PRINTED: 11/03/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	COMPLETED		
		40.000			С	
NAME OF F	DOWNER OF CURPUIED	495143	B. WING _	CTREET APPRECS CITY STATE ZID CODE	09/	14/2021
NAME OF PROVIDER OR SUPPLIER MARTINSVILLE HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFEDER OF THE APPROPRIES OF THE	D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	F 00	0		
	survey was conduction of the compliance with 42 Term Care requirer investigated during VA00052963-U, VA	Medicare/Medicaid abbreviated ted 09/13/21 through ons are required for CFR Part 483 Federal Longments. Five complaints were the survey (VA00053089-S, .00051580-U, VA00051582-S, U) The Life Safety Code bllow.				
	85 at the time of the consisted of 4 curre closed record revie	onfidentiality of Records	F 58	3		9/24/21
- 1	The resident has a	and Confidentiality. right to personal privacy and s or her personal and medical		[2]		
	accommodations, r telephone commun and meetings of fai	onal privacy includes medical treatment, written and dications, personal care, visits, mily and resident groups, but the the facility to provide a sch resident.				
	residents right to peright to privacy in he written, and electron the right to send armail and other letter materials delivered	facility must respect the ersonal privacy, including the is or her oral (that is, spoken), inic communications, including and promptly receive unopeneders, packages and other to the facility for the resident, ivered through a means other				
LABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE
Electror	nically Signed					10/21/2021

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
495143			B. WING		#8	09/14/2021	
NAME OF PROVIDER OR SUPPLIER MARTINSVILLE HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112			
(X4) ID PREFIX TAG			ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 583	than a postal service §483.10(h)(3) The rand confidential per (i) The resident has of personal and merovided at §483.70 federal or state law (ii) The facility must office of the State I to examine a reside administrative recolaw. This REQUIREMED by: Based on resident facility document recomplaint investigate protect a residents residents, Resident #1's diagralimited to, chronic of chronic and acute remental status, demidepression, anxiety Resident #1's most (minimum data set reference date) of a BIMS (brief intervals out of 15. This in cognitively intact. Resident #1 was in a.m. and asked if the	resident has a right to secure resonal and medical records. The right to refuse the release dical records except as D(i)(2) or other applicable is. I allow representatives of the Long-Term Care Ombudsman ent's medical, social, and rids in accordance with State in accordance with State. INT is not met as evidenced interview, staff interview, eview and in the course of a tion, the facility staff failed to personal privacy for 1 of 6 in #1. Indicate the second of the second	F 5	i83	Disclaimer: This plan of correction is being subin compliance with specific regulate requirements and preparation and/execution of this plan of correction not constitute admission or agreen the provider of the facts alleged or conclusions set forth on the statem deficiencies. 1. The picture alleged in the complewas not able to be located. The aid took the picture of the resident's bis stated she deleted it from her phor additional complaints were voiced resident during the interview. 2. All residents have the potential that affected by this alleged deficient prounds to identify any potential resights violations. 3. Staff re-education was provided.	ory for does nent by nent of daint de who rief ne. No by the co be ractice. ekeeper ident	

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
495143		B. WING		<u> </u>	09/14/2021		
NAME OF PROVIDER OR SUPPLIER MARTINSVILLE HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE
F 583	without their permis "Yeah, I remember. came in and chang said I turned the lig cleaning me and to #1 was asked if the the resident stated, remember her nam it." Resident #1 was the CNA had taken stated, "I know it wa going to get in trout they had told anyon didn't tell anybody, to other CNAs, or a The UM (unit mana 09/14/21 at 9:25 a.i knew anything abor Resident #1. UM #1 on south unit. I rem don't know what rea told the therapist, I statement and gave I sat in on interview was asked if they k been reported, and	ge 2 sion. Resident #1 stated It happened pretty quick, she ed me, we were arguing, she ht on too much. She was ok her camera out." Resident y knew who the CNA was, and "Don't know her name, don't e. They made a report about a saked if it bothered them that a picture, and Resident #1 asn't right. I told her she was ole." Resident #1 was asked if te, and Resident #1 stated, "I the girl did. She was bragging t least that's what I heard." ger) #1 was interviewed on m. UM #1 was asked if they ut a CNA taking a picture of I stated, " (Resident #1) is tember an accusation, but ally happened. The resident think. Therapist wrote a e it to me, I gave it to my boss. Is with staff member." UM #1 new if the allegations had UM #1 stated they did not. d occupational therapy viewed on 09/14/21 at 9:40	F 5	683	DON or designee related to resider rights, abuse/neglect, and the facility social media policy. 4. Audits for resident rights violation be completed weekly x4 weeks. The Administrator will submit the audit to the Quality Assurance and Performance Improvement Commit The Administrator is responsible for monitoring and follow-up. 5. AOC 9/24/21	ns will ne results	
	am. The COTA if the a CNA took a picture stated, "I was in the out of (Resident #1 and she held up he wet?" I guess she wasn't sure what I wreport it." The COT	rey recalled an incident where re of a resident, and the COTA e hallway and a CNA stepped 's) room and said 'Look at this' r phone and 'Does this look was referring to the brief. I was looking at. I felt I should A was asked who they COTA stated, "The director of					

