STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495426	A. BUILDING _____ B. WING _____	11/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULBERRY CREEK NURSING AND REHAB CENTER	300 BLUE RIDGE 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness COVID-19 Focused Survey was conducted onsite on 11/10/2020 and offsite 11/12-11/13/2020. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS A unannounced COVID-19 Focused Infection Control Survey was conducted onsite on 11/10/2020 and offsite 11/12-11/13/2020. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Corrections are not required for compliance with F-880 of 42 CFR Part 483 Federal Long Term Care requirement(s). The census in this 300 certified bed facility was 158 at the time of the onsite survey. During the onsite portion of the survey 4 residents and 6 staff were positive for COVID-19. Prior to the exit conference on 11/13/2020 2 additional residents had tested positive for COVID-19 and one had recovered for a total of 5 positive COVID-19 residents. No further staff had tested positive. The survey sample consisted of 3 residents, Residents #1, #2, and #3.	F 000		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in	F 842		12/15/20

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

Electronically Signed | 11/30/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495426	A. BUILDING _____ B. WING _____	11/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULBERRY CREEK NURSING AND REHAB CENTER	300 BLUE RIDGE 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 1	F 842		

accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495426	A. BUILDING _____ B. WING _____	11/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULBERRY CREEK NURSING AND REHAB CENTER	300 BLUE RIDGE 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 2 §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to maintain accurate clinical records for 3 of 3 residents, Residents #1, #2, and #3. The findings included: The facility staff failed to ensure Resident #1's EHR (electronic health record) only included information regarding this Resident. The Residents EHR included the results of a COVID-19 test of an employee from another facility and failed to accurately document and identify the type of isolation required for Residents #1, #2, and #3. These 3 residents had tested positive for COVID-19.	F 842	The results of the positive COVID was removed from Resident's #1 EHR. Resident #1, #2 and #3 who are currently COVID positive have the correct isolation (droplet) documented in the EHR. An audit was completed for the past 30 days to ensure COVID positive results have been uploaded to the correct EHR. Current positive COVID residents have the potential to be affected by inaccurate documentation of the droplet isolation. Medical Record staff will be educated by the Director of Nursing/designee on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495426	A. BUILDING _____ B. WING _____	11/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULBERRY CREEK NURSING AND REHAB CENTER	300 BLUE RIDGE 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 3 Facility Policy titled, Isolation Categories of Transmission Based Precautions. Under droplet, this policy read in part, "...Residents who are COVID-19 positive will be placed in droplet isolation..." 1. For Resident #1, the facility staff scanned the results of a COVID-19 test for an employee from another facility into this residents clinical record and failed to consistently document what type of isolation this resident was on. This resident had tested positive for COVID-19. Resident #1's EHR included the diagnosis COVID-19. Section C (cognitive patterns) of the residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/13/2020 included a BIMS (brief interview for mental status) summary score of 14 out of a possible 15 points. The surveyor reviewed the residents EHR on 11/12 and 11/13/2020. This residents EHR included the results of a COVID-19 lab obtained on 09/04/2020 of an employee that worked at another facility. Resident #1's EHR included a document titled, "Isolation Shift Documentation." Question #2 on this form read, "What is the active infectious pathogen?" To which the facility nursing staff had answered COVID-19. Question #3 read "Isolation type What level of isolation does this patient require?" LPN (licensed practical nurse) #3 had consistently documented contact and droplet. LPN #4 had documented contact isolation 18 times and LPN #5 had documented contact	F 842	ensuring the correct medical information is uploaded to the correct EHR. In addition, licensed nurses will be educated by the Director of Nursing/designee on the new isolation template in the EHR for COVID positive isolation to indicate the droplet isolation. Medical Records staff will monitor five charts per nursing unit per week to ensure COVID positive results have been uploaded to the correct EHR. Director of Nursing/designee will monitor COVID positive isolation documentation 5 times weekly to ensure the proper isolation (droplet) is documented in the EHR. The results of the monitoring will be discussed and reviewed at the monthly QAPI committee meeting. Once the committee determines the problem no longer exists, monitoring will occur on a random basis. The Chief Executive Officer/Director of Nursing is responsible for implementation of this plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495426	A. BUILDING _____ B. WING _____	11/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULBERRY CREEK NURSING AND REHAB CENTER	300 BLUE RIDGE 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 4	F 842		

isolation 9 times.

