STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING ______ B. WING ______	C 06/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 6/12/2022 through 6/15/2022. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid survey was conducted 6/12/22 through 6/15/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey: 1. VA00054137 - substantiated with deficient practice The Life Safety Code survey/report will follow. The census in this 140 certified bed facility was 99 at the time of the survey. The survey sample consisted of 23 current Resident reviews and 3 closed record reviews.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and clinical record review, the facility staff failed to accurately complete an admission minimum data set (MDS) assessment for 1 of 23 Residents, Resident #91. The facility staff failed to code the MDS to indicate Resident #91 was receiving	F 641	Disclaimer: This plan of correction is being submitted in compliance with specific regulatory requirement and preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of	7/12/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/06/2022

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 641	Continued From page 1 dialysis. The findings included: Section C (cognitive patterns) of Resident #91's admission MDS assessment with an assessment reference date (ARD) of 05/31/22 included a brief interview for mental status (BIMS) summary score of 14 out of a possible 15 points. Section O (special treatments/procedures/programs) had been coded to indicate the resident was not receiving dialysis. Resident #91's clinical record included the diagnoses end stage renal disease, dependence on renal dialysis, and acquired absence of kidney. Resident #91's physician orders included dialysis three times a week. The order date was documented as 05/30/22. Resident #91's comprehensive care plan included the focus area alteration in kidney function due to end stage renal disease evidenced by hemodialysis. During initial tour of the facility on 06/12/22, Resident #91 stated to the surveyor they received dialysis three times a week. 06/13/22 9:00 a.m., the MDS coordinator reviewed Resident #91's admission MDS assessment and stated it was not marked for dialysis. 06/13/22 3:52 p.m., the Regional Clinical Director, Regional Vice President, and Director of Nursing (DON) were made aware of the incomplete MDS assessment in regards to dialysis.	F 641	the facts alleged or conclusions set forth on the statement of deficiencies F641 Accuracy of Assessments 1. Facility failed to accurately complete an admission MDS for resident #91 to indicate they were receiving dialysis. This was corrected during the on-site visit. 2. An audit was conducted on residents receiving dialysis services admitted within the last thirty days to ensure accurate MDS coding. 3. MDS Coordinators were reeducated on proper coding for admission MDS. 4. Audits on admissions will be conducted weekly for 4 weeks and then monthly for 3 months to ensure they are properly coded for dialysis. Results will be reviewed at the QAPI meeting for 3 months to monitor compliance. 5. Compliance date 7/12/22.	

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F 641	Continued From page 2 06/14/22 8:00 a.m., the facility staff provided the surveyor with a copy of a modification of admission MDS. This MDS had been updated to include Resident #91's dialysis status. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 641		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up	F 661		7/12/22

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F 661	Continued From page 3 care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure a discharge summary was completed for 1 of 3 closed resident record reviews, Resident #97. The facility staff failed to complete a discharge summary when Resident #97 was discharged home. The findings included: This was a closed record review. Resident #97's diagnosis list indicated diagnoses, which included, but not limited to Respiratory Failure, Chronic Obstructive Pulmonary Disease, Heart Failure, Chronic Kidney Disease Stage 3, and Cerebrovascular Disease. The admission minimum data set (MDS) with an assessment reference date (ARD) of 3/17/22 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating Resident #97 was cognitively intact. The resident was coded as requiring extensive assistance with bed mobility, transfers, dressing, toileting, personal hygiene and being independent in eating. A discharge return not anticipated MDS with an ARD of 4/06/22 coded the resident as being discharged to the community on 4/06/22. A progress note dated 4/06/22 at 4:47 pm stated in part "resident discharged home at 2:40 pm	F 661	Disclaimer: This plan of correction is being submitted in compliance with specific regulatory requirement and preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the facts alleged or conclusions set forth on the statement of deficiencies F661 Discharge Summary 1. Facility failed to provide discharge summary for Resident #97. Facility called Resident # 97 to ensure post discharge needs had been met. 2. Previously discharged residents have the potential to be affected by this. 3. Facility Social Worker or designee will review potential discharging residents□ records weekly to ensure completion of discharge summary prior to discharge from facility. 4. Audits on potential discharges will be conducted weekly for 4 weeks and then monthly for 3 months to ensure discharge summaries are completed. Results will be reviewed at QAPI meeting for 3 months to monitor compliance. 5. Compliance date 7/12/22.	

