STATEMENT OF DEFICIENCIES



(X2) MULTIPLE CONSTRUCTION

PROVIDER/SUPPLIER/CLIA

PRINTED: 06/30/2017 **FORM APPROVED**

OMB NO. 0938-0391

(X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED С 495250 B. WING 06/08/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 836 GLENDALE RD PO BOX 229 **GALAX HEALTH AND REHAB** GALAX, VA 24333 SUMMARY STATEMENT OF DEFICIENCIES ĪD PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 000 F 000 Preparation, submission and **INITIAL COMMENTS** implementation of this Plan of Correction does not constitute an An unannounced Medicare/Medicaid standard admission of or agreement with the survey was conducted 6/6/17 through 6/8/17. facts and conclusions set forth on the Three complaints were investigated during the survey report. Our Plan of survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Correction is prepared and executed requirements. The Life Safety Code as a means to continuously improve survey/report will follow. the quality of care and to comply with all applicable State and Federal The census in this 120 certified bed facility was regulatory requirements. 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 F 157 483.10(g)(14) NOTIFY OF CHANGES F 157 F157 D Notify of Changes 7/20/2017 SS=D (INJURY/DECLINE/ROOM, ETC) 1. Facility residents who receive (g)(14) Notification of Changes. sliding scale insulin have the (i) A facility must immediately inform the resident; potential to be affected by this consult with the resident's physician; and notify. practice. Resident #14 has an active consistent with his or her authority, the resident diagnosis of diabetes and receives representative(s) when there issliding scale insulin with blood sugars. Physician was not notified of An accident involving the resident which results in injury and has the potential for requiring blood sugars greater than 501. Upon physician intervention; notification of concern, physician was notified and no new orders were A significant change in the resident's given. physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:IXUB11

Facility ID: VA0037

If continuation sheet Page 1 of 72

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION IDENTIF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDING		(X3) DATE SURVEY COMPLETED
NAME OF PRO	VIDER OR SUPPLIER	495250	B. WING		C 06/08/2017
	LTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 836 GLENDALE RD PO BOX 229 GALAX, VA 24333	
PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION

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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 F 157 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.	
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	
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(g) (14)(i) of this section, the facility must ensure that all pertinent information specified in	
that all pertinent information specified in	
8483 15(c)(2) is available and provided upon DNVSICIAN NOTIFICATION.	
3 (-)(-) is a valuable and provided apoil	
request to the physician.	
3. Blood sugars requiring	
(iii) The facility must also promptly notify the notification of physician will be	
resident and the resident representative, if any, when there is-	
Manager/Designee daily during	
(A) A change in room or roommate morning clinical meeting times two	ĺ
assignment as specified in §483.10(e)(6); or weeks and weekly times one month	
to ensure that physicians are notified	
(B) A change in resident rights under	
rederal of State law of regulations as specified in	; !
paragraph (e)(10) of this section. provided to snow that notification occurred.	
(iv) The facility must record and periodically	
and the first of the second state of the secon	
phone number of the resident representative (a)	
This REQUIREMENT is not met as evidenced physician notification to focus on	İ
blood sugar parameters will be	
Based on staff interview and clinical record brought to the QAPI Committee	
review, the facility staff failed to inform the monthly for discussion/resolution.	
physician of a change in condition for 1 of 21	ļ
residents (Resident #14). 5. Date of Compliance: 7/20/2017	
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.	

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STATEMENT	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CL	(X2) MUL	TIPLE CONSTRUCTION		B NO. 0938-039
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER:	IA	NG	1	DATE SURVEY COMPLETED
						С
NIANAE (DE I		495250	B. WING			06/08/2017
IVAIVIE OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
GALAX H	HEALTH AND REHAB			836 GLENDALE RD PO BOX 229 GALAX, VA 24333		
(X4) ID PREFIX	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
TAG	REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	COMPLETION DATE
F 157	Continued From page	2	F1	157		
	l 6/8/17. Resident #14 5/8/17 with diagnoses to Type 1 Diabetes Medisease, (stage 4 sever disease now on dialys hyperlipidemia, acute in chronic kidney disease developmental disorded depressive disorder, a disease. Resident #14's admiss (MDS) assessment with reference date (ARD) or resident with a cognitive of 15 in Section C Cognot Resident #14's current dated 5/11/17 identified alteration in blood glucted dependent diabetes medications abnormal results per pliparameters/guideline. The June 2017 signed the following order for a sliding scale: "Insulin Liper sliding scale: if 0-7 units; 201-250=4 units; 301-350=8 units; 351-4 units; 451-500=14 units MD (medical doctor), sumeals and at bedtime residence in the stage of the	ere), ESRD (end stage renal sis), hypertension, respiratory failure, anemia ase, pleural effusion, er of scholastic skills, and gastroesophageal reflux sion minimum data set than assessment of 5/16/17 assessed the resummary score of 9 out nitive Patterns. comprehensive care planed that the resident had an ose due to insulin ellitus. Interventions: as as ordered. Report hysician physician orders included administration of insulin ispro Solution Inject as 0=no insulin; 151-200=2 251-300=6 units; 00=10 units; 401-450=12 c; 501 + =16 units and call ubcutaneously before elated to TYPE 1 WITH HYPERGLYCEMIA				

