STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495181	A. BUILDING _____ B. WING _____	02/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINCH VALLEY MEDICAL CENTER	2949 W FRONT ST RICHLANDS, VA 24641

(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 on 02/17/21. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 02/17/22. 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 24 certified bed facility was 11 at the time of the survey. The survey sample consisted of 8 current Resident reviews and 2 closed record reviews.	F 000		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs	F 758		3/19/21

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

Electronically Signed | 03/19/2021

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F 758	Continued From page 1 unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure 2 of 10 residents were free from unnecessary medications, Resident #8 and Resident #14. The findings included:	F 758	Resident #8 As noted in the surveyor's assessment, Resident #8 had a history of a traumatic brain injury. This was noted in the resident's History and Physical as well as stated by the Interim Nurse Manager and	

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F 758	Continued From page 2 1. For Resident #8 the facility staff failed to provide a diagnoses/indication for use for the psychotropic medication clonazepam (Klonopin). Resident #8's admission H and P (history and physical) listed diagnoses that included, but not limited to septic right lower extremity joint present on admission, hx of congestive heart failure, history of COPD (chronic obstructive pulmonary disease), hypertension, history of sleep apnea, and history of traumatic brain injury. Resident #8's admission MDS (minimum data set) assessment had not been completed, however resident is alert and oriented to person, place, time and situation. Resident #8's clinical record was reviewed on 02/17/21 and contained a physician's order summary, which read in part "Clonazepam Tab (Klonopin Tab) PO (by mouth) 0.5 mg HS (bedtime)" This order did not have a diagnosis or indication for use. Surveyor spoke with the interim nurse manager on 02/17/21 at approximately 4:00 pm regarding resident's clonazepam and the reason for receiving it. Interim nurse manager stated that it was a "home med" and that resident took it because he gets anxious at night and it helps him sleep. Pharmacy manager was present while surveyor was discussing the residents medication with the interim nurse manager, and stated that resident had a traumatic brain injury that caused his anxiety. Surveyor asked the pharmacy manager if the physician's order summary should list a diagnosis or indication for use for the medication and they stated, "yeah, it probably should".	F 758	Pharmacy Manager. Both managers stated to the surveyor the medication was necessary for his brain injury and was part of the resident's home medication regimen. Clinch Valley has an established SNF policy stating the Pharmacy reviews all patient medications within 30 days of admission to the unit. Once the resident is admitted, the medications are reviewed every 14 days for gradual dose reduction as well as behavioral interventions. Resident #8 had only been in the facility for 5 days prior to the audit. The medication administered to the resident was not ordered on a PRN basis, but as a standing order to be given daily. The resident was on day 5 of his skilled stay. Our policy stipulates every 14 days the medications are reviewed by the pharmacist for gradual dose reduction as well as behavioral interventions.	

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F 758	Continued From page 3 The concern of the medication, clonazepam, being used without a diagnosis/indication for use was discussed with the administrative team (administrator, chief nursing officer, interim nurse manager) during a meeting on 02/17/21 at approximately 7:15 pm. No further information was provided prior to exit. 2. The facility staff failed to ensure there was in indication for use/diagnosed condition for a Zoloft (Sertraline, an anti-depressant) order for Resident #14. Resident #14's clinical record was reviewed with the facility's interim nurse manager on 02/17/21. The admission history and physical (H&P) noted the resident's diagnoses included, but were not limited to, dehydration with acute kidney injury, weakness and conditioning with multiple falls, urinary tract infection positive for E-coli requiring IV (intravenous) antibiotics, thrombocytopenia (low platelet level), COPD (chronic obstructive pulmonary disease), Type 2 diabetes, rheumatoid arthritis, and mild cellulitis of left lower extremity. The minimum data set (MDS) had an assessment reference date (ARD) of 02/09/21. Section C (Cognitive Patterns) of the MDS documented Resident #14's BIMS (brief interview for mental status) score was 12 out of 15. The "Patient's Order List" included an active order dated 02/04/21 at 9:00 a.m. for Sertraline Tab (Zoloft) by mouth 25 mg every morning. The order list showed the medication was last administered on 02/17/21 at 9:32 a.m. The surveyor was unable to locate an indication for use or diagnosis for Zoloft. On 02/17/21 at approximately 6:30 p.m., the interim nurse	F 758	Resident #14 In reviewing the chart, there was no diagnosis at the time of the survey to support the administration of Zoloft for resident #14. The Pharmacy Director noted the irregularities during her 14-day review of the medication. The Director of Pharmacy sent the provider, who wrote the History and Physical an ordered the medication, a query as to the diagnosis for the medication and questioned the necessity. Due to the provider being on an alternating week schedule, the provider had not returned to duty to address the query. This query would have been completed well within the 30 day as required by the SNF standard. The Director of Pharmacy, Sarah Ramey, will educate the providers regarding these requirements and will continue to use the Skilled Nursing Unit Patient Medication Regimen Review every 14 days to assess the History and Physical and ensure we are in compliance with this standard. (See attachment)	

