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 _____	C 12/05/2022

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 survey was conducted 11/29/22 through 12/05/22. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid survey was conducted 11/29/22 through 12/05/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Four (4) complaints were investigated during the survey: 1. VA00056575 - unsubstantiated 2. VA00056057 - substantiated with no deficiencies 3. VA00056060 - substantiated with no deficiencies 4. VA00054840 - substantiated with no deficiencies The Life Safety Code survey/report will follow. The census in this 300 certified bed facility was 169 at the time of the survey. The survey sample consisted of 34 current resident reviews and 5 closed record reviews.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and	F 584	Resident #166's trash can with liner/bag was replaced on 12/2/22. This resident's privacy curtain was replaced with clean curtain on 12/2/22. Environmental Service Director/Designee will audit all resident rooms to identify and replace trash can requiring replacement	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robert Nelson — TITLE: Administrator — (X6) DATE: 12/16/22

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 584	Continued From page 1 supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, and family interview the facility staff	F 584	Continued From Page 1 and replace privacy curtains with stains. This will be completed by 12/23/22. Environmental Services Director/Designee will provide inservice to all Environmental Services staff regarding cleaning resident rooms to include floors, dusting, trash removal, trash can and liners protocal by 12/30/22. Environmental Services Director will round daily, observing no less than 30% of residents rooms on each unit to monitor for acceptable comfortable interior. The Environmental Services director will immediately correct any items identified needing to maintain acceptable and sanitary environment. The results of the Environmental Services daily findings will be reported monthly to the Qaulity Assurance Committee for review and discussion. Once the QA committee determines the problem no longer exists, observation will be conducted on a random basis.	1/16/23

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F 584	Continued From page 2	F 584		

failed to ensure a clean, comfortable, and home like environment for 2 of 34 residents, Resident #166 and Resident #141.

The findings included:

1. For Resident #166 the facility staff failed to ensure trash receptacle was clean, in good repair and contained a liner.

Resident #166's face sheet listed diagnoses which included but not limited to chronic obstructive pulmonary disease, dementia, and chronic respiratory failure.

Resident #166's most recent minimum data set with an assessment reference date of 10/19/22 assigned the resident a brief interview for mental status score of 9 out of 15 in section C, cognitive patterns. This indicates that the resident is moderately cognitively impaired.

Surveyor observed Resident #166 on 11/29/22 at 2 pm. Resident was seated in wheelchair in room. Surveyor observed small trash can located beside resident's bed. Trash can observed to have dried reddish substance on inside and outside of can. No can liner was observed, and trash can was cracked down one side. Resident #166 stated to surveyor, "I had some congestion in my chest and was spitting it up. They told me to just spit in the trash can."

Surveyor observed Resident #166 again on 11/30/22 at 8:30 am. Resident was resting in bed. Resident's trash can was observed against the wall at the end of resident's bed. Trash can had no liner and had reddish dried substance on inside and outside of can.

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F 584	Continued From page 3 Surveyor informed the administrator, director of nursing, assistant director of nursing and administrator in training of the concern of Resident #166's trash can on 12/01/22 at 3:40 pm. Administrator informed surveyor on 12/02/22 at 8 am that the soiled and cracked trash can had been removed from Resident #166's room and replaced with a new trash can. No further information was provided prior to exit. 2. Resident #166's privacy curtain was observed to have dark brown stains present on the bottom of the privacy panel. Resident #166's clinical record included the diagnosis Alzheimer's disease. Section C (cognitive) of Resident #166's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/26/22 was coded to indicate the resident had problems with long-and short-term memory and was severely impaired in cognitive skills for daily decision making. 11/30/22 11:56 a.m., family in room and voiced concerns over dark stains on the privacy curtain in room. Surveyor observed brown stains on bottom of privacy curtain. 12/01/22 8:40 a.m., rechecked privacy curtain in room, remains with stained dark areas at bottom of curtain. Unit Manager made aware and stated they would have housekeeping change the	F 584		

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F 584	Continued From page 4 privacy curtain. 12/01/22 3:43 p.m., during an end of the day meeting with the Administrator, Director of Nursing and Assistant Administrator the issue with the stained privacy curtain was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 584		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.	F 607	Director of Nursing was educated on 12/5/22 regarding reporting resident to resident abuse within the two hour timeframe even if no injury occurs. Current residents in the center have the potential to be affected. Licensed nurses will receive education by the Director of Nursing/Designee to report all allegations or suspected abuse immediately to the Director of Nursing or Administrator if the Director of Nursing is not available. Education to be complete by 12/30/22. The Administrator will review all FRI's (Facility Reportable Incidents) to ensure timely reporting. For any FRI not reported timely, education and discipline action as necessary will follow. The results of the Administrators' observation will be reported monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, observation will be conducted on a random basis.	1/16/23

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F 607	Continued From page 5 §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to implement written policies and procedures regarding the reporting of resident abuse within the specified timeframe of two (2) hours for 1 of 34 residents in the survey sample, Resident #56. The findings included: For Resident #56, the facility staff failed to implement facility policy regarding the reporting of an incident of resident-to-resident abuse occurring on 12/04/22 in which another resident tied them to their wheelchair with a blanket. Facility staff failed to report the incident within the specified two (2) hour timeframe. Resident #56's diagnosis list indicated diagnoses, which included, but not limited to Unspecified Dementia Moderate with Agitation, Chronic Obstructive Pulmonary Disease, Chronic Diastolic Congestive Heart Failure, Epilepsy, and Generalized Muscle Weakness. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 10/17/22 assigned the resident a brief interview for mental status (BIMS) summary score of 6 out of 15 indicating Resident #56 was severely cognitively impaired. The resident was coded as requiring limited assistance with bed mobility, transfers and extensive assistance with	F 607		

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F 607	Continued From page 6 locomotion on unit. Resident #56's clinical record included a nursing progress note dated 12/04/22 at 5:50 pm which read "This resident was found in another resident's room restrained. (He/she) was tied to (his/her) wheelchair with a blanket. The blanket was over the resident's hands that laid on (his/her) abdomen and went around to the back of the wheelchair and wrapped in big knots around the handlebars keeping (him/her) restrained. (He/she) was sitting there very quiet. A member of staff went into the room to check the residents and immediately notified the charge nurse. RP (responsible party) and MD notified of the incident". Surveyor requested and received the Facility Reported Incident (FRI) dated 12/05/22 for the incident date of 12/04/22 which read in part "(Resident #372) placed a blanket around (Resident #56) waist to hold (him/her) in the chair". The fax confirmations for the 12/05/22 initial FRI notifications were time stamped as follows: (number omitted) 10:38 am, (number omitted) 10:39 am, and (number omitted) 10:40 am indicating a greater than 2-hour delay in notification. On 12/05/22 at 12:02 pm, surveyor spoke with the director of nursing (DON) who stated facility staff notified them of the incident last night, staff did a full body assessment and there were no injuries. Surveyor asked why the incident was not reported until the next morning and the DON stated because there was no injury. Surveyor spoke with the DON again at 3:10 pm and asked the facility's reporting procedures, the DON stated if there was no harm and the resident was	F 607		

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F 607	Continued From page 7 removed from harm, the facility had within 24 hours to report. On 12/05/22 at 2:10 pm, surveyor spoke with the administrator who stated they did not know about the incident until this morning. Surveyor requested and received the facility policy entitled "Free from Abuse" with a revised date of 9/13/22 which read in part: "7) a) The organization will maintain systems to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility, or his or her designee, and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures ..." On 12/05/22 at 3:01 pm, the survey team met with the administrator, assistant administrator, and DON and discussed the concern of the facility failing to report an incident of resident-to-resident abuse within two (2) hours. No further information regarding this concern was presented to the survey team prior to the exit conference on 12/05/22.	F 607		
F 609 SS=D	Reporting of Alleged Violations	F 609	Director of Nursing was educated on 12/05/22 regarding reporting resident to	

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F 609	Continued From page 8 CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to report an incident of resident-to-resident abuse within two (2) hours of when the abuse was discovered for 1 of 34 residents in the survey sample, Resident #56.	F 609	Continued From page 8 resident abuse within two hour timeframe even if no injury occurs. Current residents in the center have the potential to be affected. Licensed nurses received inservice by the Director of Nursing/Designee to report all allegations and observations of suspected abuse immediatley to the Director of Nursing or administrator if the Director of Nursing is not available. Education will be provided by 12/30/22. The Administrator will review all FRI's (Facility Reported Incidents) to ensure timely reporting. For any FRI not reported timely, education and discipline action as necessary will follow. The results of the Administrators' observations will be reported monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exisits, observation will be conducted on a random basis.	1/16/23

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F 609	Continued From page 9 The findings included: For Resident #56, the facility staff failed to report an incident of resident-to-resident abuse within two (2) hours occurring on 12/04/22 in which another resident tied them to their wheelchair with a blanket. Resident #56's diagnosis list indicated diagnoses, which included, but not limited to Unspecified Dementia Moderate with Agitation, Chronic Obstructive Pulmonary Disease, Chronic Diastolic Congestive Heart Failure, Epilepsy, and Generalized Muscle Weakness. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 10/17/22 assigned the resident a brief interview for mental status (BIMS) summary score of 6 out of 15 indicating Resident #56 was severely cognitively impaired. The resident was coded as requiring limited assistance with bed mobility, transfers and extensive assistance with locomotion on unit. Resident #56's clinical record included a nursing progress note dated 12/04/22 at 5:50 pm which read "This resident was found in another resident's room restrained. (He/she) was tied to (his/her) wheelchair with a blanket. The blanket was over the resident's hands that laid on (his/her) abdomen and went around to the back of the wheelchair and wrapped in big knots around the handlebars keeping (him/her) restrained. (He/she) was sitting there very quiet. A member of staff went into the room to check the residents and immediately notified the charge nurse. RP (responsible party) and MD notified of the incident".	F 609		

