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MOUNTAIN VIEW NURSING HOME	1776 ELLY ROAD ARODA, VA 22709

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 1/25/22 through 1/27/22. The facility was in compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 1/25/22 through 1/27/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 40 certified bed facility was 37 at the time of the survey. The survey sample consisted of 18 current resident reviews and one closed record review.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident	F 657		3/11/22

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

Electronically Signed | 02/11/2022

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 657	Continued From page 1 and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to review and revise a comprehensive care plan for 2 of 19 residents in the survey sample; Residents #5 and #34. The findings include: 1. For Resident #5, the facility staff failed to review and revise the comprehensive care plan for the use of an opioid medication regarding the monitoring of related side effects and adverse reactions. Resident #5 was admitted to the facility on 5/18/20 and had the diagnoses of, but not limited to, insomnia, chronic kidney disease, rectal cancer, anxiety, depression, diabetes, high blood pressure, heart attack, atrial fibrillation, pacemaker, congestive heart failure, and hypothyroidism. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 1/9/22. The resident was coded as cognitively intact in ability to make daily life decisions. The resident was coded as requiring extensive assistance for bathing; supervision for dressing and transfers,	F 657	F657: Care Plan Revision: Monitoring of side effects and reactions of opioids Criterion 1. The care plans for residents #5 and #24 were revised on 1/27/2022 to reflect monitoring the side effects and adverse reactions of opioid medication. Criterion 2. Clinical Leadership will conduct an audit of other residents on opioids to ensure care plans include monitoring of related side effects and adverse reactions of opioids. Any variance noted will be corrected immediately. Criterion 3. The DON or designee will educate the nursing team to ensure monitoring of side effects and adverse reactions of opioid medications are included on the care plan. Criterion 4. DON or designee will conduct monthly audits on 10% of residents on opioid medication x 4 months to assure care plans include monitoring side effects and adverse reactions. Identified variances will be corrected. The results of	

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F 657	Continued From page 2 and was independent for all other areas of activities of daily living. A review of the physician's orders revealed an order dated 5/28/21 for, "Tramadol (1)....Tablet 50 MG (milligrams) Give 1 tablet by mouth two times a day for pain." A review of the comprehensive care plan revealed one dated 5/18/20 for, "(Resident #5) has chronic pain r/t (related to) aging and disease process." This care plan included an intervention dated 5/27/20 for, "Give medications as ordered. Monitor for effectiveness." However, the care plan did not include any intervention for monitoring of side effects and adverse reactions related to pain medication. On 1/27/22 at 8:53 AM in an interview with LPN #1 (Licensed Practical Nurse) the MDS nurse, she stated that the Pain care plan addresses administering medications as ordered but that she did not know it had to be as specific as to address side effects or adverse reactions of pain medication. A review of the facility policy, "Policy for Updating Careplans," revealed the policy only addressed updating the care plan for the specific areas of "skin impairment," "antibiotic" and "fall." It was not written as a guide for the comprehensive care plan as a whole, for any required updates and revisions relating to any resident specific changes and needs. On 1/27/22 at 9:38 AM, ASM #1 (Administrative Staff Member), the Administrator, stated that he did not have a policy for anything more general for updating care plans that applied to any/all	F 657	the audits will be tracked and trended and reported to QAPI. Criterion 5. Friday, March 11, 2022	

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resident needs outside of skin impairment, antibiotic, and falls. When asked what professional standards the facility uses, he stated that he believed it was Lippincott.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77: "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..."

No further information was provided by the end of the survey.

References:

(1) Tramadol is used to treat moderate to moderately severe pain and is in a class of medications called opiate (narcotic) analgesics. Information obtained from https://medlineplus.gov/druginfo/meds/a695011.html

2. For Resident #34, the facility staff failed to review and revise the comprehensive care plan for the use of an opioid medication regarding the monitoring of related side effects and adverse reactions.

Resident #34 was admitted to the facility on 4/26/21 with the diagnoses of, but not limited to,

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insomnia, high blood pressure, asthma, benign prostatic hyperplasia, and progressive supranuclear opthalmoplegia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 11/2/21. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for bathing, extensive care for all other areas of activities of daily living except for eating, which was coded as requiring supervision only.

A review of the physician's orders revealed one dated 6/18/21 for, "Tramadol (1)....Tablet 50 MG (milligrams) Give 1 tablet by mouth every day and evening shift for pain."

A review of the comprehensive care plan revealed one dated 5/28/21 revealed, "(Resident #34) has pain r/t (related to) the diagnosis of neuropathy." This care plan included an intervention dated 5/28/21 for, "Give medications as ordered. Monitor for effectiveness." However, the care plan did not include any intervention for monitoring of side effects and adverse reactions related to pain medication.

On 1/27/22 at 8:53 AM in an interview with LPN #1 (Licensed Practical Nurse) the MDS nurse, she stated that the Pain care plan addresses administering medications as ordered but that she did not know it had to be as specific as to address side effects or adverse reactions of pain medication.

