STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 6/6/17 through 6/8/17. Three complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 97 at the time of the survey. The survey sample consisted of 17 current Resident reviews (Resident #1 through Resident #17) and 4 closed record reviews (Resident #18 through Resident #21).	F 000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable State and Federal regulatory requirements.	
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to	F 157	**F157 D Notify of Changes** 1. Facility residents who receive sliding scale insulin have the potential to be affected by this practice. Resident #14 has an active diagnosis of diabetes and receives sliding scale insulin with blood sugars. Physician was not notified of blood sugars greater than 501. Upon notification of concern, physician was notified and no new orders were given.	7/20/2017

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Luis Jimenez	Administrator	7/6/2017

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 157		F 157		
	Continued From page 1 commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to inform the physician of a change in condition for 1 of 21 residents (Resident #14). The findings included: The facility staff failed to inform the physician when Resident #14's blood sugars were 501+ (greater) on 6/2/17 at 1630 (4:30 p.m.) and 6/5/17 at 4:30 p.m.		2. An audit to identify residents who are on sliding scale insulin was completed and noted that attending physicians were notified per physicians' orders. Director of Nursing re-educated licensed staff regarding following physicians' orders and documentation of physician notification. 3. Blood sugars requiring notification of physician will be identified by the Unit Manager/Designee daily during morning clinical meeting times two weeks and weekly times one month to ensure that physicians are notified and documentation has been provided to show that notification occurred. 4. Any deficient practice regarding physician notification to focus on blood sugar parameters will be brought to the QAPI Committee monthly for discussion/resolution. 5. Date of Compliance: 7/20/2017	

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F 157		F 157		

Continued From page 2

The clinical record of Resident #14 was reviewed 6/8/17. Resident #14 was admitted to the facility 5/8/17 with diagnoses that included but not limited to Type 1 Diabetes Mellitus, chronic kidney disease, (stage 4 severe), ESRD (end stage renal disease now on dialysis), hypertension, hyperlipidemia, acute respiratory failure, anemia in chronic kidney disease, pleural effusion, developmental disorder of scholastic skills, depressive disorder, and gastroesophageal reflux disease.

Resident #14's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/16/17 assessed the resident with a cognitive summary score of 9 out of 15 in Section C Cognitive Patterns.

Resident #14's current comprehensive care plan dated 5/11/17 identified that the resident had an alteration in blood glucose due to insulin dependent diabetes mellitus. Interventions: Administer medications as ordered. Report abnormal results per physician parameters/guideline.

The June 2017 signed physician orders included the following order for administration of insulin sliding scale: "Insulin Lispro Solution Inject as per sliding scale: if 0-70=no insulin; 151-200=2 units; 201-250=4 units; 251-300=6 units; 301-350=8 units; 351-400=10 units; 401-450=12 units; 451-500=14 units; 501 + =16 units and call MD (medical doctor), subcutaneously before meals and at bedtime related to TYPE 1 DIABETES MELLITUS WITH HYPERGLYCEMIA (E10.65). Order ate 06/01/2017 Start Date 06/01/2017."

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F 157	Continued From page 3 The surveyor reviewed the June 2017 electronic medication administration record (eMAR). The blood sugar result for 6/2/17 at 1630 (4:30 p.m.) was documented as 599 and 16 units of Insulin Lispro was administered. The blood sugar result for 6/5/17 at 4:30 p.m. was 555 and 16 units of Insulin Lispro was administered. Based on the current order for physician notification, the MD should have been notified when the blood sugars were 599 and 555. The surveyor reviewed the facility progress note for 6/2/17. There were seven (7) progress notes for 6/2/17. The times of those notes were 6:31 a.m., 6:48 a.m., 2:15 p.m., 7:27 p.m., 7:31 p.m., 9:19 p.m., and 11:08 p.m. There was no documentation that the physician had been informed of Resident #14's blood sugar of 599. There were five (5) progress notes written 6/5/17 at 7:01 a.m., 7:08 a.m., 3:11 p.m., 5:38 p.m., and 5:39 p.m. There was no documentation that the physician had been informed of the blood sugar of 555. The surveyor informed the assistant director of nursing of the blood sugar results for 6/2/17 and 6/5/17 on 6/8/17 at 2:40 p.m. After reviewing the progress notes, the ADON stated there was no documentation that the physician had been informed of the elevated blood sugar results. The surveyor informed the administrative staff of the above concern on 6/8/17 at 4:00 p.m. No further information was provided prior to the exit conference on 6/8/17.	F 157		
F 167	483.10(g)(10)(i)(11) RIGHT TO SURVEY	F 167		

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F 167 SS=D	Continued From page 4 RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to post previous year survey results in an area that was readily accessible to all who entered the facility to review. The findings included: The survey team, which consisted of 5 surveyors,	F 167	**F167 D Right to Survey Results Readily Accessible.** 1. Facility residents have the potential to be affected by this practice. Upon notification that Survey Results Book was not in an accessible area, and signage regarding the two previous years from the most current Survey Results were not accessible for review, Administrator had Survey Results Book placed in the lobby next to the front desk and previous years' results were added to the Book. 2. Residents had the potential to be affected by this practice. 3. Administrator had Survey Results Book placed in the lobby next to the front desk and previous years' results were added to the Book. 4. Any deficient practice regarding accessibility of survey results will be brought to the QAPI Committee monthly for discussion/resolution. 5. Date of Compliance: 7/20/2017	7/20/2017

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F 167	Continued From page 5 entered the facility on 6/6/17 for an annual Medicare/Medicaid survey. Observations were made to locate the book that contained the previous year of survey results of the facility. These observations were made from 6/6/17 through 6/8/17. On 6/8/17 at approximately 9 am, the surveyor found the previous survey results in the hallway off of the lobby through a set of double doors beside the social workers' office hanging on a wall in a notebook label "Survey Results". There was no signage in the front lobby that directed anyone interested in reviewing these survey results of where they were located. There was also no signage that directed the public of where to obtain the past 3 years of survey results if they were anting to be reviewed. On 6/8/17 at approximately 9:30 am, the surveyor notified the administrator of the above documented findings. The administrator stated "I was unaware that there needed to be at least the past 3 years available for the public to review if requested. I will take care of this immediately." No further information was provided to the surveyor prior to the exit conference on 6/8/17.	F 167		
F 252 SS=E	483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.	F 252	**F252 E Safe, Clean, Comfortable Homelike Environment.**	7/20/2017

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F 252	Continued From page 6 §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 supports for daily living safely. The facility must provide- (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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to provide a clean, comfort and homelike environment for 2 of 2 units in the facility. The findings included: During the course of the survey from 6/6/17 through 6/8/17, it was noted on numerous occasions the strong smell of urine in the hallways of Unit 1 and Unit 2. The survey team also observed large amounts of paint missing from the door frames of the resident's rooms along with long white marks on the bottom third of the resident doors. On 6/8/17 11:00 am, the surveyor, maintenance director and housekeeping director walked along the facility. During this observation, there was a	F 252	1. Facility residents have the potential to be affected by this practice. Upon notification of odors in the facility, Housekeeping Director guided staff to areas indicated by surveyor for further cleaning. Maintenance Director developed a plan to address doors and frames that lacked painting. 2. An audit of doors and frames in the facility took place; no further concerns were noted. An audit by the Housekeeping Director showed no further areas with odors noted. 3. During morning meeting, the Administrator/Designee will request that Care Keeper Round Sheets be submitted by department heads with any concerns of odors and newly identified concerns with doors and frames for discussion and resolution. 4. Any deficient practice regarding the odors and doors/frames will be brought to the QAPI Committee monthly for discussion/resolution. 5. Date of Compliance: 7/20/2017	

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F 252		F 252		

Continued From page 7 faint urine odor noted by the observers in the long hallway of Unit 1 that contained the rooms from B 19 to B 30. There were 2 door frames on Unit 2 at rooms B 4 and B 1 that had the large amounts of chipped paint or paint missing from the resident's door frame. Along this same hall, the following resident room doors had white marks at the bottom third of the door: B20, B19, B18, B17, B16, B15, B14, B10, B9, B8, B7, B6, B4, B1, B21, B22, B23, B24, B25, B26, B27, B28, B29, B30 and B31.

These environmental observational rounds continued with the same team as mentioned above on Unit 1. There was noted to be a strong foul urine odor in the hallway that housed the rehabilitation room and resident rooms A1 through A6. The same strong foul urine odor was noted in the hallway of resident rooms A22 through A31. There were 4 door frames that had large chips of paint missing on resident rooms A13, A15, A12 and the utility room beside of the nurses' station. Along this same hall, the following resident room doors had white marks at the bottom third of the door: A12, A13, A20, A21, A22, A24, A27, A29 and A31.

The maintenance director stated to the surveyor "I would love to paint or fix all these doors but the budget hasn't allowed for it to happen yet. I know it looks bad." The housekeeping director stated to the surveyor "We have tried different things in order to keep the smells down like, mopping the resident rooms extra if they are known to have accidents in the floor and I have even tried different cleaning solutions but nothing seems to help this problem."

The administrative team was notified of the above

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F 252	Continued From page 8 documented findings by the surveyor in the conference room on 6/8/17 at 4 pm. No further information was provided to the surveyor prior to the exit conference on 6/8/17.	F 252		
F 271 SS=D	483.20(a) ADMISSION PHYSICIAN ORDERS FOR IMMEDIATE CARE (a) Admission orders At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure 1 of 21 residents in the survey sample had readmission orders. (Resident # 17) The findings included: The facility staff to ensure that Resident #17 had readmission orders when readmitted to the facility. Resident #17 was readmitted to the facility on 4/13/17 with the following diagnoses of, but not limited to congestive heart failure, chronic respiratory failure, high blood pressure, urinary tract infection, diabetes, atrial fibrillation, chest pain and chronic kidney disease. The entry MDS (Minimum Data Set) dated for 4/13/17 had been completed but the significant change MDS with an ARD (Assessment Reference Date) of 6/22/17 was still in progress at the time of this survey. The surveyor completed a clinical record review	F 271	**F271 D Admission Physician Orders for Immediate Care.** 1. Facility residents have the potential to be affected by this practice. Resident #17's readmission orders were found to be missing from resident's clinical record. Orders were located and placed on the clinical record. 2. A physician orders audit of residents who admitted or readmitted within the last 30 days to facility was performed to verify admission/ readmission orders were found in their clinical records; no deficient practice noted. Unit Manager re-educated licensed staff on admission/re-admission procedure to focus on ensuring physician orders are in the correct section of the clinical record.	7/20/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

