STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495131	A. BUILDING _____ B. WING _____	C 07/15/2021

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NHC HEALTHCARE, BRISTOL	245 NORTH STREET BRISTOL, VA 24201

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 07/13/2021 through 07/15/2021. The facility was in substantial compliance with 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000	**Disclaimer:** The Center's sumbission of this plan of correction does not constitute an admission on the part of the Center that the findings constitute deficiencies.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 07/13/21 through 07/15/21. Corrections were required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 120 certified bed facility was 103 at the time of the survey. The final survey sample consisted of 21 current resident reviews and 3 closed record reviews. One complaint was investigated.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult	F 578	**F578:** 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. • The incomplete DDNR forms for residents #11 and #2 were appropriately completed. The unit manager confirmed code status with resident #11 who is capable of making his own decisions as evidenced by his BIMS score. Resident #2 is not capable of confirming his code status. Two nurses called the family to confirm that the code status on his DDNR form was accurate. Completed: 7/16/2021.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dan Stephens | TITLE: Admin | (X6) DATE: 9/10/2021

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 578	Continued From page 1 residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to participate in assisting residents to formulate an advance directive by accurately completing DDNR's (durable do not resuscitate) orders for 2 of 24 residents. Residents #11 and #2. The findings included: 1. For Resident #11, the facility staff failed to ensure the DDNR order form was complete. Section's 1 and 2 had been left blank. Resident #11's clinical record included the	F 578	2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. • All patients had the potential to be affected by this same deficient practice. The Virginia DDNR is not a required form. We are no longer utilizing the Virginia DDNR form in our facility. This will eliminate the potential for other residents to be affected by the deficient practice cited. Completed 7/16/2021. 3. Address what measures will be put into place or systematic changes made to ensure that the deficient process will not recur. • Our process has been updated and the Virginia DDNR forms are no longer being utilized for transportation. Completed 7/16/2021. • We contacted the local ambulance service and the 911 emergency ambulance service. Both entities have agreed to accept a physician's order when transporting patients rather than requiring the Virginia DDNR form as they have in the past. Completed 7/15/2021. • The code status process has been reviewed, updated, and signed by the Director of Nursing and the Medical Director. Completed 7/27/2021. • All Licensed Nurses have been educated on this change in our process. Any provider or licensed nurse not present will be educated prior to their next shift to work. To be completed on or before 8/5/2021.	

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F 578	Continued From page 2 diagnoses hemiplegia/hemiparesis, diabetes, and hypertension. Section C (cognitive patterns) of Resident #11's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 04/19/2021 included a BIMS (brief interview for mental status) summary score of 13 out of a possible 15 points. The "DNR" binder located at the nurses station included a DDNR order form from the Virginia Department of Health for Resident #11. This form was dated 01/14/2021 and read in part. Under section 1 "I further certify [must check 1 or 2]: 1. The patient is CAPABLE of making an informed decision... 2. The patient is INCAPABLE of making an informed decision..." Neither box had been checked. Section 2 read, "If you checked 2 above, check A, B, or C below..." All three boxes had been left blank. 07/14/21 9:48 a.m., the unit manager was made aware of the incomplete DDNR for Resident #11. 07/14/21 the unit manager provided the surveyor with a copy of a progress note that read, "Discussed and verified code status with patient. Patient wishes to remain a Do Not Resuscitate Code Status. Wishes will be honored by staff." 07/14/21 5:27 p.m., the administrator and DON (director of nursing) were made aware that Resident #11's DDNR was incomplete.	F 578	4. Indicate how the facility plans to monitor its performance to make sure solutions are sustained. • The use of the Virginia DDNR form has been discontinued. • All nurses have been educated to utilize the physician's order regarding code status versus using the Virginia DDNR form. • The code procedure has been updated to reflect this change and revised procedure has been signed by the Director of Nursing and the Medical Director. • The HIM and the Unit Managers will audit all new admissions to ensure each patient has an appropriate code status order and documentation. Audit will continue weekly for (4) weeks and then monthly for (2) months. Results will be reported monthly to the Quality Assurance Performance Improvement (QAPI) Committee. • The Center's QAPI Committee consists of the Administrator, Director of Nursing, Medical Director, QA Physicians, Dietician, Social Services Director, Housekeeping and Laundry Supervisor, Maintenance Director and meets monthly. Additional inservices and/or monitoring may done as determined necessary by the QAPI Committee. To be completed on or before 8/27/2021.	