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′		E CONSTRUCTION	COMPLETED		
		495143	B. WING	;		09/1	 4/2021
NAME OF PROVIDER OR SUPPLIER MARTINSVILLE HEALTH AND REHAB				1	TREET ADDRESS, CITY, STATE, ZIP CODE 607 SPRUCE STREET MARTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 583	name) (UM #2) I write a written state UM #2 was intervieud #2 was asked incident and UM #4 us that (Resider picture of them. Wresident and their gathered that the pof brief on the resident and investigation of the facility reported incident and their gathered that the pof brief on the resident investigation of the facility reported incident that the resident's adult protective se Professions and Ianotified on 04/14/2 contained a 5 day the facility which resident involved in the acceptance of the allegations is be unsubstantiated and it was determitated it was determitated in the acceptance of the allegation and could be unsubstantiated and it was determitated and it was determitated in the acceptance of the allegation and could be unsubstantiated and it was determitated and it was determitated and it was determitated and it was determinated and could be unsubstantiated and it was determinated an	at and reported to (UM #2 ater came and asked me to ement, which I did." ewed on 09/14/21 at 10:30 a.m. if they knew anything about 2 stated, " (COTA name) told at #1) said a CNA had taken a se took statements from the roommate, and COTA. We bicture was taken of a brief, not		583			
		ok off my diaper and took a					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495143	B. WING			1	14/2021	
NAME OF PROVIDER OR SUPPLIER MARTINSVILLE HEALTH AND REHAB				160	REET ADDRESS, CITY, STATE, ZIP CODE 07 SPRUCE STREET ARTINSVILLE, VA 24112			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG			BE	(X5) COMPLETION DATE	
F 583	the picture down the heard her say 'Look think her name is diaper in her hand.' The written stateme (roommate), writter (CNA name) came wasn't wet. The diathe CNA took pictur #2) said she held the room to show the stated 'I told (Resident #1 told (Resident #1) wasn't went to the nurse and a my phone of the diathe (Resident #1) wasn't may phone." The written stateme "On Thursday, Apri was in the hallway gym on South wing (Resident #2 and Fapproached me. Siphone. When she is some photos and cat this. Do you see She said 'do you see She said 'n part "When diaper brief, skin aid to the said in part "When diaper brief, skin aid think they read in part "When diaper brief, skin aid think they read in part "When diaper brief, skin aid think they read in part "When diaper brief, skin aid think they read in part "When diaper brief, skin aid they have the said they read in part "When diaper brief, skin aid they read in part "When diaper brie	d it wasn't even wet. She took e hall to show co-workers. I c at this, she ain't even wet'. I She took the picture with the '. ent from Resident #2 h by UM #2, read in part, " in and told (Resident #1) she per was laying on the bed and re of the diaper." (Resident he diaper up and took it out of he nurse. (Resident #2) then lent #1) it was wrong." ent from the CNA read in part, 1 changed (Resident #1), she heded to be dried. So to prove therapy I took a picture with laper just to prove to them that h't wet. I did delete the picture ent from COTA read in part, I 8, 2021 at about 3:30-3:45, I walking toward the therapy I. A CNA stepped out of Resident #1) room and he asked me to look at her held it up, she scrolled down eneld it up, she scrolled it up, she scrolled down eneld it up, she scrolled down eneld it up, she scrolled it up, she scrolled it up, she said 'look anything?' I asked her 'what?' ene anything there?' and she included it up, she scrolled	F	583				
		nd hair. I could not tell if the casian or African American						

PRINTED: 11/03/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495143 B. WING 09/14/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1607 SPRUCE STREET** MARTINSVILLE HEALTH AND REHAB MARTINSVILLE, VA 24112 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 583 Continued From page 5 F 583 person. I assumed they photo was of the genital or anal area of the person. I only glanced at the picture and looked away." The facility investigation also contained "Employee Education" form regarding HIPAA and electronic device policy signed by the CNA and in-service forms regarding electronic devices and social media signed by all other facility employees. The concern of the facility failing to protect the resident's personal privacy discussed with the administrator, director of nursing and unit manager on 09/14/21 at 1:30 pm. No further information was provided prior to exit.