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F 271	Continued From page 9 of Resident #17's chart on 6/8/17. It was noted by the surveyor that on 4/13/17 when the resident was readmitted to the facility from the hospital, there were no readmission orders present in the clinical record. The only physician orders that were in the clinical record were dated for 5/2/17. At 10:40 am, licensed practical nurse (LPN) #2 was notified by the surveyor that readmission orders for this resident could not be found when the resident returned to the facility on 4/13/17. The only physician orders noted by the surveyor and LPN #2 were dated for 5/2/17. LPN #2 stated "I will go and look for these." At 1:30 pm, the assistant director of nursing returned to the surveyor and stated "I cannot find any readmission orders on the record for this resident. The one physician orders that I have found were dated for 5/2/17." The administrative team was notified of the above documented findings by the surveyor on 6/8/17 at 4 pm in the conference room. No further information was provided to the surveyor prior to the exit conference on 6/8/17.	F 271	3. Clinical Records of residents admitting or readmitting to facility will be reviewed in daily clinical review within 24 hours by Unit Manager/Designee to ensure physician orders are filed correctly in the clinical record. 4. Any deficient practice regarding the filing of physician orders in the clinical record will be brought to the QAPI Committee monthly for discussion/resolution. 5. Date of Compliance: 7/20/2017	
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F 278	**F278 D Assessment Accuracy/Coordination/Certified**	7/20/2017

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F 278	Continued From page 10 (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to ensure a complete and accurate Minimum Data Set (MDS) assessment for 2 of 21 Residents in the sample survey, Resident #7 and Resident #11. The Findings Included: 1. For Resident #7 the facility staff failed to ensure a complete and accurate Section D. 0100. Mood and D. 0200 Resident Mood Interview on a	F 278	1. Facility residents have the potential to be affected by this practice. Resident #11 was found to have an inaccurate MDS assessment in section K. Upon identification of concern, MDS Coordinator modified assessment to ensure accuracy. Resident #7 was found to have an inaccurate MDS assessment in section D. Resident #7 was coded as "Not Assessed" on MDS with an ARD of 5/3/17; concern was identified during survey process; MDS unable to be modified as resident interview had not been completed within ARD time-frame.	

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GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 278	Continued From page 11 Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/3/17. Resident #7 was an 87 year old female who was admitted on 2/1/16. Admitting diagnosis included, but were not limited to: dementia with behaviors, glaucoma, psychosis, diabetes mellitus, anxiety, hypertension, syncope with collapse and abnormal weight loss. The most current Minimum Data Set (MDS) located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 5/3/17. The facility staff coded that Resident #7 had a Cognitive Summary Score of 3. The facility staff also coded that Resident #7 required set up (1/1) to total nursing care (4/2) with Activities of Daily Living (ADL's). In Section D. 0100 Should the Resident Mood Interview be Conducted? The facility staff coded a dash (-). In Section D. 0200 Resident Mood Interview the facility staff coded a dash (-) for all sections. The surveyor noted that Section D. 0300. Total Severity Score was also coded as a dash (-). On June 7, 2017 at 10:30 a.m. the surveyor met with the 2 MDS Nurse's. The surveyor reviewed Section D. Mood with the MDS Nurse's. The MDS Nurse's stated that Resident #7 was assessed but she could not answer questions due to her cognitive status. The surveyor pointed out that Section D. 0300 should have been coded as a 9 and not as a dash (-); as 9 indicated "No response (leave column 2 blank)." (sic) On June 8, 2017 at 4:10 p.m. the survey team met with the Administrator (Adm), Director of Nurses (DON), Assistant Director of Nursing (ADON), Social Workers (SW) and Corporate	F 278	2. An audit of residents' section D of the MDS for the last 30 days was done to identify any other residents affected. No other resident section D MDS assessment was found to be coded incorrectly. Social Services Director re-educated Social Services Assistant on accurate section D completion. An audit of residents' section K of the MDS for the last 30 days was done to identify any other residents affected. No other resident section K MDS assessment was found to be coded incorrectly. Registered Dietitian re-educated Dietary Manager on accurate section K completion. 3. Completed MDS's section D will be reviewed by Social Services Director to ensure accurate coding of this section weekly times one month, then monthly times one quarter. Completed MDS's section K will be reviewed by the Registered Dietitian to ensure accurate coding of this section weekly times one month, then monthly times one quarter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

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F 278	Continued From page 12 Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the facility staff failed to ensure a complete and accurate MDS for Resident #7. The surveyor notified the AT that Resident #7's Quarterly MDS with the ARD of 5/3/17 was incorrect. The surveyor informed the AT that the facility staff had documented dashes (-) in Section D0100 and D0200. The surveyor notified the AT that Resident #7 was unable to answer the questions related to her cognitive status and therefore should have been coded as a 9 (no response). No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate MDS assessment for Resident #7. 2. For Resident #11 the facility staff failed to ensure a complete and accurate Quarterly Minimum Date Set with an Assessment Reference Date (ARD) of 3/20/17. The facility staff failed to code a significant weight gain-39.2 pounds- in Section K. The facility staff also failed to ensure a complete and accurate Admission MDS assessment with an ARD of 10/17/16. The facility staff failed to code/capture a UTI in the past 30 days. Resident #11 was an 80 year old female who was admitted on 10/8/16. Admitting diagnosis included, but were not limited to: adult failure to thrive, osteoporosis, protein calorie malnutrition and a urinary tract infection (UTI). The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 3/20/17. The facility	F 278	4. Any deficient practice regarding section K and section D of MDS assessments will be brought to the QAPI Committee monthly for discussion/resolution. 5. Date of Compliance: 7/20/2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 278	Continued From page 13	F 278		

staff coded that Resident #11 had a Cognitive Summary Score of 13. The facility staff also coded that Resident #11 was independent (0/1) to requiring total nursing (4/2) with Activities of Daily Living (ADL's). In Section K. 0200 the facility staff coded that Resident #11's height was 63 inches and weight was 138 pounds. In Section. K 0310 weight gain-Gain of 5% or more in the last month or gain 10% or more in the past 6 months - the facility staff coded "0" (no).

On June 7, 2017 at 7:35 a.m. the surveyor reviewed Resident #11's clinical record. Review of the clinical record produced Resident #11's weights since admission. The weights were documented as:

10/8/2016 98.8 pounds
10/22/16 100.6 pounds
10/26/16 100 pounds
11/2/16 103 pounds
11/9/16 103 pounds
11/16/16 107 pounds
11/23/16 109 pounds
12/6/16 115 pounds
12/21/16 117 pounds
12/29/16 124 pounds 12/30/16 124 pounds
1/7/17 122 pounds
2/6/17 125 pounds
3/10/17 138 pounds

The surveyor noted that Resident #11 gained 39.2 pounds from admission until 3/20/17. A total of 32.3% weight gain in 6 months.

Continued review of the clinical record produced Resident #11's Admission Record where she was admitted into the local hospital on 10/7/16. The hospital admission documented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 278		F 278		

Continued From page 14 that Resident #11 had symptoms of hematuria, a urine culture that the Doctor diagnosed as a UTI and received Levaquin for the treatment of a UTI.

Further review of the clinical record produced an Admission MDS assessment with an ARD of 10/17/16. The facility staff coded that Resident #11 had a Cognitive Summary Score of 14. The facility staff also coded that Resident #11 required set up (1/1) to total nursing care (4/2) with ADL's. In Section I. Active Diagnoses I2300 the facility staff did not code/capture a UTI in the past 30 days.

On June 7, 2017 at 8:40 a.m. the surveyor notified the MDS Nurse that Resident #11's Quarterly MDS with the ARD of 3/20/17 was inaccurate. The surveyor notified the MDS Nurse that Section K did not code/capture Resident #11's significant change weight. The surveyor reviewed the MDS with the MDS Nurse. The surveyor reviewed Section K with the MDS Nurse. The surveyor pointed out that Section K did not code/capture a significant weight change. The surveyor then reviewed Resident #11's weights since admission. The surveyor pointed out that Resident #11 had a 39.2 pound weight gain from 10/8/16 through 3/10/17. The MDS Nurse stated that the Dietary Manager was new in her position and had just started completing Section K. The surveyor also notified the MDS Nurse that Resident #11's admission MDS assessment with an ARD of 10/17/16 was incorrect. The surveyor reviewed Resident #11's clinical record with the MDS Nurse. The surveyor pointed out the hospital admission where the physician documented signs and symptoms of a UTI-hematuria, a urine culture where the Doctor diagnosed that Resident #11 had a UTI and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 278	Continued From page 15 antibiotic treatment with Levaquin. The surveyor reviewed the Admission MDS with the MDS Nurse. The surveyor pointed out that Section I. I12300 was not coded to capture the UTI within the last 30 days. On June 8, 2017 at 4:10 p.m. the survey team met with the Administrator (Adm), Director of Nurses (DON), Assistant Director of Nursing (ADON), Social Workers (SW) and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the facility staff failed to ensure complete and accurate MDS's for Resident #11. The surveyor notified the AT that Resident #11's Quarterly MDS assessment with the ARD of 3/20/17 did not code/capture a significant weight gain-39.2 pounds- in the past 6 months. The surveyor also notified the AT that Resident #11's admission MDS assessment with the ARD of 10/17/17 did not code/capture a UTI within that past 30 days. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure complete and accurate MDS assessments for Resident #11.	F 278		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281	**281 D Services Provided Meet Professional Standards**	7/20/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 281	Continued From page 16 Based on staff interview and clinical record review, facility staff failed to follow professional standards of nursing practice for 1 of 24 residents in the survey sample (Resident #6). Resident #6 was admitted to the facility on 9/6/14. Diagnoses included congestive heart failure(CHF), chronic kidney disease (CKD), dementia, and hypertension (HTN). On the minimum data set assessment with assessment reference date 5/18/17, the resident scored 3 of 15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting others. Section I 2300 was coded for urinary tract infection (UTI). During clinical record review, the surveyor noted laboratory results for a urinalysis from the clinical laboratory with order date 4/28/17 and fax stamp to the facility 5/2/17 noted faxed to the physician on 5/3/17. Written on the lab results was "Noted & faxed AF 5-3-17", "Ceftin 500 mg po BID X 3 days" unsigned, and "[physician initials] 5/3/17". The surveyor was unable to locate evidence of symptoms associated with urinary tract infection or communication with a physician concerning those symptoms. Nursing notes did not indicate that a physician had ordered the test. On 6/7/17, the surveyor discussed the issue with LPN #1. LPN #1 stated she had written the order on the basis of standing orders. The surveyor asked if there should have been a nursing note documenting the order had been written, the basis for the order, and notification of the physician and the resident's responsible party. The nurse said she thought she had written a note. The surveyor asked the assistant director of nursing (ADON) for a copy of the standing orders. The ADON provided the standing orders	F 281	1. Facility residents have the potential of being affected by this practice. Resident #6 had results from a urinalysis on clinical record without proper indication. Order was initiated from standing orders due to resident spitting out medications on 4-27-17 and increased confusion on 4-28-17. Urinalysis was positive for UTI and treatment was ordered. 2. An audit of residents with urinalysis for the past 30 days for proper indication per standing orders was performed by Assistant Director of Nursing; no further concerns were noted. 3. Assistant Director of Nursing/Designee will run an order listing report to focus on proper indication for urinalysis per standing order and will report during morning meeting. 4. Any deficient practice regarding improper indications of urinalysis per standing orders will be brought to the QAPI Committee monthly for discussion/resolution. 5. Date of Compliance: 7/20/2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 281		F 281		

Continued From page 17 and a copy of a note (which had not shown on the surveyor's clinical record access) titled SBAR-Change of condition Effective Date: 4/26/2017 11:15 Situation: Resident spit out med's Background: 95 y/o with CHF, CKD, Dementia with Behavioral Disturbance, Hypothyroidism, HTN, DNR (do not resuscitate), NEURONTIN, TAGAMET, ACE INHIBITORS Assessment: Resident spit out all her medication this AM. Medication included ASA (aspirin) 81 mg, Coreg, Mirilax Response: Dr [name] group aware[family name] aware. The surveyor asked why the note had not been visible during clinical record review and to LPN #1. The ADON stated they were available to her.