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F 661	Continued From page 4 transported via private care accompanied by brother in law. Resident left with discharge instructions and medication list in hand ..." Surveyor reviewed Resident #97's clinical record and was unable to locate a discharge summary. On 6/15/22 at 8:22 am, surveyor spoke with the DON who stated they did not have a discharge summary for Resident #97. Surveyor asked the DON who monitors for the completion of discharge summaries and they stated "I would say medical records". Surveyor requested and received the facility policy entitled, "Interdisciplinary Discharge Summary" which read in part: Policy: All residents discharged from the facility will have an Interdisciplinary Discharge Summary completed as part of the Medical Record. 5. Medical Records personnel or designee will ensure a complete recapitulation of the resident's stay (Interdisciplinary Discharge Summary) is placed in the resident's medical record. No further information regarding this concern was presented to the survey team prior to the exit conference on 6/15/22.	F 661		
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	F 684		7/12/22

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F 684	Continued From page 5 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, clinical record reviews, and facility document reviews, facility staff failed to ensure ordered medications were administered for 2 of 23 sampled current residents (#47, #70). 1- For Resident #47, the antidepressant medication Wellbutrin was unavailable and the ordered dose of Adderall was not available. Resident #47 was admitted to the facility with diagnoses that included sequelae of cerebral infarction, encounter for surgical aftercare following surgery on the digestive system, dementia, major depressive disorder, fibromyalgia, rheumatoid arthritis, attention deficit hyperactivity disorder, dysphagia, hemiplegia and hemiparesis following cerebral infarction on right dominant side, and iron deficiency anemia. On the minimum data set assessment with assessment reference date 5/2/2022, the resident scored 10/15 on the brief interview for mental status (indicating some cognitive impairment) and was assessed as without signs of delirium, psychosis, or behaviors affecting care. On 6/13/2022 at 10:21 AM during medication pass and pour observation, Licensed Practical nurse (LPN) #7 administered medications to Resident #47. LPN #7 stated that Wellbutrin 300 milligrams was unavailable. The nurse checked that the medication had been ordered and charted the medication as not administered. LPN #7 administered Adderall 15 mg. Adderall 15 mg was in the narcotic book and the nurse signed out the dose and noted that the count on the drug	F 684	Disclaimer: This plan of correction is being submitted in compliance with specific regulatory requirement and preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the facts alleged or conclusions set forth on the statement of deficiencies. F684 Quality of Care 1. Physician and Responsible Party were made aware of missed administrations of Wellbutrin and Adderall on for Resident #47 and Vitamin D for Resident #70 on June 14, 2022. No further orders given, no negative outcomes noted and medication is available for administration. 2. An audit of residents receiving Wellbutrin, Adderall, and Vitamin D was conducted to ensure availability of ordered medications. 3. DON or designee reeducated licensed nurses surrounding proper procedures for medication administration. 4. Audits of residents receiving Adderall, Wellbutrin, and Vitamin D will be conducted weekly for 4 weeks then monthly for 3 months to ensure ordered medications were administered. Results will be reviewed at QAPI meeting to monitor compliance.	

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F 684	Continued From page 6 card matched the signout sheet. The Order Summary Report with active orders as of 6/14/2022 included orders for Wellbutrin and Adderall: 6/9/2022 Wellbutrin XL tablet extended release 24 Hour 300 milligram (MG) Give 300 mg by mouth one time a day related to major depressive disorder, recurrent, moderate 6/10/2022 Adderall 10 MG Give 10 mg by mouth in the morning for ADHD The resident's June 2022 Medication Administration Record Documented that Wellbutrin XL Extended Release 300 milligrams by mouth one time a day Was Marked 7=Other/See Nurse Notes on June 4, 5, 9, 11, 12, and 13. The June 4, 5, and 11 notes stated "not received from pharmacy. The June 9 and 11 notes stated "ordered not received from pharmacy". The June 12 note stated "medication not available ordered from pharmacy". The resident's June 2022 Medication Administration Record Documented that Adderall 15 MG was administered June 1 through June 10, then Adderall 10 MG was administered June 11-13. The surveyor reported the concerns during an end of day meeting on June 13, 2022. The surveyor and director of nursing checked the resident's medications together on 6/13/22 at approximately 4:30 PM. They found a full card of Wellbutrin 300 MG with fill date 6/13/22 and a card containing Adderall 15 mg with 27 doses remaining. The final dose was signed out on 6/13/2022. The surveyor and director of nursing	F 684		