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ANDPLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG		MPLETED	
NAME OF		495250	B. WING		06	C 5/08/2017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE	7,00,2011	
GALAX	HEALTH AND REHAB			836 GLENDALE RD PO BOX 229 GALAX, VA 24333		.,	
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
TAG	REGULATORY OR I	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	COMPLETION DATE	
F 15		- 0	F 1	57			
	Continued From page	93					
	The surveyor reviewe	ed the June 2017 electronic					
	medication administra	ation record (eMAR). The					
	was documented as F	6/2/17 at 1630 (4:30 p.m.) 599 and 16 units of Insulin					
		red. The blood sugar result					
	for 6/5/17 at 4:30 p.m	was 555 and 16 units of					
	Insulin Lispro was add	ministered. Based on the					
	should have been not	ician notification, the MD ified when the blood sugars					
	were 599 and 555.	mod Wilely the blood sugars					
	The surveyor reviews	d the facility progress note					
	for 6/2/17. There were	e 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	o.m., 7:27 p.m., 7:31 p.m.,					
	9:19 p.m., and 11:08 p documentation that the	D.M. There was no					
	informed of Resident #	#14's blood sugar of 599.					
	There were five (5) pro	ogress notes written 6/5/17					
	at 7:01 a.m., 7:08 a.m.	., 3:11 p.m., 5:38 p.m., and					
	physician had been inf	no documentation that the ormed of the blood sugar					
	of 555.	ormed of the blood sugar					
	The surveyor informed	the assistant director of					
	nursing of the blood su	igar results for 6/2/17 and					
	6/5/17 on 6/8/17 at 2:4	0 p.m. After reviewing the					
	documentation that the	OON stated there was no					
	informed of the elevate	ed blood sugar results.			1		
	The surveyor informed	the administrative staff of					
	the above concern on 6	6/8/17 at 4:00 p.m.					
77.71	No further information v	was provided prior to the					
E 10-	exit conference on 6/8/	17.					
F 167	483.10(g)(10)(i)(11) RIC	GHT TO SURVEY	F 167				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI	AI	E CONSTRUCTION	<u> </u>	O. 0938-039 E SURVEY
1,40,40	CONTECTION	IDENTIFICATION NUMBER:	A. BUILDING			PLETED
		405250				С
NAME OF F	PROVIDER OR SUPPLIER	495250	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	06	/08/2017
				836 GLENDALE RD PO BOX 229		
GALAX	IEALTH AND REHAB		1	GALAX, VA 24333		
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	i	(X5)
TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE
F 167 SS=D	RESULTS - READILY	ACCESSIBLE	F 167	F167 D Right to Survey Resulted Readily Accessible.	lts	7/20/2017
	of the facility conductes surveyors and any plates respect to the facility; (g)(11) The facility must (i) Post in a place residents, and family no representatives of resimost recent survey of (ii) Have reports we certifications, and compressed to the facility of years, and any plan of respect to the facility, at to review upon request (iii) Post notice of reports in areas of the facility of the plant o	s of the most recent survey d by Federal or State n of correction in effect with and st e readily accessible to nembers and legal dents, the results of the the facility. with respect to any surveys, plaint investigations made luring the 3 preceding correction in effect with vailable for any individual; and the availability of such facility that are prominent ublic.		1. Facility residents have the potential to be affected by this practice. Upon notification that Survey Results Book was not in accessible area, and signage regarding the two previous year from the most current Survey Results were not accessible for review, Administrator had Surv Results Book placed in the lobb next to the front desk and previyears' results were added to the Book. 2. Residents had the potential traffected by this practice. 3. Administrator had Survey Resord placed in the lobby next to the front desk and previous years' results were added to the Book.	ey ous o be esults o the	
	identifying information a residents. This REQUIF evidenced by: Based on observation a facility staff failed to post results in an area that wall who entered the facility findings included:	REMENT is not met as and staff interview, the st previous year survey was readily accessible to ity to review.		were added to the Book. 4. Any deficient practice regard accessibility of survey results we brought to the QAPI Committee monthly for discussion/resolution. 5. Date of Compliance: 7/20/20	rill be	
	rne survey team, which	consisted of 5 surveyors,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495250	B. WING		06/	08/2017
	EALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 836 GLENDALE RD PO BOX 229 GALAX, VA 24333		
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F 252 SS=E	made to locate the boprevious year of survey. These observations we through 6/8/17. On 6/8/17 at approximation found the previous surveyor prior to the examples of the administration of the lobby through the anyone interested in results of where they had also no signage that the anyone interested in results of where they had also no signage that the documented findings. Were anting to be reviewed to obtain the past 3 years available requested. I will take the past 3 years available requested. I will take the surveyor prior to the example of the survey of the surveyor prior to the example of the survey of the surveyor prior to the example of the surveyor prior to the e	de/6/17 for an annual arvey. Observations were sook that contained the ey results of the facility. Were made from 6/6/17 Inately 9 am, the surveyor rivey results in the hallway the a set of double doors kers' office hanging on a sel "Survey Results". There is front lobby that directed eviewing these survey were located. There was lirected the public of where ears of survey results if they ewed. Inately 9:30 am, the surveyor stor of the above The administrator stated "I re needed to be at least the for the public to review if care of this immediately." Was provided to the xit conference on 6/8/17. DRTABLE/HOMELIKE In and use personal of furnishings, and clothing, less to do so would infringe	F 16		ble	7/20/2017