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F 578	Continued From page 3 No further information regarding the incomplete DDNR was provided to the survey team prior to the exit conference. 2. For Resident #2, the facility staff failed to accurately complete the resident's DDNR (Durable Do Not Resuscitate) Order form. All boxes on the DDNR Order form were left unchecked. This DDNR Order form was part of the resident's electronic health record and filed in a DDNR binder on the nursing unit. Resident #2's diagnosis list indicated diagnoses, which included, but not limited to Other Early-Onset Cerebellar Ataxia, Adult Failure to Thrive, Unspecified Dementia with Behavioral Disturbance, and Post-Traumatic Hydrocephalus Unspecified. The most recent admission MDS (minimum data set) with an ARD (assessment reference date) of 7/07/21 coded the resident as being severely impaired in cognitive skills for daily decision making with short-term and long-term memory loss. A review of Resident #2's clinical record revealed an active physician's order dated 6/30/21 stating "Code Status - DNR (do not resuscitate)". The resident's electronic health record included a Virginia Department of Health DDNR Order form dated 7/01/21 and signed by the physician. The DDNR form was also observed in a 3-ring binder labeled "DNR Forms 2nd Floor" located at the nurse's desk on the 2nd floor. This DDNR Order form read in part under section 1, "I further certify (must check 1 or 2): 1. The	F 578		

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F 578	Continued From page 4 patient is CAPABLE of making an informed decision ... 2. The patient is INCAPABLE of making an informed decision ...". Neither box had been checked. Section 2 of the DDNR Order form read in part, "If you checked 2 above, check A, B, or C below ..." All three boxes were left unchecked. On 7/14/21 at approximately 11:45 am, surveyor notified the DON (director of nursing) of Resident #2's incomplete DDNR Order form. At 1:50 pm, the DON provided the surveyor with a revised copy of Resident #2's DDNR Order form dated 7/01/21 with option "2" checked in Section 1 and option "C" checked in Section 2. Surveyor requested and received the facility policy entitled, "Code Status Procedure", which states in part, "Each form has check boxes that address if the patient is capable of making an informed decision regarding code status, check the boxes appropriately. CAUTION: If check box #2 is selected then A, B, or C is required to be checked in the following section." The concern of Resident #2's incomplete DDNR Order form was discussed with the administrator and DON during a meeting with the survey team on 7/14/21 at 5:27 pm. No further information regarding this issue was presented to the survey team prior to the exit conference on 7/15/21.	F 578		
F 658 SS=E	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,	F 658		

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F 658	Continued From page 5 as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility staff failed to follow professional standards of practice as evidenced by the presence of physician pre-signed blank Virginia Department of Health DDNR (Durable Do Not Resuscitate) Order forms on 2 of 2 nursing care units. The findings included: The facility staff failed to obtain the physician's signature on VDH (Virginia Department of Health) DDNR Order forms at the time of completion. The facility staff maintained the process of a physician pre-signing blank resident DDNR Order forms for availability as needed by the nursing staff. The surveyor observed 43 physician pre-signed blank VDH DDNR Order forms available on the nursing care units. On 7/14/21 at 9:20 am, surveyor observed a 3-ring binder labeled "DNR Forms 2nd Floor" located at the 2nd floor nursing station. In the front of the binder was a plastic sheet protector containing 40 physician signed VDH DDNR Order forms. The VDH DDNR Order forms were undated, did not include a resident's name, and were signed by Physician #1. At 9:29 am, surveyor spoke with LPN (licensed practical nurse) #1 who stated the forms are used when they need to address code status. LPN #1 further stated if the resident is able, they sign the form and if not, code status is addressed with the family. Surveyor asked LPN #1 if the facility usually keeps extra physician signed VDH DDNR	F 658	**F658** 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. • The 43 pre-signed DDNR forms did not have patient names on them. All 43 pre-signed forms have been appropriately destroyed. The DDNR forms found in the notebook have been removed from both nurses stations and appropriately destroyed. Completed 7/16/2021. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. • All patients had the potential to be affected by the deficient practice prior to the change in our procedure. With the new procedure, no future patients will be affected by this practice. 3. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur. • Our process has been updated and the Virginia DDNR forms are no longer being utilized for transportation. Completed 7/16/2021. • We contacted the local ambulance service and the 911 emergency ambulance service. Both entities have agreed to accept a physician's order when transporting patients rather than requiring the Virginia DDNR form as they have in the past. Completed 7/16/2021.	