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F 684 Continued From page 7 F 684

did not find a supply of Adderall 10 MG.

The surveyor asked the director of nursing if there was a pharmacy record of delivery of Wellbutrin that could have been administered on June 6, 7, 8, and 10. On June 14, the director of nursing reported that the pharmacy had not delivered Wellbutrin between June 4 and June 13.

2- For Resident #70, facility staff failed to administer the ordered dose of Vitamin D.

Resident #70 was admitted to the facility with diagnoses that included diabetes mellitus, hypertension, schizoaffective disorder, psychosis, bipolar disorder, anxiety, and depression. On the minimum data set assessment with assessment reference date 5/20/2022, the resident scored 11/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care.

On 6/14/2022 at 10:54 AM, during medication pass and pour observation, the surveyor observed LPN #10 administer medications to Resident #70. The resident received vitamin D 10 mg.

The Order Summary Report with active orders as of 6/15/2022 included an order for Vitamin D3 capsule 125 mcg (5000 UT) (cholecalciferol) Give 1 capsule by mouth 1 time per day.

The resident's June 2022 Medication Administration Record Documented administration of Vitamin D 3 capsule 125 mcg (5000 UT) daily June 1 through 13.

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F 684	Continued From page 8 The surveyor reported the concern during an end of day meeting on June 13, 2022. On June 14, the director of nursing offered documentation that the correct dose of Vitamin D had been obtained and placed in the medication cart and the resident and physician had been notified that the wrong dose was administered.	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	F 732		7/12/22

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F 732	Continued From page 9	F 732		

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.

§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 observations, staff interviews, and facility document review, the facility staff failed to ensure the completion and posting of the facility's daily 'nurse staffing information.'

The findings include:

On the afternoon of 6/12/22, the facility staff's posting of 'nurse staffing information, was observed to be posted in the front lobby of the facility. The posted 'nurse staffing information' was dated 6/9/22.

The failure of the facility staff to post the facility's 'nurse staffing information' since 6/9/22 was discussed with the facility's Regional Vice-President on 6/12/22 at 3:24 p.m. On the afternoon of 6/12/22, the Regional Vice-President reviewed the posted 'nurse staffing information', it was noted the only posted 'nurse staffing information' was dated 6/9/12. The device holding the posted 'nursing staff information' form did not include 'nurse staff information' for any other dates.

On 6/15/22 at 11:40 a.m., the facility's Administrator was interviewed about

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F732 Posted Nurse Staffing Information

1. Facility corrected the nurse staffing information and posted during on-site inspection. Additionally, the facility completed staffing information for 6/10/22 and 6/11/22 for facility internal records.

2. Daily nurse staffing information has the ability to be affected by this.

3. Staffing Coordinator/Manager on Duty were reeducated surrounding posting staffing information daily.

4. Nurse staffing information audit will be conducted weekly for 4 weeks and then monthly for 3 months to ensure they are

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F 732	Continued From page 10 aforementioned 6/12/22 observation of the facility's 'nurse staffing information' not being posted since 6/9/22. The Administrator acknowledged being aware of the aforementioned survey team observation of the facility's posted 'nurse staffing information.'	F 732	posted for viewing daily. Results will be reviewed at the QAPI to monitor compliance. 5. Compliance Date 7/12/2022	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in	F 755		7/12/22

