and the regional corporate nurse of the above documented findings on 10/16/19 at approximately 11 am and then again on 10/18/19 at approximately 2 pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 83	F 657		

No further information was provided to the surveyor prior to the exit conference on 10/18/19.

3. The facility staff failed to review and revise Resident #58's Comprehensive Care Plan (CCP) to reflect the specific targeted behaviors that were being monitored by the facility staff while the resident was receiving psychotropic medications.

Resident #58 was admitted to the facility with the following diagnoses of, but not limited to high blood pressure, Alzheimer's disease, dementia, depression and psychotic disorder. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/14/19 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 8 out of a possible score of 15. Resident #58 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene.

During the clinical record review on 10/16/19 and 10/17/19, the surveyor noted that there were no specific targeted behaviors that the staff was to be monitoring The CCP for the focus of " ...Potential for drug related complications associated with use of psychotropic medications relate to Anti-depressant medication, Anti-Psychotic medications ..." had an initiated date of 6/6/17. The surveyor noted a revision date of 7/15/19 which read, " ...Observe for side effects and report to physician: Antipsychotic medications-sedation, drowsiness, dry mouth, constipation, blurred vision, ...weight gain, edema, postural hypotension, sweating, loss of appetite, urinary retention ..." The surveyor did not find documentation of specific targeted behaviors that the facility staff was to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 84	F 657		

monitoring while the resident was receiving psychotropic medications for psychosis and major depressive disorder.

The surveyor notified the administrator, director of nursing and the regional corporate nurse on 10/16/19 at 5:15 pm in the conference room.

No further information was provided to the surveyor prior to the conference room on 10/18/19.

4. The facility staff failed to review and revise the comprehensive care plan for Resident # 47 to include Resident-to-Resident altercations.

Resident # 47 was a 60-year-old-female that was admitted to the facility on 5/11/17. Diagnoses included but were not limited to, anxiety, major depressive disorder, traumatic brain injury, and hypertension.

The clinical record for Resident # 47 was reviewed on 10/9/19 at 2:27 pm. The most recent MDS (minimum data set) assessment for Resident # 47 was a quarterly assessment with an ARD (assessment reference date) of 8/5/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 47 had a BIMS score (brief interview for mental status) of 15 out of 15, which indicated that Resident # 47 was cognitively intact.

The surveyor reviewed the progress notes for Resident # 47. The surveyor reviewed a" SBAR Change of Condition" note that was documented on 9/8/19 at 8:23 pm. The note was documented as " Situation: Resident # 47 approached another resident after resident called her son a bastard

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 85	F 657		

child and pulled her hair then resident fell. Background: COPD (chronic obstructive pulmonary disorder) anxiety, TBI (traumatic brain injury) Assessment: Upon assessment Resident # 47 is upset about her son being called a bastard child. She has no new injury, her skin assessment completed no new bruising Response: MD (medical doctor) notified DNS (director of nursing services) administrator, police notified. Skin check complete Resident # 47 aware that resident was seeking to press charges against Resident # 47, she became upset."

The surveyor reviewed the current plan of care for Resident # 47. The surveyor did not locate any documentation that the plan of care for Resident # 47 had been updated to reflect the Resident-to-Resident altercation that occurred on 9/8/19.

On 10/10/19 at 3:54 pm, the administrator and director of nursing were made aware of the findings as stated above. 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.

5. The facility staff failed to review and revise the plan of care to reflect that Resident # 63 had episodes of excessive vaginal bleeding.

Resident # 63 was a 47-year-old-female that was originally admitted to the facility on 3/22/18, and had a readmission date of 7/2/19.
Diagnoses included but were not limited to,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 86	F 657		

anemia, abnormal uterine and vaginal bleeding, paraplegia, and muscle weakness.

The clinical record for Resident # 63 was reviewed on 10/10/19 at 9:46 am. The most recent MDS (minimum data set) assessment for Resident # 63 was a quarterly assessment with an ARD (assessment reference date) of 8/21/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 63 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicated that Resident #63 was cognitively intact.

On 10/10/19 at 1:28 pm, the surveyor was in Resident # 63's room conducting a Resident interview. The surveyor asked Resident # 63 if she had been readmitted to the hospital since her admission to the facility. Resident # 63 informed the surveyor that she had lost a lot of blood and was admitted to the hospital. Resident # 63 stated, "I was as white as that sheet."

The surveyor reviewed the progress notes for Resident # 63. The surveyor observed a "SBAR-Change in Condition" note that had been documented on 12/23/18 at 9:47 am. The note contained documentation that included but was not limited to ..."Situation: Resident is bleeding from vaginal area Assessment: Resident is bleeding from vaginal area with heavy bright blood with clots present. Resident states she feels weak Response: MD (medical doctor) notifies. New orders to send to ER (emergency room) ED (emergency department) notified of transfer)." ...

The surveyor observed a nurse's note that had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 87	F 657		

been documented on 6/27/19 at 10:59 am. The nurse's note contained documentation that included but was not limited to ..."Resident alert and oriented, complained of menstrual was on for a month. She appears to be pale and states she felt weak. VS (vital signs) 96.5, 122/70, 73, 16, 98%. MD (medical doctor) notified of concern." ...

The surveyor reviewed a SBAR- Change of Condition note for Resident # 63 that was documented on 6/27/19 at 2:42 pm. The note was documented as, "Situation: Lab drawn today and had critical low HGB (hemoglobin) 5.0 and HCT (hematocrit) 16.0, albumin 2.9 Background: Resident stated her period was on for longer than a month and this was not the 1st time she experienced this. Assessment: VS 122/70, 96.5, 73, 16, 98%, MD notified to have CBC (complete blood count) which was already in place due to neurology appointment being schedule after results. Response: MD (physician's name withheld) stated send resident to hospital."
The surveyor reviewed the current plan of care for Resident # 63. The surveyor did not locate any documented revisions on the plan of care that reflected that Resident # 63 had episodes of excessive vaginal bleeding.

On 10/16/19 at 5:14 pm, the administrator and director of nursing were made aware that the plan of care for Resident # 63 had not been revised to reflect that Resident # 63 had episodes of excessive vaginal bleeding. The administrator and director of nursing agreed that the plan of care for Resident # 63 should have been revised to reflect episodes of excessive vaginal bleeding. The administrative team was provided the opportunity to ask questions and submit additional documentation in response to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 88	F 657		

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.

6. The facility staff failed to review and revise the comprehensive care plan for Resident # 94 to include the use of a neck brace per physician's orders and Resident # 94's noncompliance with wearing a neck brace.

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.

The clinical record for Resident # 94 was reviewed on 10/11/19 at 8:48 am. The most recent MDS (minimum data set) assessment for Resident # 94 was a quarterly assessment with an ARD (assessment reference date) of 9/13/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 94 had a BIMS (brief interview for mental status) score of 10 out of 15, which indicated that Resident # 94's cognitive status was moderately impaired.

Resident # 94 had orders that included but were not limited to, "Hard neck brace in place at all times. Soft neck brace on while in the shower only every shift."

On 10/08/19 at 2:12 pm, the surveyor was in Resident # 94's room conducting a resident interview. The surveyor observed a hard neck brace on Resident # 94's nightstand. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 89	F 657		

surveyor asked Resident # 94 if he was supposed to be wearing the neck brace that was on his nightstand. Resident # 94 stated that he took the neck brace off himself.

The surveyor reviewed the current plan of care for Resident # 94. The surveyor did not observe and documentation that reflected that the comprehensive care plan for Resident # 94 had been revised to reflect the use of the neck brace per physician's orders or Resident # 94's noncompliance with wearing the neck brace.

On 10/11/19 at 11:31 am, the surveyor interviewed MDS nurse # 1. The surveyor and MDS nurse # 1 reviewed the comprehensive care plan for Resident # 94. The surveyor asked MDS nurse # 1 if the comprehensive care plan should be updated to reflect the use of a neck brace ordered by a physician and that Resident # 94 was non-compliant with wearing the neck brace. MDS nurse # 1 stated, "Yes," and agreed that the comprehensive care plan for Resident # 94 did not reflect the use of neck brace and did not reflect Resident # 94's non-compliance with wearing the neck brace.

On 10/16/19 at 5:14 pm, the administrator and director of nursing were made aware that the plan of care for Resident # 94 had not been revised to reflect that Resident # 94 had physician's orders for a neck brace and that Resident # 94 was non-compliant with wearing the neck brace. The administrative team was provided the opportunity to ask questions and submit additional documentation in response to the deficient practice as stated above.

No further information regarding this issue was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 90 presented to the survey team prior to the exit conference on 10/18/19.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and facility document review, the facility staff failed to provide care consistent with professional standards of practice for two of 30 Residents in the survey sample, Resident # 47 and Resident # 96. The findings included 1. The facility staff failed to document the administration of Clonazepam on the medication administration record for Resident # 47. Resident # 47 was a 60-year-old-female that was admitted to the facility on 5/11/17. Diagnoses included but were not limited to, anxiety, major depressive disorder, traumatic brain injury, and hypertension. The clinical record for Resident # 47 was reviewed on 10/9/19 at 2:27 pm. The most recent MDS (minimum data set) assessment for Resident # 47 was a quarterly assessment with an ARD (assessment reference date) of 8/5/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff	F 658	1.Residents # 47 and # 96 are currently receiving care consistent with professional standards. 2. Residents admitted to the facility or residing in the facility with medication orders are at risk for this deficient practice. 3. Re-education was provided by the Director of Nursing or designee to nursing staff to complete the MAR when administering medication and ensure assessments will not be initiated prior to the resident arriving at the facility. 4. The ADON or designee will conduct random audit of admissions and readmissions for assessment initiation date and administration of medication documentation on the MAR at least weekly for 8 weeks. The ADON will submit audit findings to the Quality Assurance and Performance Improvement Committee. The DON is responsible for monitoring and follow up. 5. 12/06/2019	12/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 91	F 658		

documented that Resident # 47 had a BIMS score (brief interview for mental status) of 15 out of 15, which indicated that Resident # 47 was cognitively intact.

Resident # 47 had orders that included but were not limited to, "Clonazepam tablet 0.5 mg (milligram) Give 0.5 mg every 12 hours as needed for anxiety," which was initiated by the physician on 8/26/19 and was discontinued on 9/13/19.

The current plan of care for Resident # 47 was reviewed and revised on 8/19/19. The facility staff documented a focus area for Resident # 47 as, "Potential for drug related complications associated with the use of psychotropic medications related to: anti-anxiety medication, anti-depressant medication, hypnotic medication." Interventions included but were not limited to, "Provide medications as ordered by physician and evaluate for effectiveness."

The surveyor reviewed the September 2019 eMAR (electronic medication administration record) for Resident # 47. The surveyor observed documentation on the eMAR that reflected that Resident # 47 had received clonazepam prn (as needed) on the following dates: 9/2/19, 9/6/19, 9/11/19 and 9/12/19. The surveyor reviewed the "Controlled Drug Record" for Clonazepam for Resident # 47 and observed documentation that reflected that Resident # 47 had been administered Clonazepam 0.5 mg on 9/4/19, 9/5/19, 9/7/19, and 9/8/19 that had not been documented on the September 2019 eMAR.

On 10/10/19 at 3:54 pm, the surveyor informed the director of nursing and the administrator of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 92	F 658		

the discrepancy in the documentation of administration of Clonazepam that had been identified for Resident # 47.

On 10/15/19 at 10:22 pm, the director of nursing informed the surveyor that she had interviewed the nurse that administered the medication and the nurse reported that she was used to the Clonazepam being scheduled and that she had forgotten to document on the eMAR. The surveyor asked the director of nursing when nursing staff is expected to document medication administration. The director of nursing stated, "Immediately after administration."

The facility policy and standard of practice for "Medication Administration" contained documentation that included but was not limited to,
..."Documentation:
1. The individual who administers the medication dose, records the administration on the resident's MAR (medication administration record) immediately following the medication being given." ...

On 10/17/19 at 4:52 pm, the administrator, director of nursing, and regional director of clinical services were made aware of the deficient practice as stated above. The administrative team was provided the opportunity to ask questions and provide further information in response to the deficient practice as stated above.

No further information regarding this issue was provided to the survey team prior to the exit conference on 10/18/19.
2. The facility staff failed to follow professional

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 93	F 658		

standards of practice for Resident #96 when documenting in the clinical record.

Resident #96 was readmitted to the facility on 11/6/18 with the following diagnoses of, but not limited to coronary artery disease, heart failure, high blood pressure, renal failure, diabetes, stroke and depression. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 9/11/19 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #96 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and being totally dependent on 1 staff member for bathing.

During the clinical record review, the surveyor on 10/17/19 noted the resident had been admitted to the hospital on 9/2/19 at 6:48 am due to the resident having chest pain. The surveyor was reviewing the "Admission Data Collection Form" and the most recent admission was documented as being "09/06/19 1928 (7:28 pm)". The surveyor reviewed the nursing notes documented for "9/7/19 06:38 (6:38 am)" Admission, which read in part, " ...Resident readmitted to _____ (name of nursing facility) in room ____ (room number) at approx... (approximately 0530 (5:30 am) ..." The surveyor reviewed the MDS with ARD of 9/6/19 in which the documented entry date was "09/06/19" in Section A Identification Information. On 10/17/19 at 12:30 pm, the surveyor notified the administrator of the above documented findings of the inconsistent admission dates for Resident #96.