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495250	D MAINIO		į	C /08/2017	
NAME OF PROVI	DER OR SUPPLIER	493250	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	00/2017	
	TH AND REHAB			836 GLENDALE RD PO BOX 229 GALAX, VA 24333			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	NC	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)		COMPLETION DATE	
igli envired saf. (i)(envired saf. (i)(envired saf. (ii) car phy ind (ii) for loss Thi by: Ba fact. hor fact. The Duri three occurs hall also from alor the On dire	nt to a safe, clean, vironment, including treatment and rely. The facility mut. 1) A safe, clean, covironment, allowing personal belonging. This includes a receive care and visical layout of the ependence and do a second to the ependence and the environment of the ependence and the ependenc	comment. The resident has a comfortable and homelike g but not limited to nd supports for daily living list provide-comfortable, and homelike g the resident to use his or ligs to the extent possible. It ensuring that the resident services safely and that the facility maximizes resident lies not pose a safety risk. In all exercise reasonable care he resident's property from is not met as evidenced in and staff interview, the rovide a clean, comfort and the for 2 of 2 units in the	F 2	1. Facility residents have the potential to be affected by the practice. Upon notification of in the facility, Housekeeping Director guided staff to areast indicated by surveyor for furcleaning. Maintenance Director developed a plan to address and frames that lacked paint. 2. An audit of doors and frathe facility took place; no furconcerns were noted. An audit Housekeeping Director show further areas with odors note. 3. During morning meeting Administrator/Designee will that Care Keeper Round Shows submitted by department he any concerns of odors and midentified concerns with door frames for discussion and results of the QAPI Commitment of the QAPI Commitment of Compliance: 7/2 5. Date of Compliance: 7/2	is f odors if odors ther tor doors ng. mes in ther lit by the ved no ved. the request vets be ads with ewly ors and solution. garding will be ittee lution.		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL	TIPLE CONSTRUCTION	(X:	(X3) DATE SURVEY		
1	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	1,,,,	COMPLETED	
						С	
		405250				06/08/2017	
NAME OF P	ROVIDER OR SUPPLIER	495250	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE		00/00/2017	
TO THE COLUMN	NOVIDEN ON OUR LIEN						
GALAXH	EALTH AND REHAB			836 GLENDALE RD PO BOX 229 GALAX, VA 24333			
	LAND III AND ILLIAD	***************************************		OALAX, VA 24000			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR		(X5) COMPLETION	
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		,	,,,,	DEFICIENCY)			
F 050				250			
F 252			F.	252			

	Continued From page	e 7 faint urine odor noted by					
	the observers in the le	ong hallway of Unit 1 that					
	contained the rooms	from B 19 to B 30. There					
	were 2 door frames o	n Unit 2 at rooms B 4 and B					
	1 that had the large a	mounts of chipped paint or					
		e resident's door frame.					
		the following resident room					
		s at the bottom third of the					
	door: B20, B19, B18,	, B17, B16, B15, B14, B10,					
		B1, B21, B22, B23, B24,					
	B25, B26, B27, B28, I						
	DEO, DEO, DEI, DEO, 1	BEO, BOO and BOY.					
	These environmental	observational rounds					
		me team as mentioned					
		ere was noted to be a strong					
		hallway that housed the					
	rehabilitation room an	-					
		e strong foul urine odor was					
	noted in the hallway of	-					
		were 4 door frames that had					
		issing on resident rooms					
		e utility room beside of the					
HEROTO CONTRACTOR CONT		this same hall, the following					
	resident room doors h	•					
		or: A12, A13, A20, A21,					
The state of the s	A22, A24, A27, A29 a	, , , , , , , , , , , , , , , , , , , ,					
2	722, 724, 721, 723 a	IId AST.					
	The maintenance dire	ctor stated to the surveyor				samocourtecour	
		or fix all these doors but the				POST POPULATION	
		for it to happen yet. I know					
		usekeeping director stated					
	-	ave tried different things in					
		ells down like, mopping the					
		f they are known to have					
1	accidents in the floor					Vince of the second sec	
		tions but nothing seems to					
	help this problem."						
	The administrative too	m was notified of the above					
	The administrative tea	in was notified of the above			·		

