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 _____	R-C 02/26/2020

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	{E 000}		
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid second revisit to the standard survey conducted 10/08/2019 through 10/18/2019 and the first revisit conducted 01/02/2020 through 01/03/2020, was conducted 02/25/2020 through 02/26/2020. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. The census in this 142 certified bed facility was 114 at the time of the survey. The survey sample consisted of 10 current Resident reviews (Residents #201 through #210) and 1 closed record review (Resident #211).	{F 000}		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(l)(1)-(7) §483.10(l) 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(l)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (I) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (II) The facility shall exercise reasonable care for	F584	1. The shower room on the North Unit was Cleaned on 2/25/20. 2. The shower rooms in the facility were monitored by the Administrator for any odors, mold and overall cleanliness on 2/25/20. 3. Staff were re-educated by DON / designee on reporting any odors or cleanliness issues to housekeeping immediately to ensure shower rooms are maintained by 3/15/20 4. Shower rooms will be audited 5 x week by administrator to ensure they are cleaned and free of odors. Results of audits will be reviewed in the monthly/quarterly QAPI meeting. Any identified issues will be corrected immediately and staff re-educated as needed.	3/15/20

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

Mary Lynn Wescott — Administrator — 3/16/20 (0518 2nd)

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F 584	Continued From page 1 the protection of the resident's property from loss or theft. §483.10(l)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(l)(3) Clean bed and bath linens that are in good condition; §483.10(l)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(l)(5) Adequate and comfortable lighting levels in all areas; §483.10(l)(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(l)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview, the facility staff failed to provide a clean and comfortable homelike environment on 1 of 3 units the North unit. The shower room on the North unit had a pervasive musty/moldy odor and a black substance was observed on the bottom of the shower stall. The findings included: The surveyor observed a black substance on the shower stall on the North unit and there was a pervasive musty/moldy smell that could be smelled in the hallway outside the shower room.	F 584		

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F 584	Continued From page 2 On 02/26/2020 at approximately 8:00 a.m., the surveyor was walking up the hallway outside the shower room on the North unit. The surveyor noted a pervasive musty/moldy smell. Upon entering the shower room the smell became more apparent. Housekeeper #1 was observed to be in this shower room cleaning. The surveyor observed several black areas on the bottom portion of the wall in the 2nd shower stall. Housekeeper #1 was asked about the smell and the black substance and stated it was mold and they (the facility) had that problem before. On 02/26/2020 at 8:05 a.m., the surveyor asked the administrator to accompany the surveyor to the shower room. Upon entering the shower room and observing the black substance the administrator stated, "Oh, I see what you are talking about." The administrator stated they would have someone to clean the shower room. The surveyor asked to speak with the housekeeping supervisor and was informed they were out due to the flu. On 02/26/2020 at 8:25 a.m., during an interview with Resident #207, this resident was asked if they used the shower room on the North unit. Resident #207 verbalized to the surveyor that they did use the shower room and that they thought it was nasty. When asked if it smelled Resident #207 verbalized to the surveyor that they had taken showers in there and it smelled so bad. Resident #207 then added that had been awhile and they leave dirty clothes and dirty diapers in the shower room. On 02/26/2020 at 9:10 a.m., the surveyor again	F 584		

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F 584	Continued From page 3 checked the shower room on the North hall with the district manager. The district manager stated they had scrubbed the black substance with a bleach and water solution and the black substance was a little mildew. During a meeting with the survey team on 02/26/2020 at 11:45 a.m., the issues with the shower room on the North hall was reviewed with the administrator and DON (director of nursing). No further information regarding this issue was provided to the survey team prior to the exit conference on 02/26/20 at 4:20 p.m. (F 684) Quality of Care SS=E 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 resident interview, staff interview, and clinical record review, the facility staff failed to ensure the highest practicable well-being for 4 of 11 residents as evidenced by failure to provide needed care and services as ordered by the physician and/or nurse practitioner. Residents #203, #207, #208, and #204. The findings included:	F 584 F684	1. Residents #203 weight was reported to physician on or before 3/15/20 . Resident's #207 & #204 are currently receiving medications as prescribed. Resident #208 is receiving accuchecks as ordered. {F 684} 2. Audit was completed by the DON/Designee by 3/15/20 of MAR & TAR's to ensure orders were followed per order. 3. Staff were re-educated by DON/ Designee on 3/15/20 on how to appropriately follow a physician's order and also on how to appropriately document orders. An audit will be completed 5 x week by DON/Designee to review MAR and TAR to ensure they are completed appropriately and that the physician was notified as needed. 4. Results of the audits will be reviewed in the monthly/quarterly QAPI meeting. any discrepancies will be addressed immediately and staff will be re-educated as needed. 3/15/20	