A review of the facility policy, "Policy for Updating Careplans," revealed the policy only addressed updating the care plan for the specific areas of

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"skin impairment," "antibiotic" and "fall." It was not written as a guide for the comprehensive care plan as a whole, for any required updates and revisions relating to any resident specific changes and needs.

On 1/27/22 at 9:38 AM, ASM #1 (Administrative Staff Member) the Administrator, stated that he did not have a policy for anything more general for updating care plans that applied to any/all resident needs outside of skin impairment, antibiotic, and falls. When asked what professional standards the facility uses, he stated that he believed it was Lippincott.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77: "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..."

No further information was provided by the end of the survey.

References:

(1) Tramadol is used to treat moderate to moderately severe pain and is in a class of medications called opiate (narcotic) analgesics. Information obtained from https://medlineplus.gov/druginfo/meds/a695011.html

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F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review it was determined that the facility staff failed to follow physician's orders for 1 of 19 residents in the survey sample, Resident #20. The facility staff failed to obtain a monthly weight in September 2021 for Resident #20. The findings include: Resident #20 was admitted to the facility on 5/2/18 and had the diagnoses of, but not limited to, hypothyroidism, epilepsy, depression, diabetes, high blood pressure, atrial fibrillation, and Alzheimer's disease. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 11/10/21. The resident was coded as being severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for all areas of activities of daily living. A review of the clinical record revealed a physician's order dated 3/1/20 for "Obtain weight monthly and as needed."	F 684	F684: Quality of Care: Follow Physician Orders Criterion 1. Unable to get weight from Sept 2021. Criterion 2. Clinical Leadership will conduct an audit of monthly weight to ensure compliance with obtaining weights per facility protocol. Any variances identified will be corrected Criterion 3. DON or designee will educate the Nursing Team on the importance of following physician orders r/t monthly weights. Criterion 4. DON or designee will conduct monthly audits on 10% of residents x 4 months to assure compliance. Identified variances will be corrected; audits will be tracked and trended and reported to QAPI. Criterion 5. Friday, March 11, 2022	3/11/22

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A review of the weights documented in the clinical record revealed that there was no weight recorded for September 2021. The August 2021 weight was recorded on 8/3/21 at 146.2 pounds and on 10/3/21 at 143.6 pounds. This reflected a weight loss of 2.6 pounds over the period of time that a weight was missed.

A review of the comprehensive care plan revealed one dated 5/2/18 and revised on 1/20/20 for "(Resident #20) has potential for having a nutritional problem r/t (related to) disease process diagnosis (sic) of Dementia, Diabetes, and Alzheimer's Disease." Interventions included one dated 5/2/18 for "Weigh monthly and PRN (as needed)."

On 1/27/22 at 10:08 AM, in an interview with ASM #2 (Administrative Staff Member) the Director of Nursing, he stated that the facility "realized in October (2021) that the September (2021) weight was missed and that there was nothing that could be done about it by then. It was missed." A copy of the facility policy on following physician's orders was requested.

On 1/27/22 at 10:18 AM, ASM #2 provided the "Weight Policy and Procedure" stating that the facility does not have a policy on "following physicians orders." He stated that "it is the expectation that orders are followed."

A review of the above weight policy revealed, "B. Every client should be weighed at least once a month and recorded on the Monthly Weight/Vital Signs Record sheet....C. All monthly weights should be obtained by the 10th of each month, if at all possible."

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F 684	Continued From page 8 On 1/27/22 at 10:08 AM, ASM #2 was made aware of the findings. No further information was provided prior to exit.	F 684		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 732		3/11/22

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F 732	Continued From page 9 §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that the facility failed to post nursing staffing hours as required. The facility's staff posting for the past 30 days did not contain the required hour amounts of nursing staff. The findings include: On 1/25/21 at 1:08 p.m., the facility's staff posting was observed on the table near the nurse desk. The posting contained the facility census, vertical columns for the dates for all seven days in the week, the listing for registered and licensed practical nurses, and for nursing assistants. The posting contained horizontal rows containing the actual number of each of these staff members working on each shift. The posting did not contain the number of hours worked on each shift by each type of nursing staff member. On 1/25/21 at 4:55 p.m., ASM (administrative staff member) #1, the administrator, was asked to review the staff posting for all elements required by the regulation. On 1/26/21 at 11:26 a.m., ASM #1 stated he had identified several elements that the current staffing posting did not contain: accurate resident census, LPNs (licensed practical nurses) and RNs (registered nurses) were not distinguished	F 732	F732: Posted Nursing Staffing Info: Nursing staffing information posting Criterion 1. Nursing Staffing Posting was revised on 1/27/2022 Criterion 2. All residents potentially affected Criterion 3. Administrator or designee will educate the Office Staff on the requirements of posting nurse staffing hours and the elements required within the posting. Criterion 4. Administrator or designee will conduct biweekly audits x 3 months to assure compliance with posting of nurse staffing. Variances will be corrected; audits will be tracked and trended and reported to QAPI. Criterion 5. Friday, March 11, 2022	