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F 658	Continued From page 6 Order forms available and LPN #1 stated "yes". The surveyor met with the administrator and notified them of the above observations at 9:45 am. On 7/14/21 at 9:51 am, surveyor observed an open 3-ring binder at the 3rd floor nursing station. In the front pocket of the binder were three (3) physician signed VDH DDNR Order forms. The VDH DDNR Order forms were undated, did not include a resident's name, and were signed by a physician. Surveyor spoke with LPN #2 and asked when would staff use the pre-signed forms, LPN #2 stated they do not use them and do not know why they were there. LPN #2 immediately took the three VDH DDNR Order forms and stated they were going to shred them. LPN #2 took the forms prior to the surveyor documenting the name of the physician that had pre-signed the forms. Surveyor met with the DON (director of nursing) on 7/14/21 at 11:40 am and notified them of the observation of the 43 physician pre-signed VDH DDNR Order forms. The DON was aware of this process and stated the DDNR Order forms do not serve as an order and the DNR orders are signed by the physician. The DON further stated a DNR is obtained following discussion with the family and provider and then a DDNR form is completed. DON stated the DDNR forms are only used when a resident is transported. On 7/15/21 at 9:20 am, surveyor #1 and #2 spoke with the DON who acknowledged the facility is still using the pre-signed VDH DDNR Order forms. DON stated the forms have been removed from the nursing units and placed in the administrator's office at this time. DON stated the	F 658	• The code status process has been reviewed, updated and signed by the Director of Nursing. Completed 7/27/2021. • All providers and licensed nurses have been educated on this change in our process. Any provider or licensed nurse not present will be educated prior to their next shift to work. To be completed on or before 8/5/2021. 4. Indicate how the facility plans to monitor its performance to make sure solutions are sustained. • The HIM Director and the Unit Managers will audit all new admissions from 7/15/2021 to 9/16/2021 to ensure each patient has an appropriate code status order and documentation. Audit will continue weekly for (4) weeks and then monthly for (2) months. Results will be reported to the QAPI Committee. • The Center's QAPI Committee consists of the Administrator, Director of Nursing, Medical Director, QA Physicians, Dieticians, Social Services Director, Housekeeping and Laundry Supervisor, Maintenance Director, Activities Director, Direcot of Rehab and HIM Director and meets monthly. Additional in-services and/or monitoring may be necessary as determined by the QAPI Committee. To be completed on or before 8/27/2021.	

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F 658	Continued From page 7 forms were being stored in the unit manager's office in a filing cabinet with a lock but someone thought they were being helpful and placed them in the front of the books. DON further stated they plan to discuss the process with the physician. Surveyor requested and received the facility policy entitled, "Code Status Procedure", which states in part: 1. For ALL New Admissions/Returns. 2. Verify code status order. (FULL CODE CPR/DNR Do Not Resuscitate) 3. Discuss code status with patient and/or patient representative. 4. Document conversation of patient's wishes in the medical record including who you spoke to, risks versus benefits, and outcome of patient's and/or patient representative's decision. 5. Notify provider of patient's wishes if code status order is required to be changed (i.e. Full Code > DNR). 6. Durable Do Not Resuscitate Order (Virginia Department of Health) is required to be completed and signed by the patient and/or patient representative AND the physician. On 7/15/21 at approximately 10:10 am, the survey team met with the administrator, DON, and the facility's Regional Medical Director and discussed the concern of physician pre-signed VDH DDNR Order forms. The Regional Medical Director stated the reason for the pre-signed DDNR forms is due to the facility being on the border between Virginia and Tennessee and EMS will not honor the patient's DNR if they do not have the Virginia form. The Regional Medical Director stated the patient already has the DNR order on their chart, the form is not creating a new order, it is reflecting what is in their chart.	F 658		