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{F 684}	Continued From page 4 1. For Resident #203, the facility staff failed to report a weight gain of 14 pounds in one day to the physician. The resident had an order for a daily weight and to call the MD (medical doctor) for a weight gain of 3 pounds in a day or greater than 5 pounds in a week. The clinical record did not include a daily weight for 02/20/2020. The resident's clinical record was reviewed on 02/25 and 02/26/2020. The face sheet in the clinical record included, but was not limited to the following diagnosis, chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, systolic congestive heart failure, acute pulmonary edema, and fluid overload. Section C (cognitive patterns) of the residents initial MDS (minimum data set) assessment with an ARD (assessment reference date) of 12/12/2019 included a BIMS (brief interview for mental status) summary score of 10 out of a possible 15 points. The residents clinical record included a physicians order dated 02/06/2020 for "Daily weight. Call MD if gain 3 lbs (pounds) in a day or > (greater than) 5 lbs in a week, every day shift related to UNSPECIFIED SYSTOLIC (CONGESTIVE) HEART FAILURE." Resident #203's comprehensive care plan included the focus area has the potential for weight changes and altered nutrition and hydration status related to diagnoses that included diabetes, chronic kidney disease, anemia, diabetic peripheral nephropathy and fluid restrictions. Interventions included, but were not limited to, monitor weights as ordered.	{F 684}		

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(F 684)	Continued From page 5 A review of the Residents eTARs (electronic treatment administration records) on 02/25/2020 revealed that the facility nursing staff had documented a weight of 145 pounds on 02/23/2020 and a weight of 159 pounds on 02/24/2020. For a weight gain of 14 pounds. There was no documented weight for 02/20/2020. The surveyor was unable to locate any information in Resident #203's clinical record to indicate this weight gain had been reported to the physician or why there was no weight for 02/20/2020. On 02/25/2020 at approximately 2:22 p.m., Resident #203 was observed resting on their bed and no complaints were voiced to the surveyor. On 02/25/2020 at 4:50 p.m., the administrator and DON (director of nursing) were notified that the nursing staff had documented a 14-pound weight gain between the dates of 02/23/2020 and 02/24/2020. The surveyor asked for information to indicate the physician had been notified of the weight gain and for any evidence of a weight that had been obtained on 02/202020. On 02/26/2020 at 11:45 a.m., the administrator and DON were again notified by the survey team of the Residents 14 pound weight gain and the missing weight for 02/20/2020 and any information was again requested. The facility provided the surveyor with paper copies of the residents face sheet, eTARs, physician orders, care plan information, and progress notes. However, no information regarding Resident	(F 684)		

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{F 684}	Continued From page 6 #203's weight gain or for the missing weight on 02/02/2020 was provided to the survey team prior to the exit conference on 02/6/2020 at 4:20 p.m. At times, the DON was not observed to be taking notes regarding information requested by the survey team. 2. For Resident #207, the resident had an order for Mucinex 600 mg BID (twice a day) for 5 days. Indicating the resident should have received 10 doses of Mucinex. However, Resident #207 only received 9 doses of the medication. The residents clinical record was reviewed on 02/25/2020 and 02/26/2020. The face sheet in the clinical record included, but was not limited to the following diagnosis, generalized osteoarthritis, bipolar disorder, paranoid schizophrenia, and muscle weakness. Section C (cognitive patterns) of the residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/03/2020 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. The residents clinical record included a handwritten physicians order dated 02/18/2020 for Mucinex 600 mg po (by mouth) BID X 5 days. The diagnosis on the eMARs (electronic medication administration records) indicated the Mucinex was for cough/congestion. A review of Resident #207's eMARs revealed that Resident #207 was administered 1 dose of Mucinex on 02/18/2020 at 2100 (9:00 p.m.) and was administered 2 doses each day on 02/19-02/22/2020 at 0900 (9:00 a.m.) and 2100.	{F 684}		

