STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	**09/21/2020**

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

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 0773 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.** Based on staff interview, clinical record review, and facility document review, the facility staff failed to obtain a physicians order prior to obtaining COVID19 laboratory tests for 3 of 3 residents (Resident #1, #2, and #3). The findings included: The facility failed to obtain a physicians order prior to obtaining COVID19 laboratory tests for the residents of the facility. On 09/17/2020 during the clinical record review, the surveyor was unable to locate any orders for COVID19 laboratory testing. On 09/17/2020 at approximately 9:15 a.m., during a phone conference with the administrator, DON (director of nursing), and IP (infection preventionist). The DON verbalized to the surveyor that they were in outbreak status and were testing the residents of the facility for COVID19 every 3 to 7 days. On 09/17/2020 at approximately 2:55 p.m., during a phone call with the administrator, DON, and IP nurse. These staff were asked about the missing orders. Oreders could not be found for Resident #1, #2, and #3. On 09/18/2020 at approximately 9:20 a.m., during a phone call with the administrator, DON, and IP nurse. The DON stated there were no orders for COVID19 testing. On 09/18/2020, the facility provided the surveyor with a copy of their policy/procedure titled, Facility COVID-19 Testing. This document read in part, .Symptomatic Testing .Secure order and get written consent to test any staff or resident with symptoms of COVID-19 .Outbreak testing .Secure order and get written consent for each resident and staff member . The administrator was made aware of the above issue regarding no physician order(s) in regards to COVID19 testing during the exit conference on 09/21/2020. The administrator stated the DON was working on getting these orders. No further information regarding this issue was provided to the surveyor prior to the exit conference.

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

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.