During a summary meeting on 6/7/17, the surveyor asked for the nursing policy concerning use of standing orders. The surveyor was interested in specific situations where they would be used, when the physician and family should be notified, and what should be documented. The surveyor pointed to two times during April 2017 when there were new orders and the nurse documented receiving the order and notifying the family. During a meeting on 6/8/17, the DON reported that there was no policy concerning use of standing orders. The surveyor read the standing orders. Standing orders are as follows " IV. Symptom Treatment E. Dysuria, Foul Smelling, decreased LOC, or Agitation---- Obtain urinalysis with C&S. If positive report results to MD". The surveyor read the urinalysis. The order dated 4/27/17 10:20 documented a phone order from Dr [name] UA C&S d/t (urinalysis with culture and sensitivity due to) confusion. The surveyor stated that confusion was not one of the reasons the standing orders listed for obtaining a urinalysis. The ADON said that the resident spit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 281	Continued From page 18 out medications (on the morning of 4/26/17) and that was a sign of agitation. The surveyor observed that the order for the urinalysis was written 24 hours later and a different reason stated. The surveyor also noted that the physician could have been contacted during that time. The physician progress note dated 5/10/17 documented no nursing concerns. There was no mention of treating a urinary tract infection in the last week. During the final summary meeting with facility administrative staff on 6/8/17, the surveyor reiterated concerns with the utilization of standing orders without indication and notification and the lack of a nursing policy concerning the use of the standing orders.	F 281		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 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	F 309	**F309 D Provide Care Services for Highest Well Being.** 1. Facility residents have the potential to be affected by this practice. Resident #9 was ordered Bactrian bid times 10 days on 4/29/17. It was noted that only 19 doses of this antibiotic were administered. Antibiotic was discontinued by physician during facility rounds on 5/9/17. Resident #10 was administered 6pm medications twice. Upon physician notification, vital signs were ordered, but vital signs were not obtained per frequency order.	7/20/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 309	Continued From page 19 practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to follow physician's orders for 3 of 21 residents (Resident #3, Resident #10 and Resident #9). The findings included: 1. The facility staff failed to follow physician orders for the administration of Resident #3's medications. Resident #3 received her roommate's medications during the medication pass on 10/6/16. The clinical record of Resident #3 was reviewed 6/7/17. Resident #3 was admitted to the facility 10/28/14 with diagnoses that included but not limited to paranoid schizophrenia, type 2 diabetes mellitus, depressive disorder, polyosteoarthritis, constipation, hyperlipidemia, personality disorder,	F 309	2. An audit of residents with antibiotic orders was performed by Assistant Director of Nursing to identify any other concerns; no other concerns were noted. A medication error audit was performed by Assistant Director of Nursing to identify physician orders post medication error; no other concerns were noted. 3. Director of Nursing/Designee will be reviewing order listing report in morning meeting to identify any new orders post medication errors and new antibiotic orders to insure the physician's orders are followed. 4. Any deficient practice regarding following physicians orders will be brought to the QAPI Committee monthly for discussion/resolution. 5. Date of Compliance: 7/20/2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 309		F 309		

Continued From page 20 secondary parkinsonism, hypertension, and gastroesophageal reflux disease.

Resident #3's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 4/20/17 assessed the resident with a cognitive summary score of 15 out of 15 in Section C Cognitive Patterns.

The surveyor reviewed the progress notes for Resident #3 from July 2016 through June 2017. The progress note dated 10/6/16 at 18:25 (6:25 p.m.) read "Medication error at 1730 Background: 69yr (year) old female with hx (history) of paranoid schizophrenia, constipation, MDO (major depressive disorder), personality disorder, parkinsonism, essential HTN (hypertension), GERD (gastroesophageal reflux disease). Allergies: Banana, strawberry, valium. Assessment: Inadvertently administered lamictal 100 mg (milligrams), metformin 1000 mg, zarontin 250 mg, diazepam 5 mg, and glipizide 2.5 mg VS (vital signs): B/P (blood pressure) 135/55, P (pulse)-64, R (respirations)-17, T (temperature), 97.8, O2 (oxygen saturation) 91%. Resident stated feeling tired at this time. No other reactions noted at this time. No noted rash at this time. Response: Spoke with on-call MD Received order to monitor VS and blood sugar q (every) 4 hrs (hours) times 16 hrs and monitor for steven-johnson rash and if this develops then to send resident to the hospital immediately. May administer Benadryl per standing order in needed."

Resident #3's October 2016 physician orders did not include the medications administered above but included Zaditor eye drops and Glycol.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 309		F 309		

Continued From page 21

The surveyor informed the administrative staff of the medication administration error that occurred when the physician's orders were not followed in the end of the day meeting on 6/7/17 at 4:10 p.m. and requested the medication error for 10/6/16. The director of nursing stated the nurse handed the pills to Resident #3 and she took them. The DON stated the nurse received education.

The medication error form dated 10/6/2016 had three columns. The last column titled "Medication Administration" was checked. The first question read "Which of the following was involved?" Checked was "Right patient". "What Procedure was not followed?" Checked was "Resident not properly identified". "How did this error occur?" Checked was "Other: med administered to wrong resident." "Section 4: Categorize the error: Did the resident experience any negative effects from the error?" Checked were "NO. An error or omission occurred, but corrective action took place before the resident was negatively harmed. NO: An error or omission occurred, but monitoring confirmed the absence of negative effects. Were resident's vital signs monitored every 15 min after the error was discovered? No. Was the resident admitted to the hospital after transfer? No."

No further information was provided prior to the exit conference on 6/8/17.

2. The facility staff failed to follow physician orders for medication administration for Resident #10. Resident #10 received medications (Xanax and Oxycodone) on 3/28/17 at 4:45 p.m. and again 1 hour and 15 minutes later at 6:00 p.m.

The clinical record of Resident #10 was reviewed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 309		F 309		

Continued From page 22

6/7/17. Resident #10 was admitted to the facility 9/1/16 with diagnoses that included but not limited to right shoulder pain, atrial fibrillation, chronic obstructive pulmonary disease (COPD), anxiety disorder, gastroesophageal reflux disease (GERD), major depressive disorder, hyperlipidemia, type 2 diabetes mellitus (DM), hypertension, and nicotine dependence.

Resident #10's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/27/17 assessed the resident with a cognitive summary score of 15 out of 15 in Section C Cognitive Patterns and with no signs or symptoms of delirium, psychoses or behaviors affecting others.

Current comprehensive care plan initiated 9/2/16 and revised 1/16/17 identified that Resident #10 needs pain management and monitoring related to chronic back pain. Interventions: Administer pain medication as ordered. Care plan also included one for potential for drug related complications associated with use of psychotropic medications related to anti-anxiety and antidepressants. Interventions: Provide medications as ordered by physician and evaluate the effectiveness.

The clinical record contained a telephone order dated 3/28/17 18:30 (6:39 p.m.) that read "Monitor vital signs every hour x 15 hours every hour for 15 administrations."

The surveyor reviewed the progress notes for 3/28/17. The 3/28/17 18:18 (6:18 p.m.) progress note read "SBAR-Change of Condition Situation: Nurse administered Xanax 0.5 mg (milligrams) and oxycodone 10 mg at 1645 (4:45 p.m.). Meds

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 309		F 309		

Continued From page 23

(medications) were due at 6pm. Meds were administered again at 6pm. Background: 80 year old male with a history of atrial fibrillation, COPD, anxiety, GERD, DM due to underlying condition with hyperglycemia, hyperlipidemia, major depressive disorder, HTN, Type 2 DM with diabetic neuropathy, autonomic neuropathy, anemia, Code Status: Full Code. Allergies: NKA (No Known Allergy). Response: MD (name omitted) contacted and stated resident may be very relaxed but will be okay. Message left for RP to return call to facility. DON notified. VS (vital signs) to be checked q (every) hr (hour) x 15 hrs d/t (due to) half-life of Xanax is 15 hrs."

Resident #10's March 2017 physician orders were reviewed and included Xanax 0.5 mg Give 0.5 mg by mouth four times a day related to anxiety Order date 10/6/2016 and Oxycodone HCL 10 mg Give 10 mg by mouth every 6 hours for pain Order date 9/8/2016.

The surveyor requested the medication error for Resident #10 from the assistant director of nursing on 6/7/17. The "Medication Incident" dated 3/28/17 read "Xanax 0.5 mg and Oxycodone 10 mg given at 1645 (4:45 p.m.) and 1800 (6:00 p.m.). Explanation: Nurse forgot to sign out med. Action taken: Nurse educated on eMAR and how it works."

The surveyor informed the administrative staff of the concern in the end of the day meeting on 6/7/17 at 4:10 p.m. The DON stated the nurse had received education.

No further information was provided prior to the exit conference on 6/8/17.

