STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495167	A. BUILDING _____ B. WING _____	02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYTHE CNTY COMMUNITY HOSP ECU	600 W RIDGE RD WYTHEVILLE, VA 24382

(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 02/05/2020 through 02/06/2020. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 02/05/2020 through 02/06/2020. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 8 certified bed facility was 5 at the time of the survey. The survey sample consisted of 5 current Resident reviews and 2 closed record reviews.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure an accurate MDS (minimum data set) assessment for 1 of 7 records, Resident # 7. The findings included: The discharge MDS was coded that Resident #7 was discharged to an acute care hospital when the resident was actually discharged home with home health services.	F 641	The MDS assessment was corrected to accurately reflect the correct discharge disposition.To ensure accuracy of the MDS assessments beginning immediately the nurse that completes the MDS discharge assessment will verify with a second nurse that the discharge disposition chosen is the correct information. The nurse will initial a performance monitoring sheet after verification and turn it into the unit director	3/16/20

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

Electronically Signed | 03/06/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495167	A. BUILDING _____ B. WING _____	02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYTHE CNTY COMMUNITY HOSP ECU	600 W RIDGE RD WYTHEVILLE, VA 24382

(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 641	Continued From page 1 Resident #7's closed electronic clinical record was reviewed on 02/06/2020. The physician's discharge summary listed the resident's diagnoses that included, but not limited to, physical therapy and occupational therapy strengthening status post hospitalization, atrial fibrillation, and chronic kidney disease stage 3 to 4. The discharge MDS with an ARD (assessment reference date) of 11/20/19 noted in Section C (Cognitive Patterns) that Resident #7 had a BIMS (brief interview for mental status) score of 6 out of 15. In Section A (Type of Assessment) the resident's discharge was described as "planned" and "return was not anticipated." Also in Section A (Identification Information), the MDS noted Resident #7 was discharged to an "Acute Hospital." The clinical record included a nurse's note dated 11/20/19 that indicated Resident #7, with their medical power of attorney, were given discharge instructions, education and prescriptions before being escorted by staff via wheelchair to the facility's front entrance for discharge. The clinical record also included a discharge summary that read within the "Hospital Course" that Resident #7 would be discharged home with home health. The discharge summary was written and electronically signed by a nurse practitioner and also electronically signed by the attending physician. The facility's administrator was interviewed on 2/06/2020 at 10:40 a.m. regarding the inaccurate MDS concern. The administrator stated that none of the facility's MDS coordinators were available	F 641	at the end of every month. The deficient practice will be monitored as part of a performance improvement monitor and reported quarterly to the performance improvement team for no less than 6 months or until 100% compliance is achieved for 6 months. REVISED POC 3/16/2020 The discharge MDS assessment noted was corrected to accurately reflect the correct discharge disposition. To ensure accuracy of future MDS discharge assessments beginning immediately the facility has implemented a new double check process. Prior to the MDS nurse completing the MDS discharge assessment verification with a second nurse that the discharge disposition chosen is the correct information will be performed. The nurse will initial a performance monitoring sheet after verification and turn it into the unit director at the end of every month. An audit will be performed by the unit director or designee on each resident discharged for 45 days ending 3/20/2020. The unit director will report compliance to the QAPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495167	A. BUILDING _____ B. WING _____	02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYTHE CNTY COMMUNITY HOSP ECU	600 W RIDGE RD WYTHEVILLE, VA 24382

(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 641	Continued From page 2 at the time to be interviewed; the MDS coordinator who filled out Resident #7's discharge MDS was out sick. The administrator recalled Resident #7 and remembered the resident leaving the facility with family after being discharged home with home health services. After viewing the MDS, the administrator acknowledged the MDS read that Resident #7 was discharged to an acute hospital. No further information regarding this issue was provided to the survey team prior to exit.	F 641		
F 684 SS=D	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 and clinical record review the facility staff failed to ensure that residents receive treatment and care by following physician's orders for medication administration for 1 of 7 residents (Resident #107). The findings included: The facility staff failed to wait 6 hrs between two doses of Ultram which was ordered every 6 hrs prn (as needed) and failed to administer Lipitor in the evening as ordered for Resident #107.	F 684	An internal audit performed by the administrator confirmed that the behavior was isolated to one healthcare provider,upon confirmation the nurse was counseled and a performance improvement plan was created. The performance improvement plan includes no repeated incidences in the 90 day monitoring period. An adventitious audit will be performed monthly by the unit director for three months of the individual's medication administration to	3/16/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495167	A. BUILDING _____ B. WING _____	02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYTHE CNTY COMMUNITY HOSP ECU	600 W RIDGE RD WYTHEVILLE, VA 24382