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(F 684)	Continued From page 7 Indicating Resident #207 had been administered 9 doses of Mucinex. The residents clinical record included a progress note documented on 02/18/2020 at 13:19 (1:19 p.m.) that read in part, "new order per NP (nurse practitioner)...Mucinex 600 mg po bid X 5 days." On 02/26/2020 at 9:00 a.m. during an interview with Resident #207, the resident was asked if there was ever a time when they had not received their medication(s). Resident #207 verbalized to the surveyor that it would be hard for them to say but they knew there had been times when their medication was incorrect and they had given it back to the nurse. On 02/26/2020 at 11:45 a.m., during a meeting with the survey team, the administrator and DON (director of nursing) were notified that Resident #207 had an order for Mucinex 600 mg BID for 5 days and that the resident had only received 9 doses when they should have receive 10 doses. On 02/26/2020 at 2:25 p.m., the DON provided the surveyor with a copy of a form titled "Summary Report of Meeting: Type of Meeting: Training." This form was dated 02/26/2020 at 1300 (1:00 p.m.) and had been signed by LPN (licensed practical nurse) #1. This form read in part, "Be sure to enter order in computer correctly example-Make sure if its for 5 days it for a full days." [sic] No further information regarding the missing Mucinex dose was provided to the survey team prior to the exit conference on 02/26/2020 at 4:20 p.m.	(F 684)		

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(F 684)	Continued From page 8 3. For Resident #208, the facility staff failed to obtain a blood sugar. Resident #208's clinical record was reviewed on 02/26/2020. The face sheet in the clinical record included the diagnosis of type 2 diabetes. Section C (cognitive patterns) of the residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 12/12/19 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. The resident's comprehensive care plan included the focus area of alteration in blood glucose due to insulin dependent diabetes mellitus. Interventions included, but were not limited to, administer medications as ordered. Resident #208's clinical record included the following orders related to their diabetes. Notify MD (medical doctor) if BS (blood sugar) less than 60 or greater than 400. Order date 05/31/2019. Accu-chek guide strip (glucose blood) before meals and at bedtime for diabetes mellitus. Order date 01/06/2020. Levemir flexpen inject 70 units subcutaneously every 12 hours for diabetes. Order date 01/14/2020. Novolog insulin per sliding scale before meals. Order date 08/14/2019. A review of the residents eTARs (electronic treatment administration records) revealed that for 02/22/2020 at 2100 (9:00 p.m.) the facility nursing staff had placed an "X" in the administration box.	(F 684)		

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(F 684)	Continued From page 9 The surveyor was unable to locate any information regarding the missing BS. On 02/26/2020 at 11:45 a.m., during a meeting with the survey team, the administrator and DON (director of nursing) were notified that Resident #208's BS on 02/22/2020 was marked with an "X." The facility staff did not provide the survey team with any information regarding the residents missing BS. The facility did provide the surveyor with paper copies of the residents face sheet, eMARs, physician orders, and care plan information prior to the exit conference on 02/26/2020 at 4:20 p.m. 4. The facility a) failed to notify a physician of Resident #204's blood sugar result being 506 and b) failed to administer NovoLOG Solution, KlonoPIN Tablet, and Mirapex Tablet to Resident #204 according to physician orders. Resident #204's ADMISSION RECORD listed the resident's diagnoses that included, but were not limited to, type 1 diabetes mellitus without complications, chronic kidney disease stage 3 (moderate), Parkinson's disease, peripheral vascular disease, bipolar disorder, and acquired absence of left leg above knee. The clinical record for Resident #204 was reviewed on 02/25/2020 and 02/26/2020. The resident's quarterly MDS (minimum data set) had an assessment reference date of 02/07/2020. Section C of the MDS which listed assessed cognitive levels, showed the resident's BIMS (brief interview for mental status) score was 15 out of 15.	(F 684)		