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F 658	Continued From page 8 The Regional Medical Director stated they realize this is not the ideal practice but they tried to figure out a way they could honor the resident's preference and it is only done in the best interest of the patient. They further stated that for a patient with a newly decided DNR, the physician will have a conversation with the patient and/or the family and will also confirm the code decision with a face to face during the next visit. The administrator stated they are working on a tracking process for the forms that will document the resident's name, date, and nurse when a DDNR Order form is used. Administrator stated they are trying to take care of the residents and do not want to code anyone that does not want to be coded. Administrator stated they will continue to use the pre-signed forms but they will be kept in the medication rooms. The administrator and the Regional Medical Director confirmed to the survey team that the facility policy does not address the use of pre-signed DDNR Order forms. At approximately 11:15 am, surveyor asked the administrator for the facility's professional standards of practice addressing the pre-signing of forms, administrator stated they do not have anything. Administrator stated to Surveyor #3 they rely on their policies. On 7/15/21 at approximately 1:25 pm, surveyor met with the administrator and DON and discussed the concern of the facility utilizing physician pre-signed VDH DDNR Order forms. No further information regarding this issue was presented to the survey team prior to the exit conference on 7/15/21.	F 658		

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F 684 F 684 SS=D	Continued From page 9 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, facility document review and clinical record review the facility staff failed to ensure that residents receive treatment and care by following physician's orders for 1 of 24 Residents, Resident #12 The findings included: For Resident #12 the facility staff failed to administer the medications amiodarone and metoprolol as ordered by the physician. Resident #12's face sheet listed diagnoses which included but not limited to dysphagia, hypertension, atherosclerotic heart disease, atrial fibrillation, chronic obstructive pulmonary disease, gastroesophageal reflux disease, depression, anxiety, and hypothyroidism. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 07/12/21 assigned the resident a BIMS (brief interview for mental status) score of 13 out 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact.	F 684 F 684	F684 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. • Resident #12 had no negative outcome as a result of this finding during the survey. After evaluation by the Provider, Resident #12 is no longer on a medication and parameters. Completed 7/16/2021. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. • An audit was completed on all patients with medication orders that included parameters on 7/14/2021. No other patients were identified to not have had appropriate parameters documented. 3. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur. • The Nurse who documented that a medication was not administered was re-educated on proper medication administration and documentation. Completed 7/14/2021. • All Licensed Nurses will be re-educated on safe medication administration and documentation, according to our facility policy, by the Director of Nursing or Unit Manager. Any Licensed Nurse not available will be re-educated prior to their next scheduled shift. To be completed on or before 8/16/2021.	

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F 684	Continued From page 10 Resident #12's clinical record was reviewed on 07/14/21. It contained a physician's order summary for the month of June 2021 which read in part, "04/16/2021-06/10/2021 (DC [discontinue] Date) amiodarone tablet; 200 mg; amt: 2 tabs; oral Special Instructions: Hold for HR (heart rate) < (less than) 69 Twice A Day; 08:00 AM, 08:00 PM", "04/16/2021-06/22/2021 (DC Date) metoprolol tartrate tablet; 25 mg; amt: 0.5 mg tab; oral Special Instructions: dose is 12.5 mg hold for HR <69 Twice A Day; 08:00 AM, 04:00 PM", "06/10/2021-06/18/2021 (DC Date) amiodarone tablet; 200 mg; amt: 2 tabs; oral Special Instructions: Hold for HR <69 Once a Day; 08:00 AM", "06/18/2021-06/22/2021 (DC Date) amiodarone tablet; 200 mg; amt: 1 tabs; oral Special Instructions: Hold for HR <69 Once A Day; 08:00 AM", and "06/27/2021-Open-Ended amiodarone tablet; 200 mg; amt: 1 tabs; oral Special Instructions: Hold for HR <69 Once A Day; 08:00 AM". Resident #12's eMAR's (electronic medication administration record) for the month of June 2021 was reviewed and contained entries as above. The orders for "amiodarone 200 mg, 2 tabs twice a day-hold for HR < 69" and "metoprolol 25 mg 0.5 tab twice a day- hold for HR < 69" were initialed as not being administered on 06/02/21 at 8 am. Per the vital signs sheet the resident's heart rate was 72. The order for "amiodarone 200 mg 2 tabs once a day-hold for HR < 69" was initialed as not being administered on 06/21/21 at 8 am. Per the vital signs sheet the resident's heart rate was 70. Surveyor requested and was provided with a copy of a facility policy entitled "Medication	F 684	4. Indicate how the facility plans to monitor its performance to make sure solutions are sustained. • Beginning 7/14/2021. the Unit Manager will audit patients on medications with parameters weekly for (4) weeks and then monthly for (2) months to ensure compliance with parameter documentation according to MD orders. Results will be submitted to the DON weekly for review and reported monthly to the QAPI Committee. • The Center's QAPI Committee consists of the Administrator, Director of Nursing, Medical Director, QA Physicians, Dietitian, Social Services Director, Housekeeping and Laundry Supervisor, Maintenance Director, Activities Director, Director of Rehab and HIM Director and meets monthly. Additional in-services and/or monitoring may be necessary as determined by the QAPI Committee. To be completed on or before 8/27/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495131	A. BUILDING _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, BRISTOL	245 NORTH STREET BRISTOL, VA 24201