3. For Resident #9, facility staff failed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 309	Continued From page 24 administer an antibiotic medication per physician orders. Resident #9 was admitted to the facility on 6/21/15. Diagnoses included traumatic amputation of a limb, peripheral vascular disease, kidney disease, depression, congestive heart failure, diabetes mellitus, and Crohn's disease. On the minimum data set assessment with assessment reference date 3/21/17, the resident scored 15/15 on the brief interview for mental status. The resident was assessed with out signs of delirium, psychosis, or behavior affecting others. During clinical record review on 6/7/17, the surveyor noted a physician telephone order dated 4/29/17 for Bactrim DS Tablet 800-160 MG (Sulfamethoxazole-Trimethoprim) Give 1 mg (milligram) by mouth once a day for UTI (urinary tract infection) for 10 days Give 1 tab (tablet) by mouth BID (twice per day) X 10 days. The medication administration record (MAR) documented administration of the medication two times per day 4/30/17 through 5/8/17 and 1 dose on 5/9/17 for a total of 19 doses. The surveyor reported the concern to the assistant director of nursing on 6/7/17 and requested information concerning the omitted dose of antibiotic. No additional information was available. The surveyor discussed the concern again during a summary meeting with the administrator and director of nursing on 6/8/17.	F 309		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out	F 312	**F312 D ADL Care Provided for Dependent Residents.**	7/20/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 312	Continued From page 25 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 interview, group interview, staff interview, clinical record review and in the course of a complaint investigation, the facility staff failed to provide ADL (activities of daily living) care to 1 of 21 residents (Resident #1). The findings included: The facility staff failed to provide ADL care to a dependent resident (Resident #1). The facility staff failed to provide showers two times a week to Resident #1. The clinical record of Resident #1 was reviewed 6/6/17 and 6/7/17. Resident #1 was admitted to the facility 4/30/14 with diagnoses that included but not limited to Parkinson's disease, constipation, muscle weakness and difficulty in walking, type 2 diabetes mellitus, hyperlipidemia, heart failure, depressive disorder, anxiety disorder, hypertension, and atrial fibrillation. Resident #1's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/29/17 assessed the resident with a brief interview for mental status as 15 out of 15 in Section C Cognitive Patterns. No signs of delirium, psychoses or behaviors that affected others were assessed. Resident #1 needed extensive assistance of one person for bed mobility, transfers toilet use; limited assistance of one for personal hygiene, and was totally dependent on one person for bathing.	F 312	1. Facility residents have the potential to be affected by this practice. Resident #1's ADL record did not show that resident received two shower within a week. Resident did not show any adverse reaction to such practice. Resident has had two showers per week since concern was identified. 2. A shower audit was performed to focus on two showers per week per resident for the past 30 days; no deficient practice was noted. Unit Manager re-educated certified staff on ensuring showers are provided timely and documented accurately. 3. Resident shower records will be audited by Director of Nursing/Designee weekly during morning meeting to identify any deficient practice and allow for immediate intervention. 4. Any deficient practice regarding shower delivery or documentation will be brought to the QAPI Committee monthly for discussion/resolution. 5. Date of Compliance: 7/20/2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

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F 312		F 312		

Continued From page 26

Resident #1's current comprehensive careplan initiated 10/22/14 and revised 5/3/17 read that the resident had a physical functioning deficit related to self-care management. Interventions: Dressing assistance from staff, personal hygiene assistance from staff. The care plan also identified impaired neurological status related to Parkinson's disease. Interventions: Assist in ADL's as needed.

The surveyor interviewed Resident #1 on 6/7/17 at 7:55 a.m. Resident #1 stated she had some concerns about the staff on the unit and the care that was provided. Resident #1 stated she was not always given a bath or shower twice a week.

The surveyor reviewed the August 2016, September 2016, and October 2016 bath/shower sheets. The facility staff provided the ADL (activities of daily living) Flow Sheet Log for the requested months.

The September 2016 ADL Flow Sheet Log revealed Resident #1 did not receive two showers the week of 9/4/16 (Sunday) through 9/10/16 (Saturday). Resident #1 did not receive a shower for 10 days in September 2016 from 9/3/16 through 9/12/16.

The surveyor reviewed the progress notes from 9/1/16 through 9/14/16. There was no documentation that Resident #1 refused a bath or shower. Resident #1 was on a leave of absence with her family from 1:29 p.m. on 9/11/16 until 5:00 p.m. 9/11/16.

The surveyor interviewed certified nursing assistant #3 on 6/7/17 at 12:35 p.m. C.N.A. #1 stated baths are given 2 times a week as long as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 312	Continued From page 27 the resident doesn't refuse. C.N.A. #3 stated the certified nursing assistants chart when she gives the residents their baths. C.N.A. #3 stated she was the bath team for the A unit and worked Monday-Friday. The surveyor interviewed certified nursing assistant #4 on 6/7/17 at 9:30 a.m. C.N.A. #4 stated baths are given 2 times a week. C.N.A. #4 stated she was the bath team on B unit and the bath team worked Monday through Friday. The surveyor held a group meeting with seven residents of the facility on 6/7/17 at 10:00 a.m. The group stated that most got their showers at least 2 times a week. The surveyor informed the administrative staff of the failure to provide two showers/baths to Resident #1 during September 2016 (9/3/16 through 9/12/16) during the day meeting on 6/8/17 at 11:55 a.m. The administrative staff stated they thought that Resident #1 had a death in the family in September 2016 and the resident was away from the facility but couldn't recall the exact days. No further information was provided prior to the exit conference on 6/8/17. This is a complaint deficiency.	F 312		
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must:	F 328	**F328 D Treatment Care for Special Needs.**	7/20/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 328	Continued From page 28 (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the	F 328	1. Facility residents have the potential to be affected by this practice. Resident #2's nebulizer tubing was noted by the surveyor not to be dated. Nurse immediately identified concern. 2. An audit of nebulizer tubing was completed by Regional Clinical Consultant; no concerns were noted. Administrator re-educated Central Supply Coordinator/Backup to utilize a census sheet and check off nebulizer tubing as changed and dated during weekly rounds. 3. During morning meeting, the Administrator/Designee will request that Care Keeper Round Sheets be submitted by department heads with any nebulizer tubing concerns for correction. 4. Any deficient practice regarding nebulizer tubing will be brought to the QAPI Committee monthly for discussion/resolution. 5. Date of Compliance: 7/20/2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 328		F 328		

Continued From page 29 comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.

(j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and clinical record review, the facility staff failed to store nebulizer equipment in a clean and sanitary condition for 1 of 21 residents in the survey sample (Resident #2).

The findings included:

Resident #2 was readmitted to the facility on 10/13/16 with the following diagnoses of, but not limited to high blood pressure, dementia, anxiety disorder, depression, manic depression and chronic obstructive pulmonary disease. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/26/17, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 3 out of a possible score of 15. Resident #2 also requires extensive assistance of 2 staff members for dressing and is totally dependent on 2 staff members for personal hygiene and bathing.

On 6/7/17 at 7:40 am, the surveyor went into Resident #2's room and was attempting to talk with resident. The surveyor observed a plastic bag on the table beside the bed that contained a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 328	Continued From page 30 nebulizer mask in it. On the outside of the bag was written a date of 5/6/17 on it. The surveyor lifted the bag to view the nebulizer tubing on it and there was no date written on the tubing either. The assistant director of nursing stepped in the room and the surveyor asked how often the nebulizer mask and tubing was changed. The assistant director of nursing stated "they are to be changed weekly." The surveyor asked how someone would know if this had been done. The assistant director of nursing stated "they should write the date of the change on the outside of the plastic bag or put a piece of tape on the tubing with the date written on it." The surveyor asked if she could see a date on either and the assistant director of nursing stated "I do but it says 5/6/17. I will go and change out this complete set now and label it correctly." The administrative team was notified of the above documented findings on 6/7/17 at 4:10 pm in the conference room by the surveyor. No further information was provided to the surveyor prior to the exit conference on 6/8/17.	F 328		
F 364 SS=D	483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP (d) Food and drink Each resident receives and the facility provides- (d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature; This REQUIREMENT is not met as evidenced	F 364	**F364 D Nutritive Value/Appear, Palatable/Prefer Temp.** 1. Facility residents have the potential to be affected by this practice. Resident #1's lunch chicken patty was noted to be tough and dry. Dietary Manager offered other options to Resident #1; resident denied offer.	7/20/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 364	Continued From page 31 by: Based on observation, group interview, resident interview, staff interview, and in the course of a complaint investigation, the facility staff failed to serve food that was palatable to 1 of 21 residents (Resident #1). The findings included: The facility staff failed to ensure that the food served to Resident #1 was palatable. The clinical record of Resident #1 was reviewed 6/6/17 and 6/7/17. Resident #1 was admitted to the facility 4/30/14 with diagnoses that included but not limited to Parkinson's disease, constipation, muscle weakness and difficulty in walking, type 2 diabetes mellitus, hyperlipidemia, heart failure, depressive disorder, anxiety disorder, hypertension, and atrial fibrillation. Resident #1's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/29/17 assessed the resident with a brief interview for mental status as 15 out of 15 in Section C Cognitive Patterns. No signs of delirium, psychoses or behaviors that affected others were assessed. Resident #1 needed extensive assistance of one person for bed mobility, transfers toilet use; limited assistance of one for personal hygiene, and was totally dependent on one person for bathing. The surveyor interviewed Resident #1 on 6/7/17 at 7:55 a.m. Resident #1 stated she had some concerns about food service at the facility and requested the surveyor to eat lunch with her. Resident #1 stated the boiled eggs were so hard they bounce, the meatloaf was a hamburger patty	F 364	2. Random verbal interviews were done with residents who had received chicken patties on their tray to focus on toughness and dryness of the meat; no further concerns were voiced by residents. 3. An in-service was completed by Dietary Manager with dietary team to focus on the placement of chicken patties on the pans in the steamer oven to allow the steam to make contact with each patty more evenly to help prevent toughness and dryness. A random audit of chicken patties will be performed by the Dietary Manager/Designee to ensure proper texture and moistness when such food item is offered times one month. 4. Any deficient practice regarding tough and dry chicken patties will be brought to the QAPI Committee monthly for discussion/resolution. 5. Date of Compliance: 7/20/2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 364		F 364		

Continued From page 32 with ketchup, sweet potatoes were served with lima beans, and hamburgers were served with boiled cabbage and chips. Resident #1 stated the gravy was so thin you could see through it. The potato soup had no potatoes-it looked like milk.

Resident #1's physician's order was for the resident to receive a regular diet.

The surveyor conducted a group interview on 6/7/17 at 10:00 a.m. with seven residents of the facility. These residents were asked if the foods they were served were hot and if the flavor and appearance was satisfactory. The majority of the group stated the food was not served hot.

Statements made by the group included: "Can't chew the meat. It's like shoe leather. Sometimes it's hot. They don't believe in heating cornbread. They won't toast a piece of white bread. Too much rice and noodles and pinto beans. Anything covered with gravy is something that's probably tough."

The tray line temperatures were obtained for lunch on 6/7/17 at 11:15 a.m. by a second surveyor. The temperatures were as follows:
Beef liver and onions-187
Potatoes-178
Corn-200
Gravy-200
Pureed meat-200
Mash potatoes-204
Ground liver-196
Pureed cream corn-195
Chicken patty-163
Cream of chicken soup-200
Pureed bread-165

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 364		F 364		

Continued From page 33

Noodles-198
Rice-200
Green beans-175
Potatoes-200

Resident #1's tray along with a test tray was served at 11:50 a.m. by the dietary manager and the regional dietary service manager. Resident #1 received green beans, corn, and a chicken patty on a bun but stated her family had brought her something to eat from outside. The surveyors and the regional dietary manager sampled the food. Two surveyors tasted the chicken patty, corn and green beans along with the regional dietary manager.

The first surveyor cut the chicken patty. The chicken patty was tough and hard to cut and both surveyors stated the chicken patty was dry when eaten. The regional dietary manager agreed the chicken was hard to cut and dry to the taste. All agreed the temperature was warm enough.

Two surveyors and the regional dietary manager sampled a test tray in the dining room on 6/7/17 at 12:45 p.m. The test tray completed in the dining room was found to be warm and palatable when eaten (green beans, liver and onions, and corn).

