| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495384 | A. BUILDING _____ B. WING _____ | C 11/04/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| FRANCIS MARION MANOR HEALTH & REHABILITATION | 100 FRANCIS MARION LANE, MARION, VA 24354 |

| (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 |
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| E 000 | Initial Comments<br><br>An unannounced Emergency Preparedness survey was conducted 11/3/21 through 11/4/21. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid standard survey was conducted 11/3/2021 through 11/4/2021. Corrections were required for compliance with 42 CFR Part 483 Federal Long Term Care requirements.<br><br>The census in this 109 certified bed facility was 55 at the time of the survey. The final survey sample consisted of 17 current resident reviews and 4 (four) closed record reviews. One (1) complaint was investigated. | F 000 | | |
| F 578 SS=D | Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir<br>CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)<br><br>§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.<br><br>§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.<br><br>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).<br>(i) These requirements include provisions to | F 578 | F578<br>Ensuring implementation of policies, procedures and/or processes relating to DNR (do not resuscitate) status of residents at FMM is important to the team at FMM.<br><br>1. Resident #15 and Resident #49 received no treatments outside of their wishes because of the deficient practice. Both DDNR documents were updated per physician direction. The missing purple star was placed on residents arm band.<br><br>Continued | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Teri Martin | TITLE: Administrator | (X6) DATE: 11/22/21

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<br>inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.<br>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.<br>(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.<br>(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.<br>(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.<br>Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews, and facility document review, it was determined the facility staff failed to accurately implement facility policies, procedures, and/or processes relating to DNR (do not resuscitate) status for two (2) of 21 facility residents (Resident #15 and Resident #49).<br><br>The following information was found in a facility policy titled "DO NOT RESUSCIATE ORDERS (DNR) AND DURABLE DO NOT RESUSCITATE (DDNR) ORDERS - VIRGINIA - (medical corporation name omitted)" (with an effective date | F 578 | 2. All residents have the potential to be affected by the same practice. 100% audit completed of charts to ensure all procedures were in place.<br><br>3. Audit the 24-hour report for changes and/or new admissions for DNR orders or changes in code status. Re-educate nursing team on steps for fully implementing the DNR process. (Full completion of the DDNR order form, flagging the chart with a purple adhesive and updating the resident wrist band to include a purple star as well as updating the care plan).<br><br>4. Nurse Manager or designee will monitor DDNR forms and/or DNR orders. Monthly audits will be conducted to check for completion of all steps. Audit results will be reported to the QAPI team for further interventions.<br><br>5. Corrective action will be complete by 12/19/21.<br><br>6. Nurse Manager or designee | |

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| F 578 | Continued From page 2<br>of 10/1/21): "To issue a DDNR order, an Authorized Practitioner must: a. Explain to the patient or Legally Authorized Representative the DDNR Order and alternatives available for response in the event of Cardiac or Respiratory Arrest. b. If the option of a DDNR Order is agreed upon, an Authorized Practitioner will: ... Complete the state approved DDNR form ..."<br><br>The findings include:<br><br>1. The facility staff failed to ensure Resident #15's Virginia Department of Health DDNR (durable do not resuscitate) Order form was complete. The facility staff failed to ensure Resident #15's wristband had a 'purple star' on it; the purple start indicated the resident had a DNR (do not resuscitate) order.<br><br>Resident #15 minimum data set (MDS) assessment, with an assessment reference date (ARD) of 8/27/21, was completed on 8/31/21. Resident #15 was assessed as able to make self understood and as usually able to understand others. Resident #15's BIMS (Brief Interview for Mental Status) summary score was a five (5) out of 15. Resident #15 was assessed as requiring assistance with bed mobility, dressing, toilet use, and personal hygiene. Resident #15's diagnoses included, but were not limited to: anemia, renal disease, diabetes, and dementia.<br><br>Resident #15's active plan or care included the following 'focus' area: "(Resident #15's name omitted) wishes to be a Do Not Resucitate [sic] in the event of cardiopulmonary arrest."<br><br>Resident #15's clinical record contained a signed Virginia Department of Health DDNR Order form | F 578 | | |

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| F 578 | Continued From page 3<br>dated 10/15/21. This form included an area which read in part "I further certify (must check 1 or 2)"; this documented whether or not the resident was 'capable' of making an informed decision. Neither 1 nor 2 was checked. A completed copy of this form, for Resident #15, was provided to the survey team prior to the conclusion of the survey.<br><br>On 11/3/21 at 5:05 p.m., CNA (certified nurse aide) #21 stated one of the ways to know a resident's DNR status is to check the resident's armband for a "purple star". CNA #21 reported a 'purple star' indicates the resident has a DNR order.<br><br>Review of Resident #15's clinical record revealed a medical provider order for a DNR but Resident #15's armband did not have a 'purple star' on it. On 11/3/21 at 5:09 p.m., the facility's Nurse Manager confirmed that Resident #15's armband did not have a 'purple star' but that it should. The Nurse Manager corrected Resident #15's armband to include a 'purple star'.<br><br>On 11/4/21 at 8:30 a.m., the facility's Administrator reported the facility's DNR policy did not address the use of a 'purple star' on residents' armband to identify presence of a DNR order for the resident.<br><br>On 11/4/21 at 2:23 p.m., the facility's Administrator, Director of Nursing, Infection Preventionist, and Unit Manager participated in a survey team meeting. During this meeting the failure of the facility staff to ensure Resident #15 had a completed DDNR from and the failure of the facility staff to ensure Resident #15's armband had the resident's DNR status indicated | F 578 | | |

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| F 578 | Continued From page 4 | F 578 | | |

with a 'purple star' was discussed for a final time.
2. For Resident #49 the facility staff failed to ensure a complete Virginia Department of Health DDNR (durable do not resuscitate) form.

Resident #49's face sheet listed diagnoses which included but not limited to respiratory failure, congestive heart failure, chronic obstructive pulmonary disease, anorexia, dysphagia, dementia, and atrial fibrillation.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 10/15/21 assigned the resident a BIMS (brief interview for mental status) score of 5 out of 15 in section C, cognitive patterns. This indicates the resident is severely cognitively impaired.

Resident #49's clinical record was reviewed on 11/03/21 and contained a signed physician's order summary, which read in part "Code Status: DNR (do not resuscitate)".

Resident #49's clinical record contained a Virginia Department of Health DDNR form dated 04/28/21, which read in part "I further certify (must check 1 or 2)". On this section of the form, 2 was checked. The form also read "If you check 2 above, check A, B or C below". In this section, no areas were checked.

The incomplete DDNR was discussed with the administrator on 11/03/21 at 5:15 pm. Administrator stated they would correct the DDNR.

Administrator provided the surveyor with a copy of a corrected DDNR for on 11/04/21 at 8:50 am.

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| F 578 | Continued From page 5<br>No further information was provided prior to exit. | F 578 | | |
| F 756 SS=D | Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)<br><br>§483.45(c) Drug Regimen Review.<br>§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>§483.45(c)(2) This review must include a review of the resident's medical chart.<br><br>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.<br>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.<br>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.<br>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.<br><br>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in | F 756 | F756<br>Ensuring pharmacy reviews are completed, including follow-up and documentation is a priority for the team at FMM<br><br>1. Resident #41 received no ill effects from the practice. All other pharmacy reviews are on the chart and have been followed up on.<br><br>2. All residents have the potential to be affected by the same practice.<br><br>3. A copy of the pharmacy review, along with the physician's response to recommendations, will be kept in a binder in the Nurse Manager's office. A file will be submitted to the pharmacist with the physician's response monthly.<br><br>Continued | |

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| F 756 | Continued From page 6<br>the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and clinical record review, the facility staff failed to demonstrate a review of pharmacy recommendations for one 1 of 21 residents (Resident #41).<br><br>The findings included:<br><br>The facility staff failed to follow up on a pharmacy recommendation for the month of August 2021.<br><br>Resident #41's clinical record included the diagnosis unspecified psychosis, dementia, depressive disorder, and anxiety disorder.<br><br>Section C (cognitive patterns) of Resident #41's quarterly (MDS) minimum data set assessment with an (ARD) assessment reference date of 10/04/2021 included a (BIMS) brief interview for mental status summary score of 12 out of 15 points.<br><br>Resident #41's clinical record included a drug regimen review dated 08/20/2021. The reviewing pharmacist had marked the box beside the statement that read, "Recommendations made, review Pharmacy Report for recommendations."<br><br>The surveyor was unable to locate a pharmacy report with the date of 08/20/2021 that referenced a recommendation in Resident #41's clinical record.<br><br>11/04/2021 11:16 a.m., the (DON) director of nursing was made aware of the missing | F 756 | 4. Nurse Manager or designee will monitor all pharmacy reviews monthly. If variation is found, an investigation will be initiated and corrections made to the process or education given. Audit results will be reported to the QAPI team for further interventions.<br><br>5. Corrective action will be complete by 12/19/21.<br><br>6. Nurse Manager or designee | |

