STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495384	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Francis Marion Manor Health & Rehabilitation	100 Francis Marion Lane, Marion, VA 24354

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 28567 Based on staff interview, employee record review, and facility document review, the facility staff failed to follow their policy regarding screening of new hires for 2 of 15 employees. New hire #1 and #14. The findings include: The facility staff failed to follow their policy for screening of new employees. The facility staff failed to obtain criminal background checks through the Virginia State Police (VSP) criminal records exchange. The facility administrative staff provided the surveyor with a copy of their policy titled, Background Checks-Human Resources. This policy read in part, The Recruitment Team will initiate the background investigation after a conditional job offer has been made .screenings are done in addition to the required criminal history records obtained through the state of Virginia .candidates for positions to be employed in Virginia who are working in those areas required by the state of Virginia to have a criminal history background check obtained through the Central Criminal Records Exchange, Department of State Police will consent to a full criminal background check . On 08/14/24 at approximately 12:27 p.m., the surveyor completed a review of employee records for the staffing task with Human Resource (HR) personnel #1 and #2. Fifteen employee records were reviewed of these 15 records 2 employee files were identified as not having VSP background checks. New hire #1 was employed as an Occupational Therapist, their hire date was documented as 07/29/24. The employee record did not include a VSP background check through the central records exchange. HR personnel #1 stated this employee worked at a hospital for the same company prior to working at this facility and the hospital staff were not aware a VSP background check needed to be completed. New hire #14 was employed in the dietary department, their hire date was documented as 09/14/23. The employee record did not include a VSP background check through the central records exchange. HR personnel #1 confirmed this was a contract employee and the VSP background check had not been completed. On 08/14/24 at 4:00 p.m., during an end of the day meeting with the Administrator/Chief Executive Officer (CEO) and Director of Nursing (DON) the issue with the missing VSP background checks were reviewed. (continued on next page)

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information regarding this issue was provided to the survey team prior to the exit conference.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 28567 Based on staff interview and facility document review, the facility staff failed to ensure Registered Nurse (RN) coverage for 8 consecutive hours a day 7 days a week for quarter 3 of 2023. The findings include: The facility staff failed to ensure they had RN coverage for 8 consecutive hours a day 7 days a week for quarter 3 of 2023 (April, May, June). There was no facility employed RN on staff on 04/30/23, 05/14/23, 05/27/23, 05/28/23, 06/11/23, and 06/25/23. The facility census was as follows 04/30/23 (40), 05/14/23, 05/27/23, 05/28/23 (39), 06/11/23 (38), and for 06/25/23 (35). Three surveyors entered the facility on 08/12/24 at 6:10 p.m., staffing was as follows 1 RN, 2 Licensed Practical Nurses (LPN's), and 3 Certified Nursing Assistants (C.N.A.'s). The census was 25. This facility had triggered for one star staff rating and No Registered Nurse (RN) coverage for quarter 3 of 2023 (April, May, June). A review of the facility payroll-based journal (PBJ) reports revealed that the facility had no RN coverage on the above named dates. On 08/13/24 at 3:10 p.m., during a meeting with the Administrator/Chief Executive Officer (CEO) and Director of Nursing (DON) the issue regarding RN coverage was reviewed. These staff confirmed they did not have RN coverage on these days as they had a staff person out on medical leave. On 08/14/24 at 10:50 a.m., during an interview with LPN #2 this staff stated they did not recall any issues when they did not have an RN, and this would have been their weekends to work. LPN #2 stated if they had issues, they could have called the house supervisor at the hospital (same company), the DON, or RN #2 as they lived near the facility. LPN #2 stated they weren't accepting admissions at one point due to staffing issues. During interviews with C.N.A. #1, #2, #3, #4, and #5, no staff expressed any concerns regarding nursing coverage and issues with the residents of the facility. On 08/14/24 at 1:10 p.m., the Administrator/CEO and DON stated they did not recall any issues regarding not having an RN on site at the facility for the above dates. On 08/14/24 at 1:35 p.m., during an interview with the Social Worker this staff denied having any complaints from families and/or residents regarding RN coverage. No issues regarding staffing were observed while on site. No further information regarding this issue was provided to the survey team prior to the exit conference.