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F 755	Continued From page 11 order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, facility document review, and in the course of a complaint investigation, the facility staff failed to ensure medications were available for administration for 2 of 26 sampled residents, Resident #96 and Resident 47. Resident #96's eye drops, Amiodarone, and Spironolactone were not available for administration. Resident #47's Wellbutrin was not available for administration. The findings included: 1. This was a closed record review. Section C (cognitive patterns) of Resident #96's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 01/11/22 included a brief interview for mental status (BIMS) summary score of 15 out of a possible 15 points. Indicating Resident #96 was alert and orientated. Resident #96's clinical record included the diagnoses, congestive heart failure, diabetes, urinary retention, chronic kidney disease, and dementia. Resident #96's clinical record included the following orders. Ketorolac Tromethamine solution 1 drop in left eye two times a day order date 01/07/22. The start date was documented as 01/08/22 at 9:00	F 755	Disclaimer: This plan of correction is being submitted in compliance with specific regulatory requirement and preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the facts alleged or conclusions set forth on the statement of deficiencies. F755 Pharmacy 1. Facility failed to administer Resident #47s Wellbutrin and Resident #96s eye drops, Amiodarone, and Spironolactone due to medication not available. Facility alerted Resident #96 and Resident #47s Attending Physician and Responsible Party of missed administrations. No further orders given, no negative outcomes noted. 2. An audit was conducted on residents receiving Wellbutrin, eye drops, Amiodarone, and Spironolactone to ensure medications were available and administered per physician orders. 3. DON or designee reeducated licensed nurses surrounding proper procedures for medication administration. 4. Medication administration audits for eye drops, Amiodarone, and Spironolactone will be conducted weekly for 4 weeks and then monthly for 3 months to ensure all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING ______ B. WING ______	C 06/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 12 a.m. Prednisolone acetate suspension 1 drop in left eye two times a day. The order date was documented as 01/07/22. The start date was documented as 01/08/22 at 9:00 a.m. Brimonidine Tartrate 1 drop in right eye two times a day. Order date 01/07/22. Start date 01/08/22 9:00 a.m. A review of Resident #96's medication administration records (MARs) revealed that the facility nursing staff documented a 7 for all three of these eye drops on 01/08/22 at 9:00 a.m. Per the preprinted code on the MARs a 7=Other/See Nurses Notes. 01/08/22, Licensed Practical Nurse (LPN) #7 documented "med ordered not received from pharmacy" for all 3 of these eye drops. 01/08/22, LPN #7 had also documented that the medication Amiodarone 200 mg was not given as it was "...ordered not received from pharmacy." The order date for this medication was documented as 01/07/22. The start date was documented as 01/08/22 at 9:00 a.m. 01/11/22, Registered Nurse (RN) #1 documented the medication Spironolactone was not given as it was "...held until arrives from pharmacy, MD notified with NNO (no new orders) given." The order date was documented as 01/11/22 and the start date was documented as 01/11/22 at 9:00 a.m. 06/13/22 2:12 p.m., LPN #7 stated if a resident was admitted and did not have their medications, they would check their back up supply and if the medication was not available for administration in	F 755	medications are given as ordered. Results will be reviewed at the QAPI meeting to monitor compliance. 5. Compliance Date 7/12/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING ______ B. WING ______	C 06/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 13	F 755		

the back up supply they would contact the pharmacy.

06/13/22, the facility staff provided the surveyor with a copy of their policy titled, "Medication Ordering and Receiving From Pharmacy Provider Medication Shortages." This policy read in part, "...The facility nurse must make every effort to ensure that a medication ordered for the resident is available to meet their needs...The pharmacy staff shall...suggest alternative, comparable drug(s) and dosage of drug(s) that is/are available...Nursing staff shall, if the shortage will impact the patient's immediate need of the ordered product: Notify the attending physician of the situation explain the circumstances, expected availability and optional therapy(ies) that are available. Obtain a new order and cancel/discontinue the order for the non-available medication..."

06/14/22 at approximately 8:30 a.m., the Director of Nursing (DON) provided the surveyor with a copy of the back up box list. None of these medications were listed as being available for administration in the back up box.

06/14/22 4:00 p.m., during an end of the day meeting with the DON, Regional Vice President, and Regional Clinical Director the issue regarding the unavailability of Resident #96's medication was reviewed.

No further information regarding this issue was provided to the survey team prior to the exit conference.