The administrator returned to the surveyor at 1:55 pm and stated, "I got this from _____ (name of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 94 hospital) and the discharge date from the hospital was 9/7/19 at 5:02 am. So the nurses' notes are correct in saying the resident was admitted to the facility on 9/7/19." The surveyor stated to the administrator, "But there is still an issue with the nursing assessment dated as the admission to the facility was 9/6/19 at 19:28 (7:28 pm). This is reflecting that the nursing admission documentation on the "Admission Data Collection Form" was documented before the resident was actually physicially in the nursing facility. Is it acceptable for the nursing staff to document in the nursing notes' before the resident is in the building?" The administrator stated, "No, the nurses' should not document before the resident arrives in the building." The surveyor requested and received a copy of the facility's policy on nursing documentation titled "Admission Data Collection" which read in part, " ...Upon admission and/or readmission to Facility, the nurse in charge shall complete a Data Collection Form to facilitate the beginning and/or revisions of the plan of care ... Nurses' notes should include the following information. If not on the Admission Data Collection Form: A. Time of admission B. Date of admission ..." Basic Nursing, Essentials for Practice, 6th Edition (Potter and Perry, 2007 Pages 136-149), Was Used as a Reference for Documentation. Documentation within a Client's Medical Record Is a Vital Aspect of Nursing Practice. Nursing Documentation Must Be Accurate, Comprehensive, and Flexible Enough to Retrieve Critical Data, Maintain Continuity of Care, Track Client Outcomes and Reflect Current Standards of Nursing Practice. As Members of the Health Care Team, Nurses Need to Communicate Information about the Client's accurately and in a	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 95 Timely, Effective Manner. No further information was provided to the surveyor prior to the exit conference on 10/18/19.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interview, and during the course of a complaint investigation, the facility staff failed to provide ADL (activities of daily living) care of one of 30 residents in the survey sample, Resident # 88. The findings included The facility staff failed to ensure that Resident # 88's hair was washed. Diagnoses included but were not limited to, anxiety, dementia with behavioral disturbance, and schizophrenia. The clinical record for Resident # 88 was reviewed on 10/10/19 at 11:28 am. The most recent MDS (minimum data set) assessment for Resident # 88 was a quarterly assessment with an ARD (assessment reference date) of 9/10/19. Section B of the MDS assesses hearing speech and vision. In Section B0700, the facility staff documented that Resident # 88 was rarely or never understood. Section G of the MDS	F 677	1. Resident # 88 hair was washed on 10/17/2019. 2. Audits were completed during Carekeeper Rounds to to identify any resident in need of personal hygiene care. 3. The Director of Nursing or designee re-educated nursing staff on providing and maintaining residents' personal hygiene. 4. Audits will be completed at least 5 times a week of residents through Carekeeper Rounds by the Director of Nursing or designee to identify any resident personal hygiene concerns for 8 weeks. The Director of Nursing will submit findings to the Quality Assurance and Performance Improvement Committee. The DON is responsible for monitoring and follow up. 5. 12/06/2019	12/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 96	F 677		

assesses functional status. In Section G0120, the facility staff documented that Resident # 88 was totally dependent with one person providing physical assistance for bathing.

The current plan of care for Resident # 88 was reviewed and revised on 10/8/19. The facility staff documented a focus area for Resident # 88 as, "I have a physical functioning deficit related to : mobility impairment, self-care impairment, Resident sits on the side of bed then lays opposite way, head towards foot of bed." Interventions included but were not limited to, "Provide all needed assistance w (with)/ADL's and mobility.

On 10/8/19 at 12:40 pm, the surveyor observed Resident # 88 sitting in her room being fed lunch by facility staff. The surveyor observed that Resident # 88's hair had a greasy appearance.

On 10/9/19 at 9:10 am, the surveyor observed Resident # 88 as she sat in her room in her wheelchair. The surveyor observed that Resident # 88's hair had a greasy appearance.

On 10/17/19 at 4:52 pm, the administrator, director of nursing, and regional director of clinical services were made aware of the observations of Resident # 88's hair on the days mentioned above. The surveyor requested ADL documentation for Resident # 88 from the past 30 days that provided information on hair washing.

The facility staff provided the surveyor with shower sheets from the following dates:
8/2/19- no documentation of shampoo
8/6/19- documentation of bed bath provided
8/23/19- documentation of shower provided

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 677		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, the facility staff failed to follow physician's orders for 4 of 30 residents (Resident #40, #103, #47 and #316 and failed to assess and monitor for 2 of 25 residents (Resident #77 and #63) in the survey sample. The findings included:	F 684	1. Resident # 63 was treated for excessive vaginal bleeding on 6/27/2019. Resident # 103 received oxycodone on 6/4/2019. Resident # 47 medication administration time was changed on 10/17/2019. Resident # 316 no longer resides at the facility. Resident # 40 received medication on 10/15/2019. Resident # 77 received treatment to the identified toe on 10/10/2019. 2. Residents that reside at the facility are at risk of this deficient practice. 3. Re-education was provided to the nursing staff by the Director of Nursing or designee related to ensuring that physician orders are followed and the interact system (SBAR and stop and	12/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 98 1. The facility staff failed to assess and monitor Resident # 63 for excessive vaginal bleeding, which lead to Resident # 63 having a critical hemoglobin and hematocrit and was subsequently admitted to the hospital with a diagnosis of menorrhea and anemia and required a blood transfusion. Resident # 63 was originally admitted to the facility on 3/22/18, and had a readmission date of 7/2/19. Diagnoses included but were not limited to, anemia, abnormal uterine and vaginal bleeding, paraplegia, and muscle weakness. The clinical record for Resident # 63 was reviewed on 10/10/19 at 9:46 am. The most recent MDS (minimum data set) assessment for Resident # 63 was a quarterly assessment with an ARD (assessment reference date) of 8/21/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 63 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicated that Resident #63 was cognitively intact. Section G of the MDS assesses functional status. In Section G0110, line I assessed toilet use. Toilet use assessment included but was not limited to, how the Resident #63 used the toilet room, commode, or bedpan; cleansed self after elimination, and changed pad. The facility staff documented that Resident # 63 was totally dependent requiring the assistance of two or more persons for toilet use. Section G0120 assessed bathing. The facility staff documented that Resident # 63 was totally dependent, requiring the assistance of two or more persons for bathing.	F 684	watch) is utilized to identify and monitor resident changes in condition. 4. Audits will be conducted by the Director of Nursing or designee of nursing notes, 24 hour reports and MAR/TAR for changes of condition and to ensure physician orders are followed at least 5 times a week for 8 weeks. The Director of Nursing will submit findings to the Quality Assurance and Performance Improvement Committee. The DON is responsible for monitoring and follow up. 5. 12/06/2019 .	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 99 On 10/10/19 at 1:28 pm, the surveyor was in Resident # 63's room conducting a Resident interview. The surveyor asked Resident # 63 if she had been readmitted to the hospital since her admission to the facility. Resident # 63 informed the surveyor that she had lost a lot of blood and was admitted to the hospital. Resident # 63 stated, "I was as white as that sheet." The surveyor reviewed the progress notes for Resident # 63. The surveyor observed a "SBAR-Change in Condition" note that had been documented on 12/23/18 at 9:47 am. The note contained documentation that included but was not limited to ..."Situation: Resident is bleeding from vaginal area Assessment: Resident is bleeding from vaginal area with heavy bright blood with clots present. Resident states she feels weak Response: MD (medical doctor) notifies. New orders to send to ER (emergency room) ED (emergency department) notified of transfer)." ... The surveyor observed a nurse's note that had been documented on 6/27/19 at 10:59 am. The nurse's note contained documentation that included but was not limited to ..."Resident alert and oriented, complained of menstrual was on for a month. She appears to be pale and states she felt weak. VS (vital signs) 96.5, 122/70, 73, 16, 98%. MD (medical doctor) notified of concern." ... The surveyor reviewed a SBAR- Change of Condition note for Resident # 63 that was documented on 6/27/19 at 2:42 pm. The note was documented as, "Situation: Lab drawn today and had critical low HGB (hemoglobin) 5.0 and HCT (hematocrit) 16.0, albumin 2.9 Background: Resident stated her period was on for longer than	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 100	F 684		

a month and this was not the 1st time she experienced this. Assessment: VS 122/70, 96.5, 73, 16, 98%, MD notified to have CBC (complete blood count) which was already in place due to 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. 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."

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 until the nurse had informed her in June of 2019 that Resident # 63

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 101	F 684		

was pale. RN # 1 stated that she instructed the nurse to inform the physician. The surveyor asked RN # 1 if she would expect the certified nursing assistants to inform the nurses if they noticed that Resident # 63 was having excessive vaginal bleeding. RN # 1 stated, "Yes." The surveyor asked RN # 1 if she expected the nursing staff to document episodes of excessive bleeding in the clinical record and notify the physician. RN # 1 stated, "Yes." The surveyor informed RN # 1 that there was no documentation in the clinical record for Resident # 63 that reflected that Resident # 63 had vaginal bleeding for a month or more prior to 6/27/19.

On 10/17/19 at 3:35 pm, the surveyor interviewed LPN # 1 (licensed practical nurse) the surveyor asked LPN # 1 if she was aware that Resident # 63 had episodes of excessive vaginal bleeding. LPN # 1 stated, "Yes." The surveyor asked LPN # 1 if the certified nursing assistants informed her when Resident # 63 had episodes of excessive vaginal bleeding. LPN # 1 stated, "Yes." The surveyor asked LPN # 1 if information that Resident # 63 was having episodes of excessive vaginal bleeding should be documented in the clinical record and the physician be notified. LPN # 1 stated, "Yes it should be."

On 10/17/19 at 4:52 am, the administrator, the director of nursing, and the regional director of clinical services were made aware of the findings as stated above. The surveyor asked the administrative team if they would expect the nursing staff to document abnormal vaginal bleeding in the clinical record and notify the physician at the time the abnormality was noted. All three administrative team members agreed that abnormal vaginal bleeding should have been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 102	F 684		

documented in the clinical record and the physician should have been notified at the time the abnormality was noted.

The facility staff presented the following information to the survey team as the standard of practice for documentation. Information included but was not limited to ..."5. A deviation from protocol should be documented in the patient's chart with, clear, concise statements of the nurse's decisions, actions, and reasons for care provided, including any apparent deviation. This should be done at the time the care is rendered because passage of time may lead to less than accurate recollection of the specific events." ...

Reference
Nettina, S.M. (2013) Lippincott manual of nursing practice. 10th ed. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins.

On 10/18/19 at 3:45 pm, the surveyor provided the administrator, the director of nursing, and the regional director of clinical services the opportunity to ask further 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 #103, facility staff failed to ensure the resident received treatment and care based on the comprehensive assessment when it failed to ensure ordered pain medication oxycodone was available for administration.

Resident #103 was admitted to the facility on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 103	F 684		

3/30/16. Diagnoses included malignant carcinoid tumor of the rectum, major depression, low back pain, diabetes mellitus type 2 with ophthalmic 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.

On 10/15/19 at 7:37 AM, resident said his pain is generally under control. He did state that there were several days a few months ago when oxycodone was unavailable.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 104	F 684		

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 arrival --coded 2=refused
6/1/19 12:38 nursing note awaiting pharmacy arrival
6/1/19 17:28 nursing note awaiting pharmacy arrival
6/1/19 20:29 nursing note awaiting pharmacy arrival-- --coded 2=refused
6/2/19 08:59 nursing note awaiting pharmacy arrival
6/2/19 12:16 nursing note awaiting pharmacy arrival
6/2/19 16:40 nursing note awaiting pharmacy arrival
6/2/19 21:03 nursing note awaiting pharmacy arrival
6/3/19 16:55 nursing note awaiting pharmacy arrival
6/3/19 20:35 nursing note awaiting pharmacy arrival
6/4/19 09:34 nursing note awaiting pharmacy arrival
6/3/19 for 09:00 and 13:00 no documentation in MAR and no nursing notes concerning resident status

This review indicated the resident missed 14 consecutive doses of oxycodone. The pain assessments associated with those 14 doses were either 'X' or blank except for the 6/2 assessment at 21:00 was documented as '0' on the medication administration record.

The clinical record included no indication that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 105	F 684		

physician was notified that the oxycodone was missing. The surveyor discussed the concern with the director of nursing (DON) on 10/16/19 at 8:44 AM. The DON said that the doctor on call would not write a replacement prescription or a prescription to pull doses from the stat box because the doctor wanted to avoid DEA scrutiny. The Pain clinic said that they would not replace the prescription and the resident could do without the drug until time for a new prescription to start. The DON stated the resident showed no signs of withdrawal. The DON provided hand written employee statements dated 10/16/19 from two LPNs stating they had contacted physician offices concerning the medication being unavailable.

Surveyors discussed the failure to make pain medication available with the administrator and DON during individual discussions on 10/16/19.

3. The facility staff failed to follow physician's order with regard to Restoril administration for Resident # 47.

Resident # 47 was admitted to the facility on 5/11/17. Diagnoses included but were not limited to, anxiety, major depressive disorder, traumatic brain injury, and hypertension.

The clinical record for Resident # 47 was reviewed on 10/9/19 at 2:27 pm. The most recent MDS (minimum data set) assessment for Resident # 47 was a quarterly assessment with an ARD (assessment reference date) of 8/5/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 47 had a BIMS score (brief interview for mental status) of 15 out

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 106	F 684		

of 15, which indicated that Resident # 47 was cognitively intact.

Resident # 47 had orders that included but was not limited to, "Clonazepam tablet 0.5 mg (milligram) give 0.5 mg by mouth two times a day related to anxiety disorder give 2nd dose with dinner do not give w/n (within) 5 hours of restoril," which was initiated by the physician on 9/13/19. Resident # 47 also had orders for "Restoril capsule 7.5 mg give 1 capsule by mouth at bedtime related to insomnia, which was initiated by the physician on 9/2/19.

On 10/17/19 at 2:59 pm, the surveyor reviewed the September 2019 medication administration record for Resident # 47. The surveyor observed that Clonazepam 0.5 mg was scheduled to be administered at 1700 (5:00 pm) and Restoril 7.5 mg was scheduled to be administered at 2100 (9:00 pm). The surveyor observed that the documented administration times did not comply with physician's orders. The physician's orders specified that clonazepam was not to be administered within 5 hours of restoril and the documented administration times reflected a 4-hour period between administration of clonazepam and restoril.

On 10/17/19 at 4:54 pm, the administrator, director of nursing, and regional director of clinical services were made aware of the findings as stated above.

No further information regarding this issue was provided to the survey team prior to the exit conference on 10/18/19.

4. The facility staff failed to administer Xanax to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 107	F 684		

Resident # 316 per physician's orders.

Resident # 316 was a 59-year-old-male who was admitted to the facility on 9/18/18. Diagnoses included but were not limited to, anxiety disorder, bipolar disorder, and major depressive disorder.

The clinical record for Resident # 316 was reviewed on 10/9/19 at 9:38 am. Resident # 316 had orders for "Alprazolam tablet 1 mg (milligram) by mouth at bedtime related to generalized anxiety," which was initiated by the physician on 9/18/18. The surveyor reviewed the September 2018 medication administration record for Resident # 316. The surveyor observed a "7" documented on the medication administration record for the 2100 (9:00 pm) dose of Alprazolam 1 mg tablet for Resident # 316. The surveyor observed documentation on the medication administration record that "7" = "Other/see nurse's notes."

The surveyor reviewed a nurse's note to Resident # 316 that had been documented on 9/19/18 at 8:43 pm. The nurse's note had been documented as, "Alprazolam tablet 1 mg by mouth at bedtime related to generalized anxiety awaiting arrival from pharmacy MD (medical doctor) is aware."

On 10/9/19 at 10:46 am, the surveyor reviewed the facility "Stat box Listing." The surveyor observed that 4 tablets of Alprazolam 0.25 mg were available in the facility stat box and that the 4 tablets equaled the scheduled dose and could have been administered to Resident # 316 to prevent a missed dose of medication.

On 10/10/19 at 3:54 pm, the administrator and director of nursing were made aware of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 108	F 684		

findings as stated above. The administrative team agreed that the Alprazolam could have been retrieved from the stat box and administerd to Resident # 316 to prevent a missed dose of medication.

No further information regarding this issue was presented to the survey team prior to the exit conference on 10/18/19.