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F 609	Continued From page 10 Surveyor requested and received the Facility Reported Incident (FRI) dated 12/05/22 for the incident date of 12/04/22 which read in part "(Resident #372) placed a blanket around (Resident #56) waist to hold (him/her) in the chair". The fax confirmations for the 12/05/22 initial FRI notifications were time stamped as follows: (number omitted) 10:38 am, (number omitted) 10:39 am, and (number omitted) 10:40 am indicating a greater than 2-hour delay in notification. On 12/05/22 at 12:02 pm, surveyor spoke with the director of nursing (DON) who stated facility staff notified them of the incident last night, staff did a full body assessment and there were no injuries. Surveyor asked why the incident was not reported until the next morning and the DON stated because there was no injury. Surveyor spoke with the DON again at 3:10 pm and asked the facility's reporting procedures, the DON stated if there was no harm and the resident was removed from harm, the facility had within 24 hours to report. On 12/05/22 at 2:10 pm, surveyor spoke with the administrator who stated they did not know about the incident until this morning. Surveyor requested and received the facility policy entitled "Free from Abuse" with a revised date of 9/13/22 which read in part: "7) a) The organization will maintain systems to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the	F 609		

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F 609	Continued From page 11 events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility, or his or her designee, and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures ..." On 12/05/22 at 3:01 pm, the survey team met with the administrator, assistant administrator, and DON and discussed the concern of the facility failing to report an incident of resident-to-resident abuse within two (2) hours. No further information regarding this concern was presented to the survey team prior to the exit conference on 12/05/22.	F 609		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to provide activities of daily living (ADL) care for a dependent resident, for 1 of 34 residents, Resident #10. The findings included:	F 677	The finger nails and toe nails for resident #10 were trimmed and cleaned on 12/1/22. Assistant Director of Nursing will coordinate with unit managers (charge nurses) to conduct an audit of all residents to identify any residents needing nail care. This audit will be completed by 12/30/22. The facility also provides nail care by a Podiatrist that makes monthly visits to the facility. CNA's will be inserviced to report to the charge nurse any residents whom they observe to need nail care. Director of Nursing will monitor weekly during facility clinical review with unit managers and discuss any resident nail care needed. DON/designee will then monitor for care provided.	

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(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 677	Continued From page 12 The facility staff failed to provide ADL care. Resident #10 was observed to have long and jagged fingernails and toenails. Debris was observed underneath Resident #10's fingernails. Resident #10's diagnoses included, but were not limited to, diabetes, schizophrenia, and cerebrovascular disease. Section C (cognitive patterns) of Resident #10's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/22/22 included a brief interview for mental status (BIMS) score of 11 out of a possible 15 points. Section G (functional status) was coded 3/2 for personal hygiene indicating Resident #10 required extensive assistance of one person to complete this task. Resident #10 was coded as having limitations in range of motion in the upper extremity and as using wheelchair/walker for mobility. Resident #10's comprehensive care plan included the focus area requires assistance with ADL's related to impaired cognition and mental illness. Interventions included, but were not limited to, provide assistance with personal hygiene as needed. 11/30/22 1:53 p.m., resident observed in room, fingernails observed to be long, jagged, with debris present. Resident #10 stated their fingernails needed to be trimmed and asked the surveyor if they wanted to look at their feet. Bilateral feet observed with certified nursing assistant (CNA) #1 left foot toenails observed to be long and jagged. CNA #1 stated they were not allowed to cut nails.	F 677	Contnued From page 12 The results of the weekly findings will be reported monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance committee determines the problem no longer exists, observation will be conducted on a random basis.	1/16/23

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	495426	A. BUILDING _____ B. WING _____	C 12/05/2022

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F 677	Continued From page 13 11/30/22 3:02 p.m., during a meeting with the Administrator, Director of Nursing, Assistant Director of Nursing, and Assistant Administrator, the issue with Resident #10's nail care was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 677		
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 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 store, prepare, distribute and serve food in accordance with professional standards for food service safety. The facility staff failed to discard an out of	F 812	The facility removed the pre-cooked eggs with use date of 11/25/22 immediately upon identification by the surveyor. The Dietary manager removed and discarded the milk immediately as identifed in the initial tour by surveyor. The Dietary manager removed the (4) chafing pans identified, rewashed them and hung them for air drying. The Dietary Manager/designee will monitor the food dates and lables daily to ensure compliance of opened food per facility policy. Dietary manager/deignee will monitor the pans and pots to ensure they are first air dried after wash before hanging. Staff will receive education by the Dietary Manager of proper dating and labeling of food items and to ensure all pans and pots are air dried immediately after wash. Education to be complete by 1/13/23. The Administrator/designee will observe daily (5) times weekly to ensure compliance and that corrective action is maintained. The results of the Administrator/designee observations will be reported monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committe determines the problem no longer exists, observation will be conducted on a random basis.	1/16/23

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F 812	Continued From page 14	F 812		

date food item, failed to label pre-poured beverages, and stacked wet pans together.