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F 732	Continued From page 10 from each other, and the posting did not contain the actual number of hours worked by each type of staff member. He stated the secretary has been taking care of filling out this form. On 1/26/21 at 11:29 a.m., OSM (other staff member) #5, the secretary, was interviewed. She stated she looks over the schedule for each week, and has been filling out the staffing according to the number of RNs, LPNs, and CNAs. She stated she was not aware until the afternoon before that she was supposed to include the number of actual hours worked by each type of staff member on the staff posting. On 1/26/21 at 11:40 a.m., ASM #1 stated the facility did not have a policy regarding the nursing staffing posting. No further information was provided prior to exit.	F 732		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		3/11/22

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F 812	Continued From page 11 §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 and staff interview, it was determined the facility staff failed to store food in a safe and sanitary manner. The facility staff failed to dispose of expired food during an observation on 1/25/22 at 11:09 AM. The findings include: On 1/25/22 at 11:09 AM, an observation was conducted in the main kitchen. In the dry storage room, a 4.64 pound bag of dried milk was labeled "opened 12/9/21, use by 1/9/22." A 49.6 ounce cornbread stuffing mix bag was labeled "opened 10/15/21, use by 11/25/21." OSM (other staff member) #1, a dietary aide, was shown the two bags. When asked what the dates signified, OSM #1 stated, "That means that they should be disposed of by those 'use by' dates. I will dispose of them now." OSM #3, the dietary manager, was informed of the expired items on 1/25/22 at 11:45 AM. A policy on food storage/expired food was requested on 1/26/22 at 3:20 PM. On 1/26/22 at 4:30 PM ASM (administrative staff member) #1, the administrator, was made aware of the above finding and stated, "We do not have any policy regarding food storage or expired food."	F 812	F812: Food Procurement/Storage: Store food in a safe manner Criterion 1. The dried milk powder and cornbread stuffing mix were discarded on 1/25/2022 Criterion 2. All residents potentially affected Criterion 3. Administrator, Dietician or designee will educate the Dietary Staff on the facility practice of ensuring food items are stored in a safe and sanitary manner and ensuring items are discarded prior to the expiration dates on food items. Criterion 4. The Dietary Manager or designee will conduct weekly audits x 2 months to assure that food items in dry storage are stored in a safe and sanitary manner and within expiration dates. Variances will be corrected immediately; audits will be tracked and trended and reported to QAPI. Criterion 5. Friday, March 11, 2022	

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F 812	Continued From page 12 No further information was provided prior to exit.	F 812		
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility QAPI (quality assurance and performance improvement) committee failed to meet in two of four quarters in 2021. The facility QAPI committee failed to meet in the third and fourth quarters of 2021. The findings include: A review of QAPI committee meeting sign in sheets revealed meetings for the first and second quarters of 2021. The review failed to include sign in sheets for the third and fourth quarters of 2021.	F 868	F868: QAA Committee: Quarterly QAA meetings Criterion 1. The Q4 QAPI meeting was held as scheduled on 1/31/2022 Criterion 2. All residents potentially affected Criterion 3. Compliance and Regulatory Consultant will educate the Executive Team on ensuring scheduled routine QAPI meetings, quarterly at minimum. Criterion 4. Board of Trustees Chair will	3/11/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E050	A. BUILDING _____ B. WING _____	01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW NURSING HOME	1776 ELLY ROAD ARODA, VA 22709

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 868	Continued From page 13 On 1/27/22 at 9:38 a.m., ASM (administrative staff member) #1, the administrator, was interviewed. He stated the QAPI committee includes him, the directors of personnel and discipleship, the director of nursing, the assistant director of nursing, the MDS (minimum data set) coordinator, the CNA (certified nursing assistant) supervisor, activities director, social services director, housekeeping supervisor, maintenance supervisor, dietary manager, occupational health nurse, consultant pharmacist, and medical director. He stated ordinarily the QAPI committee meets four times a year, at least once a quarter. When asked why there was no evidence that the committee met in quarters three and four of 2021, he stated he just did not get it scheduled. He stated the meeting for combined third and fourth quarters of 2021 is scheduled for the upcoming week. He stated it was difficult to coordinate remote schedules with the consultant pharmacist and medical director. A review of the facility policy, "Quality Assurance and Performance Improvement," revealed, in part: "The QA (quality assurance) committee shall...meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects under the QAPI program, are necessary." No further information was provided prior to exit.	F 868	conduct quarterly audits x 2 quarters to assure compliance. Variances will be corrected and reported to QAPI Criterion 5. Friday, March 11, 2022	