This is a complaint deficiency.

5. The facility staff failed to follow psychiatric physician recommendation for an increase in Resident #40's anxiety medication, Clonazepam.

Resident #40 was readmitted to the facility with the following diagnoses of, but not limited to anemia, heart failure, diabetes, anxiety disorder, depression, manic depression and Schizophrenia. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/24/19, coded the resident as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #40 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and being totally dependent on 1 staff member for bathing.

Resident #40 asked to speak to the surveyor during the dates of 10/8/19 through 10/18/19. The surveyor interviewed the resident on 10/15/19 at 10:30 am in the resident's room. The resident reported to the surveyor that her doctor that she sees for her psychiatrist issues ordered her anxiety medication to be increased. That was supposed to be done 2 weeks ago and it has not been increased yet. The resident stated, "_____

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 109	F 684		

(name of nurse) comes by my room each morning and tells me that the pharmacy is having issues in getting her anxiety medication increased and as soon as they resolve the issues, it will be done. She keeps telling me this over and over but nothing gets done about this. All I can do is sit in this bed and worry about everything. I feel helpless and I feel that I cannot get anything done to help me. So I lay in here and worry about this. The staff uses me as a sounding board and talks to me about everything that is going on with all the new changes in staff that has occurred. I don't mind because everyone needs someone to talk to but then the rest of the time, I think back over what they tell me and I think well if they are not doing this like they are supposed to then what makes me think they will do what the doctor wants then to do for me. So I worry about this consistently and I get myself worked up about all of this. I just feel helpless and I need some help in getting my medication increased so I can deal with all of the worries that I am having. The surveyor verbalized to the resident that these concerns would be investigated and resident would be notified of the findings of these concerns. The resident verbalized understanding of this to the surveyor.

The surveyor performed a clinical record review of Resident #40's clinical record from 10/15/19 to 10/18/19. During this review, the surveyor noted the following documentation from the nurse practitioner with the _____ (name of the psychiatric medical group) dated for the following:

" "8/22/19 ...Pt. reports feeling overwhelmed because she is trying to get to be able to go home for Christmas this year but she is having trouble participating in therapy. She is reporting anxiety r/t (related to) this ...She is reportedly only getting 3 hours of sleep at night because the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 110	F 684		

doctor recently decreased her Trazodone ...Patient reports sleep as Not as good at all. Patient reports mood as anxious ..." Under Assessment/Plan " ...Anxiety-Currently stating it is uncontrolled and wants hers Valium back. I suggested Buspar 5 mg TID to start and she was agreeable to this plan ..."

" "9/13/19 ...Pt (patient) is reporting that "my nerves are real bad" and she cannot relax. She reports that it started about a week after she met this provider for the first time. She is reporting that it is an 8/10 right now and that nothing seems to make it better. Says the only thing that has ever helped has been Valium. Patient reports sleep as Not good at all. Patient reports mood as anxious ..." Review of Medications " ...8/23/19 Buspar (1) 5 mg (milligram) Tablet TID (three times a day)..." Assessment/Plan " ...Anxiety-Pt states her anxiety has gotten much worse since she was started on Buspar 2 or 3 weeks ago and that Buspar has not touched it. She reports that even 1 mg of Valium was helpful for her in the past and that her anxiety worsened 3 weeks to a month after stopping it in June. She was on Valium for about 3 years d/t (due to) her "nerves." Will increase Buspar to 10 mg PO (by mouth) TID and if anxiety does not improve over next 2 weeks, I will consider restating low dose benzo (benzodiazepine) ..." Recommendations: " ...Increase Buspar to 10 mg PO TID for anxiety ..."

" "9/25/19 ..."I'm not good" Pt is reporting that her anxiety is really bad. She has been in bed all weekend because of her anxiety. She shakes and has a horrible time dealing with people right now, she states she is really crabby. Patient reports sleep as Not good at all. Patient reports mood as anxious ..." Review of medication: " ...8/23/19 Buspar (1) 5 mg Tablet TID ..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 111	F 684		

Assessment/Plan " ...Anxiety. Pt states anxiety has gotten worse since she was started on Buspar. Is not working for her. I am going to decrease Buspar and then start Clonazepam ...Will continue to get anxiety under control since the patient believes that is her most pressing issue and will readdress depression to the future ..." Recommendation only: " ...Decrease Buspar to 5 mg PO TID x (times) 7 days, then decrease to 5 mg PO BID (twice a day) x 7 days, and then d/c (discontinue) Start Clonazepam 0.25 mg PO BID for anxiety ..."
" "10/9/19 ...Pt was started on Clonazepam and started it last Friday. She states it "helps a little but not much and not for long." She states she feels like she is sitting on pins and needles and was wondering if the medication could be increased. Patient reports sleep as Not good at all. Patient reports mood as anxious ..." Review of medication " ... 5/24/19 Trazodone 0.5 50 mg Tablet TID 8/23/19 Buspar (1) 5 mg Tablet BID ...9/25/19 Clonazepam 0.5 0.5 mg Tablet BID ..." Assessment/Plan "Anxiety - Pt states her anxiety is about the same. She says the Clonazepam helps just a little bit but not much and not for long. She is asking for an increased dose or using it more frequently. I told her we can increase the dose to see if this helps ...Will get anxiety under control since the patient believes that this is her most pressing issue and will readdress depression in the future. Insomnia - pt says she cannot sleep at all at night and wants to go back to her Trazodone. I explained to the patient that Trazodone is better for insomnia at a lower dose but the patient was not buying this so I told her if she thinks it will make her sleep better than we can try Trazodone 100 mg PO WHS (at bedtime) ..." Recommendations only: "Increase Trazodone back to 100 mg PO QHS (at bedtime)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 112	F 684		

for insomnia. Increase Clonazepam to 0.5 mg PO BID for anxiety ..."
The surveyor reviewed the physician order sheets (POS) and noted the start date for each of these medications:
" Buspar 5 mg Give 10 mg by mouth three times a day -- start date of 9/13/19
" Trazodone 50 mg Give 0.5 tablet by mouth at bedtime - start date of 5/24/19
The surveyor noted supplemental physician orders that were the following medications with orders dates as follows:
" Buspar 5 mg Give 5 mg by mouth three times a day related to anxiety disorder -- The order date for this medication was 10/3/19.
" Clonazepam 0.5 MG Give 0.25 mg by mouth two times a day - The order date for this medication was 10/3/19.
The surveyor reviewed the MAR (medication administration record) for Resident #40 for the month of October 2019. It was noted that "Clonazepam Tablet 0.5 mg Give 0.5 mg by mouth two times a day ...Order date 10/15/19 1041 (10:41 am) ..." The surveyor also noted that Clonazepam 0.5 mg tablet Give 0.25 mg by mouth two times a day ...D/C Date 10/15/19 1041 ... This medication with dosage of 0.5 mg ½ tablet was d/cd on 10/15/19 and the dosage of 0.5 mg two times a day was started on 10/15/19. This was noted to be discontinued and started the correct dosage of Clonazepam after the surveyor began to investigate and ask the administrator and the director of nursing questions about the psychiatric recommendations that had occurred between 8/22/19 through 10/9/19.
The surveyor notified the administrator and the director of nursing of the above documented findings on 10/15/19 at approximately 4:15 pm.
The director of nursing stated that she was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 113	F 684		

the director of nursing for the facility until approximately 2 weeks before this survey had begun and that she was not aware of these incidents or recommendations for this resident. The assistant director of nursing (ADON) and regional corporate nurse and director of nursing (DON) came to the surveyor in the conference room and stated that they wanted to discuss the issue concerning the medication for _____ (name of Resident #40). This occurred on 1016/19 at 2 pm. The surveyor asked the ADON if the nurse practitioner that was in the psychiatric group ordered for a resident to start, increase, decrease or discontinue a medication could the nurses' not treat this as a regular order and order what the practitioner had ordered for the resident. The ADON stated that _____ (name of the psychiatric group that was contracted to see the residents in the nursing facility) started "seeing the residents in August 2019. The FNP (Family Nurse Practitioner) would order the medications; the nurses would treat this as a regular order and put this order into the computer. The pharmacy would receive this order and send the medication as ordered for the resident. Then around 9/13 or 9/18, the FNP called and stated that his boss only wanted him to recommend what medications the resident would be needing then let the medical director at the facility to approve or disapprove and order the medications based upon the psychiatric group's recommendations. The medical director would sign off on it and then the nurses would order the medications from the pharmacy and administer it to the residents. The surveyor asked what is an appropriate time period that this process should take to get the Medical Director to sign off this recommended order and get this to the pharmacy then the resident receives the medication that was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 114	F 684		

recommended for them to have. The ADON stated, "I believe that 48 hours for this to occur would be an appropriate time period for this to occur." The surveyor asked what was the time period that all of this process occurred for Resident #40 to have and get the medications recommended for her to have for the anxiety that she was verbalizing to the psychiatric nurse practitioner in the above documented findings. The ADON did not respond to the surveyor's question. The ADON responded later and stated, The recommended changes in the resident's medications were faxed to the doctor. Then he responded and asked questions that I answered and faxed back to him several times. The final response from the doctor was on 9/30/19 which he stated no new orders." The surveyor asked if she had called or faxed and asked for a clarification to this since the psychiatric nurse practitioner had recommended an increase in Clonazepam due to the resident verbalizing increased anxiety that was to the point that she had remained in bed one whole weekend due to this anxiety she was experiencing. The ADON stated, "The doctor stated no new orders. So I didn't ask him further if he wanted anything else for this resident."

The surveyor again discussed the above documented findings on 10/18/19 at 4:15 pm with the administrator, director of nursing and the regional corporate nurse.

No further information was provided to the surveyor prior to the exit conference on 10/18/19.

6. For Resident #77, the facility staff failed to assess and treat an area on the resident's right great toe.

Resident #77's face sheet listed an admission date of 8/21/14 and a readmission date of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 115	F 684		

5/15/15. The resident's diagnosis list indicated diagnoses, which included, but not limited to Type 2 Diabetes Mellitus with Diabetic Neuropathy, Hypothyroidism, Essential Hypertension, and Heart Failure.

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 in section C, cognitive patterns. Resident #77 was also coded as being independent in bathing and requiring supervision only in dressing and personal hygiene.

While interviewing Resident #77 on 10/10/19 at approximately 3:15pm, the resident stated her right big toe is sore and there is a place on it that looks like it is turning black. Resident stated she told a nurse about one month ago and no one has looked at it. Resident also stated "the nurses check my skin for sores but they never look at my feet and I'm diabetic."

The surveyor spoke with LPN #1 on 10/10/19 at approximately 3:20pm regarding resident's right great toe. Surveyor asked LPN #1 if Resident #77 had an area on her right foot, LPN #1 stated no, nothing had been reported but she would check it.

Following the resident interview, the surveyor reviewed the medical record and did not locate any documentation related to an area on the resident's right great toe.

On 10/11/19 at approximately 9:00am, the administrator provided the surveyor with a copy of a progress note for Resident #77 dated 10/10/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 116 15:30 written by LPN #1 stating in part, "this nurse assessed pt and noted black area to R great toe 0.3 x 0.2 cm, skin cool and color wnl. Pt c/o of numbness r/t neuropathy, and noted weak pedal pulses. NP notified and new order for ABI to R extremity Surveyor reviewed Resident #77's "Weekly Skin Integrity Check" assessment in the medical record dated 10/05/19 which is checked for the statement "Skin clear, no change of condition assessed". Surveyor requested and was provided with a copy of the facility policy "Skin Assessment - Weekly" which stated in part, "A Licensed Nurse will complete a total body assessment on each resident weekly, paying particular attention to any skin tears, bruises, stasis ulcers, rashes, pressure ulcers, lesions, abrasions, reddened areas and skin turgor problems. The purpose of the Skin Assessment is to evaluate the condition of the resident's skin on a regular basis". The concern of the lack of assessment and treatment to the area on Resident #77's right great toe was discussed with the administrative staff (administrator, director of nursing and regional director of clinical services) on 10/17/19 at approximately 5:00pm. No further information was provided prior to exit conference on 10/18/19.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689	1. Oxygen cylinders were stored securely on 10/8/2019. Resident # 13 oxygen cylinders were stored securely on 10/8/2019. Resident #314 no longer resides at facility.	12/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 117 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, resident interview and facility document review, the facility staff failed to prevent accident hazards for 7 of 30 residents and in (1) oxygen storage room in the nursing facility (Resident #29, #9, #63, #68, #314, #13 and #97). The findings included: 1. The facility staff failed to ensure that Resident # 9 was positioned properly while in the lift, which resulted in Resident # 9 sliding out of the lift onto the floor and hitting her head on the foot rest of the lift. As a result of the fall, Resident # 9 experienced pain to the head and back and was transferred to the emergency room and was diagnosed with mechanical fall with head contusion, contusion to left hip and lumbar strain. This is harm. Resident # 9 was a 68-year-old-female who was originally admitted to the facility on 1/27/11, and had a readmission date of 9/10/18. Diagnoses included but were not limited to, schizoaffective disorder, psychotic disorder, anxiety, and major depressive disorder. The clinical record for Resident # 9 was reviewed on 10/10/19 at 11:10 am. The most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment	F 689	Resident # 68 oxygen storage bag and tank were securely affixed to the wheelchair on 10/17/2019. Residents # 63 and # 9 are safely transfered via lift on 6/6/2019. Resident # 97 resides on lower level 4/18/2019. Resident # 29 currently resides at facility and is free from abuse from another resident. 2. Residents that reside at facility are at risk deficient practice. 3. Re-education was provided by the Director of Nursing to nursing staff on proper storage of oxygen cylinders, monitoring residents for aggressive behaviors, reporting signs of aggression immediately, proper use of lifts, monitoring residents for abnormal wandering patterns and appropriate fall interventions. 4. Audits will be conducted by the Director of Nursing or designee for oxygen cylinder storage, signs of aggressive behaviors, proper use of lift, appropriate fall intervention, and excessive wandering weekly for 8 weeks. The Director of Nursing will submit findings a report to the Quality Assurance and Performance Improvement Committee. The DON is responsible for monitoring and follow up. 5. 12/06/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 118	F 689		

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. Section G of the MDS assesses functional status. In Section G0110, the facility staff documented that Resident was totally dependent on staff requiring two or more persons to assist with transfers.

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 "At risk for falls related to: Use of medication, history of falls, decreased mobility, bladder/bowel incontinence, requires maxi lift w(with)/staff assistance for transfers." Interventions included but were not limited to, "Transfer using the Maxie Move lift with two person assistance at all times."

The surveyor observed a "SBAR-Change of Condition" note that was documented on 4/1/19 at 11:55 pm. The note included documentation that included but was not limited to ..."Situation: Called to room by aid, resident was laying on floor, resident slide out of Hoyer lift during transfer. Assessment: resident c/o (complained of) mid and lower back pain and a headache, notice resident head was laying on foot rest of lift." ...