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	T	E 0150-033
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG_			E SURVEY IPLETED
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		495250	B. WING			06	6/08/2017
NAME OF F	PROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		70072017
					36 GLENDALE RD PO BOX 229		
GALAXH	IEALTH AND REHAB			G	ALAX, VA 24333		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	Ī	PROVIDER'S PLAN OF CORRECTION		(X5)
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F 252			F2	252			
	Continued From page	e 8 documented	The state of the s				
	findings by the survey						TT 100000000000000000000000000000000000
	room on 6/8/17 at 4 p						
	No further information						Office and a second
F 271	483 20(a) ADMISSIO	exit conference on 6/8/17. N PHYSICIAN ORDERS	F-0		TOTAL DATE OF THE		
SS=D			F 2	271	F271 D Admission Physician		7/20/2017
	3,1				Orders for Immediate Care.		
	(a) Admission orders	***************************************					
					1. Facility residents have the		
		ent is admitted, the facility			potential to be affected by this		
	must nave physician o immediate care.	orders for the resident's			practice. Resident #17's readmis	ssion	
		is not met as evidenced			orders were found to be missing		
Description and the second	by:	is not met as evidenced			from resident's clinical record.		AND THE REAL PROPERTY AND THE PROPERTY A
	Based on staff intervi	ew and clinical record			Orders were located and placed	on	
and the same of th	review, the facility stat	ff failed to ensure 1 of 21			the clinical record.		7770
	residents in the survey						
	readmission orders. (f .			2. A physician orders audit of		
	findings included:	,,,,,,,			residents who admitted or readm	iitted	
	manigo moradoa.				within the last 30 days to facility	, was	
	The facility staff to ens	sure that Resident #17 had			performed to verify admission/	ļ	
	readmission orders wh	nen readmitted to the			readmission orders were found i	n	
	facility.				their clinical records; no deficien	1	
T TO MINORAL	Recident #17 was res	dmitted to the facility on			practice noted. Unit Manager re-		
		ing diagnoses of, but not			educated licensed staff on		
	limited to congestive h				admission/re-admission procedu	re to	
		n blood pressure, urinary			-	1	
	tract infection, diabetes	s, atrial fibrillation, chest			focus on ensuring physician order are in the correct section of the	215	
		y disease. The entry MDS					
		ated for 4/13/17 had been			clinical record.		
		ificant change MDS with					
	an ARD (Assessment I was still in progress at	Reference Date) of 6/22/17					ļ
	was sun in progress at	are ame or ans survey.		and the same of th			
9 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	The surveyor complete	ed a clinical record review					

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		495250	B. WING		C 06/08/2017	7	
	PROVIDER OR SUPPLIER HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 836 GLENDALE RD PO BOX 229 GALAX, VA 24333			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLE	ETION	
F 278 SS=D	Continued From page on 6/8/17. It was note 4/13/17 when the resi facility from the hospir readmission orders properly from the only physician or record were dated for At 10:40 am, licensed was notified by the sure orders for this resident the resident returned to the only physician order and LPN #2 were date stated "I will go and look At 1:30 pm, the assistance of the survey any readmission order resident. The one phy found were dated for 50 the administrative tead documented findings to 4 pm in the conference of the conference	resent in the clinical record. Iders that were in the clinical 5/2/17. practical nurse (LPN) #2 rveyor that readmission t could not be found when to the facility on 4/13/17. Iders noted by the surveyor ed for 5/2/17. LPN #2 ok for these." ant director of nursing or and stated "I cannot find is on the record for this risician orders that I have 6/2/17." Im was notified of the above by the surveyor on 6/8/17 at e room. was provided to the kit conference on 6/8/17. MENT NATION/CERTIFIED ssessments. The assessment the resident's status. st conduct or coordinate the appropriate	F 27	3. Clinical Records of resident admitting or readmitting to fact will be reviewed in daily clinic review within 24 hours by Unit Manager/Designee to ensure physician orders are filed corresion the clinical record. 4. Any deficient practice regat the filing of physician orders is clinical record will be brought QAPI Committee monthly for discussion/resolution. 5. Date of Compliance: 7/20/2	rding the to the 7/20/20	017	