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F 758	Continued From page 4 manager was asked and she acknowledged there was no indication for use listed within the order for Zoloft and no diagnosis related to the order for Zoloft located within the medical record. She reported that since Zoloft was a home medication when the doctor wrote the order, the indication for use would not be addressed. The interim nurse manager attempted to call the facility's director of pharmacy but there was no answer. On 02/17/21 at 7:15 p.m., the facility's chief executive officer (CEO), chief operating officer (COO), chief nursing officer (CNO), and interim nurse manager were informed of the above described findings. No further information was provided prior to the exit conference on 02/17/21 at 7:45 p.m. with the facility's CEO, COO, CNO, and interim nurse manager.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		3/19/21

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F 761	Continued From page 5 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and during a medication pass and pour observation facility staff failed to store drugs in locked compartments for 1 of 1 nursing units. The findings included: The facility staff failed to secure the following medications: lactobacillus (restores intestinal flora and prevents post-antibiotic yeast infections), docusate sodium (stool softener), lantus (long acting insulin), omeprazole (proton pump inhibitor used to treat conditions caused by excess stomach acid), synthroid (thyroid medication), amlodipine besylate (calcium channel blocker that lowers blood pressure), and simvastatin (statin that reduces cholesterol). LPN (licensed practical nurse) #1 left the medications out on top of the medication cart and out of their view during a medication pass. On 2/17/21 at 4:11pm LPN #1 opened a single dose package of lactobacillus and placed the tablet in a medication cup on top of the medication cart. LPN #1 left the medication cart to retrieve required PPE (personal protective equipment) leaving the cart and the medication	F 761	The Director of Pharmacy, Sarah Ramey, and the Manager of the Skilled Nursing Unit will review with all Skilled Nursing Staff the process for medication passes and the importance of securing all drugs in locked compartments when not directly in attendance. To ensure this process is carried out, the Pharmacy Director and Unit Manager will perform five audits of mediation passes each week for two week. The Unit Manager will randomly audit staff once a week for six weeks and then on a PRN basis to ensure compliance.	

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F 761	Continued From page 6	F 761		

cup with the lactobacillus tablet on top of the cart and out of their view. LPN #1 returned to the medication cart with isolation gowns and stated "I only left it because you were here".

On 2/17/21 at 4:48pm LPN #1 retrieved a resident's individual medication drawer from a medication cart and placed it on top of another medication cart that they were using to pass medication. LPN #1 placed the medication cart with the individual open medication drawer on top at the doorway of Resident #12's room. LPN #1 turned their back to the medication cart with the open drawer of medications on top and out of view, went in the room and administered a subcutaneous injection in the resident's arm and dialed the resident's phone at their request prior to returning to the medication cart. Surveyor asked LPN #1 about leaving the drawer of medications on top of the medication cart, LPN #1 stated it was in the doorway and "don't ding me for that". The medications left unattended and out of view in the open drawer on top of the medication cart included individual dose packages of docusate sodium, omeprazole 40mg, synthroid 75mcg, amlodipine besylate 10mg, simvastatin 10mg, and a vial of lantus insulin.

On 2/17/21 at approximately 6:10pm, surveyor notified the interim nurse manager of the issue regarding the medications being left on top of the medication cart unattended and out of view by LPN #1 during the medication pass and pour observation.