The surveyor reviewed emergency department discharge instructions for Resident # 9 dated 4/1/19. The surveyor observed documentation on the discharge instructions that included but was not limited to ..."Diagnosis: mechanical lift fall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 119 with head contusion, contusion to lumbar hip, and lumbar strain." ... On 10/10/19 at, 12.10 pm, the surveyor reviewed the "Fall Investigation" from Resident # 9's fall on 4/1/19. The surveyor reviewed documentation on the fall investigation that included but was not limited to ..."10. Was a Hoyer lift used? (Surveyor observed a handwritten check mark next to Yes) Was resident positioned correctly? (Surveyor observed a handwritten check mark next to No) Were 2-3 assists used? (Surveyor observed a handwritten check mark next to No) Were "legs" of Hoyer lift in correct position? (Surveyor observed a handwritten check mark next to No)." ... On 10/10/19 at 2:51 pm, the surveyor interviewed LPN # 2 (licensed practical nurse). The surveyor asked LPN # 2 if she had documented the SBAR-Change of Condition note and fall investigation that was documented on 4/1/19 for Resident #9. LPN # 2 stated, "Yes." The surveyor asked LPN # 2 to explain the events that happened with Resident # 9 on 4/1/19. LPN # 2 informed the surveyor that a CNA (certified nursing assistant) had gotten Resident # 9 up with the lift and the lift pad was not criss crossed at the bottom, which caused Resident # 9 to slide out of the lift pad onto the floor. LPN # 2 stated, "She hit her head on the lift." "She complained of back and head pain, and we sent her out." The surveyor asked LPN # 2 if two staff members had assisted with the lift transfer for Resident # 9 on 4/1/19. LPN #2 informed the surveyor that the CNA was working alone during the transfer on 4/1/19 when Resident # 9 slid from the lift.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 120	F 689		

On 10/11/19 at 9:19 am, the surveyor interviewed CNA # 4. The surveyor asked CNA # 4 if she provided care for Resident # 9 on 4/1/19. CNA # 4 stated, "Yes." The surveyor asked CNA # 4 to describe the events that led to Resident # 9's fall from the lift on 4/1/19. CNA #4 stated, "That morning they had a different lift pad." "I had never used that before." "I asked for assistance, but the girl didn't come back." "The lift I usually use was different." "I was unaware that you had to criss cross." "I started to get her up, and she slid out."

On 10/17/19 at 4:52 am, the administrator, the director of nursing, and the regional director of clinical services were made aware of the findings 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. The facility staff failed to implement appropriate interventions for fall prevention for Resident # 314, which led to continued falls leading up to a fall on 7/3/18 in which Resident # 314 was transferred to the hospital and diagnosed with a fractured hip and brain bleed. This is harm.

Resident # 314 was a 90-year-old-male who was admitted to the facility on 10/16/17. Diagnoses included but were not limited to, dementia, unsteadiness on feet, and muscle weakness.

The clinical record for Resident # 314 was reviewed on 10/9/19 at 9:54 am. The most recent MDS (minimum data set) assessment for Resident # 314 was a discharge assessment with an ARD (assessment reference date) of 7/3/18. Section C of the MDS assesses cognitive status.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 121 In Section C1000, the facility staff documented that Resident # 314's cognitive status was severely impaired. On 10/9/19 at 9:54 am, the surveyor observed a general note for Resident # 314 that had been documented on 10/16/17 at 6:56 pm. The general note contained documentation that included but was not limited to ..."Resident is alert and oriented to person only, resident is not oriented to place or time." "Resident is a high fall risk." "Resident is a heavy wetter due to Lasix." ... The surveyor observed a general note for Resident # 314 that was documented on 10/26/17 at 12:35 pm. The note was documented as, "Resident was found sitting on the floor by the CNA assigned to him. He sustained a large skin tear on the right elbow and a smaller skin tear on the right upper arm. Areas were cleaned with normal saline, triple antibiotic ointment applied, followed by a tegaderm. Resident tolerated procedure well. VSS (vital signs) T (temperature) 97.6 P (pulse) 52 R (respirations) 18 B/P (blood pressure) 146/78." The surveyor reviewed the plan of care for Resident # 314. The surveyor observed a focus area for Resident # 314 was initiated by facility staff on 10/26/17. The focus area was documented as, "At risk for falls related to: new environment, use of medication." Interventions initiated on 10/26/19 were as follows: "Assess for pain," "Assess that wheelchair is of appropriate size, assess need for foot rests, assess for need to have wheelchair locked/unlocked for safety, anti-tippers," "Call light or personal items available and in reach or private reacher," "Keep environment well lit and free of clutter," "Observe	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 122	F 689		

for side effects of medications," and Orientation to new room and roommate."

The surveyor reviewed the facility "Fall Investigation" from Resident # 314's fall on 10/26/17 that was completed on 10/27/17. The fall investigation contained documentation that included but was not limited to,
..."3. What is the resident's cognition? (The surveyor observed handwritten documentation) A&O x1 (alert and oriented times one), confused. (Indicate what may have caused the incident (The surveyor observed handwritten documentation) Confused and got out of the bed without assistance." ...

The surveyor observed an intervention of "Fall matt beside bed" was initiated on 10/27/17.

The surveyor observed a general note for Resident # 314 that had been documented on 10/26/19 at 11:04 am. The general note was documented as, "MDS (minimum data set) assessment for ARD (assessment reference date)/14 day: Resident is alert and oriented at times. However, he experiences episodes of confusion at times as well. Resident needs assistance with transfer and completed ADLs (activities of daily living). He has problems with short and long term memory. He is able to express his needs to the staff. Resident stated that in the last two weeks he has experienced depression, feeling bad about himself, and trouble concentration on watching television. The total severity score is 06. BIMS (brief interview for mental status) score is 02."

The surveyor observed a general note for Resident # 314 that was documented on 12/12/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 123	F 689		

at 10:35 am. The note was documented as, "MDS assessment for ARD/Medicare 60 day: Resident was in bed resting when SW (social worker) entered the room. Resident was alert and oriented. He is able to express his needs to the staff. Resident has short term and long term memory problems. Resident agreed to do the interview. During the mood interview, resident sated that he has experienced in the last two weeks depression, trouble falling asleep, tiredness, feeling bad about himself, and trouble concentrating on reading/watching television. Total severity score is 05. Resident received a BIMS of 05."

The surveyor observed a nurse's note for Resident # 314 that was documented on 12/14/17 at 11:28 am, the note was documented as, "Resident has a fall this am (morning) @ (at) 7:30 am. He was attempting to toilet himself unattended and fell in the bathroom, skin tear noted to right elbow and c/o pain, notified MD (medical doctor) orders given for xray of right elbow, neuro checks in place due to unsupervised fall. RP (responsible party) (name withheld) notified of incident."

The surveyor reviewed the facility "Fall Investigation" from Resident # 314's fall on 12/14/17 that was completed on 12/14/17. The fall investigation contained documentation that included but was not limited to,
..."3. What is the resident's cognition? (Handwritten) Alert with confusion
7. When was the resident's last toileting time? (Handwritten) Toileting himself at the time of the incident
9. Is assistance required to transfer/ambulate? (Handwritten) Yes continuous reminders to call

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 124 for assistance What intervention was implemented after the fall? (Handwritten) correct footwear Indicate what may have caused the incident (handwritten) Resident states he doesn't know he had one shoe on and one shoe off attempting to toilet self unattended." ... The surveyor noted that an intervention was added to the plan of care for Resident # 314 on 12/14/17 as "Ensure Resident has on both shoes when he is up ambulating." The surveyor observed a nurse's note that for Resident # 314 that was documented on 12/31/17 at 9:22 am. The note was documented as, "Resident calling out for help and staff rushed to resident's room. Resident was found sitting upright on his buttocks with his feet up against the wall near the door. Scant amount of blood noted on the fitted sheet to his bed and on his right elbow. A nickel size skin tear was noted to his outer left wrist and a scabbed area about the size of a nickel was noted to have a scant amount of blood on it. Rsd (resident) stated he fell out of the bed but he has memory loss and he was far away from his bed. ROM WNL (range of motion within normal limits) vitals 132/100-56-18-97% RA (room air). Daughter of resident (daughter's name withheld) was called and a message was left for her to call the facility in regards to a non-urgent matter. Tx (treatment) rendered per standing order to left wrist and wright elbow and tol (tolerated) well. Resident assisted by two staff to his chair. No c/o (complaints of) pain at this time. Resident's MD was notified. Will continue to monitor. The surveyor reviewed the facility "Fall	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 125	F 689		

Investigation" from Resident # 314's fall on 12/31/17 that was completed on 12/31/17. The fall investigation contained documentation that included but was not limited to,
..."3. What is the resident's cognition? (Handwritten) Alert with confusion
12. Was the call bell in place (handwritten check mark beside) YES
Can resident use it? (Handwritten check mark beside) NO (handwritten) Resident confused
What intervention was implemented after the fall? (Handwritten) nonskid footwear given to prevent slipping
Indicate what may have caused the incident (handwritten) ambulating unassisted." ...

The surveyor noted that an intervention was added to the plan of care for Resident # 314 on 12/31/17 as "Footwear to prevent slipping," and "Encourage resident to call for assistance when needed" on 1/1/18.

The surveyor observed a nurse's note that was documented on 4/12/18 at 11:23 pm. The nurse's note was documented as, Resident is alert with confusion noted, had ears washed out today. Resident states he can hear some better. Resident was noted sitting on the floor at bedroom door, stated he fell in the bathroom and scooted to the door, denies hitting his head, c/o pain to left back, notified MD, family MD ordered x-ray to back. Encourage resident to ask for assistance when he needs to go to the bathroom, reminded resident of urinal at his bedside."

The surveyor reviewed the facility "Fall Investigation" from Resident # 314's fall on 4/12/18 that was completed on 4/13/18. The fall investigation contained documentation that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 126 included but was not limited to, ..."3. What is the resident's cognition? (Handwritten) Alert, confusion What intervention was implemented after the fall? (Handwritten) encourage resident to use call light -assessed and placed back to bed Indicate what may have caused the incident (handwritten) tired and was ambulating by himself." ... The surveyor noted that an intervention was added to the plan of care for Resident # 314 on 4/13/18 as "Encourage resident to utilize call bell." The surveyor observed a nurse's note for Resident # 314 that was documented on 5/18/18 at 11:17 am. The note was documented as, "Resident was found by nursing staff in the bath tub in resident's bathroom. Resident was attempting to use the bathroom and fell backwards. Resident had small blanchable area to the back of head. No c/o pain from resident. Neuro checks in place. ND notified. Called and spoke with (daughter's name withheld) about fall. Resident resting in bed at this time. VS WNL. Call light in reach. Will continue to monitor." The surveyor reviewed the facility "Fall Investigation" from Resident # 314's fall on 5/18/18 that was completed on 5/18/18. The fall investigation contained documentation that included but was not limited to, ..."3. What is the resident's cognition? (Handwritten) confused What intervention was implemented after the fall? (Handwritten) medication review (Norco) assessed, placed in bed neuros started Indicate what may have caused the incident	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 127 (handwritten) unsteady." ... The surveyor noted that an intervention was added to the plan of care for Resident # 314 on 5/18/18 as "Med review." The surveyor observed a SBAR-Change of Condition note for Resident # 314 that was documented on 6/27/18 at 6:59 am. The note was documented as, "Situation: Resident fell in bathroom and hit head on wall Background: History of falls, hard of hearing Assessment: Resident has skinned up head on back and skin tear on right hand, resident is awake and alert Response: Sending resident to ER (emergency room) for test to make sure everything is ok. MD and RP notified 911 called." The surveyor reviewed the facility "Fall Investigation" from Resident # 314's fall on 6/27/18/18 that was completed on 6/27/18. The fall investigation contained documentation that included but was not limited to, ..."3. What is the resident's cognition? (Handwritten) confused/alert What intervention was implemented after the fall? (Handwritten) education Indicate what may have caused the incident (handwritten) ambulating unassisted while sleepy." ... The surveyor noted that an intervention was added to the plan of care for Resident # 314 on 6/28/18 as "Educate resident to ask for assist with toileting during early morning hours." The surveyor observed a SBAR-Change of Condition note for Resident # 314 that was documented on 7/3/18 at 9:50 pm. The note was	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 128	F 689		

documented as, "Situation: Found resident on floor in room Background: unspecified combined systolic and diastolic congestive heart failure, unsteadiness on feet, benign prostatic hyperplasia without lower urinary tract symptoms, chronic kidney disease, vascular dementia without behavioral disturbance, essential hypertension, chronic obstructive pulmonary disease Assessment: Resident alert, yelling out. Resident is very hard of hearing. Skin warm and dry. Noted to have small hematoma above left eyebrow, laceration to right forehead, skin tear to right elbow. Also c/o right hip/leg pain, right leg rotated outward and shortened. C/O pain upon movement and touch. VS 97.4, 57, 20, 164/82, PEARL (pupils equal and reactive to light) Response: (Physician's name withheld) new order to send to ER for eval. RP (daughter's name withheld) notified. EMS (emergency medical services) notified."

The surveyor observed a nurse's not for Resident # 314 that was documented on 7/4/18 at 3:03 am. The note was documented as, "Called ER spoke to (name withheld) resident is being transferred to (facility name withheld) with DX (diagnosis) right hip fracture and brain bleed. DON (director of nursing) notified."

The surveyor reviewed the facility "Fall Investigation" from Resident # 314's fall on 7/3/18 that was completed on 7/4/18. The fall investigation contained documentation that included but was not limited to,
..."3. What is the resident's cognition?
(Handwritten) alert normally confused
What intervention was implemented after the fall?
(handwritten) sent to ER
Indicate what may have caused the incident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 129	F 689		

(handwritten) resident was ambulating while tired and sleepy and lost balance." ...

On 10/10/19 at 1:15 pm, the surveyor and the MDS coordinator reviewed the clinical record for specifically nurse's notes, MDS, and plan of care for Resident # 314. The surveyor reviewed each of the falls and interventions put in place after the falls with the MDS coordinator. The surveyor and the MDS coordinator also reviewed documentation that Resident # 314's cognitive status was severely impaired; Resident # 314 often ambulated unassisted with an unsteady gait. After review of the documentation in the clinical record the MDS coordinator agreed that the interventions implemented for Resident # 314 following falls were not appropriate due to his cognitive status and level of confusion.

On 10/17/19 at 4:54 pm, the administrator, director of nursing, and regional director of clinical services were informed of the incident as stated above. The administrative team was provided the opportunity to ask questions and provide additional information.

No further information regarding this issue was presented to the survey team prior to the exit conference on 10/18/19.

This is a complaint deficiency

3. The facility staff failed to ensure that Resident # 63 was appropriately positioned in the lift during a transfer, which resulted in the lift tilting and Resident # 63 being lowered to the floor.