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28567 Based on staff interview and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for 2 of 14 residents, Resident #19 and #23. The findings include: 1. For Resident #19, the facility staff failed to ensure the residents' order for Digoxin was accurate regarding administering the medication with food. Resident #19's diagnoses included atrial fibrillation and chronic heart failure. Section C (cognitive patterns) of Resident #19's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 08/08/24 included a brief interview for mental status (BIMS) summary score of 15. Per the MDS manual a score of 15=cognitively intact. The clinical record included an order dated 08/07/24 for Digoxin 62.5 mcg to be given daily at 8:00 a.m. the administration instructions included with this order read as follows, Digoxin should be given one hour before or two hours after eating. On 08/14/24 at 9:03 a.m., during an interview with the Director of Nursing (DON) the DON stated the original order for the Digoxin had a stop date, the physician rounded, and the resident requested it be reordered. Their software pre-populated the documentation regarding mealtimes, and it previously had to hold if the pulse less than 60. The DON stated the nurse putting the order in did not notice that the software had pre-populated the comment regarding meals. On 08/14/24 at 9:45 a.m., during an interview with Medical Director #1, this staff stated the residents Digoxin level was sub-therapeutic and they wanted them off it. Resident #19 has a cardiologist appointment coming up and insisted on the time that it's administered. The part of the order that speaks of it being given with or without food is part of EPIC (software).I did not remove it from the order . On 08/14/24 at 12:18 p.m., during an interview with Registered Nurse (RN) #1 this staff stated the original Digoxin order ended after the dosage on 08/03/24, Resident #19 wanted the medication back, they were seen by the physician, and it was reordered. RN #1 stated breakfast was served around 7 a.m. till 8:30 a.m. and they did not know the order regarding the food and holding the medication was attached to the order, before it was just the heart rate. RN #1 stated the dosage this morning was given by the night shift nurse this at 7:02 a.m. The surveyor was able to verify through the clinical record review that the pulses had been obtained daily. On 08/14/24 at 4:00 p.m., during a meeting with the Administrator/Chief Executive Officer and Director of Nursing (DON) the issue regarding the Digoxin was reviewed. The DON stated a ticket had been put in regarding the food and administration of Digoxin to get it removed from the software. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information regarding this issue was provided to the survey team prior to the exit conference. 34307 2. For Resident #23 the facility staff failed to accurately complete a Virginia Department of Health Durable Do Not Resuscitate (DDNR) form. Resident #23's clinical record was reviewed and contained a signed DDNR for dated 07/28/22. This form read in part, I, the undersigned, state that I have a [NAME] fide physician/patient relationship with the 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 box one nor two was checked. The form continued to read, If you checked 2 above, check A, B, or C below. No boxes were checked in this section. The concern of the incomplete DDNR form was discussed with the administrator and director of nursing on 08/13/24 at 3:30 pm. No further information was provided prior to exit.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 28567 Based on staff interview and facility document review, the facility staff failed to ensure information provided on the payroll-based journal (PBJ) was accurate. The findings include: The facility staff were including Hospice staff not employed by the facility on the PBJ report. This facility had triggered for one star staff rating and No Registered Nurse (RN) coverage for quarter 3 of 2023 (April, May, June). When reviewing these reports, the surveyor noted the facility staff had included Hospice staff on the report. On 08/14/24 at 9:15 a.m., the surveyor interviewed the staff the facility identified as being responsible for these reports RN #3. This staff stated Hospice personnel were contracted and they were patient care givers. RN #3 confirmed they were not paid by the company, and they would reach out to the email provided on the guidelines for completing the PBJ reports. On 08/14/24 at 10:12 a.m., RN #3 stated they had received a response from their email, and they should not have been including Hospice personnel on their PBJ reports. This staff provided the surveyor with copies of their email and part of a booklet titled, Electronic Staffing Data Submission Payroll-Based Journal Long-Term Care Facility Policy Manual Version 2.6 June 2022. Page 3 of this document read in part, .Reminder .visits to residents billed to Medicare or another payer, hours for service provided by hospice staff and private duty nurses shall not be reported . On 08/14/24 at 1:10 p.m., during a meeting with the Administrator/Chief Executive Officer and Director of Nursing (DON) the issue with Hospice personnel being included on the PBJ report was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference.