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	495157	A. BUILDING _____ B. WING _____	C 09/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHAMPTON MEMORIAL HOSP	100 FAIRVIEW DR FRANKLIN, VA 23851

(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 09/19/23 through 09/22/23. 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 standard survey was conducted 09/19/23 through 09/22/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Two (2) complaints were investigated during the survey: VA00055044-Substantiated, without a deficiency, VA00052871-Substantiated, without deficiency, The census in this 129 certified bed facility was 93 at the time of the survey. The survey sample consisted of 38 Resident record reviews.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.	F 657	**F- 657** Resident #26 Care Plan was revised on 9-22-2023 to address the indwelling catheter had been removed and sacral pressure area had healed. A 100% review of all residents with current orders for indwelling catheters and pressure ulcers was completed to ensure that the care plans had been revised to reflect the resident's condition change.	

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

Esther Francis, RN LNHA 10-20-23

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F 657	Continued From page 1 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and a clinical record review, the facility staff failed to revise the Person-Centered care plan as the Resident's condition changed for 1 of 38 residents (Resident 26), in the survey sample. The findings included: Resident #26 was originally admitted to the facility 2/9/22 and readmitted 7/9/23 after an acute care hospital stay. The current diagnoses included heart failure, deep vein thrombosis, schizophrenia, and intellectual disability. The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 7/22/23 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 8 out of a possible 15. This indicated Resident #26's cognitive abilities for daily decision making were moderately impaired.	F 657	Care plans for residents with new orders will be reviewed at the weekly IDC committee meeting about updating the Person-Centered Care Plan with changes in orders. The IDC team has been re-educated to revise/updating the Person-Centered Care Plan be revised as the resident's condition changed for residents. The DON and/or designee will complete a monthly review for 3 months of 20% of the residents who have an indwelling catheter and pressure wounds. The audit will review the care plan to ensure that the plan addresses the resident's condition change. Areas of concern will be corrected, and findings of the analysis will be used for education to the interdisciplinary team and a report of the analysis will be submitted to the PI committee for further oversight and recommendations. This plan will be effective 10-31-2023 and measures will be maintained to ensure compliance.	

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F 657	Continued From page 2 In section "G" (Physical functioning) the resident was coded as requiring total care of one person with locomotion on unit, personal hygiene, bathing, dressing, and toileting, extensive assistance of two people with bed mobility, and supervision after set-up with eating. The Resident was also coded as transferring, walking and off unit locomotion once or twice with one person assistance. A review of the current and active care plan revealed a problem dated 7/31/23 which read, The Resident has a catheter related to a sacral wound. The goals read the resident will be/remain free from catheter-related trauma through review date 10/29/23. The interventions included, Monitor and document intake and output as per facility policy. Monitor/record/report to MD signs/symptoms of a urinary tract infection (UTI) pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Another care plan program dated 7/31/23 read, the resident has unstageable pressure ulcer to the sacrum. The goal read, the resident will have intact skin, free of redness, blisters, or discoloration by/through review date 10/29/2023. The resident's pressure ulcer will show signs of healing and remain free from infection by/through review date 10/29/2023. The interventions included, administer medications as ordered. Monitor/document for side effects and effectiveness. Administer treatments as ordered	F 657		

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F 657	Continued From page 3 and monitor for effectiveness. Resident #26 was observed in his room on 9/19/23 and 9/21/23. An indwelling catheter was not identified as being in use on either observation. On 9/21/23 at approximately 1:50 PM the Director of Nursing (DON) performed a skin assessment on the Resident in the presence of the Surveyor. The skin assessment was unremarkable for a sacral pressure ulcer and an indwelling catheter was not present. An interview was conducted with the DON directly after the skin observation. The DON stated on 8/23/23 the sacral pressure ulcer resolved, and the indwelling catheter was removed, but the card care was not updated to reflect the changes. On 9/22/23 at approximately 12:10 p.m., a final interview was conducted with the Administrator and Corporate Consultant. The Administrator stated she would follow-up on the care plan revisions. An opportunity was offered to the facility's staff to presented additional information regarding the care plan revisions, but they did not, and no concerns were voiced.	F 657		
F 677 SS=E	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 resident interviews, staff interviews and clinical record review, the facility staff failed	F 677	***F – 677*** Resident #12 and Resident #47 were offered showers 9-22-2023. Any residents who preferred a	