Resident # 63 was a 47-year-old-female that was originally admitted to the facility on 3/22/18, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 130	F 689		

had a readmission date of 7/2/19. Diagnoses included but were not limited to, paraplegia, and muscle weakness.

The clinical record for Resident # 63 was reviewed on 10/10/19 at 9:46 am. The most recent MDS (minimum data set) assessment for Resident # 63 was a quarterly assessment with an ARD (assessment reference date) of 8/21/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 63 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicated that Resident #63 was cognitively intact. Section G of the MDS assesses functional status. In Section G0110, line B assessed transfer status. The facility staff documented that Resident # 63 was totally dependent requiring the assistance of two or more persons for transfers.

The plan of care for Resident # 63 was reviewed and revised on 9/3/19. The facility staff documented a focus area for Resident # 63 as, "At risk for falls related to: Use of medication, Dx's (diagnoses) of chronic inflammatory demyelinating polyneuropathy, morbid obesity, paraplegia, and due to fear of falling." Interventions included but were not limited to, "Transfer using the Hoyer lift w/at least 2-staff persons assisting," and "Education provided after fall 6/5/19."

The surveyor observed a nurse's note for Resident # 63 that had been documented on 6/5/19 at 3:06 pm. The nurse's note was documented as, "Resident was lowered to the floor during transportation to chair due to it overturning. She was not hurt during the incident. There were 3 CNAs present at the time I entered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 131	F 689		

the room. Resident was still on part of the bed while the CNAs were holding her. DON (director of nursing) and unit manager came to witness the incident. Statements will be written in regards to the situation."

On 10/10/19 at 3:30 pm, the surveyor requested to see the facility investigation of the incident on 6/5/19, which led to Resident # 63 being lowered to the floor.

On 10/15/19 at 11:04 am, the surveyor reviewed a hand written statement that was written by the director of nursing on 6/5/19. The statement was documented as, "Had (Three employee's name's withheld) concerning lowering Resident # 63 to the floor. Had CNAs re-inact the transfer with therapy, administration, and myself. CNAs stated that as they went to move Resident # 63 the lift tilted and they has to lower her to the floor. The re-inactment revealed that the CNAs did not have Resident # 63's weight balanced in the sling but had her feet on one side and her upper body on the other side which caused the lift to tilt to the side that had her upper body on it."

On 10/16/19 at 10:32 am, the surveyor interviewed CNA # 2. The surveyor asked CNA # 2 if she was providing care to Resident # 63 on 6/5/19 when she was lowered to the floor. CNA # 2 stated, "Yes." The surveyor asked CNA # 2 to describe the events that led to Resident # 63 being lowered to the floor. CNA # 2 stated, "We were getting her out of bed and putting her in the chair." "They didn't have her positioned properly, and the lift tilted, so we lowered her to the floor."

On 10/17/19 at 4:54 pm, the surveyor reviewed the investigative findings of Resident # 63's fall on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 132	F 689		

6/5/19 with the administrator, director of nursing, and regional director of clinical services.

No further information was provided to the survey team prior to the exit conference to 10/18/19.

4. The facility staff failed to ensure that a portable oxygen cylinder was properly secured on Resident # 68's wheelchair.

Resident # 68 was a 62-year-old-male who was originally admitted to the facility on 3/18/19, and had a readmission date of 10/8/19. Diagnoses included but were not limited to, chronic obstructive pulmonary disorder and shortness of breath.

The clinical record for Resident # 68 was reviewed on 10/17/19 at 2:52 pm. The most recent MDS (minimum data set) assessment for Resident # 68 was a quarterly review assessment with an ARD (assessment reference date) of 8/23/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 68 had a BIMS score (Brief interview for mental status) of 15 out of 15, which indicated that Resident # 68 was cognitively intact. Section O of the MDS assesses special treatments, procedures, and programs. In Section O0100, the facility staff documented that Resident # 68 had received oxygen therapy during the last 14 days during the look back period for the 8/23/19 ARD.

Resident # 68 had orders that included but were not limited to, "Oxygen at 3L/min (liters per minute) via NC (nasal cannula) continuous," which was initiated by the physician on 10/9/19.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 133	F 689		

On 10/9/19 at 11:25 am, the surveyor observed Resident # 68 sitting in the hallway in his wheelchair. The surveyor observed a portable oxygen cylinder that was in a nylon holder on the back of Resident # 68's wheelchair. The surveyor observed that the bottom straps of the nylon holder that held the oxygen cylinder were not secured to the wheelchair frame.

On 10/17/19 at 2:52 pm, the surveyor observed Resident # 68 sitting in his wheelchair in his room. The surveyor observed a portable oxygen cylinder held in a black nylon holder on the back of Resident # 68's wheelchair. The surveyor observed that the bottom straps of the nylon holder were not secured to the wheelchair frame. The manufacturer's instructions for "W/C (wheelchair) Oxygen Tank Holder" contained documentation that included but was not limited to,
..."Application Instructions:
1. Place the oxygen cylinder in the sleeve.
2. With the cylinder facing away from the backrest, hang the top straps on the push handles and secure the bottom straps to the wheelchair frame.
3. To secure and position the oxygen tank holder, tighten all four straps as desired." ...

On 10/17/19 at 4:52 pm, the administrator, director of nursing, and regional director of clinical services were made aware of the findings as stated above.

On 10/18/19 at 12:02 pm, the director of nursing informed the surveyor that the administrative team had reviewed the oxygen tank holder for Resident # 68 and agreed that the straps were not properly secured to the wheelchair for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 134	F 689		

Resident # 68.

No further information regarding this issue was presented to the survey team prior to the exit conference on 10/18/19.
5. The facility staff failed to ensure that Resident #29 was free from abuse from another resident that resided in the nursing facility.

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 Interview for Mental Status) score of 15 out of a possible score of 15. Resident #29 was also coded as requiring supervision of 1 staff member for dressing and personal hygiene and requiring physical help in part of the bathing activity from 1 staff member.

During the clinical record review from 10/8/19 through 10/18/19, the surveyor noted the following documentation in the nursing notes dated and timed for:
" " ...9/8/19 19:33 (7:33 pm) Situation: Writer called into dining room by aide; resident sitting in front of wheelchair. Aide states resident had an altercation with another resident.
Background: Bipolar, Anxiety Disorder
Assessment: Upon assessment _____ (name of Resident #29) scalp is reddened and missing hair. No other injuries noted. Response: On call MD (medical doctor) made aware, Own R.P. (responsible party), DNS (director of nursing services) and Administrator made aware. Police notified. Deputy _____ (name of deputy)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 135 returned call stating that he doesn't have to come out, whom ever is harmed needs to go to the magistrates office to file charges, This information given to _____ (name of resident). She got in touch with her daughter and she came and signed her mom out to go to the Office ... " 9/13/19 16:27 (4:27 pm) Resident stated her head was sore from where the other resident pulling her hair out. Resident reported she is doing ok and has filed charges against the other resident ..." The surveyor reviewed the care plan for Resident #29 and the following was documented in the care plan: " " ...Focus: I sometimes have behaviors which include: demanding my showers at shift change and to be the first resident showered. Demanding staff to stay with for hour long intervals during the showers. Making false accusations against staff. Reporting missing objects that are not missing. Trying to sneak and take showers unassisted ... Interventions: Attempt interventions before my behaviors begin. " Explained to resident she cannot always be first, but will try to get her showered ASAP (as soon as possible) " Give me my medications as my doctor has ordered " Help me to avoid situations or people that are upsetting to me " Let my physician know if I my behaviors are interfering with my daily living " Make sure I am not in pain or uncomfortable " Offer me something I like as diversion " Please refer to my psychologist/psychiatrist as needed " Please tell me what you are going to do before you begin	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	1607 SPRUCE STREET MARTINSVILLE, VA 24112

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F 689	Continued From page 136 " Speak to me unhurriedly and in a calm voice ..." The surveyor noted the date documented for the focus and interventions were initiated on 3/3/14 with a revision date of 1/16/17. There were no interventions noted by the surveyor after the resident-to-resident altercation that had occurred on 9/8/19. The surveyor also noted an "Emergency Protective Order" dated for 9/8/19 at 8:10 pm in which named Resident #29 as being the alleged victim was to have no contact with the other resident involved in the altercation. The order expired on 9/11/19 at 11:59 pm. The survey team interviewed Resident #29 in the conference room on 10/15/19 at 11:20 am. The surveyor asked Resident #29 if she could tell the surveyor what had happened with another resident on 9/8/19 that resulted in this resident obtaining an Emergency Protective Order against another resident that was involved in an altercation that had occurred on 9/8/19. Resident #29 stated, "_____ (name of the resident involved in the altercation on 9/8/19) came over while we were in the dining room and pulled a lot of my hair out of my head. It was a handful of hair and pulled out by the roots. ____ (Name of resident involved in altercation) and I were friends and we set together in the dining room for our meals. But one day she started saying things to me that were not nice and then she accused me of saying things about her son. I really don't know how it started. But after she pulled my hair and called me names, the staff called the police and they were told that I would have to go to the Magistrate's office to press charges against her. So I called my daughter and she took me down	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 137	F 689		

there. I got a Protective Order for her to keep away from me but I still saw her coming down the hallway where my room is and she would say things to me as she passed my room, but they stopped and told her that she could not come down that hallway where I was without a staff member being with her. I still saw her down the hallway from time to time without anyone with her. The surveyor asked the resident if she felt safe in the facility. The resident stated, "I really don't. She (referring to resident involved in altercation) could come in my room, she is a big woman, and she could smother me by sitting on my face or putting a pillow over it. But I feel better now because since Friday, she has had a staff person sitting with her all the time. Did you hear what happened on Friday at supper time?" The surveyor stated that she had read the documentation in the nurses' notes for Friday about the details of another altercation. The resident stated, "I had asked an aide for some vanilla ice cream. Then ____ (name of other resident involved in altercation) said, "Why don't you get it your damn self." She came full force toward me and an aide stopped her and the wheelchair before she could get to me. Since then she has had to have a sitter be with her all the time and she has had to eat her meals in her room.

The surveyor noted the following documentation in the nurses' notes timed and dated for 10/12/19 at 20:40 (10:40 pm) which read in part, " ...Altercation with another resident during meal time in dining room. Resident asked to come out dining room and go back to room. This resident telephoned the sheriff department ..." For 10/12/19 21:32 (9:32 pm) the nurses' note read in part, " ...Resident is her own responsible party,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 138	F 689		

but she states she called her daughter anyway. ____ (name of medical doctor) on call ...was made aware of the incident with NNO (no new orders)."
The surveyor interviewed the administrator on 10/18/19 at approximately 1 pm in the conference room. The surveyor asked about the altercation between Resident #29 and another resident on 10/12/19. The administrator stated that another resident was not verbally nice to _____ (name of Resident #29). They were eating in the dining room with _____ (name of Resident #29) was sitting at one table and the other resident was sitting at another table away from _____ (name of Resident #29). Since that altercation, we have had a sitter with _____ (name of resident involved in altercation with Resident #29) constantly with her until we can resolve this issue between _____ (name of Resident #29) and _____ (name of other resident). We don't know at this time how this will be resolved but we are actively looking for a resolution to this issue between these 2 residents."

No further information was provided to the surveyor prior to the exit conference on 10/18/19.
6. For Resident #13 facility staff failed to ensure the environment remained free of accident hazards by securing oxygen tanks stored in the resident's room.

Resident #13 was admitted to the facility on 2/23/12. Diagnoses included chronic obstructive pulmonary disease, cutaneous abscess of back, difficulty walking, chest pain, depression, angina, schizoaffective disorder, lymphedema, heart failure, hypertension, type 2 diabetes, and morbid obesity. On the quarterly Minimum Data Set assessment with assessment reference date

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 139	F 689		

9/23/19, the resident scored 10/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting others. The resident was assessed as using oxygen in the 14 days prior to the assessment.

During initial tour on 10/8/19, surveyors observed two unsecured full oxygen tanks without rack or stands in the resident's room. The full oxygen tanks stood in the floor between the resident's air conditioning unit and the resident's wheelchair, The resident was in bed and the tanks were close enough to the bed that they could be bumped by the resident if the resident chose to sit with legs dangling from the side of the bed facing the window.

The administrator and director of nursing were notified of the concern during a summary meeting on 10/10/19 at 3:45 PM.

8. For Resident #97 facility staff failed to ensure the resident received adequate supervision to prevent accidents by ensuring the non-ambulatory resident did not have access to stairs.

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 reference date 8/21/19, the resident was assessed with short and long term memory

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 140	F 689		

deficits and severely impaired cognitive skills for daily decision making and as without signs of delirium, psychosis, or behaviors affecting care. The resident was assessed as requiring extensive assistance of 2 or more persons for transfer, supervision for locomotion on the nursing unit in a wheelchair, and extensive assistance of one person for locomotion in a wheelchair off the unit.

A Facility Reported Incident (FRI) dated 4/14/19 reported Resident #97 was found on the floor at the bottom of the stairwell near the laundry area. The resident was assessed in Emergency Department and returned to the facility. Prior to the fall, the resident was ambulatory with wheelchair, wandering, and seeking exit. After the fall, the resident was moved to a ground level floor and a wanderguard was placed.

During the tour on 10/8/19, the surveyor observed that the stairwell doors were locked with a numbered keypad. Staff members interviewed by the surveyor were unable to say how a wheelchair dependent resident might gain access to the stairwell. The surveyor interviewed the director of nursing (DON) about the incident and the DON was unable to offer an explanation. The DON explained that the resident now resided on the lower level of the facility and was not at risk for falling down stairs.

The resident was unable to answer questions about the incident.

The administrator and DON were notified of the concern during a summary meeting on 10/10/19.