Surveyor requested and received the facility policy entitled "Medication Security" which states in part:

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F 761	Continued From page 7 Purpose: All areas in the hospital are required to meet federal and state regulations regarding the safe and secure storage of medications. Policy: All areas of the hospital that store and utilize medications, as defined by the Centers for Medicare and Medicaid Services (CMS), will at a minimum maintain all ordered and floor stock medications in either a locked-secure container (such as an Acudose System) or under constant surveillance. On 2/17/21 at 7:13pm, surveyor notified the CNO (Chief Nursing Officer), CEO (Chief Executive Officer), and the COO (Chief Operational Officer) of the issue regarding medications being left unattended on top of the medication cart and out of view by LPN #1. No further information regarding this issue was presented to the survey team prior to the exit conference on 2/17/21.	F 761		
F 812 SS=D	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	F 812		3/19/21

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F 812	Continued From page 8 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review the facility staff failed to ensure food was properly stored for one of one unit. The findings were: 1. The facility staff failed to consistently document refrigerator and freezer temperatures and failed to document what action was taken when temperatures fell outside the acceptable range. In the afternoon of 02/17/21, the chief nursing officer (CNO) accompanied the surveyor to the clean utility room to observe the unit's only patient refrigerator. The refrigerator and freezer's temperature logs were reviewed for the months of January 2021 and February 2021. January 2021 Nourishment Temperature Log for the Refrigerator: For the 31 days in January 2021, there were eight (8) days refrigerator temperatures were not documented. On the Freezer Temperature Log, there were ten (10) days freezer temperatures were not documented. February 2021 Nourishment Temperature Log for the Refrigerator: For the 16 days prior to the survey, there were nine (9) days refrigerator temperatures were not documented. There was one (1) day the temperature fell below the acceptable range which was noted on the log as "33 degrees to less than 40 degrees." (February 9th: temperature = 28 degrees). There was no	F 812	Our policy and standards are consistent with documenting daily temperatures and interventions taken when the temperatures are out of range. To ensure this occurs the night shift staff, who have been noted as responsible staff, will be re-educated regarding the expectations for the documentation. Audits will be performed by the Unit Manager daily for two weeks, then weekly for six months, and then PRN to ensure compliance. These audits will be reviewed and forwarded to the CNO for review. The Director of Dietary, Debbie Gillespie, now monitors SNF refrigerator for expired items every two days, to ensure there are no expired items, for the next three months. After the three months, if there are no identified problems, it will be randomly monitored. When items are found to be out of date, actions will be taken with the staff who are responsible.	

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F 812	Continued From page 9	F 812		

documented action taken to correct the refrigerator temperatures. On the Freezer Temperature Log, there were nine (9) days freezer temperatures were not documented. The logs' instructions read to plot temperatures daily with initials, if the temperature was out of range notify dietary services and adjust the temperature control, re-check temperature in 30 minutes, plot 2nd temperature, and if temperature remains out of range send work order to Plant Operations for repair.

2. The facility staff failed to dispose of orange juice that had expired.

On 02/17/21 at 5:55 p.m., the interim unit manager accompanied the surveyor to the same patient refrigerator in the clean utility room. Items observed in the refrigerator: whole milk, 2% milk, Ensure, grape juice, apple juice, soft drinks, and applesauce. There were five (5) cartons of orange juice found with a sticker on it dated 02/15/21. The interim nursing manager spoke with someone in the dietary department on the phone and then reported to the surveyor the date on the sticker was the expiration date. The interim nurse manager acknowledged the orange juice was therefore expired and should be removed. She removed the expired orange juice from the refrigerator.

The interim nurse manager reported it was the night shift nurses' responsibility to document the refrigerator and freezer temperatures and dispose of expired food/drink items.