The surveyor informed the administrative staff of the concern with the palatability of the test tray served to Resident #1 in the end of the day meeting on 6/7/17 at 4:10 p.m.

No further information was provided prior to the exit on 6/8/17.

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
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 372 SS=C	483.60(i)(4) DISPOSE GARBAGE & REFUSE PROPERLY (i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined that the facility staff failed to ensure that the dumpster area was clean and well maintained. The Findings Included: On June 6, 2017 at 1:30 p.m. the surveyor made an initial tour of the kitchen with the Dietary Manager (DM). The surveyor requested to view the dumpster area. The surveyor and DM left the kitchen and exited the back of the building. The surveyor observed the dumpster area. The surveyor observed that the dumpster area was littered with straws, empty packets of mayonnaise, plastic medicine cups, chocolate milk cartons, regular milk cartons, sweet and low "sugar" packets, used plastic envelopes-used to crush medications in, and drink tabs. The surveyor also noted that the door to the dumpster was open. The surveyor pointed out the trash that littered the ground surrounding the dumpster and that the dumpster door was open to the DM. The surveyor asked the DM who was responsible for keeping the dumpster area clean. The DM stated maintenance was responsible for keeping the dumpster area clean. On June 8, 2017 at 8:30 a.m. the surveyor notified the Maintenance Director (MD) that the dumpster area was littered with trash and that the door to the dumpster was left open. The surveyor asked the MD who was responsible for maintaining the dumpster area. The MD stated	F 372	**F372 C Dispose Garbage and Refuse Properly.** 1. No facility residents had the potential to be affected by this practice. 2. No facility residents had the potential to be affected by this practice. 3. Administrator re-educated Dietary Manager on the importance of keeping dumpster area clean. During morning meeting, Dietary Manager/Designee will report on sanitary conditions of dumpster area via Care Keeper Round Sheets. 4. Any deficient practice regarding the sanitation an overall apperance of the dumpster area will be brought to the QAPI Committee monthly for discussion/resolution. 5. Date of Compliance: 7/20/2017	7/20/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 372	Continued From page 35 he thought it was the dietary department was responsible for keeping the area clean. On June 8, 2017 at 11:50 a.m. the survey team met with the Administrator (Adm), Director of Nurses (DON), Assistant Director of Nursing (ADON), Social Workers (SW), Corporate Compliance Nurse (CCN) and House Supervisor. The surveyor notified the Administrative Team (AT) that the dumpster area was not clean and well maintained. The surveyor notified the AT of the multiple items that littered the ground surrounding the dumpster area on June 6, 2017. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure that the dumpster area was clean and well maintained.	F 372		
F 425 SS=E	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (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. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to ensure physician	F 425	**425 E Pharmaceutical SVC Accurate Procedures.** 1. Facility residents have the potential to be affected by this practice. Residents #1, #14, #7, #8, #2, and #5 were noted to have missed medication doses due to medications not being available/not delivered timely by pharmacy.	7/20/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 425	Continued From page 36 ordered medications were available for administration for 5 of 21 residents (Resident #1, Resident #14, Resident #7, Resident #8, Resident #2, and Resident #5). The findings included: 1. The facility staff failed to ensure Resident #1's medication for Parkinson disease was available for administration. Neupro patch was not available for administration on 11/21/16 and 11/22/16. The clinical record of Resident #1 was reviewed 6/6/17 and 6/7/17. Resident #1 was admitted to the facility 4/30/14 with diagnoses that included but not limited to Parkinson's disease, constipation, muscle weakness and difficulty in walking, type 2 diabetes mellitus, hyperlipidemia, heart failure, depressive disorder, anxiety disorder, hypertension, and atrial fibrillation. Resident #1's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/29/17 assessed the resident with a brief interview for mental status as 15 out of 15 in Section C Cognitive Patterns. No signs of delirium, psychoses or behaviors that affected others were assessed. Resident #1 needed extensive assistance of one person for bed mobility, transfers toilet use; limited assistance of one for personal hygiene, and was totally dependent on one person for bathing. Resident #1's current comprehensive care plan initiated 10/22/14 and revised 5/3/17 included impaired neurological status related to Parkinson's disease. Interventions: Medication as ordered by physician.	F 425	2. An audit of medication administration and availability was performed to focus on the past 30 days; no further deficient practice was noted. Director of Nursing re-educated licensed staff regarding immediate contact with pharmacy when a medication is not available and request it be sent by backup pharmacy. 3. Unit Manager/Designee will review nursing documentation during daily morning meeting to identify medications not available documented in the clinical record for follow up with pharmacy, physician and responsible party. 4. Any deficient practice regarding unavailable medications will be brought to the QAPI Committee monthly for discussion/resolution. 5. Date of Compliance: 7/20/2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 425		F 425		

Continued From page 37

The surveyor interviewed Resident #1 on 6/7/17 at 7:55 a.m. Resident #1 stated she had some concerns about medication administration. She showed the surveyor a notebook where she documented important information. Resident #1 stated in November 2016 on 11/20/16, 11/21/16 and 11/22/16, the staff didn't have her Parkinson's patch to put on.

The surveyor reviewed the November 2016 progress notes and November 2016 electronic medication administration records (eMAR) on 6/7/17.

The November 2016 electronic medication administration record (eMAR) had entries for Neupro Patch 24 hour 2 mg/24 hr. The first entry read to remove (at 8:29 a.m.) and the second entry read to apply (0830). The boxes for apply on 11/21/16 and 11/22/16 had "7" in both boxes. The legend at the bottom read "7=Other/See Nurse's Notes".

The progress note for 11/21/16 8:47 a.m. read "Neupro Patch 24 hour 2 mg (milligram)/24 HR (hour) Apply 1 patch transdermally one time a day related to Parkinson's disease and remove per schedule Awaiting arrival."

The progress note for 11/22/16 8:05 a.m. read "Neupro Patch 24 hour 2 mg (milligram)/24 HR (hour) Apply 1 patch transdermally one time a day related to Parkinson's disease and remove per schedule Awaiting arrival."

The progress note of 11/22/16 14:55 (2:55 p.m.) read "Contacted Alixa and spoke with ___ (name omitted) at alixa related to neupro patch. Patch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 425	Continued From page 38 will be on next pharmacy run." The surveyor informed the administrative staff of the above concern during the end of the day meeting on 6/7/17 at 4:40 p.m. The director of nursing stated that the facility had self-identified the issue of medications not available in April 2017. The DON stated they found they were running out of medications so a count sheet was started. The DON stated the issue had been a daily struggle. The DON stated the facility does have a back-up pharmacy. The surveyor reviewed the facility policy titled "Unavailable Medications" on 6/8/17. The policy read in part "Medications used by residents in the nursing facility may be unavailable for dispensing from the pharmacy on occasion. The situation may be due to the pharmacy being temporarily out of stock of a particular product, a drug recall, manufacturer's shortage of an ingredient, or the situation may be permanent because the drug is no longer being made. The facility must make every effort to ensure that medications are available to meet the needs of each resident. Procedures B. Nursing staff shall: 1) Notify the attending physician of the situation and explain the circumstances, expected availability and optional therapy (ies) that are available. A. If the facility nurse is unable to obtain a response from the attending physician, the nurse should notify the nursing supervisor and contact the Facility Medical Director for orders and/or direction. 2) Obtain a new order and cancel/discontinue the order for the non-available medication. 3) Notify the pharmacy of the replacement order." No further information was provided prior to the exit conference on 6/8/17.	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 425	Continued From page 39 2. The facility staff failed to ensure Resident #14's medications were available for administration. Cyanocobalamin 1000 mcg (micrograms) was not available for administration on 5/26/17; Rena-Vite tablet was not available for administration on 5/26/17; Calcium Acetate 667 mg (milligram) was not available for administration on 6/3/17, 6/4/17, 6/5/17, 6/6/17, and 6/7/17; Dialyvite was not available for administration on 6/4/17; and Gabapentin 300 mg was not available for administration on 6/5/17. The clinical record of Resident #14 was reviewed 6/8/17. Resident #14 was admitted to the facility 5/8/17 with diagnoses that included but not limited to Type 1 Diabetes Mellitus, chronic kidney disease, (stage 4 severe), ESRD (end stage renal disease now on dialysis), hypertension, hyperlipidemia, acute respiratory failure, anemia in chronic kidney disease, pleural effusion, developmental disorder of scholastic skills, depressive disorder, and gastroesophageal reflux disease. Resident #14's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/16/17 assessed the resident with a cognitive summary score of 9 out of 15 in Section C Cognitive Patterns. Resident #14's current comprehensive careplan initiated 5/11/17 included alteration in kidney function evidenced by CKD (chronic kidney disease) current receiving hemodialysis. Interventions: Administer medications as ordered collaborating with Physician and/or pharmacist for optimal medication dose times.	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 425		F 425		

Continued From page 40

The surveyor reviewed Resident #14's progress notes from May 2017 through June 2017. The progress note dated 5/26/17 at 10:22 a.m. read "Cyanocobalamin Tablet Give 1000 mg by mouth one time a day related to anemia in chronic kidney disease Not available pharmacy called."

The progress note also dated 5/26/17 at 10:22 a.m. read "Rena-Vite Tablet Give 1 tablet one time a day related to chronic kidney disease Drug not available, pharmacy called."

The progress note date 6/3/17 12:43 p.m. read "Calcium Acetate Capsule 667 mg Give 1 capsule by mouth before meals related to Gastro-esophageal reflux disease without esophagitis none available called pharmacy."

The progress note dated 6/3/17 17:40 (5:40 p.m.) read "Calcium Acetate Capsule 667 mg Give 1 capsule by mouth before meals related to Gastro-Esophageal Reflux Disease Without Esophagitis awaiting med from pharmacy."

The 6/4/17 7:44 a.m. progress note read: Calcium Acetate Capsule 667 mg Give 1 capsule by mouth before meals related to Gastro-esophageal reflux disease without esophagitis Not arrived from pharmacy."

The progress note dated 6/5/17 at 17:30 (5:39 p.m.) read "Calcium Acetate Capsule 667 mg Give 1 capsule by mouth before meals related to Gastro-esophageal reflux disease without esophagitis Pharmacy aware still waiting."

The progress note dated 6/6/17 16:54 (4:54 p.m.) read "Calcium Acetate Capsule 667 mg Give 1 capsule by mouth before meals related to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 425		F 425		

Continued From page 41

Gastro-esophageal reflux disease without esophagitis Pharmacy notified and still waiting."

The progress note dated 6/7/17 16:54 (11:02) read "Calcium Acetate Capsule 667 mg Give 1 capsule by mouth before meals related to Gastro-esophageal reflux disease without esophagitis Pharmacy notified and still waiting."

The progress note dated 6/4/17 10:58 read "Dialyvite tablet Give 1 tablet by mouth one time a day for supplement Have not received from pharmacy."