9. Facility staff failed to ensure the environment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 141 remained free of accident hazards by when partially depleted oxygen storage tanks were stored free-standing in the oxygen storage room creating a potential fire hazard. In 10/08/19 at 4:56 PM, the surveyor inspected the oxygen storage room. The room contained 6 empty oxygen tanks standing loose in the floor. There were open spaces in the empty tank rack and empty portable carriers. The CNA with the surveyor moved the empty tanks to the storage rack while the surveyor was present. On 10/10/19 at 3:45 PM during a summary meeting, the administrator and director of nursing were notified of the safety concern. No oxygen tanks were observed to be improperly stored for the duration of the survey.	F 689		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and during the course of a complaint investigation, the facility staff failed to pain management was provided to residents who require such services resulting in unavailability of the pain medication oxycodone for administration according to physician orders for 1 of 30 residents in the survey sample (Resident #103).	F 697	1. Resident #103 received replacement medication on 6/4/2019. 2. Residents prescribed pain medication are at risk for the deficient practice. 3. Director of Nursing or designee re-educated nursing staff on the process to properly complete the controlled medication log and notify the DON/ADON of discrepancies and monitoring for increased pain. 4. Audits will be conducted by the Director of Nursing or designee for discrepancies on the Controlled Medication Log and increases in resident pain for 4 weeks. The Director of Nursing will submit a report to the Quality Assurance	12/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 pain, diabetes mellitus type 2 with ophthalmic 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	and Performance Improvement Committee. The DON is responsible for monitoring and follow-up. 5. 12/06/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 143	F 697		

follows:

6/1/19 00:48 nursing note awaiting pharmacy arrival
6/1/19 09:43 nursing note awaiting pharmacy arrival --coded 2=refused
6/1/19 12:38 nursing note awaiting pharmacy arrival
6/1/19 17:28 nursing note awaiting pharmacy arrival
6/1/19 20:29 nursing note awaiting pharmacy arrival-- --coded 2=refused
6/2/19 08:59 nursing note awaiting pharmacy arrival
6/2/19 12:16 nursing note awaiting pharmacy arrival
6/2/19 16:40 nursing note awaiting pharmacy arrival
6/2/19 21:03 nursing note awaiting pharmacy arrival
6/3/19 16:55 nursing note awaiting pharmacy arrival
6/3/19 20:35 nursing note awaiting pharmacy arrival
6/4/19 09:34 nursing note awaiting pharmacy arrival
6/3/19 for 09:00 and 13:00 no documentation in MAR and no nursing notes concerning resident status

This review indicated the resident missed 14 consecutive doses of oxycodone. The pain assessments associated with those 14 doses were either 'X' or blank except for the 6/2 assessment at 21:00 was documented as '0' on the medication administration record.

The surveyor discussed the concern with the director of nursing (DON) on 10/16/19 at 8:44

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 144 AM. The DON said that the doctor on call would not write a replacement prescription or a prescription to pull doses from the stat box because the doctor wanted to avoid DEA scrutiny. The Pain clinic said that they would not replace the prescription and the resident could do without the drug until time for a new prescription to start. The DON stated the resident showed no signs of withdrawal. The DON provided hand written employee statements dated 10/16/19 from two LPNs stating they had contacted physician offices concerning the medication being unavailable. On 10/16/19 at 3:30 PM, the medical director met with surveyors and talked about several issues. During that meeting, the medical director stated that some of the residents dislike him because he does not give them the pills they want. Surveyors discussed the failure to ensure pain medication was available with the administrator and DON during individual discussions on 10/16/19.	F 697		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based clinical record review and staff interview, the facility staff failed to ensure adequate and complete communication between the nursing facility and the dialysis facility for 1 of 30 residents	F 698	1. Dialysis communication forms for resident # 68 were reviewed for completion on 10/17/2019. 2. Residents receiving dialysis are at risk for deficient practice. 3. Re-education was provided by the Director of Nursing or designee to the licensed nursing staff related to completing and obtaining a completed dialysis communication sheet from the dialysis provider. 4. Audit will be completed by the Director of Nursing or designee to ensure dialysis	12/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 145 in the survey sample (Resident #68). The findings included: The facility staff failed to ensure adequate and complete communication between the nursing facility and the dialysis facility for Resident #68. Resident #68 was readmitted to the facility on 9/14/19 and discharged on 10/6/19 The resident had the following diagnoses of, but not limited to anemia, heart failure, high blood pressure, diabetes, dementia and depression. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/23/19, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #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 10/16/19 at 3:30 pm, the surveyor reviewed the "Dialysis Communication Form" from 9/3/19 to 10/15/19. The surveyor noted that the communication sheets were not filled out completely with either the information that the facility was supposed to document before and after dialysis or the dialysis center portion was not completely filled out to communicate back to the facility aspects of dialysis or any medications that were given to the resident while receiving dialysis. The surveyor notified the administrator, director of nursing and the regional corporate nurse of the above documented findings on 10/18/19 at approximately 2 pm. No further information was provided to the	F 698	communication sheets continue to be completed. The audit findings will be submitted to the Quality Assurance and Performance Improvement Committee. The DON is responsible for monitoring and follow up. 5. 12/06/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 146 surveyor prior to the exit conference on 10/18/19.	F 698		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on clinical record review, and staff interview, the facility staff failed to assure that	F 726	1. Nurses and CNAs providing care to residents # 9 and # 63 completed mechanical lift training and competencies. 2. Audit of employee personnel file was completed by the Director of Nursing to ensure competencies/ lift training of nursing staff are completed. 3. Re-education was provided by the Director of Nursing or designee on mechanical lift transfers and clinical competencies. 4. The Director of Nursing or designee will audits new employee personnel files for completed orientation competencies, within the first 30 days of employment weekly for 8 weeks. The Director of Nursing will submit findings to the Quality Assurance Committee. The Administrator is responsible for monitoring and follow up. 5. 12/06/2019	12/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 147	F 726		

nursing staff had the appropriate competencies and skill sets to provide nursing and related services to assure resident safety for two of 30 residents in the survey sample, Resident #9 and Resident # 63.

The findings included:

The facility staff failed to produce documentation that nursing staff had the appropriate competencies related to safety with the Hoyer lift following falls from the Hoyer lift for Resident # 9 and Resident # 63.

Resident # 9 was originally admitted to the facility on 1/27/11. Resident # 9 had a facility readmission date of 9/10/18. Diagnoses included but were not limited to, schizoaffective disorder, psychotic disorder, anxiety, and major depressive disorder.

The clinical record for Resident # 9 was reviewed on 10/10/19 at 11:10 am. The most recent MDS (minimum data set) assessment was a significant change assessment with an 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. Section G of the MDS assesses functional status. In Section G0110, the facility staff documented that Resident was totally dependent on staff requiring two or more persons to assist with transfers.

The plan of care for Resident # 9 was reviewed and revised on 10/10/19. The facility staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 148	F 726		

documented a focus area for Resident # 9 as "At risk for falls related to: Use of medication, history of falls, decreased mobility, bladder/bowel incontinence, requires maxi lift w(with)/staff assistance for transfers." Interventions included but were not limited to, "Transfer using the Maxie Move lift with two person assistance at all times."

On 10/11/19 at 9:19 am, the surveyor interviewed CNA # 4. The surveyor asked CNA # 4 if she provided care for Resident # 9 on 4/1/19. CNA # 4 stated, "Yes." The surveyor asked CNA # 4 to describe the events that led to Resident # 4's fall from the lift on 4/1/19. CNA #4 stated, "That morning they had a different lift pad." "I had never used that before." "I asked for assistance, but the girl didn't come back." "The lift I usually use was different." "I was unaware that you had to criss cross." "I started to get her up, and she slid out."

Resident # 63 was a 47-year-old-female that was originally admitted to the facility on 3/22/18, and had a readmission date of 7/2/19. Diagnoses included but were not limited to, paraplegia, and muscle weakness.

The clinical record for Resident # 63 was reviewed on 10/10/19 at 9:46 am. The most recent MDS (minimum data set) assessment for Resident # 63 was a quarterly assessment with an ARD (assessment reference date) of 8/21/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 63 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicated that Resident #63 was cognitively intact. Section G of the MDS assesses functional status. In Section G0110, line B assessed transfer status. The facility staff documented that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 149 Resident # 63 was totally dependent requiring the assistance of two or more persons for transfers. The plan of care for Resident # 63 was reviewed and revised on 9/3/19. The facility staff documented a focus area for Resident # 63 as, "At risk for falls related to: Use of medication, Dx's (diagnoses) of chronic inflammatory demyelinating polyneuropathy, morbid obesity, paraplegia, and due to fear of falling." Interventions included but were not limited to, "Transfer using the Hoyer lift w/at least 2-staff persons assisting," and "Education provided after fall 6/5/19." The surveyor observed a nurse's note for Resident # 63 that had been documented on 6/5/19 at 3:06 pm. The nurse's note was documented as, "Resident was lowered to the floor during transportation to chair due to it overturning. She was not hurt during the incident. There were 3 CNAs present at the time I entered the room. Resident was still on part of the bed while the CNAs were holding her. DON (director of nursing) and unit manager came to witness the incident. Statements will be written in regards to the situation." On 10/15/19 at 11:04 am, the surveyor reviewed a hand written statement that was written by the director of nursing on 6/5/19. The statement was documented as, "Had (Three employee's name's withheld) concerning lowering Resident # 63 to the floor. Has CNAs re-inact the transfer with therapy, administration, and myself. CNAs stated that as they went to move Resident # 63 the lift tilted and they has to lower her to the floor. The re-inactment revealed that the CNAs did not have Resident # 63's weight balanced in the sling but	F 726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 150 had her feet on one side and her upper body on the other side which caused the lift to tilt to the side that had her upper body on it." On 10/16/19 at 10:32 am, the surveyor interviewed CNA # 2. The surveyor asked CNA # 2 if she was providing care to Resident # 63 on 6/6/19 when she was lowered to the floor. CNA # 2 stated, "Yes." The surveyor asked CNA # 2 to describe the events that led to Resident # 63 being lowered to the floor. CNA # 2 stated, "We were getting her out of bed and putting her in the chair." "They didn't have her positioned properly, and the lift tilted, so we lowered her to the floor." The surveyor asked CNA # 2 if she had been trained to use the lift. CNA # 2 stated, "I have been, but not with people that are her size." On 10/16/19 at 4:15 pm, the administrator and director of nursing were made aware of the incidents as stated above and the surveyor requested to see documentation of competencies that the CNA involved in the incident with Resident # 9 sliding from the lift and the three CNAs involved in the incident which led to Resident # 63 being lowered to the floor, were properly trained on safe transfers while using the Hoyer lift prior to the incident. The facility staff failed to produce competencies for the CNAs involved in the incidents that involved Resident # 9 falling from the lift and Resident # 63 being lowered to the floor. No further information regarding this issue was presented to the survey team prior to the exit conference on 10/18/19.	F 726		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40	F 740	1. Resident #9 was seen by Deer Oaks Behavioral Health Services on 11/16/2019.	12/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 151 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and during the course of a complaint investigation, the facility staff failed to ensure that three of 30 residents in the survey sample received behavioral health care and services to maintain the highest practicable well-being, Resident # 9, Resident # 17, and Resident # 63. The findings included 1. The facility staff failed to ensure that Resident # 9 had a follow up visit with behavioral health services in a timely manner. Resident # 9 was originally admitted to the facility on 1/27/11, with a readmission date of 9/10/18. Diagnoses included but were not limited to, schizoaffective disorder, anxiety, and major depressive disorder. The clinical record for Resident # 9 was reviewed on 10/9/19 at 12:00 pm. The most recent MDS (minimum data set) assessment for Resident # 9 was a significant change assessment with an	F 740	Resident # 17 was seen by Deer Oaks Behavioral Health Services on 11/6/2019. Resident # 63 was seen by Deer Oaks Behavior Health Services on 11/6/2019. 2. Residents requiring Behavior health services are at risk for this deficient practice. 3. Re-education was provided to the nursing staff by the DON or designee to ensure residents receive behavior health services and follow up visits as ordered. 4. Audits will be completed by the Director of Nursing or designee to ensure residents are receiving behavior health services as ordered weekly for 8 weeks. The Director of Nursing will submit findings to the Quality Assurance and Performance Improvement Committee. The DON is responsible for monitoring and follow up. 5. 12/06/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	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 IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 153	F 740		

surveyor that the behavioral health provider is not able to see all of the residents when he comes in and if he is unable to see the resident when he is in he will see the resident on the following week when he visits the facility. The assistant director of nursing agreed that Resident # 9 should have been seen in 2 weeks as documented on the psychiatric initial assessment.

The "Psychological Services Agreement" included documentation that included but was not limited to ..."Description of Services. Provider will make available a professional clinician to perform the following psychological services:
A. Psychological Consultations. Provider will make available clinical staff to provide on-site psychological services to residents covered by Medicare Part B (or other insurance accepted by Provider)," ...

On 10/17/19 at 4:54 pm, the administrator, director of nursing, and regional director of clinical services were made aware of the findings as stated above.

No further information regarding this issue was provided to the survey team prior to the exit conference on 10/18/19.

2. The facility staff failed to ensure that Resident # 17 received behavioral health services.

Resident # 17 was originally admitted to the facility on 11/24/09, and had a readmission date of 12/4/10. Diagnoses included but were not limited to, schizoaffective disorder and major depressive disorder.

The clinical record for Resident # 17 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 155	F 740		

On 10/16/19 at 5:14pm, the administrator and director of nursing were informed that the surveyor did not locate any documentation in the clinical record for Resident # 17 that reflected that behavioral health services had been provided since 11/1/18. The surveyor asked the administrative team if the new behavior health provider had seen Resident # 17. The administrator stated she would look into it and report to the survey team.

On 10/17/19 at 2:37 pm, the director of nursing provided the surveyor with information that Resident # 17 had not been seen by the new behavioral health provider and had not received behavioral health services since 11/1/18.

On 10/17/19 at 4:52 pm, the administrator, director of nursing, and regional director of clinical services were made aware of the findings as stated above.

No further information regarding this issue was presented to the survey team prior to the exit conference on 10/18/19.

3. The facility staff failed to ensure that Resident # 63 had a follow up visit with behavioral health services in a timely manner.

Resident #63 was originally admitted to the facility on 3/22/18, and had a readmission date of 7/2/19. Diagnoses included but were not limited to, bipolar disorder, anxiety disorder, and major depressive disorder.

The clinical record for Resident # 63 was reviewed on 10/10/19 at 9:46 am. The most recent MDS (minimum data set) assessment for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 156	F 740		

Resident # 63 was a quarterly assessment with an ARD (assessment reference date) of 8/21/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 63 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicated that Resident #63 was cognitively intact.

Resident # 63 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.

On 10/10/19 at 1:37 pm, the surveyor was in Resident # 63's room conducting a resident interview. Resident # 63 became tearful and stated, "I just wanna go home." The surveyor asked Resident # 63 if she received behavioral health services at the facility. Resident # 63 informed the surveyor that the facility was doing something for her depression but all of a sudden, it stopped. Resident # 63 informed the surveyor that she had talked to a person a couple weeks ago and has not talked to anyone since. The surveyor asked Resident # 63 if she wanted to talk with someone from behavioral health services. Resident # 63 stated, "Yes."