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(F 684)	Continued From page 10 a) Resident #204's "Order Summary Report" listed physician orders that included, but were not limited to, an order dated 03/16/18 that read, "Notify MD (medical doctor) for BS (blood sugar) greater than 500 or less than 60 every shift." There was no end date listed for that order. The resident's MAR (medication administration record) noted on 02/02/2020 at 5:00 p.m., Resident #204's blood sugar was 506. The nurse documented a "7" on the MAR. According to the Chart Codes/Follow Up Codes on the MAR, a "7" meant "Other/See Nurse Notes." The surveyor did not find a nurse's note within pointclickcare (facility's software program) for that date and time, that addressed the resident's blood sugar and whether a physician was notified. The next blood sugar documented in the MAR was 495 on 02/02/2020 at 9:00 p.m. afterwhich 6 units of NovoLOG Solution 100 unit/ml (Insulin Aspart) was administered per the sliding scale ordered on 12/21/2019. That sliding scale read to provide 6 units of NovoLOG Solution 100 units/ml (Insulin Aspart) for blood sugars between 300 and 500. On 02/25/2020 at 4:50 p.m., the administrator and interim director of nursing were informed by a surveyor of the concern related to Resident #204's blood sugar result being 506 and whether a physician had been notified. On 02/26/2020 at 11:45 a.m., the interim director of nursing informed the survey team they had not found any more information related to the resident's blood sugar of 506 being reported to a physician. No further information was provided prior to exit.	(F 684)		

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{F 684}	Continued From page 11 b) On 02/25/2020 at 12:25 p.m., Resident #204 arrived in the facility's conference room via wheelchair asking to speak with the survey team. Resident #204 discussed various topics and reported there had been one day when the resident's 2nd insulin shot had not been given. When asked when the insulin shot was omitted, the resident was not sure but thought it was about two weeks ago. Resident #204's MAR showed three medications due during the afternoon of 02/18/2020 that were not coded as having been administered. The entries on the MAR were coded with a "7," indicating (per the chart codes/follow up codes on the MAR) there would be a nurse's note corresponding to that medication, date and time. Those three medications' orders within the MAR read: 1. NovoLOG Solution 100 UNIT/ML (Insulin Aspart) Inject as per sliding scale: if 0-199=0 units less than 60 notify md (medical doctor); 200-249 = 2 units; 250-299 = 4 units; 300-500 = 6 units if above 500 notify MD, subcutaneously before meals and at bedtime related to TYPE 1 DIABETES MELLITUS WITHOUT COMPLICATIONS. Notify MD for blood sugar less than 60 or greater than 500. This medication was ordered on 12/21/2019 and did not have a discontinue date. 2. KlonoPIN Tablet 0.5 MG (clonazePAM) Give 0.25 mg by mouth in the afternoon for anxiety. This medication was ordered on 02/04/2020 with a discontinue date of 02/22/2020. 3. Mirapex Tablet 0.25 MG (Pramipexole Dihydrochloride). Give 1 tablet by mouth three times a day related to PARKINSON'S DISEASE.	{F 684}		