This is a complaint deficiency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING ______ B. WING ______	C 06/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	1607 SPRUCE STREET MARTINSVILLE, VA 24112

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F 755	Continued From page 14	F 755		

2. For Resident #47, the antidepressant medication Wellbutrin was unavailable and the ordered dose of Adderall was not available.

Resident #47 was admitted to the facility with diagnoses that included sequelae of cerebral infarction, encounter for surgical aftercare following surgery on the digestive system, dementia, major depressive disorder, fibromyalgia, rheumatoid arthritis, attention deficit hyperactivity disorder, dysphagia, hemiplegia and hemiparesis following cerebral infarction on right dominant side, and iron deficiency anemia. On the minimum data set assessment with assessment reference date 5/2/2022, the resident scored 10/15 on the brief interview for mental status (indicating some cognitive impairment) and was assessed as without signs of delirium, psychosis, or behaviors affecting care.

On 6/13/2022 at 10:21 AM during medication pass and pour observation, Licensed Practical nurse (LPN) #7 administered medications to Resident #47. LPN #7 stated that Wellbutrin 300 milligrams was unavailable. The nurse checked that the medication had been ordered and charted the medication as not administered. LPN #7 administered Adderall 15 mg. Adderall 15 mg was in the narcotic book and the nurse signed out the dose and noted that the count on the drug card matched the signout sheet.

The Order Summary Report with active orders as of 6/14/2022 included orders for Wellbutrin and Adderall:
6/9/2022 Wellbutrin XL tablet extended release

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING ______ B. WING ______	C 06/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	1607 SPRUCE STREET MARTINSVILLE, VA 24112

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F 755	Continued From page 15	F 755		

24 Hour 300 milligram (MG) Give 300 mg by mouth one time a day related to major depressive disorder, recurrent, moderate
6/10/2022 Adderall 10 MG Give 10 mg by mouth in the morning for ADHD

The resident's June 2022 Medication Administration Record Documented that Wellbutrin XL Extended Release 300 milligrams by mouth one time a day Was Marked 7=Other/See Nurse Notes on June 4, 5, 9, 11, 12, and 13. The June 4, 5, and 11 notes stated "not received from pharmacy. The June 9 and 11 notes stated "ordered not received from pharmacy". The June 12 note stated "medication not available ordered from pharmacy".

The resident's June 2022 Medication Administration Record Documented that Adderall 15 MG was administered June 1 through June 10, then Adderall 10 MG was administered June 11-13.

The surveyor reported the concerns during an end of day meeting on June 13, 2022.

The surveyor and director of nursing checked the resident's medications together on 6/13/22 at approximately 4:30 PM. They found a full card of Wellbutrin 300 MG with fill date 6/13/22 and a card containing Adderall 15 mg with 27 doses remaining. The final dose was signed out on 6/13/2022. The surveyor and director of nursing did not find a supply of Adderall 10 MG.

The surveyor asked the director of nursing if there was a pharmacy record of delivery of Wellbutrin that could have been administered on June 6, 7, 8, and 10. On June 14, the director of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING ______ B. WING ______	C 06/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	1607 SPRUCE STREET MARTINSVILLE, VA 24112