(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 3 Resident #107's electronic clinical record was reviewed on 02/05/2020. Diagnoses noted within physician documentation included but were not limited to cerebrovascular accident (CVA - stroke), neurosarcoidosis (long-term inflammatory disease affecting the nervous system), left side weakness, and severe right lower weakness. Resident #107 was a new admission and therefore no MDS (minimum data set) was reviewed. The resident was alert and oriented on 02/05/2020. Physician orders included but were not limited to: 1. Tramadol Tab (Ultram Tab) 50mg by mouth every 6 hours as needed for pain (pain scale 4-10). 2. Atorvastatin Tab (Lipitor Tab) 80mg by mouth every night at bedtime. The electronic Medication Administration Record (eMAR) provided documentation that Resident #107 received Ultram 50mg by mouth on 02/04/2020 three times. The first time at 7:15 a.m. for a pain scale of 4, the second time at 11:36 a.m. for a pain scale of 6, and the third time at 9:20 p.m. for a pain scale of 4. There was 4 hours and 21 minutes between the first and second dose instead of 6 hours that was ordered. The eMAR provided documentation that Resident #107 received Lipitor 40mg by mouth on 01/26/2020 at 9:02 a.m. even though the medication was ordered to be given at bedtime. The facility's administrator was informed of these medication administration concerns on 02/05/2020 at approximately 4:30 p.m. The	F 684	ensure no repeated incidences have occurred. REVISED 3/16/2020 An internal audit performed by the unit director confirmed that the behavior was isolated to one healthcare provider, upon confirmation the nurse was counseled and a performance improvement plan was created. The performance improvement plan includes no repeated incidences in a 45 day monitoring period ending 3/20/2020. Medication administration policy and procedure education will be provided to nursing staff by 3/20/2020 and placed in HR files. An adventitious audit will be performed monthly for 3 months by the unit director or designee on following physician□s orders for medication administration to ensure no repeated incidences have occurred. The unit director will report compliance to the QAPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495167	A. BUILDING _____ B. WING _____	02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYTHE CNTY COMMUNITY HOSP ECU	600 W RIDGE RD WYTHEVILLE, VA 24382

(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 4 administrator acknowledged the eMAR showed there was less than 6 hrs between the first two doses of Ultram on 02/04/2020 and Lipitor was given in the morning of 01/26/2020 (9:02 a.m.) instead of the ordered bedtime (scheduled for 9:00 p.m.). The facility's administrator was interviewed on 02/06/2020 at 11:53 a.m. regarding the medication administration time concerns. The administrator had spoken with the nurse who had administered the medications and there was no more information provided. No further information regarding the medication administration times was provided to the survey team prior to exit.	F 684		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		3/16/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495167	A. BUILDING _____ B. WING _____	02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYTHE CNTY COMMUNITY HOSP ECU	600 W RIDGE RD WYTHEVILLE, VA 24382

(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 812	Continued From page 5 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to store food and items used to prepare food in a manner to prevent the outbreak of foodborne illness. As evidenced by outdated items in the kitchen area and nesting of wet pans. The findings included: The facility kitchen included 7 containers of out of date water chestnuts, 18-gallon jugs of out of date water, and nesting of wet pans. Two surveyors entered the facility kitchen (dietary department) on 02/05/2020 at approximately 11:00 a.m. The registered dietician (RD) accompanied the surveyors on this observation. Surveyor #1 identified the following issues. Eighteen-gallon jugs of water with a best buy date of 12/27/2019. The RD verbalized to the surveyor that the jugs of water were not for oral consumption, they knew they were out of date, and they were going to discard them. However, the jugs of water were stored with items that were currently being used in the facility kitchen. This surveyor also observed metal baking pans turned upside down and stacked on top of each other. The surveyor visualized water droplets on the outside of one of these pans. When brought to the attention of the RD, the RD stated they should have been placed on a drying rack and they would "have them redone." Surveyor #2 identified 7 cans of water chestnuts labeled best before 12/2019. After reviewing the	F 812	Both products destroyed day of survey. Dry storage items will be monitored weekly for 6 months by the FNS team lead. Any expired product will be logged and removed from the shelf immediately. Dry storage items consists of cereal, canned products, chips and other miscellaneous items. All FNS staff will receive in-service on proper drying techniques of steam table pans by 3/20/2020. An additional drying rack will be purchased to ensure adequate time allowed for drying before being put in circulation for use. Steam table pans will be inspected for moisture weekly by the department director or registered dietitian. Deficient pans will be sanitized and air dried. Monitoring will continue for 6 months an must achieve 100% compliance for at least 3 consecutive months. The results of the monitoring will be reported quarterly to the performance improvement team. REVISED 3/16/2020 The containers of expired water chestnuts identified where for cafeteria use and not patient menu items, therefore no residents had been affected by this finding. The expired product was destroyed day of survey so no other residents had the potential to be affected. Dry storage expiration date checks will be performed/recorded daily for 45 days by the FNS team lead to ensure 100%	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495167	A. BUILDING _____ B. WING _____	02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYTHE CNTY COMMUNITY HOSP ECU	600 W RIDGE RD WYTHEVILLE, VA 24382

(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 812	Continued From page 6 date on the container dietary staff person #1 stated these were expired. When asked who was responsible for discarding expired items the RD verbalized to the surveyors that it was everyone responsibility to identify out of date products and they used the process "First in first out." On 02/06/2020 at 9:53 a.m., surveyor #1 made a second observation of the dietary department. The 18-gallon jugs of water remained on the same shelf in the dietary department. On 02/06/2020 at 12:08 p.m., Registered nurse #1 was made aware of the issues in the kitchen area. No further information regarding these issues were provided to the survey team prior to the exit conference on 02/06/2020.	F 812	compliance. Any expired product found will be removed from the shelf immediately. Dry storage items consists of cereals, canned products, chips and other miscellaneous items. After 45 days the FNS team lead will perform a dry storage expiration date monthly audit to ensure 100% compliance is sustained. The FNS team lead will report compliance to the QAPI committee quarterly.	