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| F 756 | Continued From page 7<br>pharmacy report.<br><br>11/04/2021 2:23 p.m., an end of the day meeting was held with the administrator, DON, infection preventionist, and unit manager. The missing pharmacy review recommendation was reviewed with these staff.<br><br>11/04/2021 3:14 p.m., the DON stated they were unable to locate anything in regards to the pharmacy review for the month of August 2021 for Resident #41.<br><br>No further information regarding the pharmacy review for August 2021 was provided to the survey team prior to the exit conference. | F 756 | | |
| F 760 SS=D | Residents are Free of Significant Med Errors<br>CFR(s): 483.45(f)(2)<br><br>The facility must ensure that its-<br>§483.45(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and clinical record review, the facility staff failed to ensure residents were free of significant medication errors for 1 of 21 residents in the survey sample, Resident #27.<br><br>The findings included:<br><br>For Resident #27, the facility staff failed to follow physician's orders for the administrator of Clonidine, a medication used to treat high blood pressure, on six (6) separate occasions.<br><br>Resident #27's diagnosis list indicated diagnoses, which included, but not limited to Chronic | F 760 | F760<br>Ensuring the residents are free from significant medication errors is a priority for the team at FMM<br><br>1. Resident #27 received no ill effects from the practice. Nurses responsible will be counseled.<br><br>2. All residents receiving a blood pressure medication prn have the potential to be affected by the same practice. Nursing will be re-educated to follow the specific order for administering prn blood pressure medication and document appropriately on the MAR.<br><br>Continued | |

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| F 760 | Continued From page 8<br>Combined Systolic and Diastolic Heart Failure, Chronic Kidney Disease Stage 4 Severe, Hypertensive Heart and Chronic Kidney Disease with Heart Failure, and Paroxysmal Atrial Fibrillation.<br><br>The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 9/22/21 assigned the resident a BIMS (brief interview for mental status) score of 14 out of 15 in section C, Cognitive Patterns.<br><br>Resident #27's current physician's orders included an active order dated 6/21/21 for Clonidine HCL 0.1 mg tablet by mouth as needed for systolic blood pressure greater than 160 twice daily.<br><br>A review of Resident #27's October 2021 MAR (medication administration record) revealed Clonidine was administered in error on 10/05/21 at 9:13 pm for a blood pressure of 160/70.<br><br>A review of Resident #27's October 2021 MAR and blood pressure summary revealed the following systolic blood pressure readings greater than 160 in which Clonidine was not administered: 10/02/21 8:13 am 183/75, 10/02/21 8:28 pm 161/72, 10/11/21 10:33 am 180/79, 10/24/21 9:09 pm 161/71, and 10/28/21 6:09 am 162/72.<br><br>On 11/04/21 at 10:06 am, surveyor spoke with the UM (unit manager) who verified the above surveyor findings for Resident #27.<br><br>Resident #27's current comprehensive person-centered care plan included a focus area stating "(Resident #27) is at risk for altered | F 760 | 3. Nursing will be re-educated to follow the specific physician orders for residents receiving prn blood pressure medication and document on the MAR.<br><br>4. The Nurse Manager or designee will audit records of residents who receive prn blood pressure medication two times weekly for twelve weeks and monthly for six months. The Nurse Manager will provide education to the team members as needed if a variance occurs. She will address and monitor for trends. Audit results will be reported to the QAPI team for further interventions.<br><br>5. Corrective action will be complete by 12/19/21.<br><br>6. Nurse Manager or designee | |

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| F 760 | Continued From page 9<br>cardiovascular status r/t (related to) CHF (congestive heart failure), atrial fibrillation, cardiomegaly, hx (history) of hypertension, MI (myocardial infarction), ASCVD (atherosclerotic cardiovascular disease)" with an intervention stating "check blood pressure every shift, administer meds as indicated".<br><br>On 11/04/21 at 2:31 pm surveyor met with the administrator, director of nursing, UM, social worker, and the infection preventionist and discussed the concern of Resident #27 not receiving Clonidine as ordered by the physician on six (6) separate occasions.<br><br>No further information regarding this issue was provided to the survey team prior to the exit conference on 11/04/21. | F 760 | | |

State of Virginia

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| F 000 | Initial Comments<br><br>An unannounced biennial State Licensure Inspection was conducted 11/3/21 through 11/4/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. One (1) complaint was investigated during the survey.<br><br>The census in this 109 certified bed facility was 55 at the time of the survey. The survey sample consisted of 17 current resident reviews and four (4) closed record reviews. | F 000 | | |
| F 001 | Non Compliance<br><br>The facility was out of compliance with the following state licensure requirements:<br><br>This RULE: is not met as evidenced by:<br>The facility was not in compliance with the following Virginia Rules and Regulations for Licensure of Nursing Facilities:<br><br>Nursing Services:<br>12 VAC 5-371-220 (B) - cross reference to F760<br><br>Pharmaceutical Services:<br>12 VAC 5-371-300 (I) - cross reference to F756 | F 001 | Following Virginia Rules and Regulations for Licensure of Nursing facilities is important to the team at FMM.<br><br>Nursing Services:<br>F760 cross reference to 12 VAC 5-371-220 (B)<br><br>Pharmaceutical Services:<br>F756 cross reference to 12 VAC 5-371-300 (I) | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Teri Martin — TITLE: Administrator — (X6) DATE: 11/22/21