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(F 684)	Continued From page 12 This medication was ordered on 06/23/2017 and did not have a discontinue date. There was no blood sugar documented for the resident on 02/18/2020 at 12:00 p.m. (prior to lunch). The resident's next blood sugar result was documented on 02/18/2020 at 5:00 p.m. with the result being 213 at which time the resident received NovoLOG Solution 2 units per sliding scale ordered 12/21/19. After reviewing Resident #204's clinical record for 02/18/2020 nursing progress notes, the surveyor requested to speak with the nurse who documented the "7" for those three medications in the MAR. On 02/26/2020 at 3:30 p.m., one surveyor interviewed the licensed practical nurse (LPN) who was assigned to administered Resident #204 medications on 02/18/2020. The LPN reported Resident #204 was often out of the room while visiting other residents. The LPN found the nurse's notes within the clinical record and acknowledged he/she had documented them as follows: 1. An electronic MAR (eMAR) note dated 02/18/2020 at 2:13 p.m. reiterated the medication order for NovoLOG (Inject 10 unit subcutaneously two times a day). The LPN wrote, "Went to give residents [sic] (pronoun) meds 3-4 times and (pronoun) was not in (pronoun) room or anywhere to be found. MD Aware." 2. An eMAR note dated 02/18/2020 at 2:14 p.m. reiterated the medication order for KlonoPIN Tablet (give 0.25 mg by mouth in the afternoon for anxiety). The LPN wrote, "Went to give residents [sic] (pronoun) meds 3-4 times and (pronoun) was not in (pronoun) room or anywhere to be found. MD Aware." 3. An eMAR note dated 02/18/2020 at 2:14 p.m.	(F 684)		

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MARTINSVILLE HEALTH AND REHAB	1507 SPRUCE STREET MARTINSVILLE, VA 24112

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{F 684}	Continued From page 13 reiterated the medication order for Mirapex Tablet 0.25 MG (give 1 tablet by mouth three times a day). The LPN wrote, "Went to give residents [sic] (pronoun) meds 3-4 times and (pronoun) was not in (pronoun) room or anywhere to be found. MD Aware." The LPN acknowledged to the surveyor that Resident #204 did not receive those medications on the afternoon of 02/18/2020. The facility's interim director of nursing (DON) and administrator were informed of the three omitted medications and eMAR notes referenced above during a meeting with the survey team in the conference room on 02/26/2020 at 3:50 p.m. After viewing the eMAR notes in the clinical record, the interim DON acknowledged the LPN's eMAR notes could be interpreted as a possible elopement since it read that the resident could not be found anywhere. When asked what the interim DON's expectation was for administering medications to a resident when that resident was not in their room, the interim DON said if the medication was to be given daily, the staff would have the whole day to administer it. The surveyor requested the interim DON and administrator provide the facility's policy on medication administration when the resident was not present in their room if the facility had such a policy. On 02/26/2020 immediately prior to the exit conference which was held at 4:20 p.m., the interim DON reported there was no policy directing staff on how to handle medication administration when a resident was not present in their room. No further information was provided prior to exit.	{F 684}		
{F 755}	Pharmacy Srvcs/Procedures/Pharmacist/Records	{F 755}		

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{F 755} SS=D	Continued From page 14 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. §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 resident interview, staff interview, and clinical record review the facility staff failed to ensure a physician ordered medication was available for administration for 1 of 11 Residents,	{F 755}		

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(F 755)	Continued From page 15 Resident #207. The findings included: The facility staff failed to ensure Resident #207's physician ordered medication Xalatan solution was available for administration. The medication Xalatan is an eye drop that is used to treat glaucoma or high pressure inside the eye. The resident's clinical record was reviewed on 02/25/2020 and 02/26/2020. The face sheet in the clinical record included, but was not limited to the following diagnosis, ocular hypertension, bipolar disorder, and paranoid schizophrenia. Section C (cognitive patterns) of the residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/03/2020 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. The resident's clinical record included a physicians order dated 01/28/2019 for "Xalatan Solution (Latanoprost) Instill 1 drop in both eyes at bedtime for ocular hypertension." A review of the resident's eMARs (electronic medication administration records) for 02/2020 revealed that the facility nursing staff had coded the administration block for this medication with a "7" on 02/09/2020 at 2100 (9:00 p.m.). Per the preprinted code on the eMAR a 7="Other/See Nurses Notes." A review of the "Progress Notes" for 02/09/2020	(F 755) F755	1. Resident #207 has ordered medications available for administration. 2. An audit was completed by DON/Designee to ensure that residents residing in the facility had medications available for administration by 3/15/20 Licensed nursing staff were re-educated by the DON/Designee by 3/15/20 on the process of how to address unavailable medications. 3. An audit will be completed by DON/Designee 5 x week to monitor the MAR and medication cart to ensure medications are available for administration. 4. Results of the audits will be discussed in the monthly/quarterly QAPI meeting.	3/15/20