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STATEMENT	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _	MANAGEMENT AND		PLETED
							С
		495250	B. WING			1	/08/2017
NAME OF P	ROVIDER OR SUPPLIER	1 430230	B. WING	รา	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	00/2017
					36 GLENDALE RD PO BOX 229		
GALAX H	EALTH AND REHAB				ALAX, VA 24333		**************************************
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	1	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 278	that the assessment in (2) Each individual of the assessment mulaccuracy of that portion (j) Penalty for Falsifica (1) Under Medicare at who willfully and known (i) Certifies a maresident assessment in penalty of not more than assessment; or (ii) Causes anothe material and false state assessment is subject more than \$5,000 for (2) Clinical disagreem material and false state This REQUIREMENT by: Based on staff interview, it was determine failed to ensure a communication of the communicat	nurse must sign and certify is completed. Just who completes a portion just sign and certify the con of the assessment. Just ation ation and Medicaid, an individual wingly- Just aterial and false statement in a sis subject to a civil money from \$1,000 for each attement in a resident at to a civil money penalty or not leach assessment. Just a civil money penalty or not leach assessment. Just a civil money penalty or not leach assessment. Just a civil money penalty or not leach assessment. Just a civil money penalty or not leach assessment. Just a civil money penalty or not leach assessment. Just a civil money penalty or not leach assessment. Just a civil money penalty or not leach assessment. Just a civil money penalty or not leach assessment. Just a civil money penalty or not leach assessment. Just a civil money penalty or not leach assessment. Just a civil money penalty or not leach assessment.	F	278	1. Facility residents have the potential to be affected by this practice. Resident #11 was four have an inaccurate MDS assess in section K. Upon identification concern, MDS Coordinator mossessment to ensure accuracy. Resident #7 was found to have inaccurate MDS assessment in section D. Resident #7 was cod "Not Assessed" on MDS with a 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-fra	ement on of dified an ed as n	
		e facility staff failed to ensure ate Section D. 0100. Mood Mood Interview on a		and the second s			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495250	B. WING		1	C /08/2017	
NAME OF P	ROVIDER OR SUPPLIER		I I	STREET ADDRESS, CITY, STATE, ZIP CODE			
GALAX H	EALTH AND REHAB			836 GLENDALE RD PO BOX 229 GALAX, VA 24333			
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	_	PROVIDER'S PLAN OF CORREC	TION	(X5)	
PRÉFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		ULD BE	COMPLETION DATE	
F 278			F 2	78 2. An audit of residents' se	ction D		
	Continued From page			of the MDS for the last 30			
		ata Set (MDS) with an				100000	
	Assessment Referen	ce Date (ARD) of 5/3/17.		done to identify any other		A.A.A.A. (SPECIAL SPECIAL SPEC	
				affected. No other resident			
		an 87 year old female who		MDS assessment was foun			
		16. Admitting diagnosis t limited to: dementia with		coded incorrectly. Social S	ervices		
	behaviors, glaucoma,	i i		Director re-educated Socia	Services		
		ertension, syncope with		Assistant on accurate section	n D		
	collapse and abnorma			completion.			
	•			An audit of residents' secti	nn K of		
	The most current	: Minimum Data Set (MDS)		the MDS for the last 30 day		AND	
	located in the clinical	record was a Quarterly MDS					
		Assessment Reference Date		done to identify any other i			
		facility staff coded that		affected. No other resident			
		ognitive Summary Score of		MDS assessment was foun			
		o coded that Resident #7		coded incorrectly. Register	ed		
		o total nursing care (4/2) Living (ADL's). In Section		Dietitian re-educated Dieta	ry		
		esident Mood Interview be		Manager on accurate section	n K		
		ity staff coded a dash (-). In		completion.			
		dent Mood Interview the		•			
TOTAL COMMENT	facility staff coded a d	ash (-) for all sections. The		3. Completed MDS's secti	nn D will		
	surveyor noted that S			be reviewed by Social Serv			
	Severity Score was al	so coded as a dash (-).		Director to ensure accurate			
				1	U		
		at 10:30 a.m. the surveyor		this section weekly times o			
	met with the 2 MDS N	- 1		then monthly times one qua			
		Mood with the MDS Nurse's. ted that Resident #7 was		Completed MDS's section			
		Id not answer questions		reviewed by the Registered	Dietitian		
		tatus. The surveyor pointed		to ensure accurate coding o	f this		
		00 should have been coded		section weekly times one m	onth,		
		ash (-); as 9 indicated "No		then monthly times one qua			
	response (leave colun			discourse design and the design and		So community in the state of th	
		at 4:10 p.m. the survey					
		ministrator (Adm), Director					
		istant Director of Nursing					
	(ADON), Social Worke	ers (SW) and Corporate					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C 495250 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 836 GLENDALE RD PO BOX 229 GALAX HEALTH AND REHAB GALAX, VA 24333 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		CONSTRUCTION	(X3) DATE SURVEY	
MAME: OF PROMOBER OR SUPPLIER GALAX HEALTH AND REHAB JAY-10 SIMMARY STATEMENT OF DEHICLENCIES (EACH DEFOILENCY MIST SEP PROCES OF SAS GENOALE RID PO BOX 229 GALAX, VA 24333 TAG PREFIX 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 informed the AT that the facility staff had documented dashes (.) in Section D0100 and D0200. The surveyor notified the AT that the facility staff had documented dashes (.) in Section D1010 and D0200. The surveyor notified the AT that the facility staff had documented dashes (.) in Section D1010 and D0200. The surveyor notified the AT that the facility staff had documented dashes (.) in Section D1010 and D0200. The surveyor notified the AT that the facility staff had documented dashes (.) in Section D1010 and D0200. The surveyor notified the AT that the facility as an Indianal facility as to why the facility as an denotror 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 Ouarterly 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 failed to code as a dark and 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, osleoporosis, protein calorie maintaintion and a urinary treat infection (UT). The most current Minimum Data Set (MDS)	t .			A. BUILDI	NG_			