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F 755	Continued From page 16 nursing reported that the pharmacy had not delivered Wellbutrin between June 4 and June 13.	F 755		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation and clinical record review, the facility staff failed to ensure the medication error rate was 5% or less during medication pass and pour observation on 6/13/2022. During medication pass and pour observation on 6/13/2022, the surveyor observed 25 opportunities for error. The surveyor observed 3 medication errors affecting 2 residents. The calculated error rate was 12% (3/25=.12 X 100%= 12%). Error observation detail: 1- For Resident #47, the antidepressant medication Wellbutrin was unavailable and the ordered dose of Adderall was not available. Resident #47 was admitted to the facility with diagnoses that included sequelae of cerebral infarction, encounter for surgical aftercare following surgery on the digestive system, dementia, major depressive disorder, fibromyalgia, rheumatoid arthritis, attention deficit hyperactivity disorder, dysphagia, hemiplegia and hemiparesis following cerebral infarction on right	F 759	Disclaimer: This plan of correction is being submitted in compliance with specific regulatory requirement and preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the facts alleged or conclusions set forth on the statement of deficiencies. F759 Free of Medication Error 1. Facility failed to ensure medication errors were below 5% by failing to administer Resident #47s Wellbutrin and Adderall and Resident #70s Vitamin D due to medication not available. Facility alerted Resident #47 and Resident #70s Attending Physician and Responsible Party of missed administrations. 2. Medication pass observation audits were completed on licensed nurses. 3. DON or designee reeducated licensed nurses surrounding proper procedures for	7/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING ______ B. WING ______	C 06/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 17 dominant side, and iron deficiency anemia. On the minimum data set assessment with assessment reference date 5/2/2022, the resident scored 10/15 on the brief interview for mental status (indicating some cognitive impairment) and was assessed as without signs of delirium, psychosis, or behaviors affecting care. On 6/13/2022 at 10:21 AM during medication pass and pour observation, Licensed Practical nurse (LPN) #7 administered medications to Resident #47. LPN #7 stated that Wellbutrin 300 milligrams was unavailable. The nurse checked that the medication had been ordered and charted the medication as not administered. LPN #7 administered Adderall 15 mg. Adderall 15 mg was in the narcotic book and the nurse signed out the dose and noted that the count on the drug card matched the signout sheet. The Order Summary Report with active orders as of 6/14/2022 included orders for Wellbutrin and Adderall: 6/9/2022 Wellbutrin XL tablet extended release 24 Hour 300 milligram (MG) Give 300 mg by mouth one time a day related to major depressive disorder, recurrent, moderate 6/10/2022 Adderall 10 MG Give 10 mg by mouth in the morning for ADHD The resident's June 2022 Medication Administration Record Documented that Wellbutrin XL Extended Release 300 milligrams by mouth one time a day Was Marked 7=Other/See Nurse Notes on June 4, 5, 9, 11, 12, and 13. The June 4, 5, and 11 notes stated "not received from pharmacy. The June 9 and 11 notes stated "ordered not received from pharmacy". The June 12 note stated "medication	F 759	medication administration. 4. Random medication administration audits will be conducted weekly for 4 weeks and then monthly for 3 months to ensure medications are administered as ordered. Results will be reviewed at the QAPI meeting to monitor compliance. 5. Compliance Date 7/12/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING ______ B. WING ______	C 06/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	1607 SPRUCE STREET MARTINSVILLE, VA 24112

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F 759	Continued From page 18	F 759		

not available ordered from pharmacy".

The resident's June 2022 Medication Administration Record Documented that Adderall 15 MG was administered June 1 through June 10, then Adderall 10 MG was administered June 11-13.

The surveyor reported the concerns during an end of day meeting on June 13, 2022.

The surveyor and director of nursing checked the resident's medications together on 6/13/22 at approximately 4:30 PM. They found a full card of Wellbutrin 300 MG with fill date 6/13/22 and a card containing Adderall 15 mg with 27 doses remaining. The final dose was signed out on 6/13/2022. The surveyor and director of nursing did not find a supply of Adderall 10 MG.

The surveyor asked the director of nursing if there was a pharmacy record of delivery of Wellbutrin that could have been administered on June 6, 7, 8, and 10. On June 14, the director of nursing reported that the pharmacy had not delivered Wellbutrin between June 4 and June 13.

2- For Resident #70, facility staff failed to administer the ordered dose of Vitamin D.

Resident #70 was admitted to the facility with diagnoses that included diabetes mellitus, hypertension, schizoaffective disorder, psychosis, bipolar disorder, anxiety, and depression. On the minimum data set assessment with assessment reference date 5/20/2022, the resident scored 11/15 on the brief interview for mental status and

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	495143	A. BUILDING ______ B. WING ______	C 06/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	1607 SPRUCE STREET MARTINSVILLE, VA 24112