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(F 755)	Continued From page 16 revealed that the nursing staff had documented "Xalatan Solution Instill 1 drop in both eyes at bedtime for ocular hypertension pharmacy notified." The Residents comprehensive care plan included the focus area Impaired vision related to...bilateral ocular hypertension. On 02/26/2020 at 9:00 a.m. during an interview with Resident #207, the resident was asked if there was ever a time they had not received their medication. Resident #207 verbalized to the surveyor that it would be hard for them to say but they knew there had been times when their medication was incorrect and they had given it back to the nurse. On 02/26/2020 at 11:45 a.m., during a meeting with the survey team, the administrator and DON (director of nursing) were notified that the facility nursing staff had documented a "7" in the administration block for the resident's Xalatan solution on 02/09/2020 at 2100. The surveyor requested any information regarding this medication being available for administration. On 02/26/2020 at 2:40 p.m., the surveyor asked LPN (licensed practical nurse) #2 if this medication would have been available in the stat box for administration. LPN #2 verbalized to the surveyor that this medication was not available in the stat box for administration. The facility staff did not provide the survey team with any information regarding this issue. The facility did provide the surveyor with paper copies of the resident's face sheet, eMARs, physician orders, care plan information, and progress notes	(F 755)		

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{F 755}	Continued From page 17 regarding the resident's Xalatan medication prior to the exit conference on 02/26/2020 at 4:20 p.m.	{F 755}		
{F 842} S8=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 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,	(F 842) F842	1. Resident #202's medications are administered via jejunal gastric port. 2. An audit of physicians orders for residents with enteral feeding was completed by 3/15/20 by the DON/Designee to ensure route of medication administration was appropriate for residents residing in the facility. Licensed nursing staff were re-educated by the DON/Designee by 3/15/20 on appropriateness of orders and administration route for medications and consistency of orders. 3. An audit will be completed 5 x week to ensure that any new orders contain appropriate route of administration for residents. 4. Results of the audits will be discussed in the monthly/quarterly QAPI meeting. Discrepancies will be corrected immediately and re-education provided as needed.	3/15/20

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(F 842)	Continued From page 18 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 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 staff interview and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for 1 of 11 residents, Resident #202. The findings included:	(F 842)		

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{F 842}	Continued From page 19 The resident's clinical record included an order for vitamin D3 to be given by mouth. However, the clinical record also included an order for all medications to be given by jejunal port or gastric port. Resident #202's clinical record was reviewed on 02/25/2020. The resident's face sheet included the diagnoses gastrostomy status, dysphagia following cerebral infarction, and gastro-esophageal reflux disease without esophagitis. Section C (cognitive patterns) of the residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 02/09/2020 included a BIMS (brief interview for mental status) summary score of 13 out of a possible 15 points. Section K (swallowing/nutrition status) was coded to indicate the resident had a feeding tube. The resident's clinical record included the following physicians orders. "For Medication Administration All Liquid medications through Jejunal Port (yellow). IF not liquid the crush meds and administer through gastric port (red) with flush of 50ml water after administration..." Date of order 10/08/2019. "Vitamin D3 Capsule 50000 UNIT (Cholecalciferol) Give 1 capsule by mouth one time a day every 7 days(s) for low Vitamin D." Order date 10/18/2019. The DON (director of nursing) was made aware of the conflicting orders regarding medication administration on 02/25/2020 at 2:50 p.m. and verbalized to the surveyor that maybe this was a transcription error.	{F 842}		