A review of the residents progress notes revealed that the nursing staff failed to consistently document that this resident was on droplet isolation. Part of the nursing staff had documented this resident was on contact isolation and others had documented this same resident was on contact and droplet isolation.

On 11/12/2020 at 3:20 p.m., the administrator and DON (director of nursing) were notified of the issue regarding the lab results the DON stated someone from corporate had been scanning the lab results into the EHRs and they would have that deleted out of the record.

2. For Resident #2, the facility staff failed to consistently document what type of isolation this resident was on. This resident had tested positive for COVID-19.

Resident #2's EHR included the diagnosis COVID-19.

Section C of the residents quarterly MDS assessment with an ARD of 10/07/2020 included a BIMS summary score of 15 out of a possible 15 points.

Resident #2's EHR included a document titled, "Isolation Shift Documentation." Question #2 on this form read, "What is the active infectious pathogen?" To which the facility nursing staff had answered COVID-19. Question #3 read "Isolation type What level of isolation does this patient require?" A random review of these documents revealed that LPN #3 had consistently documented contact and droplet. LPN's #4 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495426	A. BUILDING _____ B. WING _____	11/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULBERRY CREEK NURSING AND REHAB CENTER	300 BLUE RIDGE 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 5	F 842		

#5 had varied between contact only and contact and droplet. LPN #2 had documented contact only.

A review of the residents progress notes revealed that the nursing staff had documented on some shifts that the resident was on contact isolation and other shifts had documented this same resident was on contact and droplet isolation.

3. For Resident #3, the facility staff failed to consistently document what type of isolation this resident was on. This resident tested positive for COVID-19 during the survey.

Resident #3's EHR included the diagnosis COVID-19. This facility had received this residents positive test results on 11/12/2020.

Section C of the residents quarterly MDS assessment with an ARD of 08/20/2020 included a BIMS summary score of 12 out of a possible 15 points.

Resident #3's EHR included three documents titled, "Isolation Shift Documentation." Question #2 on this form read, "What is the active infectious pathogen?" To which the facility nursing staff had answered COVID-19. Question #3 read "Isolation type What level of isolation does this patient require?" A review of these three documents revealed that on 11/12 LPN #3 documented that this resident was on contact and droplet isolation and LPN #4 documented that this resident was on contact isolation. On 11/13, LPN #5 documented that this resident was on contact and droplet precautions.

This documentation matched what the same

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495426	A. BUILDING _____ B. WING _____	11/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULBERRY CREEK NURSING AND REHAB CENTER	300 BLUE RIDGE 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 6	F 842		

nurses had documented in the progress notes.

On 11/13/2020 at 8:15 a.m., during an interview with LPN #3, this nurse verbalized that any resident in the COVID-19 unit was on both droplet and contact isolation/precautions and that full PPE was worn. When asked if what was on the "Isolation Shift Documentation" was typed LPN #3 verbalized to the surveyor that this was a drop down menu. When asked about some of the nursing staff just documenting contact LPN #3 stated she had not noticed that and that they marked both.

On 11/12/2020 at 3:20 p.m., the administrator and DON were notified of the conflicting information in the residents EHR's regarding isolation. The DON verbalized to the surveyor that the residents on the COVID-19 unit were on droplet precautions.

On 11/12/2020 at 4:42 p.m., during a phone conference with the administrator and DON, the DON verbalized to the surveyor that they had spoken with the staff and the staff stated they felt like they were answering the question regarding the residents current isolation status by answering question #1 on the form. This question read, "Does the resident have an active infection with a highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission?" To which the staff had marked yes.

No further information regarding this issue was provided to the surveyor prior to the exit conference on 11/13/2020.