The progress note dated 6/5/17 17:38 (5:38 p.m.) read "Gabapentin capsule 300 mg Give 1 capsule by mouth three times a day related to Type 1 Diabetes mellitus With Hyperglycemia for 1 week not available called pharmacy."

The surveyor informed the assistant director of nursing when Resident #14's medications were not available for administration on 5/26/17 and 6/3-6/7 on 6/8/17 at 2:40 p.m.

The surveyor informed the administrative staff of the above concern on 6/8/17 at 4:00 p.m. The director of nursing stated that the facility had self-identified the issue of medications not available in April 2017. The DON stated they found they were running out of medications so a count sheet was started. The DON stated the issue had been a daily struggle. The DON stated the facility does have a back-up pharmacy.

The surveyor reviewed the facility policy titled "Unavailable Medications" on 6/8/17. The policy read in part "Medications used by residents in the nursing facility may be unavailable for dispensing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 425		F 425		

Continued From page 42 from the pharmacy on occasion. The situation may be due to the pharmacy being temporarily out of stock of a particular product, a drug recall, manufacturer's shortage of an ingredient, or the situation may be permanent because the drug is no longer being made. The facility must make every effort to ensure that medications are available to meet the needs of each resident. Procedures B. Nursing staff shall: 1) Notify the attending physician of the situation and explain the circumstances, expected availability and optional therapy (ies) that are available. A. If the facility nurse is unable to obtain a response from the attending physician, the nurse should notify the nursing supervisor and contact the Facility Medical Director for orders and/or direction. 2) Obtain a new order and cancel/discontinue the order for the non-available medication. 3) Notify the pharmacy of the replacement order."

No further information was provided prior to the exit conference on 6/8/17.
3. For Resident #7 the facility staff failed to ensure that physician ordered Benicar, an antihypertensive medication, was available for administration.

Resident #7 was an 87 year old female who was admitted on 2/1/16. Admitting diagnosis included, but were not limited to: dementia with behaviors, glaucoma, psychosis, diabetes mellitus, anxiety, hypertension, syncope with collapse and abnormal weight loss.

The most current Minimum Data Set (MDS) located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 5/3/17. The facility staff coded that Resident #7 had a Cognitive Summary Score of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 425		F 425		

Continued From page 43

3. The facility staff also coded that Resident #7 required set up (1/1) to total nursing care (4/2) with Activities of Daily Living (ADL's).

On June 7, 2017 at 9:30 a.m. the surveyor reviewed Resident #7's clinical record. Review of the clinical record produced signed physician orders dated 5/10/17. Signed physician orders included, but were not limited to: "Benicar Tablet 20 MG (Olmesartan Medoxomil) Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10)." (sic)

Continued review of the clinical record produced the May 2017 Medication Administration Records (MAR's). Review of the May 2017 MAR's documented that the Benicar was not available for administration on May 5th, 6th, 8th, 24th, 26th, and 31st of 2017.

On June 7, 2017 at 10:30 a.m. the surveyor notified the Unit Manager (UM), who was a Licensed Practical Nurse (LPN #1), that Resident #7 did not have physician ordered medications available for administration in May 2017. The surveyor reviewed Resident #7's clinical record with the UM (LPN #1). The surveyor reviewed the signed physician orders and pointed out the specific order for the Benicar. The surveyor then reviewed the May 2017 MAR's with the UN (LPN #1). The surveyor pointed out that the physician ordered Benicar was not available on May 5th, 6th, 8th, 24th, 26th and 31st of 2017. The surveyor asked if the facility had a back-up pharmacy and the UM (LPN #1) named a local pharmacy. The surveyor requested the facility policy and procedure for obtaining medications. On June 7, 2017 at 11:05 a.m. the Assistant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 425	Continued From page 44 Director of Nursing (ADON) hand delivered the facility policy and procedure for "Obtaining Unavailable Medications." The facility policy and procedure read ... "Policy Medications used by residents in the nursing facility may be unavailable for dispensing from the pharmacy on occasion. This situation may be due to the pharmacy being temporarily out of stock of a particular product, a drug recall, manufacturer's shortage of an ingredient, or the situation may be permanent because the drug is no longer being made. The facility must make every effort to ensure that medications are available to meet the needs of each resident. Procedure A. The pharmacy staff shall: 1) Call of notify the nursing staff that the ordered product (s) is/are unavailable. 2) Notify nursing when it is anticipated that the drug (s) will become available. 3) Suggest alternative, comparable drug (s) and dosage of drug (s) that is/are available, which is covered by the resident's insurance. B. The nursing staff shall: 1) Notify the attending physician of the situation and explain the circumstances, expected availability and optional therapy (ies) that are available. a. If the facility nurse if unable to obtain a response for the attending physician, the nurse should notify the nursing supervisor and contact the Facility Medical Director for orders and/or direction. 2) Obtain a new order and cancel/discontinue the order for the non-available medication. 3) Notify the pharmacy of the replacement order." (sic) On June 8, 2017 at 4:10 p.m. the survey team met with the Administrator (Adm), Director of Nurses (DON), ADON, Social Workers (SW) and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT)	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 425		F 425		

Continued From page 45

that the facility staff failed to ensure that physician ordered Benicar was available for administration on May 5th, 6th, 8th, 24th, 26th and 31st of 2017.

On June 8, 2017 the DON approached the surveyor and stated that she had not been aware that she/the facility staff could call and request the primary pharmacy to call the back-up pharmacy and have the back-up pharmacy supply the medications that were unavailable.

No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure that physician ordered medication was available for administration for Resident #7.

4. For Resident # 5, facility staff failed to ensure that medications ziprasidone and macrobid were available for administration.

Resident #8 was admitted to the facility on 12/31/15. Diagnoses included dementia with behavior disturbance, bipolar disorder, urinary tract infection, and hypertension. On the minimum data set assessment with assessment reference date 5/10/17, the resident scored 12/15 on the brief interview for mental status and was without signs of delirium, psychosis, or behaviors affecting others.

During clinical record review, the surveyor noted a nurse's note dated 4/23/17 09:09 e-MAR Medication Administration Note for Ziprasidone HCl capsule 20 mg Give 1 capsule by mouth two times a day related to unspecified mood [affective] disorder Take along with 80 mg to total 100 mg not available pharmacy says will be in today and 4/23/17 09:09 e-MAR Medication Administration Note for Ziprasidone HCl capsule 80 mg Give 1 capsule by mouth two times a day

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 425		F 425		

Continued From page 46

related to unspecified mood [affective] disorder Take along with 80 mg to total 100 mg not available. Notes with effective date 4/24/17 21:05 documented e-Mar Medication Administration Note documented medication arrived at facility 4/25/17. A nurse's note dated 4/23/17 11:11 e-MAR Medication Administration Note for Macrobid Capsule 100 mg Give 1 capsule by mouth two times a day related to urinary tract infection, site not specified for 5 days waiting on pharmacy. There was no evidence, either in the medication administration record or in the nurse's notes, that the medications were administered as ordered after arriving from the pharmacy. Nursing staff on site were unable to say whether the resident received the ordered number of doses of the antibiotic.

Surveyors discussed documented lack of availability of medications for multiple residents in the survey sample with the administrator, director of nursing, and assistant director of nursing during summary meetings on 6/8/17. They reported that there was no way for the facility to activate the backup pharmacy to obtain medications when they were not available from the primary pharmacy.

5. The facility staff failed to ensure physician ordered medication were available for administration to Resident #5.

Resident #5 was readmitted to the facility on 3/21/13 with the following diagnoses of, but not limited high cholesterol, Alzheimer's disease, aphasia, stroke, depression and muscle weakness. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/28/17 the resident was coded as having a BIMS (Brief Interview for Mental Status) score of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 425	Continued From page 47 15 out of a possible score of 15. The resident was also coded as requiring extensive assistance of one staff member for bathing, personal hygiene and being totally dependent on one staff member for bathing. During the clinical record review of Resident #5's record on 6/6 and 6/7/17, the surveyor noted the following entries documented in the nurses' notes which stated the following: ...3/11/17 19:24 (7:24 pm) Cefdnir Capsule 300 mg Give 1 capsule by mouth two times a day for pneumonia for 7 days ...3/11/17 19:34 pm Acetylcysteine Solution 20% 4 ml (milliliters) inhale orally two times a day for pneumonia for 7 days Awaiting on medication to arrive from pharmacy ..." On 4/7/17 at 19:09 (7:09 pm) the following was also documented in the nurses' notes as follows: " ...Hydrea Capsule Give 500 mg (milligram) by mouth in the evening ...Awaiting from pharmacy ..." The assistant director of nursing was notified of the above documented findings on 6/7/17 at approximately 10 am. The assistant director of nursing stated to the surveyor "The staff has a backup pharmacy that can be called if a medication cannot be readily available to obtain medications from. I don't know the circumstances in which I these cases this was not followed upon." The assistant director of nursing provided a copy of a policy titled "Unavailable Medications" which stated the following: ..."Nursing staff shall call the attending physician of the situation and explain the circumstances, expected availability and optional therapies that are available. Obtain a new order and cancel/discontinue the order for the non-available medication. Notify the pharmacy of the replacement order."	F 425		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 425	Continued From page 48 The administrative team was notified of the above documented findings on 6/7/17 at 4:10 pm in the conference room by the surveyor. No further information was provided to the surveyor prior to the exit conference on 6/7/17.	F 425		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (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. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be	F 431	**431 D Drug records, Label/Store Drugs & Biological** 1. Facility residents have the potential to be affected by this practice. Upon zinc-oxide noted to be in the unlocked cabinet, it was immediately removed by the Assistant Director of Nursing. An audit was immediately performed with no other issues noted. 2. An audit of medication storage was done and found to be appropriate. No further deficient practice was noted. Unit Manager re-educated staff regarding proper storage of medications. 3. Unit Manager/Designee will perform daily checks in shower rooms to ensure medications are properly stored and be brought to morning meeting for review.	7/20/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 49 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to safely store medication on 1 of 2 units in the facility (Unit 2). The findings included: The facility staff failed to safely store a medication on Unit 2. On 6/6/17 at 2:45 pm, the surveyor went into the shower room that is used for resident care on Unit 2. There was a cabinet on the wall facing the door in which a lock was in the hole in the cabinet but was not securely locked. The lock remained opened at the time of this observation.	F 431	4. Any deficient practice regarding medication storage will be brought to the QAPI Committee monthly for discussion/resolution. 5. Date of Compliance: 7/20/2017	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 50 In this cabinet, the surveyor observed (1) 15 ounce container of Zinc Oxide Ointment Skin Protectant in this unlocked cabinet. Licensed practical nurse (LPN) #1 entered the shower room and the surveyor showed the unit manager how the cabinet was found to be unlocked. On the 1st shelf contained the above mentioned Zinc Oxide Ointment Skin Protectant. The surveyor asked LPN #1 if this was considered to be medication and LPN #1 stated "yes, it is. It is supposed to be locked up at all times either in the medication room or on the medication carts." The assistant director of nursing was notified of the above documented findings at 3:10 pm at which time this medication was taken out of the shower room by LPN #1. The administrative team was notified of the above documented findings on 6/7/17 at 4:10 pm by the surveyor in the conference room. No further information was provided to the surveyor prior to the exit conference on 6/8/17.	F 431		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 441	**441 D Infection Control, Prevent Spread, Linens** 1. Facility residents have the potential to be affected by this practice. Resident #5 was placed on contact isolation for ESBL in urine, PPE was not readily accessible. No other residents were identified to be on isolation precautions at that time.	7/20/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 441	Continued From page 51 arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed	F 441	2. An isolation precautions audit was performed. No further deficient practice was noted. Infection Control Nurse re-educated licensed staff regarding isolation precautions and making PPE readily accessible. 3. Infection Control Nurse/Designee will identify residents who are on isolation precautions for the need of PPE and will ensure PPE is readily available. 4. Any deficient practice regarding isolation precautions/PPE will be brought to the QAPI Committee monthly for discussion/resolution. 5. Date of Compliance: 7/20/2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441		F 441		

Continued From page 52

by staff involved in direct resident contact.

(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.

This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to implement an effective infection control guideline for 1 of 21 residents in the survey sample (Resident #5).

The findings included:

For Resident #5, the facility staff failed to stock personal protective equipment that was readily accessible to staff when caring for Resident #5 in contact isolation.

Resident #5 was readmitted to the facility on 3/21/13 with the following diagnoses of, but not limited high cholesterol, Alzheimer's disease, aphasia, stroke, depression, EBSL (Extended Spectrum Beta Lactamases) in urine and muscle weakness. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/28/17 the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. The resident was also coded as requiring extensive assistance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 441		F 441		

Continued From page 53 of one staff member for bathing, personal hygiene and being totally dependent on one staff member for bathing.

During the initial tour on 6/6/17 at approximately 1:15 pm, the surveyor noted a sign on =Resident #5's door that stated "Stop and go to the nurses' station before entering." The surveyor did not observe an isolation cart which contained personal protective equipment (PPE) for staff or visitors to use if going into the resident's room.

At 1:40 pm, the surveyor stopped Registered Nurse (RN) #1 in the hallway and asked what the sign meant on Resident #5's door. RN #1 explained to the surveyor that the resident was in contact isolation because she had ESBL in her urine. The surveyor did not observe an isolation cart in the hallway outside of the resident's room which would have contained the PPE for staff to use.

On 6/7/17 at 7:30 am, the surveyor went to Resident #5's room and did not observe an isolation cart beside the resident's door due to the resident being in contact isolation as the surveyor had been told the previous day by RN #1. The surveyor looked inside the resident's room due to the door being open, and there was no isolation cart inside of the room either.

During the clinical record review of Resident #5's record, the surveyor noted a physician order dated for 6/10/16 and timed for 10:51 am which stated "Contact Isolation".

At 2 pm, the surveyor made another round to Resident #5's room and there was not an isolation cart in the hallway or just inside of the

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 54 resident's door. At 4:10 pm, the administrative team was notified of the above documented findings with dates and times of observations that were made by the surveyor which revealed the resident was in contact isolation due to having ESBL in her urine per a physician's order. The surveyor asked for the policy of the facility concerning infection control and isolation. On 6/8/17 at approximately 10 am, the assistant director of nursing provided a copy of the policy titled "Personal Protective Equipment" which stated the following: " ...All employees will have access to the personal protective equipment ...Equipment will be stocked in areas that provide quick access in the event of a reasonable anticipated exposure ..." The surveyor asked the assistant director of nursing where the PPE should be kept if you have a resident in contact isolation. The assistant director of nursing stated, "We have carts that we seat right outside of the resident's door or just inside the resident's room at the door for easy access." No further information was provided to the surveyor prior to the exit conference on 6/8/17.	F 441		
F 514 SS=E	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-	F 514	**514 E Resident Records-Complete/Accurate/Accessible**	7/20/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

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F 514	Continued From page 55 (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (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; (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, facility document review and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for 5 of 21 residents in the survey sample (Resident #'s 4, 17, 6, 9 and 15). The findings included: 1. The facility staff failed to maintain a complete and accurate clinical record for Resident #4.	F 514	1. Facility residents have the potential of being affected by this practice. Resident # 4's lab was removed and filed in the correct medical record. Resident # 17's medications were not documented as given on the MAR for 5-10-17. Initial notification of this practice was received with this 2567. Paper MARs were located in the residents clinical record and all medications were signed for on 5-10-17 for administration of such medications. Resident #6 had results from a urinalysis on clinical record without proper indication. Order was initiated from standing orders due to resident spitting out medications on 4-27-17 and increased confusion on 4-28-17. Urinalysis was positive for UTI and treatment was ordered. Resident # 9 was found to have undocumented medications on MAR on 5-6, 9, 10 and 14; no medications were missed per documentation. Paper MARs were located in this resident's clinical record to reflect that medications were administered on 5-10-17. Resident #15 was ordered solumedrol on 5-3-17. MAR was not signed. However a nurse's note was provided to the surveyor that reflects the administration of this medication.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 514	Continued From page 56 Resident #4 was readmitted to the facility on 5/3/17 with the following diagnoses of, but not limited to blood clot, high blood pressure, diabetes, thyroid disorder, seizure disorder, depression, and psychotic disorder. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/9/17 the resident was coded as having short and long term memory problems and being severely impaired in making daily decisions. Resident #4 was also coded as requiring extensive assistance of 2 staff members for dressing and being totally dependent on 1 staff member for bathing. The surveyor performed a clinical record review on 6/6/17 of Resident #4's medical record. During this time, the surveyor noted a urinalysis and culture and sensitivity report of another resident filed on Resident #4's clinical record. At 3 pm on 6/6/17, the assistant director of nursing was notified of the above documented findings. The assistant director of nursing stated she would take care of this. On 6/7/17 at 4:10 pm, the administrative team was notified of the above documented findings by the surveyor in the conference room. No further information was provided to the surveyor prior to the exit conference on 6/8/17. 2. The facility staff failed to document administration of medications for Resident #17. Resident #17 was readmitted to the facility on 4/13/17 with the following diagnoses of, but not	F 514	2. A chart audit was performed by Medical Records Coordinator to focus on correct filing of resident information; no further concern was noted. An audit was performed by Unit Manager to focus on residents receiving medications during the time frame in question; no further concern was noted. An audit of residents with urinalysis for the past 30 days for proper indication per standing orders was performed by Assistant Director of Nursing; no further concerns were noted. An audit was performed by Unit Manager to focus on proper documentation of medication administration for the past 30 days; no further concern was noted.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 514	Continued From page 57 limited to congestive heart failure, chronic respiratory failure, high blood pressure, urinary tract infection, diabetes, atrial fibrillation, chest pain and chronic kidney disease. The entry MDS (Minimum Data Set) dated for 4/13/17 had been completed but the significant change MDS with an ARD (Assessment Reference Date) of 6/22/17 was still in progress at the time of this survey. A clinical record review was performed by the surveyor on 6/8/17. During this review, the surveyor noted the following medications were left blank on the (MAR) Medication Administration Record for the date of 5/10/17 at 8 am which are as follows: Celexa 20 mg (milligram) one tablet po (by mouth) daily, Aspirin 81 mg chewable 1 tablet po one time a day, Colace 100 mg 1 capsule po one time a day, Vitamin C 500 mg 1 tablet po one time a day, Miralax Give 17 grams po BID (two times a day) and Baclofen 20 mg po four times a day. The assistant director of nursing was notified of the above documented findings by the surveyor at 10 am. The assistant director of nursing stated "I can't tell if these were given or not. They are supposed to initial the box when the medication is administered to the resident." The administrative team was notified at 4 pm of the above documented findings by the surveyor. No further information was provided to the surveyor prior to the exit conference on 6/8/17. 3. For Resident #6, facility staff failed to document activation of standing orders and notification of physician and family. Resident #6 was admitted to the facility on 9/6/14.	F 514	3. Medical Records Coordinator will audit and report findings on proper filing of resident information on the clinical record during morning meeting for two weeks and then weekly times one month. Assistant Director of Nursing/Designee will utilize the missed documentation report to ensure medications are documented and will report daily during morning meeting. Assistant Director of Nursing/Designee will run an order listing report to focus on proper indication for urinalysis per standing order and will report during morning meeting. 4. Any deficient practice regarding improper filing of labs in resident clinical record, missed MAR documentation, and improper indications of urinalysis per standing orders will be brought to the QAPI Committee monthly for discussion/resolution. 5. Date of Compliance: 7/20/2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 514		F 514		

Continued From page 58

Diagnoses included congestive heart failure(CHF), chronic kidney disease (CKD), dementia, and hypertension (HTN). On the minimum data set assessment with assessment reference date 5/18/17, the resident scored 3 of 15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting others. Section I 2300 was coded for urinary tract infection (UTI).

During clinical record review, the surveyor noted laboratory results for a urinalysis from the clinical laboratory with order date 4/28/17 and fax stamp to the facility 5/2/17 noted faxed to the physician on 5/3/17. Written on the lab results was "Noted & faxed AF 5-3-17", "Ceftin 500 mg po BID X 3 days" unsigned, and "[physician initials] 5/3/17". The surveyor was unable to locate evidence of symptoms associated with urinary tract infection or communication with a physician concerning those symptoms. Nursing notes did not indicate that a physician had ordered the test. On 6/7/17, the surveyor discussed the issue with LPN #1. LPN #1 stated she had written the order on the basis of standing orders. The surveyor asked if there should have been a nursing note documenting the order had been written, the basis for the order, and notification of the physician and the resident's responsible party. The nurse said she thought she had written a note. The surveyor asked the assistant director of nursing (ADON) for a copy of the standing orders. The ADON provided the standing orders and a copy of a note (which had not shown on the surveyor's clinical record access) titled SBAR-Change of condition Effective Date: 4/26/2017 11:15 Situation: Resident spit out med's Background: 95 y/o with CHF, CKD, Dementia with Behavioral Disturbance,

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 514	Continued From page 59 Hypothyroidism, HTN, DNR (do not resuscitate), NEURONTIN, TAGAMET, ACE INHIBITORS Assessment: Resident spit out all her medication this AM. Medication included ASA (aspirin) 81 mg, Coreg, Mirilax Response: Dr [name] group aware[family name] aware. The surveyor asked why the note had not been visible during clinical record review and to LPN #1. The ADON stated they were available to her. During a summary meeting on 6/7/17, the surveyor asked for the nursing policy concerning use of standing orders. The surveyor was interested in specific situations where they would be used, when the physician and family should be notified, and what should be documented. During a meeting on 6/8/17, the DON reported that there was no policy concerning use of standing orders. The surveyor read the standing orders. Standing orders are as follows " IV. Symptom Treatment E. Dysuria, Foul Smelling, decreased LOC, or Agitation---- Obtain urinalysis with C&S. If positive report results to MD". The surveyor read the urinalysis. The order dated 4/27/17 10:20 documented a phone order from Dr [name] UA C&S d/t (urinalysis with culture and sensitivity due to) confusion. The surveyor stated that confusion was not one of the reasons the standing orders listed for obtaining a urinalysis. The ADON said that the resident spit out medications (on the morning of 4/26/17) and that was a sign of agitation. The surveyor observed that the order for the urinalysis was written 24 hours later and a different reason stated. The surveyor also noted that the physician could have been contacted during that time. During the final summary meeting with facility administrative staff on 6/8/17, the surveyor	F 514		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 514		F 514		

Continued From page 60 reiterated concerns with nursing documentation.

4. For Resident #9, facility staff failed todocument administration of medications.

Resident #9 was admitted to the facility on 6/21/15. Diagnoses included traumatic amputation of a limb, peripheral vascular disease, kidney disease, depression, congestive heart failure, diabetes mellitus, and Crohn's disease. On the minimum data set assessment with assessment reference date 3/21/17, the resident scored 15/15 on the brief interview for mental status. The resident was assessed with out signs of delirium, psychosis, or behavior affecting others.

During clinical record review on 6/7/17, the surveyor noted unexplained blanks in documentation on the May 2017 medication administration record on May 6, 9, 10, and 14. The surveyor reported the concern to the assistant director of nursing on 6/8/17. No additional information was available.

The surveyor discussed the concern again during a summary meeting with the administrator and director of nursing on 6/8/17.

5. The facility staff failed to document when medications were administered to Resident #15 on the May 2017 electronic medication administration record.

The clinical record of Resident #15 was reviewed 6/8/17. Resident #15 was admitted to the facility 2/1/17 and readmitted 3/27/17 with diagnoses that included but not limited to Alzheimer's disease, iron deficiency anemia, hypertension, chronic embolism/thrombosis, gastroesophageal

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 514		F 514		

Continued From page 61 reflux disease, pain, and chronic kidney disease.

Resident #15's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 4/4/17 assessed the resident with a cognitive summary score of 10 out of 15 in Section C Cognitive Patterns.

The clinical record revealed a physician order dated 5/3/17 that read in part "Solumedrol 62.5 mg (milligrams) IM (intramuscular) x1 at bedtime for wheezing."

The surveyor reviewed the May 2017 electronic medication administration record (eMAR). The order for the Solumedrol had been entered onto the May 2017 eMAR, however; there was no documentation that the medication had been administered. Each entry for the month of May 2017 for Solumedrol had an "X" in the block.

The surveyor reviewed the May 2017 progress notes. The5/3/17 progress note read "Received fax from ____ (medical doctor) earlier with new orders for wheezing and cough reported. Solumedrol and Albuterol ordered. RP (responsible party) made aware via phone. Solumedrol given per order IM left hip, tolerated well. Continues with BLE (bilateral lower extremity) 2+ edema, right lower ext (extremity) red and warm with 3+ edema. Negative Homans, resident reports hx (history) of DVT (deep vein thrombosis) in leg. On Coumadin therapy for this reason. Will monitor."

The surveyor informed the administrator, the director of nursing and the corporate registered nurse of the above concern in documentation on 6/8/17 at 11:35 a.m. The surveyor asked the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 514	Continued From page 62 DON what were her expectations of nurses to document medications administered on the eMAR. The DON stated she would expect nurses to document medications administered on the MAR. The surveyor requested the facility policy on medication administration in the end of the day meeting on 6/8/17 at 4:00 p.m. with the administrative staff. The policy titled "Specific Medication Administration Practices Administration Procedures for All Medications" read in part "J. After administration, return to cart, replace medication container (if multi-dose and doses remain), and document administration in the MAR or TAR, and controlled substance sign out record, if indicated." No further information was provided prior to the exit conference on 6/8/17.	F 514		
F 526 SS=D	483.70(o)(1)-(4) Hospice (o) Hospice services. (1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for	F 526	**526 D Hospice**	7/20/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 526	Continued From page 63 the provision of hospice services when a resident requests a transfer. (2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately	F 526	1. Facility residents on hospice have the potential to be affected by this practice. Resident #13's clinical record lacked substantial information regarding services provided by hospice and lack of documentation to show coordination of care between hospice agency and facility. Upon notification of such practice, hospice was contacted by facility and hospice hand delivered resident's hospice services documentation. 2. A hospice services audit performed by the Assistant Director of Nursing for the past 30 days to focus on documentation of services provided; no further concerns noted. 3. Hospice company is now required to deliver documentation weekly on services rendered to hospice patients, documentation will be placed in medical record, and exit/debrief with Director of Nursing/Designee after visiting the patient. 4. Any deficient practice regarding coordination of hospice care will be brought to the QAPI Committee monthly for discussion/resolution. 5. Date of Compliance: 7/20/2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 526		F 526		

Continued From page 64 notifies the hospice about the following:

(1) A significant change in the resident's physical, mental, social, or emotional status.

(2) Clinical complications that suggest a need to alter the plan of care.

(3) A need to transfer the resident from the facility for any condition.

(4) The resident's death.

(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.

(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.

(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 526		F 526		

Continued From page 65

(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.

(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.

(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.

The designated interdisciplinary team member is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 526	Continued From page 66 responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system.	F 526		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 526		F 526		

Continued From page 67

(F) Hospice medication information specific to each patient.

(G) Hospice physician and attending physician (if any) orders specific to each patient.

(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.

(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.20.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and facility document review it was determined that the facility staff failed to coordinate Hospice Services for 1 of 21 Residents in the sample survey, Resident #13.

The Findings Included:

Resident #13 was a 98 year old female who was originally admitted on 1/13/13 and readmitted on 2/10/17. Admitting diagnoses included, but were not limited to: dementia with behaviors, dysphagia, contracture of the right hand, bullous pemphigoid, hypertension and diabetes mellitus.

The most current Minimum Data Set (MDS) assessment located in the clinical record was a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 526		F 526		

Continued From page 68

Quarterly MDS assessment with an Assessment Reference Date (ARD) of 5/25/17. The facility staff coded that Resident #13 had short and long term memory impairment (1/1) and was severely impaired with daily decision making regarding Activities of Daily Living (ADL's). In Section P. Special Treatments, Procedures, and Programs the facility staff coded that Resident #13 was receiving Hospice Services.

On June 6, 2017 at 1 p.m. the survey team entered the facility and the surveyor requested copies of the facility's contracts with Hospice Services.

On June 6, 2017 at 2:30 p.m. the Administrator (Adm) hand delivered the facility's contracts with 4 local Hospice Agency's.

On June 8, 2017 at 10 a.m. the surveyor reviewed Resident #13's clinical record. Review of the clinical record produced signed physician orders dated 5/15/17. Signed physician orders included, but were not limited to: "Admit to (name of hospice agency withheld) as of 2/16/17." (sic)

Continued review of the clinical record produced a Hospice Admission Contract dated 2/23/17. The admission agreement identified that Resident #13 was to receive Speech Therapy and that Resident #13's medications were reviewed. The Hospice Agency also identified in their care plan that volunteer services were declined and the Social Services would visit 1-2 times a month, and that Chaplin Services would visit 1-2 times a month. There was no documentation of nursing services being provided, or documentation that a Certified Nursing Assistant would provide any services or any type of pain management

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 526		F 526		

Continued From page 69

provided for the end of life support.

Continued review of the clinical record failed to produce any additional documentation of the Hospice Services being provided or when the Hospice Agency was in to see Resident #13.

On June 8, 2017 at 10:10 a.m. the surveyor observed a Licensed Practical Nurse (LPN #2) sitting at the nurses station. The surveyor asked the LPN (#2) if the facility had binders/folders containing Hospice notes for Residents who were receiving Hospice Services. LPN (#2) stated, "Yes." The surveyor requested to see the Hospice binder/folder for Resident #13. LPN (#2) stated, "Oh (name of Hospice Agency withheld) they don't provide any notes."

On June 8, 2017 at 10:20 a.m. the surveyor notified the Assistant Director of Nursing (ADON) that Resident #13 was receiving Hospice Services and that Hospice notes could not be located since 2/23/17. The ADON stated she would look and see if she could find any additional documentation. Within 30 minutes the ADON and delivered Hospice notes dated 5/17/17 and 5/31/17. The ADON stated she had found the Hospice Notes at the nurses' station. No additional Hospice notes/documentation was provided. The Hospice note dated 5/17/17 identified that Resident #13's son was notified to check and see how he was doing with Resident #13's end of life support and education. Resident #13's son stated that he had not been able to visit Resident #13 as he was in Pittsburg and had just had a kidney transplant. The Hospice note did not specify any additional Hospice Services being provided by the Hospice Agency to Resident #13. The Hospice note dated 5/31/17 identified that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 526	Continued From page 70 Resident #13's medications were reviewed and that the Hospice Agency spoke to the facility staff and that the facility staff declined any needs at the time. The surveyor asked the ADON exactly what services was Hospice providing to Resident #13. The ADON did not respond. On June 8, 2017 at 11 a.m. the surveyor reviewed the facility contract with the Hospice Agency that was supposed to be providing Hospice Services to Resident #13. The contract was signed on 8/4/08. The Hospice Agency contract read in part ... "Plan of Care. a. Each Hospice patient will receive Services hereunder pursuant to an individualized care plan ("Plan of Care") written in accordance with 42C.F.R :§ 418.58 and based on an assessment of the Hospice Patient's needs and living situation in the Facility. Hospice shall designate a registered nurse to coordinate the implementation of the Plan of Care. b. At the time a Facility resident is admitted to the Hospice program or a patient of Hospice is admitted to Facility, Hospice shall coordinate with the Facility in the admission process and the development and implementation of the patient's Plan of Care. The parties will collaborate in jointly coordinating the implementation, evaluation and modification, as needed, of the Plan of Care on an ongoing basis. ... 5. Services Provided by Hospice ... b. Hospice shall communicate with Facility to ensure coordination of patient care services. ..." (sic) On June 8, 2017 at 11:50 a.m. the survey team met with the Adm, Director of Nursing, ADON, Corporate Compliance Nurse (CCN), Social Worker (SW) and House Supervisor. The surveyor notified the Administrative Team (AT)	F 526		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 526	Continued From page 71 that the facility staff failed to coordinate Hospice Services with the Hospice Agency. The surveyor notified the AT that Hospice notes could not be located in the clinical record and that the ADON had hand delivered several notes. The surveyor notified the AT that Hospice Services had been initiated on 2/23/17. The surveyor notified the AT that the surveyor was unsure exactly what Hospice services were being provided to Resident #13. The surveyor notified the AT that one of the notes identified that Resident #13's son had been contacted for end of life support. However, no additional services were identified as being provided to Resident #13 by the Hospice Agency. No additional information was provided as to why the facility and Hospice Agency failed to coordinate and communicate Hospice Services that were being provided to Resident #13.	F 526		