MAME: OF PROMOBER OR SUPPLIER GALAX HEALTH AND REHAB JAY-10 SIMMARY STATEMENT OF DEHICLENCIES (EACH DEFOILENCY MIST SEP PROCES OF SAS GENOALE RID PO BOX 229 GALAX, VA 24333 TAG PREFIX 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 informed the AT that the facility staff had documented dashes (.) in Section D0100 and D0200. The surveyor notified the AT that the facility staff had documented dashes (.) in Section D1010 and D0200. The surveyor notified the AT that the facility staff had documented dashes (.) in Section D1010 and D0200. The surveyor notified the AT that the facility staff had documented dashes (.) in Section D1010 and D0200. The surveyor notified the AT that the facility staff had documented dashes (.) in Section D1010 and D0200. The surveyor notified the AT that the facility as an Indianal facility as to why the facility as an denotror 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 Ouarterly 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 failed to code as a dark and 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, osleoporosis, protein calorie maintaintion and a urinary treat infection (UT). The most current Minimum Data Set (MDS)								C
GALAX HEALTH AND REHAB SAG GLINDALE RD PO BOX 229 GALAX, VA 24333 DATE OF PROVIDER OR SUPPLIER SAG GLINDALE RD PO BOX 229 GALAX, VA 24333 FAST ORTHONION MUST BE PRECEDED BY FLIL RECORD AND SHOULD BE CHOSE-REPEASED TO THE APPROPRIATE OF CONSECUTION TO BE CONSECUTION. F 278 CONTINUED FROM THE CONSECUTION TO BE CONSECUTION TO BE CONSECUTION TO BE CONSECUTION TO BE CONSECUTION. F 278 CONTINUED FROM THE CONSECUTION TO BE CONSECUTION TO BE CONSECUTION TO BE CONSECUTION. F 278 CONTINUED FROM THE CONSECUTION TO BE CONSECUTION TO BE CONSECUTION. F 278 CONTINUED FROM THE CONSECUTION TO BE CONSECUTION. F 278 CONTINUED FROM THE CONSECUTION TO BE CONSECUTION. F 278 CONTINUED FROM THE CONSECUTION TO BE CONSECUTION. F 278 CONTINUED FROM THE CONSECUTION TO BE CONSECUTION. F 278 CONTINUED FROM THE CONSECUTION TO BE CONSECUTION. F 278 CONTINUED FROM THE CONSECUTION. F 278			495250	D WING			1	
AGALAX HEALTH AND REHAB O(44)10 PRETIX PROVIDENCE MANATY STATEMENT OF DEFICIENCIES PRETIX PROVIDENCE MANATY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRESULATORY OR I.S. DESTRIPTING INFORMATION) FOR PRETIX 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. For surveyor informed the AT that the facility staff had documented dashes () in Section D0100 and D0200. The surveyor notified the AT that the facility staff had documented dashes () in Section D0100 and D0200. The surveyor notified the AT that the 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 MDS assessment for Resident #7. 2. For Resident #11 the facility staff failed to ensure a complete and accurate MDS assessment for Resident #1. Reference Date (ARD) of 3/20/17. The facility staff 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 Unit 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)	NAME OF P	ROVIDER OR SUPPLIER	453250	B. WING	S	TREET ADDRESS CITY STATE ZIP CODE	1 00	100/2017
GALAX HEALTH AND REHAB GALAX WA 24333 GALAX MA 24333 DATE CONTINUE OF CHERCIENCIES DATE CONTINUE OF CHERCIENCY MUST BE PRECEDED BY TULL PREPARATION ON LOCATION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CONTINUE OF CONTINUE OF CONTINUE OF CONTINUE OF CONTINUE OF CROSS-REFERENCED TO THE APPROPRIATE CONTINUE OF CONTINUE OF CROSS-REFERENCED TO THE APPROPRIATE CONTINUE OF CONTINUE OF CONTINUE OF CROSS-REFERENCED TO THE APPROPRIATE CONTINUE OF CO								
D4-JD SUMMARY STATEMENT OF DEFICIENCIES PREFER PROPERTY ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CONTENTS ACTION SHOULD BE PREFER PROPERTY ACTION SHOULD BE PREFER PROPERTY ACTION SHOULD BE PREFER PROPERTY ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CONTENTS ACTION SHOULD BE PREFER PROPERTY ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPERTY ACTION SHOULD BE CROSS-REFERENCED TO HE APPROPERTY ACTION SHOULD BE CROSS-REFERENCED. FOR THE TRANSPORT ACTION ACTION TO HE APPROPERTY ACTION SHOULD BE CROSS-REFERENCED. FOR THE TRANSPORT ACTION ACTION TO HE APPROPERTY ACTION TO HE APPRO	GALAX H	EALTH AND REHAB						
F278 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 the facility staff failed to ensure a complete and accurate MDS assessment or exiting the facility staff failed to ensure a complete and accurate MDS assessment will be brought to the QAPI Committee monthly for discussion/resolution. 5. Date of Compliance: 7/20/2017 6. Date of Compliance:	(XA) ID	CLIMMADV CT	ATEMENT OF DEFICIENCIES					
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. Exourterly 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 Admission MDS assessment with an ARD of 10/17/16. The facility staff failed to code a significant weight gain-39.2 pounds- in Section K. The facility staff failed to code a significant weight gain-39.2 pounds- in Section K. 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, osteoporsosis, protein calorie malnutrition and a urinary tract infection (UTI). The most current Minimum Data Set (MDS)	PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI:	- 1	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
Quarterly MDS assessment with an Assessment Reference Date (ARD) of 3/20/17. The facility	F 278	Compliance Nurse (C) the Administrative Te failed to ensure a con Resident #7. The sur Resident #7's Quarter 5/3/17 was incorrect. AT that the facility sta (-) in Section D0100 a notified the AT that Reanswer the questions status and therefore sa 9 (no response). No additional info to exiting the facility a failed to ensure a complete an Minimum Date Set with Reference Date (ARD staff failed to code a spounds- in Section K. to ensure a complete MDS assessment with facility staff failed to copast 30 days. Resident #11 was was admitted on 10/8/included, but were not thrive, osteoporosis, p and a urinary tract infer The most current assessment located in Quarterly MDS assess	cCN). The surveyor notified am (AT) that the facility staff inplete and accurate MDS for veyor notified the AT that ray MDS with the ARD of The surveyor informed the aff had documented dashes and D0200. The surveyor resident #7 was unable to related to her cognitive should have been coded as a surveyor as to why the facility staff inplete and accurate MDS rent #7. #11 the facility staff failed to diaccurate Quarterly than Assessment of 3/20/17. The facility significant weight gain-39.2 The facility staff also failed and accurate Admission in an ARD of 10/17/16. The rode/capture a UTI in the rode/capture a UTI in the rotein calorie malnutrition rection (UTI). Minimum Data Set (MDS) in the clinical record was a sment with an Assessment	F	278	section K and section D of MDS assessments will be brought to t QAPI Committee monthly for discussion/resolution.	S he	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	LIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN		COI	MPLETED	
					С	
NAME OF PROVIDED OR CURRULED	495250	B. WING		0	6/08/2017	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GALAX HEALTH AND REHAB			836 GLENDALE RD PO BOX 229 GALAX, VA 24333			
			GALAX, VA 24333			
	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE		(X5) COMPLETION	
,	SC IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)		DATE	
F 278 Continued From page	13	F 2	78			
1	lent #11 had a Cognitive	, -				
Summary Score of 13						
	t11 was independent (0/1) to					
	(4/2) with Activities of Daily					
	ction K. 0200 the facility staff					
	11's height was 63 inches				Name of the Control o	
	ounds. In Section. K 0310				in the state of th	
	% or more in the last month					
	n the past 6 months - the					
facility staff coded "0"	(no).					
On June 7, 2017	at 7:35 a.m. the surveyor					
	1's clinical record. Review					
	roduced Resident #11's					
weights since admissi	on. The weights were					
documented as:						
!	98.8 pounds					
10/22/16	100.6 pounds					
10/26/16	100 pounds					
i i	pounds					
11/9/16 103	pounds					
l l	107 pounds					
	109 pounds					
	pounds					
12/21/16	117 pounds					
12/29/16 124	pounds 12/30/16					
124 pounds						
	pounds					
2/6/17 125	pounds					
3/10/17 138	pounds					
The surveyor note	ed that Resident #11 gained					
	ission until 3/20/17. A				With a place and an artistance	
total of 32.3% weight g						
Continued review	of the clinical record					
produced Resident #17						
	ed into the local hospital on					
10/7/16. The hospital a					111111111111111111111111111111111111111	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
E .	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG			LETED
						(
		495250	B. WING				08/2017
NAME OF PI	ROVIDER OR SUPPLIER		Ī	STREET ADDRESS, CITY, STATE, ZIP CO	DE L	L	
				836 GLENDALE RD PO BOX 229			
GALAX H	EALTH AND REHAB			GALAX, VA 24333		·····	
(X4) ID	CLIMMADV CT	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		N SHOULD BE APPROPRIA		COMPLETION DATE
F 278			F2	278			
	Continued From page	e 14 that Resident #11 had					
		ria, a urine culture that the					
	Doctor diagnosed as						
	Levaquin for the treat	· ·					
	201040111011110111011						
	Further review of	f the clinical record produced					
	an Admission MDS a	ssessment with an ARD of					
	10/17/16. The facility	staff coded that Resident					
	#11 had a Cognitive S	Summary Score of 14. The					
	-	ed that Resident #11 required					
		ursing care (4/2) with ADL's.					
		iagnoses I2300 the facility					
	· .	oture a UTI in the past 30					
	days.						
	On June 7 2017	at 8:40 a.m. the surveyor					
		se that Resident #11's					
		he ARD of 3/20/17 was					
	•	eyor notified the MDS Nurse					
		t code/capture Resident					
		nge weight. The surveyor					
	•	th the MDS Nurse. The					
		ection K with the MDS Nurse.					
		out that Section K did not					
		icant weight change. The					
		ed Resident #11's weights					
	since admission. The	e surveyor pointed out that					
		39.2 pound weight gain from					
	•	/17. The MDS Nurse stated					
		ager was new in her position					
	•	completing Section K. The	Name of the state				
	surveyor also notified		AAA AAAA AAAA				
		ssion MDS assessment with	moore, and a				
		was incorrect. The surveyor	- The state of the				
and the second s		11's clinical record with the					
L. S.	MDS Nurse. The sur						
	hospital admission wh						
	documented signs an						
		e culture where the Doctor					
	ulagnosed that Resid	ent #11 had a UTI and	<u></u>				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C		(X2) MULTIF	LE CONSTRUCTION	(X3) DATE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	·	1 '	PLETED
						С
		495250	B. WING		06/	08/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	L	······································
				836 GLENDALE RD PO BOX 229		
GALAX H	EALTH AND REHAB			GALAX, VA 24333		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION DATE
F 278			F 27	8		
	Continued From pag	e 15 antibiotic treatment				
	with Levaquin. The	surveyor reviewed the				
	Admission MDS with	the MDS				
	Nurse. The surveyo	r pointed out that Section I.				
	112300 was not code	ed to capture the UTI within				
	the last 30 days.					
	0 - 1 0 004	7 -1 4.40 41				
		7 at 4:10 p.m. the survey dministrator (Adm), Director				
		sistant Director of Nursing				
		kers (SW) and Corporate				
		CCN). The surveyor notified				C. C
		eam (AT) that the facility staff				
		plete and accurate MDS's for				
		surveyor notified the AT that				
		terly MDS assessment with did not code/capture a				
		in-39.2 pounds- in the past 6				
		or also notified the AT that				
	•	ssion MDS assessment with				
	the ARD of 10/17/17	did not code/capture a UTI				
	within that past 30 da	ays.				
		formation was provided prior				
		as to why the facility staff plete and accurate MDS				
	assessments for Res					7/20/20
F 281		RVICES PROVIDED MEET	F 28	1 281 D Services Provided Me	et	7/20/2017
SS=D	PROFESSIONAL ST	ANDARDS		Professional Standards		
	(b)(3) Comprehensiv	e Care Plans				
		ed or arranged by the facility,				
	as outlined by the co	mprehensive care plan,				
	must					
	(i) Meet professional	standards of quality.				
		T is not met as evidenced				
	by:	The state of the s				