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(F 842)	Continued From page 20 On 02/25/2020 at 3:15 p.m., the DON verbalized to the surveyor that she had spoken to the nurse that had put the order for the vitamin D3 into the computer system and the order was placed into the computer system incorrectly. On 02/25/2020 at 4:50 p.m., during an end of the day meeting with the administrator and DON, the inaccurate record in regards to Resident #202's vitamin D3 was reviewed. The DON verbalized that the pharmacist was on site and she had spoken with them regarding this order. The administrator and DON were again notified of the issue regarding Resident #202's D3 on 02/26/2020 at 11:45 a.m. during a meeting with the survey team. No further information was provided to the survey team regarding the D3 prior to the exit conference on 02/26/2020 at 4:20 p.m.	(F 842)	F867 1. QAPI plan of process includes tags . and F755 and the new citations for survey. 2. The administration audited the progress on the QAPI plans on 3/9/20. The interdisciplinary team will be re-educated on the QAPI process SMART goals and PIP plans on 3/9/20 by the Chief Clinical Officer. 3. The Chief Clinical Officer/Designee will monitor the QAPI plans weekly to ensure the components of the POC are completed. 4. Any identified issues will be discussed in the monthly/quarterly QAPI meeting. Plans will be reviewed and revised as needed and identified.	3/15/20
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 observation, resident interview, staff interview and clinical record reviews, the facility staff failed to ensure the QA (quality assurance) program meet the needs of the facility as evidenced by repeated deficiencies in the areas	F 867		

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F 867	Continued From page 21 of Quality of Care, Pharmacy, and Administration and new deficiencies identified in the areas of Infection Control and Resident Rights. The findings included: As part of the survey process, the survey team identified repeated deficient practice in the areas of Quality of Care and Pharmacy Services. The administrator and DON (director of nursing) were notified of the issues regarding their QA program during the exit conference on 02/26/2020 at 4:20 p.m. Those deficient practices are detailed under the F684 and F755 in this report.	F 867		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(a)(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	F880	1. Ice scoop was placed in bag on 2/25/20. An audit was completed on 2/25/20 to ensure that ice scoops were in plastic bags and not inside the ice chest. 2. Staff was re-educated by the DON/Designee by 3/15/20 on infection control practices including passing ice and placing scoop in bag or container. Education also included wearing gloves as deemed necessary. 3. Audits will be completed 5 x week during care keeper rounds to ensure ice scoops are appropriately placed in bags or containers and gloves worn while passing ice if deemed necessary 4. Results of audits will be discussed in the monthly/quarterly QAPI meetings. Any discrepancies will be addressed immediately and staff re-educated as needed.	3/15/20

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F 880	Continued From page 22 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 23 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 and staff interview, the facility staff failed to maintain an infection prevention program that would help prevent the development or transmission of communicable diseases and infection as evidenced by leaving the ice scoop inside the ice chest and positioned on top of the ice on 1 of 3 units the North unit. The findings included: The facility staff left the ice scoop inside the ice chest and positioned on top of the ice inside. On 02/25/2020 at approximately 11:58 a.m., during initial tour of the facility, the survey observed an ice chest on the North hall. There was an empty plastic bag on a shelf underneath the ice chest. The surveyor opened the top of the ice chest and observed the ice scoop to be resting on top of the ice. CNA (certified nursing assistant) #1 approached the ice chest and identified themselves to the surveyor as the person who was passing ice. This CNA was not observed to have any gloves in place. The surveyor asked CNA #1 where the ice scoop was CNA stated it was in the ice chest and stated they did not usually put it in the cooler that they usually put it in the plastic bag and dated the bag.	F 880		

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F 880	Continued From page 24 The DON (director of nursing) was in the hallway after this observation and was notified of the issue regarding the ice scoop. The DON verbalized to the surveyor that the infection control nurse was out on maternity leave and the scoop should have been placed in the plastic bag. The DON also stated they would in-service staff. The administrator and DON were notified of the issue regarding the ice scoop during a meeting with the survey team on 02/26/2020 at 11:45 a.m. No further information regarding this issue was provided to the survey team prior to the exit conference on 02/26/2020 at 4:20 p.m.	F 880		