On 02/17/21 at 4:18 p.m., the CNO reported the unit had not been closed at any time during the

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F 812	Continued From page 10 calendar year 2021 and provided the facility's policy titled, "Temperature Logs: Refrigerators, Freezers, and Warmers." The policy read in part, "Patient Nourishment Refrigerators A. Daily logs will be maintained to monitor temperature of each refrigerator used for patient food and drinks. B. Temperatures are to be maintained between 33 to 40 degrees Fahrenheit. C. Any temperature out of recommended range will have the temperature readjusted. A recheck of the temperature will be obtained in 30 minutes. If the temperature is still out of range, Plant Operations will be notified of need for repair. Dietary will be notified to remove food items. D. Nourishment refrigerators will be cleaned weekly." And, "Nourishment Freezers A. Daily logs will be maintained to monitor the temperature of each freezer used for food or drinks. B. Temperatures are to be maintained at or below 0 degrees Fahrenheit. C. Any temperature out of recommended range will have the temperature readjusted. A recheck of the temperature will be obtained in 30 minutes. If the temperature is still out of range, Plant Operations will be notified of need for repair. Dietary will be notified. D. Nourishment freezers are to be cleaned weekly, defrosted as needed." On 02/17/21 at 7:15 p.m., the facility's chief executive officer (CEO), chief operating officer (COO), chief nursing officer (CNO), and interim nurse manager were informed of the above described findings.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		3/19/21

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F 880	Continued From page 11	F 880		

infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and

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F 880	Continued From page 12 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review, and during a medication pass and pour observation facility staff failed to maintain an infection prevention and control program to help prevent the development and transmission of communicable diseases and infections for 1 of 11 residents in the survey sample, Resident #13. The findings included: For Resident #13, the facility staff failed to sanitize a hand held scanning device following taking it into the resident's room, who is on	F 880	Remediation education will be provided to the clinician as well as any staff not meeting compliance with infection control guidelines. The unit manager will perform 25 medication pass audits per month capturing all staff to ensure compliance with infection control standards are maintained. This will be completed to ensure a compliance rate of 100% is maintained for three months. Additionally, the Unit Manager will perform 25 random audits each quarter to monitor compliance. When needed, the unit manager will implement personal action	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495181	A. BUILDING _____ B. WING _____	02/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINCH VALLEY MEDICAL CENTER	2949 W FRONT ST RICHLANDS, VA 24641

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F 880	Continued From page 13	F 880		

transmission based precautions, and laying it on the bed sheet covering the resident.

Resident #13's diagnosis list indicated diagnoses, which included, but not limited to UTI (urinary tract infection) POA (present on admission) Urine Cultures Growing ESBL (extended-spectrum beta-lactamases), Type 2 Diabetes Mellitus, Sigmoid Diverticulitis, and Generalized Weakness and Difficulty Ambulating.

Resident #13 did not have a completed admission MDS (minimum data set) at the time of the survey. The "H&P Hospitalist" note dated 2/12/21 states in part, "patient is conscious, oriented x 3".

On 2/17/21 at 4:53pm during a medication pass and pour observation, surveyor observed LPN (licensed practical nurse) #1 don a disposable gown and gloves and enter Resident #13's room carrying a hand held scanning device from the medication cart. LPN #1 scanned Resident #13's identification band and then placed the scanning device between Resident #13's upper thighs on the sheet covering the resident. After administering Resident #13's medications, LPN #1 picked up the scanning device on returned it directly to the medication cart without disinfecting and removed their disposable gown and gloves.

Surveyor observed a Contact Isolation sign and PPE (personal protective equipment) supplies on the outside of Resident #13's door.

Surveyor asked LPN #1 if the scanning devices are cleaned, LPN #1 stated "I guess if you sit it down in a room" and "probably in a perfect world". LPN #1 then disinfected the scanning device prior

plans when compliance issues occur.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 14 to entering the next resident's room to administer medications. On 2/17/21 at approximately 6:10pm surveyor notified the Interim Nurse Manager of the observation of LPN #1 laying the scanning device on Resident #13 and carrying the device out of the room and returning it to the medication cart without disinfecting the device. On 2/17/21 at 7:13pm surveyor notified the CNO (Chief Nursing Officer), CEO (Chief Executive Officer), and the COO (Chief Organizational Officer) of the observation regarding LPN #1 returning the hand held scanning device to the medication cart without disinfecting after laying it on Resident #13 who is on contact precautions for ESBL in the urine. No further information regarding this issue was presented to the survey team prior to the exit conference on 2/17/21.	F 880		