On 10/17/19 at 2:34 pm, the surveyor observed a "Psychiatric Initial Assessment" in the clinical record for Resident # 63 that was dated 9/18/19. The psychiatric initial assessment contained documentation that included but was not limited to ..."Future visits Revisit in 2 weeks." ... The surveyor reviewed the clinical record further and did not locate any documentation that reflected that Resident # 63 had received behavioral health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 157 services since 9/18/19. 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 # 63 had not been see by the behavioral health provider when the consult stated that Resident # 63 was to be revisited in 2 weeks and now 4 later Resident # 63 still had not seen the behavioral health provider. The assistant director of nursing informed the surveyor that the behavioral health provider is not able to see all of the residents when he comes in and if he is unable to see the resident when he is in he will see the resident on the following week when he visits the facility. The assistant director of nursing agreed that Resident # 63 should have been seen in 2 weeks as documented on the psychiatric initial assessment. On 10/17/19 at 4:54 pm, the administrator, director of nursing, and regional director of clinical services were made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 10/18/19. This is a complaint deficiency.	F 740		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.	F 744	1. Resident # 58 Care Plan was revised to include treatment and services for dementia care. Resident # 11 Care Plan was revised to include resident centered dementia care. 2. Residents with diagnosis of dementia are at risk for deficient practice.	12/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 744	Continued From page 158 This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed to ensure 2 of 30 residents in the survey sample received treatment and services for dementia care. (Resident #58 and #11) The findings included: 1. The facility staff failed to ensure Resident #58 received treatment and services for dementia care. There was no progression rate of the resident's Dementia and Alzheimer's disease for staff to compare to when the resident was assessed or reassessed to know if there was a sudden change or worsening from the baseline of the resident's condition. Resident #58 was admitted to the facility with the following diagnoses of, but not limited to high blood pressure, Alzheimer's disease, dementia, depression and psychotic disorder. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/14/19 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 8 out of a possible score of 15. Resident #58 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene. During the clinical record review on 10/16/19 and 10/17/19, the surveyor reviewed the comprehensive care plan (CCP) for Resident #58. The surveyor noted that there was not a baseline for the facility staff to compare to when the resident was experiencing a sudden change or worsening of the resident's condition so staff could notify the physician of these worsening or	F 744	3. Re-education was provided by the Administrator to the interdisciplinary team for residents with a dementia diagnosis to ensure a resident centered dementia care plans are in place. 4. Audits will be completed by the Director of Nursing or designee to ensure residents with dementia diagnosis have a resident centered dementia care plan weekly for 8 weeks. The Director of Nursing will submit findings to the Quality Assurance and Performance Improvement Committee. The DON is responsible for monitoring and follow up. 5. 12/06/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 744	Continued From page 159	F 744		

sudden changes of the resident's condition.

The surveyor notified the administrator, director of nursing and the regional corporate nurse of the above documented findings on 10/18/19 at approximately 2 pm. After this group was notified of these findings, they did not verbalize or provide any information to the surveyor concerning the findings.

No further information was provided to the surveyor prior to the exit conference on 10/18/19.
2. The facility staff failed to ensure that the plan of care for Resident # 11 included resident centered dementia care to ensure the highest practicable well-being.

Resident # 11 was originally admitted to the facility on 7/11/17, with a readmission date of 11/29/17. Diagnoses included but were not limited to, dementia, anxiety, psychosis, and delusional disorders.

The clinical record for Resident # 11 was reviewed on 10/9/19 at 11:57 am. The most recent MDS assessment for Resident # 11 was a quarterly assessment with an ARD of 8/26/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 11 had a BIMS score (brief interview for mental status) of 15 out of 15, which indicated that Resident # 11 was cognitively intact. The most recent annual MDS assessment for Resident # 11 had an ARD of 3/20/19. According to the care area assessments in Section V0200, the facility staff documented that cognitive loss and dementia would be addressed in the plan of care for Resident # 11.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 744	Continued From page 160 The current plan of care for Resident # 11 was reviewed and revised on 10/11/19. The facility staff documented a focus area for Resident # 11 as "Impaired neurological status related to seizure disorder, dementia." The surveyor did not observe any documentation on the plan of care for Resident # 11 that included dementia care needs and support or person centered interventions to manage behaviors associated with dementia. On 10/15/19 at 11:32 am, the surveyor reviewed the plan of care for Resident # 11 with the MDS nurse. The MDS nurse agreed that the plan of care for Resident # 11 did not include person centered dementia care needs or person centered interventions to manage behaviors associated with dementia. On 10/16/19 at 5:14 pm, the administrator and director of nursing were made aware of the findings 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 744		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 755	1. Resident # 47 received medication on 9/27/2019. 2. Residents who reside at the facility that receive prescribed medications are at risk for this deficient practice. 3. Re-education was provided to the nursing staff to ensure medications are available for administration.	12/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 161 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and facility document review the facility staff failed to ensure that medications were available for one of 30 Residents in the survey sample, Resident # 47. The findings included The facility staff failed to ensure that clonazepam was available for administration for Resident # 47. Resident # 47 was admitted to the facility on 5/11/17. Diagnoses included but were not limited to, anxiety, major depressive disorder, traumatic	F 755	Audits will be conducted by the Director of Nursing or designee of medication carts to ensure medications are available weekly for 8 weeks. 4. The Director of Nursing will submit findings to the Quality Assurance and Performance Improvement Committee. The DON is responsible for monitoring and follow up. 5. 12/06/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 162	F 755		

brain injury, and hypertension.

The clinical record for Resident # 47 was reviewed on 10/9/19 at 2:27 pm. The most recent MDS (minimum data set) assessment for Resident # 47 was a quarterly assessment with an ARD (assessment reference date) of 8/5/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 47 had a BIMS score (brief interview for mental status) of 15 out of 15, which indicated that Resident # 47 was cognitively intact.

Resident # 47 had orders that included but was not limited to, "Clonazepam tablet 0.5 mg (milligram) give 0.5 mg by mouth two times a day related to anxiety disorder give 2nd dose with dinner do not give w/n (within) 5 hours of restoril," which was initiated by the physician on 9/13/19.

The current plan of care for Resident # 47 was reviewed and revised on 9/9/19. The facility staff documented a focus area for Resident # 47 as, "Potential for drug related complications associated with the use of psychotropic medications related to anti-anxiety medication, antidepressant medication, hypnotic medications." Interventions included but was not limited to, "Medications as ordered by physician and evaluate for effectiveness."

On 10/10/19 at 2:52 pm, the surveyor reviewed the September 2019 medication administration record for Resident # 47. The surveyor observed a "7" documented on the medication administration record for the 5:00 pm dose on 9/25/19, the 9:00 am dose on 9/26/19, and the 5:00 pm dose on 9/26/19. According to the chart

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 163 codes listed on the medication administration record, "7" means "other/see nurses notes." The surveyor reviewed the nurse's notes for Resident # 47. The surveyor observed a nurse's note that was documented on 9/25/19 at 5:55pm. The nurse's note was documented as, ""Clonazepam tablet 0.5 mg (milligram) give 0.5 mg by mouth two times a day related to anxiety disorder give 2nd dose with dinner do not give w/n (within) 5 hours of restoril unavailable pharmacy notified." The surveyor observed a nurse's note that was documented on 9/26/19 at 9:11 am. The nurse's note was documented as, "Clonazepam tablet 0.5 mg (milligram) give 0.5 mg by mouth two times a day related to anxiety disorder give 2nd dose with dinner do not give w/n (within) 5 hours of restoril to be sent." The surveyor observed a nurse's note that was documented on 9/26/19 at 4:27 pm. The nurse's note was documented as, "Clonazepam tablet 0.5 mg (milligram) give 0.5 mg by mouth two times a day related to anxiety disorder give 2nd dose with dinner do not give w/n (within) 5 hours of restoril md and pharm aware." On 10/10/19 at 3:54 pm, the administrator and director of nursing were made aware of the findings as stated above. The administrative team was provided the opportunity to ask questions and/or submit additional information to the survey team to in response to the deficient practice as stated above. No further information was provided to the survey team prior to the exit conference on 10/18/19.	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	1607 SPRUCE STREET MARTINSVILLE, VA 24112

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F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.	F 756	1. Resident # 88 pharmacy recommendation was completed 11/6/2019. 2. An audit was completed of the pharmacy recommendations for the last 30 days to ensure recommendations were addressed. 3. Re-education was conducted by the Director of Nursing or designee to licensed nursing staff to ensure pharmacy recommendations are completed. 4. Audits will be completed by the Director of Nursing or designee of pharmacy to ensure recommendations continue to be completed timely monthly for 2 months. The Director of Nursing will submit a findings to the Quality Assurance and Performance Improvement Committee. The DON is responsible for monitoring and follow up. 5. 12/06/2019	12/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 165	F 756		

This REQUIREMENT is not met as evidenced by:
Based on clinical record review, and staff interview, the facility staff failed to ensure that a pharmacy recommendation was acted upon in a timely manner for one of 30 Residents in the survey sample, Resident # 88.

The findings included

The facility staff failed to act upon a pharmacy recommendation in a timely manner for Resident # 88.

Resident # 88 was admitted to the facility on 3/20/19. Diagnoses included but were not limited to, anxiety, dementia with behavioral disturbance, and schizophrenia.

The clinical record for Resident # 88 was reviewed on 10/10/19 at 11:28 am. The most recent MDS (minimum data set) assessment for Resident # 88 was a quarterly assessment with an ARD (assessment reference date) of 9/10/19. Section B of the MDS assesses hearing speech and vision. In Section B0700, the facility staff documented that Resident # 88 was rarely or never understood.

On 10/10/19 at 11:23 am, the surveyor observed pharmacy recommendation in the clinical record For Resident # 17 dated 9/25/19. The pharmacy recommendation contained documentation that included but was not limited to, ..." The resident has been taking the anxiolytic clonazepam 1 mg (milligram) po (by mouth) qhs (every hour of sleep) since March. Please evaluate the current dose and consider a dose reduction." ... The surveyor observed had the pharmacy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 166 recommendation had not been addressed and there was a handwritten note on the pharmacy recommendation that stated, "Place on psych rounds." The surveyor interviewed LPN # 1 (licensed practical nurse). The surveyor asked LPN # 1 why the pharmacy recommendation had not been addressed. LPN # 1 stated that the pharmacy recommendation would be addressed by the psych doctor when he came in on the next rotation. The surveyor asked LPN # 1 why the psych doctor didn't address the pharmacy recommendation while he was in the facility on 10/9/19. LPN # 1 stated that the psych doctor did not get to all of the residents while in the facility on 10/9/19, and that Resident #17's pharmacy recommendation would be addressed by the psych doctor next week. On 10/16/19 at 5:14 pm, the administrator and director of nursing were made aware of the delay in treatment with the pharmacy recommendation for Resident # 17. 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 provided to the survey team prior to the exit conference on 10/18/19.	F 756		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws.	F 773	1. Resident # 23 had labs completed on 8/15/2018. Resident # 77 had labs on 9/14/2019 and 10/17/2019. 2. Current residents with lab orders are at risk for this deficient practice. 3. Re-education was provided by the Director of Nursing or designee to the licensed nursing staff to ensure labs are completed as ordered.	12/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 773	Continued From page 167 (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and during the course of a complaint investigation, the facility staff failed to obtain labs as ordered for 2 of 30 residents in the survey sample (Resident #23 and #77). The findings included: 1. For resident #23 the facility staff failed to obtain a Valproic Acid Level as ordered for 8/15/18. Resident #23's face sheet listed an admission date of 1/23/15. The resident's diagnosis list indicated diagnoses, which included, but not limited to Bipolar Disorder, Generalized Anxiety Disorder, Major Depressive Disorder, Parkinson's Disease, Type 1 Diabetes, Peripheral Vascular Disease, and Chronic Kidney Disease Stage 3. The most recent quarterly MDS (minimum data set) with an ARD of 7/16/19 assigned the resident a BIMS (brief interview for mental status) score of 15 out of 15 in section C, cognitive patterns. Resident #23 was also coded as requiring extensive assistance of one staff member for dressing, personal hygiene and total dependence for bathing. Resident #23's medical record contained a physician's order dated 5/15/18 for a Valproic	F 773	4. Audits will be completed by the Director of Nursing or designee to ensure labs are completed as ordered 2 times a week for 8 weeks. The Director of Nursing will submit findings to the Quality Assurance and Performance Improvement Committee. The DON is responsible for monitoring and follow up. 5. 12/06/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 773	Continued From page 168	F 773		

Acid Level with Start Date of 8/15/18 and End Date of 8/16/18. The surveyor could not locate results in the resident's medical record for a valproic acid level obtained between 8/15/18 to 8/16/18.

The concern of the missing valproic acid level was discussed with the director of nursing on 10/17/19 at approximately 5:00pm. The director of nursing stated she could not find the results for the valporic acid level.

No further information was provided prior to the exit conference on 10/18/19.

2. For Resident #77 the facility staff failed to obtain the following labs: TSH (Thyroid-stimulating Hormone) and BMP (Basic Metabolic Panel) in July 2019, and FLP (Fasting Lipid Panel) and TSH (Thyroid-stimulating Hormone) on 9/14/19.

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 Mellitus with Diabetic Neuropathy, Essential Hypertension, Heart Failure, Hypothyroidism, and Irritable Bowel Syndrome.

The most recent quarterly MDS (minimum data set) with an ARD of 9/04/19 assigned the resident a BIMS (brief interview for mental status) score of 15 out of 15 in section C, cognitive patterns. Resident #77 was also coded as being independent in bathing and requiring supervision only in dressing and personal hygiene.

Resident #77's medical record contains a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 773	Continued From page 169 physician's order dated 2/05/19 to obtain a "BMP every 6 months Jan, July" and a physician's order dated 6/22/18 to obtain a "TSH q 6 months Jan/July". The surveyor could not locate results in the resident's medical record for a TSH (Thyroid-stimulating Hormone) or BMP (Basic Metabolic Panel) obtained in July 2019. A "MD/Nursing Communications" document in the resident's medical record dated 9/13/19 stated in part, "Fasting Lipid Panel and TSH missed in July. Do you want to draw now". Physician response stated "OK, get next lab day." The surveyor could not locate results in the medical record for a FLP (Fasting Lipid Panel) or a TSH (Thyroid-stimulating Hormone) obtained following the 9/13/19 physician's order. The concern of the missing labs was discussed with the administrative staff (administrator and director of nursing) during a meeting on 10/16/19 at approximately 5:00pm. No further information was provided prior to exit conference on 10/18/19.	F 773		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet	F 791	1. Resident #17 had dental appointment on 10/28/2019. 2. Residents who reside at facility are at risk for dental concerns. 3. Re-education was provided by the Administrator to the Social Work Director to ensure residents with denture concerns receive timely dental care as required. 4.Audits will be completed by the Social Work Director for dental concerns weekly for 8 weeks.	12/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 170 the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and clinical record review, the facility staff failed to obtain dental services to meet resident needs for one of 30 residents in the survey sample, Resident # 17.	F 791	The Social Work Director will submit findings to the Quality Assurance and Performance Improvement Committee. The Administrator is responsible for monitoring and follow up. 5. 12/06/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 171	F 791		

The findings included

The facility staff failed to set up a dental appointment for Resident # 17 after she voiced that her dentures were ill fitting.

Resident # 17 was originally admitted to the facility on 11/24/09, and had a readmission date of 12/4/10. Diagnoses included but were not limited to, dysphagia, gastro-esophageal reflux disease (GERD) and hypokalemia.

The clinical record for Resident # 17 was 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.