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F 684	Continued From page 11 Administration-General Guidelines", which read in part "Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so" and "B. Administration 2) Medications are administered in accordance with written orders of the prescriber." The concern of not following the physician's order for the administration of medications was discussed with the administrative staff during a meeting on 07/15/21 at approximately 1:25 pm No further information was provided prior to exit.	F 684		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §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 observation, staff interview, and facility document review, the facility staff failed to ensure the resident environment remained free of accident hazards on 2 of 2 nursing care units, second and third floors. The findings included: The facility staff failed to ensure water temperatures were maintained in acceptable parameters to decrease the risk of resident injury.	F 689	**F689** 1. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice. • Upon notification of the concern, patient showers were stopped. • A new mixing valve was on order at the time of survey. The mixing valve and circulating pumps arrived and were installed on 7/14/2021. • The water temperatures of patient rooms 307 and 207 were rechecked on 7/15/2021 and found to be in an acceptable safe range. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practices. • All patients had the potential to be impacted by this concern if not corrected. • As the Surveyor acknowledged, "throughout the course of the survey, no patients complained of the water temperatures being too hot."	

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F 689	Continued From page 12 All temperatures referenced reflect the Fahrenheit temperature scale. 07/14/2021 11:34 a.m., the MD (maintenance director) checked the water temperature in the bathroom sink of room 307 using a digital thermometer. This temperature read 128. 07/14/2021 11:39 a.m., the surveyor and the MD went to the roof and the MD adjusted the mixing valve. The MD stated the mixing valve was being replaced, water temperatures were checked in four rooms twice a week, and they did not have to adjust the mixing valve very often. 07/14/2021 11:56 a.m., water temperature room 307-109.5 degrees.. 07/14/2021 11:59 a.m., water temperature room 207-130 degrees. 07/14/21 12:14 p.m., the administrator was made of the water temperatures obtained by the MD. 07/14/21 12:17 p.m., LPN (licensed practical nurse) #1 and RN (registered nurse) #1 stated they had not noticed the water being hot. 07/14/21 12:19 p.m., MD stated that the administrator had been notified of the elevated water temperatures and they had stopped resident baths/showers. The MD stated that the contracted company were on their way back to the facility with a circulating pump and per this company, they would have it in today. 07/14/21 1:30 p.m., CNA (certified nursing assistant) #1 stated the water was hot. However,	F 689	3. Address what measures will be put in place or systematic changes made to ensure that the deficient practice will not recur. • A new mixing valve was on order at the time of the survey. The mixing valve and circulating pumps arrived and were installed on 7/14/2021. • On 7/15/2021, 6 patient rooms (323, 315, 333, 225, 205 and 230) water temps checked by the Surveyor were all at a safe temperature level. • The mixing valve, boiler and circulating pumps were wired so they have back up power from the generator in the event of an emergency. Completed on 7/27/2021. 4. Indicate how the facility plans to monitor its performance to make sure solutions are sustained. • The Maintenance Director or designee will complete a QA monitor of 6 random patient room water temperatures on different floors weekly for (8) weeks to ensure water temperatures for bathing are in a safe range for patient care. All patient rooms will be checked one or more times during this 8 week monitoring period. Should any water temperature not be in a safe range, showers will be stopped until water temperature issue can be resolved. Results will be reported monthly to the QAPI Committee. • The Center's QAPI Committee consists of the Administrator, DON, Medical Director, QA Physicians, Dietitian, Social Services Director, Housekeeping and Laundry Supervisor, Maintenance Director, Activities Director, Director of Rehab and HIM Director and meets monthly. Additional in-services and/or monitoring may be necessary as determined by the QAPI Committee. To be completed on or before 8/27/2021.	

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F 689	Continued From page 13 they cut the cold water on and mixed the hot/cold together to get it to the correct temperature for the resident(s). 07/14/21 1:33 p.m., LPN #2 stated they did not think the water was to hot and usually used hand sanitizer. 07/14/21 1:36 p.m., CNA #2 stated the water was hot but they mixed it with cold water and ask the resident if they wanted the water hotter or colder 07/14/21 1:38 p.m., CNA #3 stated the water was hot, they turned on the cold water, and they turned the hot water down. 07/14/21 01:42 p.m., housekeeper #1 stated they thought the water was fine. 07/14/21 1:44 p.m., CNA #4 stated the water was hot and they turned on the cold water. 07/14/21 5:05 p.m., the MD stated the mixing valve had been replaced and they would not be doing any bathing tonight. The water temperature in the bathroom of room 203 was checked and read 107.3. 07/14/2021 7:35 a.m., the administrator provided the surveyor with a document titled, "NHC Bristol Policy on Water Temperatures in Patient Care Areas." This document read, "It is the facilities policy to maintain safe water temperatures in patient care areas that are in accordance with the State of Virginia and CMS guidelines. To allow for patient preference in water temperature, our goal is to regulate water temperatures between 105-120 degrees to avoid any potential for harm or injury to patients. Water temperatures are	F 689		

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F 689	Continued From page 14 monitored routinely for compliance. If water temperatures are found to be over 120, nursing staff is notified to cease giving patient showers until maintenance staff can make appropriate adjustments. Showers will continue only when they receive the "all clear" from the maintenance staff or the administrator." 07/15/21 water temperatures obtained by MD with the administrator and surveyor in attendance. Third Floor 7:40 a.m. Room 323-109.8 7:44 a.m. Room 315-109.1 7:49 a.m. Room 333-110.1 Second Floor 7:55 a.m. Room 225-109.9 8:00 a.m. Room 205-108.9 8:04 a.m. Room 230-109.4 No patient care rooms on first floor 8:10 a.m. bathroom in therapy room first floor-107.6 Throughout the course of the survey, no residents complained of the water temperatures being too hot. 07/15/2021 7:35 a.m., the administrator provided the surveyor with documentation to indicate that the facility had been "...waiting for a promised installation of mixing valve since April..."	F 689		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F 757	F757 1. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice. • Resident #12 had no negative outcome as a result of this deficient practice. Resident #12 is no longer on a medication with parameters.	

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F 757	Continued From page 15 §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure 1 of 24 residents was free from unnecessary medications, Resident #12. The findings included: For Resident #12 the facility staff failed to follow physician ordered parameters for the administration of the medications amiodarone and metoprolol. Resident #12's face sheet listed diagnoses which included, but not limited to dysphagia, hypertension, atherosclerotic heart disease, atrial fibrillation, chronic obstructive pulmonary disease, gastroesophageal reflux disease, depression, anxiety, and hypothyroidism. The most recent quarterly MDS (minimum data	F 757	2. Address how the facility will identify other residents having the potential to be affected by the same deficient practices. • On 7/15/2021 an audit was completed of all 16 patients that had blood pressure or pulse parameters ordered with medications. No other patients were identified who received medications outside of physician ordered parameters. 3. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur. • The Nurse identified that documented a medication was not administered was re-educated on proper medication administration and documentation. Completed 7/14/2021. • All Licensed Nurses will be re-educated on safe medication administration and documentation, according to our facility policy, by the Director of Nursing or Unit Manager. Any Licensed Nurse not available will be re-educated prior to their next shift scheduled. To be completed on or before 8/16/2021. 4. Indicate how the facility plans to monitor its performance to make sure solutions are sustained. • Beginning 7/14/2021, Unit Managers will audit patients on medications with parameters weekly for (4) weeks and then monthly for (2) months to ensure compliance with parameter documentation according to MD orders. Results will be submitted to DON for review weekly and reported monthly to the QAPI Committee. • The Center's QAPI Committee consists of the Administrator, DON, Medical Director, QA Physicians, Dietitian, Activities Director, Director of Rehab and HIM Director and meets monthly. Additional in-services and /or monitoring may be necessary as determined by the QAPI Committee. The be completed by 8/27/2021.	

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F 757	Continued From page 16 set) with an ARD (assessment reference date) of 07/12/21 assigned the resident a BIMS (brief interview for mental status) of 13 out of 15 in section C, cognitive patterns. This indicates the resident is cognitively intact. Resident #12's clinical record was reviewed on 07/14/21. It contained a physician's order summary for the month of June 2021 which read in part, "04/16/2021-06/10/2021 (DC [discontinue] Date) amiodarone tablet; 200 mg; amt: 2 tabs; oral Special Instructions: Hold for HR (heart rate) < (less than) 69 Twice A Day; 08:00 AM, 08:00 PM", "04/16/2021-06/22/2021 (DC Date) metoprolol tartrate tablet; 25 mg; amt: 0.5 mg tab; oral Special Instructions: dose is 12.5 mg hold for HR <69 Twice A Day; 08:00 AM, 04:00 PM", "06/10/2021-06/18/2021 (DC Date) amiodarone tablet; 200 mg; amt: 2 tabs; oral Special Instructions: Hold for HR <69 Once a Day; 08:00 AM", "06/18/2021-06/22/2021 (DC Date) amiodarone tablet; 200 mg; amt: 1 tabs; oral Special Instructions: Hold for HR <69 Once A Day; 08:00 AM", and "06/27/2021-Open-Ended amiodarone tablet; 200 mg; amt: 1 tabs; oral Special Instructions: Hold for HR <69 Once A Day; 08:00 AM". The clinical record also contained a physician's order summary for the month of July, which read in part "06/27/2021-Open Ended amiodarone tablet; 200mg; amt: 1 tabs; oral Special Instructions: Hold for HR < 69 Once A Day; 08:00 AM" Resident #12's eMAR's (electronic medication administration record) for the month of June 2021 was reviewed and contained entries as above. The entry for "amiodarone 200 mg 2 tabs twice a day-hold for HR < 69" was initialed as administered on 06/03/21 at 8 pm. The resident's	F 757		

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F 757	Continued From page 17 heart rate was recorded on the eMAR as 54. The entry for "amiodarone 200 mg 2 tabs once a day-hold for HR < 69" was initialed as administered on 06/12/21/ at 8 am. The resident's heart rate was recorded on the eMAR as 60. The entry for "metoprolol 25 mg, 0.5 tab twice a day-hold for HR < 69" was initialed as administered on 06/12/21 at 8 am, with a heart rate of 60, 4 pm with a heart rate of 62, 06/16/21 at 4 pm with a heart rate of 57. The entry for "amiodarone 200 mg 1 tab once a day-hold for HR < 69" was initialed as administered on 07/04/21 at 8 am with a heart rate of 63, 07/08/21 at 8 am with a heart rate of 62, and on 07/09/21 at 8 am with a heart rate of 66. Surveyor spoke with the DON (director of nursing) on 07/14/21 at approximately 12:15 pm. DON stated that when the eMAR's were initialed as medications not administered, the system would automatically change the entry to administered if the nurse did not go back and change the entry. Surveyor asked the DON if there was any way to know for sure if the medication was administered or not by reading the eMAR, and DON stated that you have to go with what is documented. The concern of administering medications outside of physician ordered parameters was discussed with the administrative team during a meeting on 07/15/21 at approximately 1:25 pm. No further information provided to discharge.	F 757		

State of Virginia

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F 000	Initial Comments A unannounced biennial State Licensure Inspection was conducted 07/13/21 through 07/15/21. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. Corrections were required. The census in this 120 certified bed facility was 103 at the time of the survey. The survey sample consisted of 21 current resident reviews and 3 (three) closed record reviews. One complaint was investigated during the course of the survey.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities: Director of Nursing 658 12 VAC 5-371-200 (B)(1)(ii) - cross reference to F658 Nursing Services 12 VAC 5-371-220 (B) - cross references to F684 and F757 12 VAC 5-371-220 (C)(4) - cross references to F689	F 001		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dan Stephens — TITLE: Administrator — (X6) DATE: 9/10/2021