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F 759	Continued From page 19 was assessed as without signs of delirium, psychosis, or behaviors affecting care. On 6/14/2022 at 10:54 AM, during medication pass and pour observation, the surveyor observed LPN #10 administer medications to Resident #70. The resident received vitamin D 10 mg. The Order Summary Report with active orders as of 6/15/2022 included an order for Vitamin D3 capsule 125 mcg (5000 UT) (cholecalciferol) Give 1 capsule by mouth 1 time per day. The resident's June 2022 Medication Administration Record Documented administration of Vitamin D 3 capsule 125 mcg (5000 UT) daily June 1 through 13. The surveyor reported the concern during an end of day meeting on June 13, 2022. On June 14, the director of nursing offered documentation that the correct dose of Vitamin D had been obtained and placed in the medication cart and the resident and physician had been notified that the wrong dose was administered. The error rate was reported to the administrator and director of nursing during a summary meeting on 6/15/2022.	F 759		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain	F 770		7/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING ______ B. WING ______	C 06/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	1607 SPRUCE STREET MARTINSVILLE, VA 24112

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F 770	Continued From page 20 laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interviews, clinical record reviews, and facility document review, the facility staff failed to ensure a medical provider ordered laboratory test was completed for 1 of 23 sampled current residents, Resident #44. For Resident #44, the facility staff failed to obtain a Basic Metabolic Panel (BMP) laboratory test. A potassium level is part of a BMP. The findings include: Resident #44's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 5/5/22, was dated as completed on 5/6/22. Resident #44 was assessed as usually able to make self understood and as usually able to understand others. Resident #44's Brief Interview of Mental Status (BIMS) summary score was documented as a zero (0) out of 15; this indicated severe cognitive impairment. Resident #44 was documented as requiring assistance with bed mobility, dressing, toilet use, and personal hygiene. Resident #44's diagnoses included, but were not limited to: anemia, heart disease, high blood pressure, and malnutrition. Resident #44's care plan included a current 'focus' for "Risk for Cardiac Distress ..." An intervention for this 'focus' area was "Lab work or	F 770	Disclaimer: This plan of correction is being submitted in compliance with specific regulatory requirement and preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the facts alleged or conclusions set forth on the statement of deficiencies. F770 Laboratory Services 1. Facility failed to ensure Resident #44�s BMP lab was drawn on Jun 14, 2022. 2. Current residents with BMP lab orders for the past thirty days were audited to ensure they were obtained. 3. The facility reeducated licensed nurses on obtaining labs. 4. BMP lab orders will be audited weekly for 4 weeks and then monthly for 3 months to ensure labs were drawn as ordered. Results will be reviewed at the QAPI meeting to monitor compliance. 5. Compliance Date 7/12/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING ______ B. WING ______	C 06/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 770	Continued From page 21 X-rays as ordered by physician". Resident #44's clinical record included a medical provider order for a BMP laboratory test; this order was dated 4/20/22. The "Order Summary" for this order stated "one time only for Follow [sic] up d/c (discontinue) of K+ (potassium)." The results for this BMP order was not found in Resident #44's clinical record. Resident #44's clinical record included the following nursing note dated 4/20/22 at 1:39 p.m.: "Received new order from NP (nurse practitioner) (NP name omitted): Check BMP next lab day to follow up d/c (discontinue) or K+ (potassium)." On 6/13/22 at 3:51 p.m., the Director of Nursing (DON) was interviewed about Resident #44's 4/20/22 BMP order. The DON reported Resident #44 had not had their potassium checked on 4/20/22 or since; the DON reported a medical provider had been notified of the resident not having the aforementioned BMP completed. Prior to the conclusion of the survey, the survey team was provided a copy of BMP laboratory results obtained for Resident #44 on the morning of 6/14/22; Resident #44's potassium level was within normal limits. On 6/14/22 at 4:00 p.m., the survey team had a meeting with the facility's Regional Clinical Director, Director of Nursing (DON), and Regional Vice-President. The failure of the facility staff to obtain Resident #44's aforementioned laboratory BMP test was discussed. On 6/15/22 at 8:23 a.m., the DON reported the laboratory (lab) technician was training two (2)	F 770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING ______ B. WING ______	C 06/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 770	Continued From page 22 new lab technicians and Resident #44 refused to allow one of the lab technicians in training to draw their blood for the 4/20/22 BMP laboratory blood test. The DON reported the facility staff was not notified that Resident #44 blood sample was not obtained. The DON reported the facility's Unit Managers were expected to monitor for laboratory test results; the DON stated the Unit Managers did not catch that Resident #44's 4/20/22 BMP laboratory test was not obtained. The DON reported the facility did not have a laboratory policy; the DON stated the facility uses the policies of the laboratory company. The laboratory company policies provided to the survey team did not address situations when a laboratory sample was not obtained by the lab technician.	F 770		
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. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		7/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING ______ B. WING ______	C 06/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 23 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 stored under safe and sanitary conditions in 1 of 1 dry storage rooms and 2 of 3 nursing unit pantries, North Unit and South Unit. In the dry storage room, two (2) cans of tomato soup and three (3) cans of evaporated milk had exceed the best by dates. The West Unit pantry refrigerator contained an unlabeled container of cut watermelon, two (2) unlabeled fast food sub sandwiches, and an open, unlabeled package of precooked bacon. The South Unit pantry contained an open, unrefrigerated container of grated parmesan cheese. The findings included: On 6/12/22 at 2:00 pm, in the emergency food section of the dry storage room, surveyor observed a 51 ounce can of tomato soup with a printed "best by" date of 1/15/22 and a 51 ounce can of tomato soup with a printed "best by" date of 3/13/21. The dietary account manager was present and also observed the "best by" date printed on each can of tomato soup. On the other side of the dry storage room, surveyor observed three (3) 12 ounce cans of evaporated milk each with a printed "best if used by" date of 1/26/22. The dietary account manager stated they do not use the evaporate milk. On 6/12/22 at approximately 3:40 pm, surveyor notified the regional vice president of clinical services (RVPCS) of the above findings. On 6/14/22 at 9:25 am, surveyor observed the	F 812	Disclaimer: This plan of correction is being submitted in compliance with specific regulatory requirement and preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the facts alleged or conclusions set forth on the statement of deficiencies. F812 Food Procurement 1. Facility failed to store food safely in nursing unit pantries and dry storage. Facility removed food items that exceeded the best by dates and unrefrigerated cheese at time of on-site inspection. 2. Dry food storage and nursing unit pantries audited for safe sanitary conditions. 3. Dietary Manager or designee reeducated dietary staff surrounding proper storage of food products. 4. Audits will be conducted in the dry food storage and unit pantries weekly for 4 weeks and then monthly for 3 months to ensure food products are within best by dates and stored appropriately. Results will be reviewed at QAPI meeting to monitor compliance. 5. Compliance Date 7/12/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING ______ B. WING ______	C 06/15/2022