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, "At risk for dental problems related to: missing all of her natural teeth wears dentures. Resident voiced that her upper denture is loosely fitting and she has difficulty chewing." Interventions included but were not limited to, "Refer for dental services as needed."

On 10/8/19 at 1:52 pm, the surveyor was in Resident # 17's room conducting a resident interview. The surveyor asked Resident # 17 if she had any dental problems. Resident # 17 informed the surveyor that her top dentures did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 172	F 791		

not fit well.

The surveyor reviewed the clinical record for Resident # 17 and observed a "SBAR-Change of Condition" note that had been documented on 9/20/19 at 6:14 pm. The note contained documentation that included but was not limited to,"Situation: Resident voiced having a loosely fitting upper denture and having difficulty chewing foods, beans." ... The surveyor reviewed the clinical record further for Resident # 17 and did not observe any documentation that reflected that a dental referral had been made to evaluate Resident # 17's loosely fitting dentures.

On 10/15/19 at 2:08 pm, the surveyor interviewed the facility social worker. The surveyor asked the social worker if she was responsible for setting up dental services for residents. The social worker stated that she was responsible for setting up dental services and that she kept a list of residents that have dental issues and would communicate with nurses to get orders for the residents to be sent out to the dentist. The surveyor asked the social worker if she was aware that Resident # 17 had stated that her top dentures were ill fitting and that she was having difficulty chewing. The social worker stated, "Honestly, I can't say."

On 10/15/19 at 3:11 pm, the facility social worker informed the surveyor that she had spoken to unit manager and that the unit manager spoke with the nurses and Resident # 17 and that Resident # 17 will be put on the list to be sent out to the dentist.

On 10/16/19 at 5:14 pm, the administrator and director of nursing were made aware of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 173 findings 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 791		
F 825 SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on clinical record review, clinical record review, resident interview, staff interview, and during the course of a complaint investigation, it was determined that the facility staff failed to provide specialized rehabilitative services for one of 30 residents in the survey sample, Resident # 63.	F 825	1. Resident # 63 Prafos (pressure relief ankle foot orthosis) were ordered. 2. Residents who reside in facility with specialized equipment orders are at risk for deficient practice. 3. Re-education was provided by the the Regional Clinical Director or designee to licensed nursing staff and therapy staff to ensure equipment is being provided as ordered. 4. Audit will be completed by the Rehab Director or designee that specialized rehabilitative equipment is provided as ordered weekly for 8 weeks. The Rehab Director will submit findings to the Quality Assurance and Performance Improvement Committee. The Administrator is responsible for monitoring and follow up. 5. 12/06/2019	12/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 825	Continued From page 174	F 825		

The findings included

The facility staff failed to provide Resident # 63 with Prafos (pressure relief ankle foot orthosis) to avoid ankle contracture.

Resident # 63 was originally admitted to the facility on 3/22/18, and had a readmission date of 7/2/19. Diagnoses included but were not limited to, anemia, Guillian Barre syndrome, paraplegia, and muscle weakness.

The clinical record for Resident # 63 was reviewed on 10/10/19 at 9:46 am. The most recent MDS (minimum data set) assessment for Resident # 63 was a quarterly assessment with an ARD (assessment reference date) of 8/21/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 63 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicated that Resident #63 was cognitively intact.

Resident #63 had orders that included but were not limited to, "PRAFOs at night to avoid ankle contracture," which was initiated by the physician on 9/23/19. The surveyor reviewed the clinical record for Resident # 63 further specifically the medication administration record and the treatment administration record and did not locate any documentation that reflected that the order for PRAFOs at night to avoid ankle contracture had been carried out.

On 10/10/19 at 1:43 pm, the surveyor was in Resident # 63's room conducting a resident interview. The surveyor asked Resident # 63 if she was receiving therapy. Resident # 63

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 825	Continued From page 175	F 825		

informed the surveyor that she was receiving therapy and therapy was going well but she wished that she could get therapy on her legs.

On 10/15/19 at 3:16 pm, the surveyor interviewed the director of rehab. The surveyor reviewed the order written on 9/23/19 for PRAFOs at night to avoid ankle contracture. The surveyor informed the director of rehab that there was no documentation in the clinical record that reflected that the order for PRAFOs at night to avoid ankle contracture had been carried out. The director of rehab informed the surveyor that she had called the doctor that wrote the order for PRAFOs at night for clarification because of Resident # 63's size she needed clarification on the type of boot to order. The surveyor asked the director of rehab to provide documentation of follow up with the physician for clarification.

On 10/15/19 at 3:32 pm, the director of rehab provided the surveyor with a sheet of paper with handwritten documentation that stated that the director of rehab had reached out to the physician on 10/9/19 and 10/15/19 for clarification on the type of boot to order. The surveyor asked the director of rehab if the paper that she had presented to the surveyor was a part of Resident # 63's clinical record. The director of rehab stated, "No." The surveyor discussed the details that an order for PRAFOs at night to avoid ankle contracture had been ordered on 9/23/19 and there was documentation of clarification or follow up in the clinical record for Resident # 63 and the order that order had not been carried out. The director of rehab stated, "I understand."

On 10/17/19 at 4:52 pm, the administrator, director of nursing, and regional director of clinical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 825	Continued From page 176 services were made aware that Resident # 63 had an order for PRAFOs at night to avoid ankle contracture that was initiated on 9/23/19 that had not been carried out. 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. This is a complaint deficiency.	F 825		
F 826 SS=D	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 reference date 8/21/19, the resident was	F 826	1. Resident # 77 had on order for therapy services on 8/16/2019. 2. Residents who reside in the facility and have orders for therapy services are at risk for this deficient practice. 3.Re-education was completed by the Regional Clinical Director or designee to the Therapy staff related to ensuring required orders are obtained and present on the medical record. 4. Audits will be completed by the Rehab Director that a referral/order is obtained for therapy services weekly for 8 weeks. The Rehab Director will submit findings to the Quality Assurance and Performance Improvement Committee. The Administrator is responsible for monitoring and follow up. 5. 12/06/2019	12/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 826	Continued From page 177 assessed with short and long term memory deficits and severely impaired cognitive skills for daily decision making and as without signs of delirium, psychosis, or behaviors affecting care. The resident was assessed as requiring extensive assistance of 2 or more persons for transfer, supervision for locomotion on the nursing unit in a wheelchair, and extensive assistance of one person for locomotion in a wheelchair off the unit. During clinical record review, the surveyor noted that X-ray results dated 8/14/19 in the chart were for a resident with the same first initial and last name as Resident #97. A different long term care facility was named on the header on the results form. A note on the form said "PT, OT eval and treat". Physician orders were written on 8/16/19 for PT to eval and treat as indicated as of 8/16/19 and for OT to eval and treat as indicated as of 8/16/19. Orders written 8/19/19 for Occupational Therapy and Physical Therapy were started for services 5 X week for 4 weeks in each service. Therapy notes indicated these services were provided to the resident. On 10/18/19, the surveyor discussed the presence of another resident's results with the unit manager. When the surveyor discovered that therapy had been started in response to the order on those results, the surveyor discussed them with the director of nursing and noted this was a care area concern.	F 826		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is	F 842	1. Resident # 63 had a full skin assessment completed by the licensed nurse with no areas noted to the inner thigh. Resident # 77 record was reviewed by registered dietitian and the inaccurate	12/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 178 resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical	F 842	weight was struck-out. 2. Residents that reside at facility are at risk for deficient practice. 3. Re-education was provided by the DON or designee to the nursing staff regarding accurate documentation and maintaining a complete medical record. 4. Audits will be completed by the Director of Nursing or designee of 3 medical records per week to ensure medical records remain accurate and complete for 8 weeks. The Director of Nursing will submit findings to the Quality Assurance and Performance Improvement Committee. The Administrator is responsible for monitoring and follow up. 5. 12/06/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 179	F 842		

record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview, the facility staff failed to ensure an accurate clinical record for two of 30 residents in the survey sample, Resident # 63 and Resident # 77.

The findings included

1. The facility staff failed to document an open area to Resident # 63's right inner thigh on weekly skin sheets.

Resident # 63 was originally admitted to the facility on 3/22/18, and had a readmission date of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 180	F 842		

7/2/19. Diagnoses included but were not limited to, anemia, abnormal uterine and vaginal bleeding, paraplegia, and muscle weakness.

The clinical record for Resident # 63 was reviewed on 10/10/19 at 9:46 am. The most recent MDS (minimum data set) assessment for Resident # 63 was a quarterly assessment with an ARD (assessment reference date) of 8/21/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 63 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicated that Resident #63 was cognitively intact. Section M of the MDS assesses skin conditions. In Section M0150, the facility staff documented that Resident # 63 was at risk for developing pressure ulcers.

Resident # 63 had orders that included but were not limited to, "Apply hydrocolloid thin dressing to right inner thigh 2 x (times) weekly every day shift Mon (Monday), Fri (Friday) for protection and as needed for if dressing is soiled, dislodged or missing," which was initiated by the physician on 9/11/19.

The current plan of care for Resident # 63 was reviewed and revised on 9/3/19. The facility staff documented a focus area for Resident # 63 as, "Pressure ulcer, at risk due to: Assistance required in bed mobility, bowel incontinence, Braden score 18 or < (less)." Interventions included but were not limited to, "Skin assessments to be completed per policy."

On 10/10/19 at 1:53 pm, the surveyor was in Resident # 63's room conducting a Resident interview. The surveyor asked Resident # 63 if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 181	F 842		

she had any open areas or skin conditions in which the facility staff had to provide treatment. Resident # 63 stated, "I have one between my legs where my diaper is." "They have been trying to heal it up and it won't heal like it should, so they put ABD (abdominal) pads and ointment on it to make it comfortable for me."

The surveyor reviewed the "Weekly Skin Integrity Check" for Resident # 63. The surveyor observed documentation on the weekly skin integrity check dated 9/12/19 "Skin clear, no change of condition assessed."
The surveyor observed documentation on the weekly skin integrity check dated 9/19/19 "Skin clear, no change of condition assessed."
The surveyor observed documentation on the weekly skin integrity check dated 9/26/19 "Skin clear, no change of condition assessed."
The surveyor observed documentation on the weekly skin integrity check dated 10/3/19 "Skin clear, no change of condition assessed."
The surveyor observed documentation on the weekly skin integrity check dated 10/11/19 "Skin clear, no change of condition assessed."

The surveyor noted that the weekly skin integrity checks that were completed after 9/11/19 did not accurately reflect the open area and ongoing treatment to Resident # 63's right inner thigh.

The facility policy on "Non-Pressure Skin Condition Record" included documentation that included but was not limited to,
...Policy
To document the presence of skin impairment/new skin impairment not related to Pressure when first observed and weekly thereafter. This includes skin tears, surgical sites,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	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 in section C, cognitive patterns. Resident #77 was also coded as being independent in bathing	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 183 and requiring supervision only in dressing, personal hygiene and eating. Resident #77's weight obtained on 8/02/19 is documented as 179.0 and the following weight documented on 9/05/19 is 159.6, which is a loss of 10.84%. The surveyor reviewed the resident's medical record and did not find any documentation addressing this weight loss. Resident #77's weight obtained on 9/26/19 is documented as 178.0 The concern of Resident #77's weight loss was discussed with the director of nursing during a meeting on 10/16/19 at approximately 5:56pm. The director of nursing stated the weight meeting notes for Resident #77 state the weight on 9/05/19 is believed to be an error and the RD (registered dietitian) would strike it out. The director of nursing then stated, the RD (registered dietitian) forgot to strike out the weight and document. No further information was provided prior to exit conference on 10/18/19.	F 842		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review the facility staff failed to provide a quality	F 867	1. The facility has QAPI/QAA Committee. 2. The deficiencies and Plan of Correction were reviewed by the QAPI Committee. 3. Re-education was provided by the Regional Clinical Director to the interdisciplinary team of the Quality Assurance and Performance Improvement Program and ensuring its effectiveness. 4. Audits will be conducted by the	12/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	1607 SPRUCE STREET MARTINSVILLE, VA 24112

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F 867	Continued From page 184 assurance program to meet the needs of the facility. The findings included: The facility staff failed to ensure an effective QA (quality assurance) program to meet the needs of the facility as evidenced by repeated deficiencies from the previous 6/4/18 survey in the areas of reasonable accommodations of needs/preferences, self determinstion, confidentiality of records, develop and implement comprehensive care plan, care plan timing and revision, services provided to meet professional standards, quality of care, dialysis, drug regimen review, resident records, free of accidendent hazzards/surpervision and infection control.	F 867	Regional Clinical Director to ensure the facility is maintaining an effective Quality Assurance and Performance Improvement program to include PIP and 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	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at 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	F 880	1. CNA # 3 was re-educated on hand washing on 10/8/2019. 2. Residents that reside in facility are at risk of this deficit infection control practice. 3. Re-education was provided by the Director of Nursing or designee to staff on infection control, isolation and hand washing. 4. Audits will be completed by the Director of Nursing or designee on compliance with infection control practices through infection control surveillance 3 times a week for 8 weeks. The Director of Nursing will submit findings to the Quality Assurance Committee. The Administrator is responsible for monitoring and follow up. 5. 12/06/2019	12/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	1607 SPRUCE STREET MARTINSVILLE, VA 24112

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F 880	Continued From page 185 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F 880		

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F 880	Continued From page 186 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to follow infection control guidelines on one of three facility units. The findings included The facility staff failed to follow the infection control policy for handwashing. On 10/8/19 at 12:55pm, during initial tour the surveyor observed contact precaution signage on Resident # 88's door. The surveyor observed that CNA # 3 (certified nursing assistant) was in Resident # 88's room, with isolation gown and gloves on, as she provided feeding assistance to Resident # 88. On 10/8/19 at 1:05 pm, the surveyor observed CNA # 3 as she exited Resident # 88's room with Resident # 88's meal tray. The surveyor observed CNA # 3 as she carried the tray with her bare hands and placed the tray on the food cart. The surveyor observed that CNA # 3 did not wash or sanitize her hands. CNA # 3 entered room another Resident's room, handled items on her over bed table, and removed her meal tray from her room and placed it on the food cart. The surveyor asked CNA # 3 how facility staff was expected to handle meal trays of Resident's on	F 880		

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F 880	Continued From page 187 contact precautions. CNA # 3 stated, "They are supposed to have plastic ware." The surveyor explained to CNA # 3 the observation of her handling a meal tray from a room on contact precautions with her bare hands, and entering another Resident's room and handling items on her over bed table without washing or sanitizing her hands. CNA # 3 stated, I see what you are saying." The facility policy on "Meal Distribution: Infection Control Considerations" contained documentation that included but was not limited to, ..."Procedures 5. Soiled dishware will be handled using universal precautions, including personal protective equipment such as gloves, goggles, and disposable aprons."... On 10/10/19 at 3:54 pm, the administrator and director of nursing were made aware of 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 880		