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F 677	Continued From page 4 to provide personal care to include showers for 2 out of 38 residents (Resident #12 and #47) who were unable to independently carry out activities of daily living (ADL) care. The findings included: 1. Resident #12 was admitted to the facility on 03/07/22. Diagnosis for included but not limited to dementia with behavioral disturbances and Type II diabetes. Resident #12's Minimum Data Set (an assessment protocol) a quarterly with an Assessment Reference Date (ARD) of 06/15/23 coded the resident's Brief Interview for Mental Status (BIMS) score 10 of a possible 15 with moderate cognitive impairment for daily decision-making. In section "G" (Physical functioning) the MDS coded Resident #12 required total dependence of one with transfer, dressing toilet use and bathing, extensive assistance of one with bed mobility, eating and personal hygiene for ADL care. Resident #12's comprehensive care plan with a revision date of 09/18/23 documented Resident #12 requiring extensive to total assistance with his ADL due to deficit related to (r/t) confusion, dementia, impaired balance, limited mobility, and range of motion (ROM), muscular impairment, Parkinson, and dementia. The goal set for the resident by the staff is to maintain current level of function. One of the interventions to manage goal include to provide a sponge bath when a full bath or shower cannot be tolerated. On 09/19/23 at 3:13 p.m., an interview was conducted with Resident #12. He stated he	F 677	shower had the potential not to receive a shower. All staff will be re-educated on the shower process. The shower books have been revised to maintain compliance with residents receiving showers twice a week if that is their preference. The social worker completed a 100% audit of all residents requesting their preference of Bed bath or shower on 9-25-2023. Audits will be conducted weekly times 8 weeks then monthly to ensure showers are being offered to residents twice a week. If non-compliance is observed the nurse will be immediately re-educated on the shower schedule. Findings of these observations will be provided to the Director of Nursing for additional monitoring and further education and/or disciplinary action.	

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F 677	Continued From page 5 cannot remember the last time a shower was given to him. He stated he enjoys showers and would love to have them. Review of Resident #12's ADL Documentation Report for August and September 2023 did not indicate he had received any showers for the two (2) months mentioned. License Practical Nurse (LPN) #1 was interviewed on 09/22/23 at 9:15 p.m. She stated the shower book to include the residents shower days was removed from the unit months ago and has never been returned. She said she was not sure when Resident #12's shower days were or if he was receiving showers. An interview was conducted with Certified Nursing Assistant (CNA) #1 on 09/22/23 at 10:23 a.m. She said the shower book was removed from units months ago. She stated she use to get a list from the nurses when residents were due for their shower but once the book was removed so did the shower list from the nurses. She stated she had been assigned to Resident #12 but has never given him a shower. On 09/22/23 at 11:13 a.m., an interview was conducted with Registered Nurse (RN) #2. She stated the Director of Nursing (DON) removed the shower book/schedule from the unit months ago for revision but has never been returned. She stated she is not sure if Resident #12 is receiving his showers twice a week. A final meeting was held with the Administrator and Corporate on 09/22/23 at approximately 12:10 p.m., who were informed of the above findings. No further information was provided	F 677	An analysis of the findings will be reported to the PI committee for additional oversight, recommendation, and determination of the continued frequency of this audit. This plan will be effective 10-30-2023 and measures will be maintained to ensure ongoing compliance.	

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F 677	Continued From page 6 prior to exit. The facility policy titled Activities of Daily Living (ADL's) Supporting - revised 01/01/20. It is the facilities policy to ensure residents will be provided with care treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADL's). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. The findings included: 2. For Resident #47 the facility staff failed to ensure she received necessary services to include showers. Resident #47 was originally admitted to the facility 02/08/22 and readmitted 10/09/22 after an acute care hospital stay. The current diagnoses included; Hypertension. The quarterly review, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 7/20/23 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #47 cognitive abilities for daily decision making were intact. In section"G"(Physical functioning) the resident was coded as requiring extensive assistance of one person with bed mobility, requires supervision of one person with dressing and personal hygiene, requiring total dependence of one person with bathing, independent with eating.	F 677		

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F 677	Continued From page 7 The Care Plan dated 3/09/21 reads: Resident #47 has an ADL/Activities of Daily Living self-care performance deficit. Activity Intolerance, Impaired balance, has difficulty ambulating, sensation in legs, weakness, drowsiness at times. The resident is totally dependent on staff to provide bathes and showers. A review of the ADL documentation for the month of September 2023 09/01/23-09/20/23 reveal that Resident #47 did not receive showers. During the initial tour an interview was conducted on 9/19/23 at approximately 3:04 PM., with Resident #47 concerning showers. She said that she gets bed baths but would like to get showers. On 9/21/23 at approximately 7:25 PM., an interview was conducted with RN (Registered Nurse) #3 concerning showers. She said that the policy doesn't address how many showers a resident should have. On 9/22/23 at approximately 1:10 PM., the above findings were shared with the Administrator, and the Hospital President. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.	F 677		
F 775 SS=D	Lab Reports in Record - Lab Name/Address CFR(s): 483.50(a)(2)(iv) §483.50(a)(2) The facility must- (iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by:	F 775	***F-775*** The laboratory report has been filed in the resident's clinical record.	