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F 812	Continued From page 24	F 812		

refrigerator containing resident food in the North Unit pantry. The refrigerator contents included an unlabeled/undated container of cut watermelon, two (2) unlabeled/undated fast food sub sandwiches, and an open, unlabeled/undated package of precooked bacon. On 6/14/22 at 9:30 am, surveyor observed an open 8 ounce container of grated parmesan cheese located in an upper cabinet in the South Unit pantry with "refrigerate after opening" printed on the label. On 6/14/22 at 10:55 am, surveyor notified the district manager of dietary services (DMDS) of the North and South Unit pantry observations. The DMDS returned at 2:13 pm and stated all items of concern were thrown out and the dietary account manager had checked the refrigerators earlier that day and the aforementioned items were not present in the North Unit pantry refrigerator at that time. On 6/14/22 at 4:00 pm, surveyor notified the RVPCS, director of nursing, and the regional director of clinical services of the pantry observations.

Surveyor requested and received the facility policy entitled "Food: Safe Handling for Food from Visitors" which read in part:
4. When food items are intended for later consumption, the responsible facility staff member will:
Label foods with the resident name and the current date
5. Refrigerator/freezers for storage of foods brought in by visitors will be properly maintained and:
Daily monitoring for refrigerated storage duration and discard of any food items that have been stored for ?7 days. (Storage of frozen foods and shelf stable items may be retained for 30 days).

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 812	Continued From page 25 On 6/15/22 at 9:01 am, surveyor spoke with the dietary account manager and requested the facility process to ensure expired food items are discarded and they stated they were not sure and the RD (registered dietitian) was also supposed to check. No further information regarding this concern was presented to the survey team prior to the exit conference on 6/15/22.	F 812		