The findings included:

The facility staff failed to discard pre-cooked eggs with a use by date of 11/25/22 and failed to label pre-poured cups of lactose free milk. The facility staff also nested (stacked) wet pans together.

During the initial tour of the kitchen on 11/29/22 at 2:35 p.m., surveyor noted a large bowl of prepared eggs labeled, "eggs for egg salad" with a use by date of 11/25/22, in the reach in cooler. The dietary manager (DM) verified the eggs were out of date and removed them from the cooler to be discarded. In the walk-in beverage cooler, surveyor noted a tray with 15 unlabeled, covered cups of a white beverage. The DM stated that the beverage was lactose free milk. When asked by the surveyor if the cups should be labeled or dated, the DM stated, "they should be dated, I'll throw them away." DM removed the tray from the cooler and discarded the beverages.
Surveyor requested and received the facility policy entitled "Dietary and Food Handling", which read in part, "Leftovers must be dated, labeled, covered, cooled, and stored (within ½ hour) in a refrigerator, not at room temperature. Foods must be labeled with the date when opened, and discarded, if not used, within 72 hours."

On 11/29/22 at 3:35 p.m. surveyor noted a stack of 4 chafing pans on a wire dish rack that were wet and resting on top of one another. Surveyor pointed this out to the DM and the DM stated that they should not be stacked and would need to be re-washed to air dry.
Surveyor requested and received facility policy

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F 812	Continued From page 15 entitled "Dietary and Food Handling" which read in part, "All pots and pans must be air dried after the final sanitizing rinse." On 11/30/22 at 3:00 p.m. surveyor met with the administrator, director of nursing, assistant administrator and assistant director of nursing to discuss the concerns of unlabeled, pre-poured lactose free milk, out of date eggs and wet nesting pans. No further information regarding these concerns was presented to the survey team prior to the exit conference on 12/5/22.	F 812		
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 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	F 842	The DDNR for resident #147 was completed on 12/9/22. The facility will conduct an audit of current residents to identify those residents that may have an incomplete DDNR form. The audit will be completed by 12/30/22. Any DDNR's found to be incomplete will be corrected and complete by 1/13/23. The Admissions deparrtment will ensure that all new admits have a complete DDNR upon admission. The Unit Managers (LPN/RN charge nurses) will also check all new admits to ensure a complete DDNR before scanning into resident's chart. The Medical Records coordinator/designee will observe (5) records weekly to ensure corrective action is maintained. The results of the medical records/designee observation will be reported monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committe determines the problem no longer exists, observation will be conducted on a random basis.	1/16/23

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F 842	Continued From page 16	F 842		

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.

§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;

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F 842	Continued From page 17 (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 and clinical record review the facility staff failed to ensure a complete and accurate clinical record for 1 of 34 residents, Resident #147. The findings included: For Resident #147 the facility staff failed to ensure a Virginia Department of Health Durable Do Not Resuscitate (DDNR) form was complete. Resident #147's face sheet listed diagnoses which included but not limited to chronic kidney disease, dependence of renal dialysis, acute respiratory failure and chronic pain syndrome. Resident #147's most recent minimum data set with an assessment reference date of 09/29/22 assigned the resident a brief interview for mental status score of 14 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #147's clinical record was reviewed and contained a physician's order summary for the month of November 2022, which read in part "Do Not Resuscitate" Resident #147's clinical record contained a Virginia Department of Health Durable Do Not Resuscitate Order form, dated 05/21/21, which read in part "I, the undersigned, state that I have a bona fide physician/patient relationship with the	F 842		

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F 842	Continued From page 18 patient named above. I have certified in the patient's medical record that he/she or a person authorized to consent on the patient's behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest. I further certify (must check 1 or 2) ..." Neither 1 nor 2 had been checked on the form. Additionally, the form read in part, "If you checked 2 above, check A, B, or C below." Neither A, B nor C had been checked on the form. The director of nursing (DON) was informed of the incomplete DDNR form on 12/01/22 at 12:30 pm. DON stated they would correct the form. The concern of the incomplete DDNR form was discussed with the administrator, DON, and administrator in training on 12/05/22 at 3 pm. No further information was provided prior to exit.	F 842		