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F 775	Continued From page 8 Based on record review and staff interview the facility failed to file clinical laboratory reports in the resident's clinical record and did not ensure laboratory reports contained the name and address of the testing laboratory. This affected one of 5 residents (Resident (R) 43) reviewed for unnecessary medication reviews. Findings include: Review of the diagnosis tab in R43's electronic medical record (EMR) revealed her diagnosis included atrial fibrillation (an irregular heartbeat that can lead to blood clots in the heart). Review of "Physician's Orders" under the "Orders" tab of the paper medical record revealed R43 had a physician's order for Eliquis (an anticoagulant medication used to prevent blood clots) 5 milligrams (MG) twice a day. Review of the medication and treatments section of the paper medical record revealed the resident had a pharmacy report titled "Southampton Memorial Hospital" "Department of Pharmacy" "Consultant Pharmacist Report" "Therapeutic suggestions" dated 06/28/23. In the report the pharmacist wrote the resident was currently on Eliquis. The pharmacist wrote that a liver panel was suggested yearly or more frequently for long term patients taking direct oral anticoagulants such as Eliquis. The physician signed the report and dated it 07/13/23. Under "action taken" the physician wrote agreed and under reason the pharmacist wrote check hepatic panel. The paper medical record and the EMR were reviewed in their entirety and lacked an order for a hepatic panel and laboratory results for a	F 775	Any resident who had laboratory work completed had the potential for the laboratory report not filed in the resident's clinical record. An audit was conducted to ensure that all current lab orders are filed in the resident's clinical record. Effective immediately all laboratory reports will be reviewed by the NP, then the laboratory results will be scanned into the resident's medical record. All lab orders will be tracked by nursing administration. Audits will be conducted weekly times 4 weeks then monthly to ensure laboratory results are filed on the resident's clinical records. If non-compliance is observed the nurse will be immediately re-educated on the correct process. Findings of these observations will be provided to the Administrator for additional monitoring and further education and/or disciplinary action. An analysis of the findings will be reported to the PI committee for additional oversight, recommendation, and determination of the continued frequency of this audit.	

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F 775	Continued From page 9 hepatic panel. During an interview on 09/21/23 at 2:39 PM, Registered Nurse (RN) 1 was asked if R43 had an order for a liver panel and if a liver panel had ever been obtained. RN1 reviewed the record and called the laboratory and stated she was not able to find an order nor a liver panel laboratory report. During an interview on 09/21/23 at 4:33 PM, RN2 stated they were not able to find a liver panel laboratory report and stated it should have been ordered and completed per the pharmacy recommendation and physician's recommendation. RN2 stated it was now ordered to be completed. During an interview on 09/22/23 at 9:52 AM, RN3 provided a document titled "Hepatic Function Panel" for R43. The document contained laboratory results dated 04/09/23, 07/22/22, and 05/31/22. The document did not contain the name or address of the laboratory. RN3 stated the report was not in the paper or electronic record in the facility and she had to get it from the hospital. RN3 was questioned about why the pharmacist would recommend a liver panel when the resident already had one and she stated it was probably because it was not in R43's medical record in the facility. On 09/22/23 at 9:53 AM, Pharmacist 1, the pharmacist who completed R43's 06/28/23 medication review and recommended the liver panel be completed, was interviewed by telephone. Pharmacist 1 stated she completed the entire review from the paper record and since it was not in the record, she assumed it was not completed and she based her recommendation	F 775	The laboratory reports will contain the name and address of the testing lab. This plan will be effective 10-31-2023 and measures will be maintained to ensure ongoing compliance.	

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F 775	Continued From page 10 on that. She stated if it had been in the paper record, she would not have recommended one be completed. Review of the "Hepatic Function Panel" report revealed it did not contain the name or address of the laboratory. During an interview on 09/22/23 at 11:51 AM, R43's "Hepatic Function Panel" report provided by RN3 was reviewed with the Administrator. She verified "Hepatic Function Panel" did not contain the name and address of the testing laboratory. A copy of the facility policy regarding laboratory results was requested. She stated she would look for one. A policy was not provided.	F 775		