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STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		COMPI	LETED
						C	;
		495250	B. WING			06/0	08/2017
NAME OF PR	ROVIDER OR SUPPLIER		J. Wille	S	TREET ADDRESS, CITY, STATE, ZIP CODE	L	***************************************
				83	36 GLENDALE RD PO BOX 229		
GALAX H	EALTH AND REHAB			G	ALAX, VA 24333		
/V4UB	CHASSANDYOT	ATEMENT OF DEFINITION			PROVIDERIC DI AN OF CORRECTION		(VE)
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA	ATE	DATE
					DEFICIENCY)		
F 281			F:	281			
					 Facility residents have the 		
	Continued From page	e 16			potential of being affected by the	s	
	Based on staff interv	iew and clinical record			practice. Resident #6 had results		
		iled to follow professional		9	from a urinalysis on clinical reco	Į.	
	standards of nursing	•			without proper indication. Order		
	residents in the surve	y sample (Resident #6).				1	
					initiated from standing orders du		
	Resident #6 was adm	itted to the facility on 9/6/14.			resident spitting out medications	1	
	Diagnoses included c	-			4-27-17 and increased confusior	ı on	
		kidney disease (CKD),			4-28-17. Urinalysis was positive	for	
	dementia, and hyperte				UTI and treatment was ordered.		
		sessment with assessment			Off and freatment was stateed.		
		7, the resident scored 3 of			2. A dit of wasidants with		
		ew for mental status and			2. An audit of residents with		
	was assessed as with			urinalysis for the past 30 days for			
		ors affecting others. Section I			proper indication per standing or	rders	
	2300 was coded for u	rinary tract infection (UTI).			was performed by Assistant Dire	ector	
	During aliminal arrand				of Nursing; no further concerns	!	
		review, the surveyor noted a urinalysis from the clinical			noted.		
		date 4/28/17 and fax stamp			noccu.		
		oted faxed to the physician			2 A : D'		
		the lab results was "Noted			3. Assistant Director of		
		Ceftin 500 mg po BID X 3			Nursing/Designee will run an or	der	
		[physician initials] 5/3/17".			listing report to focus on proper		
	-	able to locate evidence of			indication for urinalysis per stan	ding	
	symptoms associated	with urinary tract infection			order and will report during mor	- !	
10000000000000000000000000000000000000		n a physician concerning			meeting.	-0	
		sing notes did not indicate			meeting.		-
		ordered the test. On 6/7/17,			1 6 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
	•	d the issue with LPN #1.			4. Any deficient practice regard	_	
		d written the order on the			improper indications of urinalys		
and the second s	•	ers. The surveyor asked if			per standing orders will be brou	ght	
our rain our rain	there should have bee	r had been written, the			to the QAPI Committee monthly		
	basis for the order, an		discussion/resolution.				
		dent's responsible party.	uiscussion/resolution.			and the second s	
		ought she had written a			5 Data of Compliance 7/20/20	17	
		sked the assistant director			5. Date of Compliance: 7/20/20	1/	
		a copy of the standing					
		ovided the standing orders					

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CTATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLI	(X2) MUL	TIPLE CONS	STRUCTION	(X3) DATE	SURVEY
i	CORRECTION	IDENTIFICATION NUMBER:		NG		1 ' '	PLETED
							С
		405050				ı	/08/2017
NAME OF D	ROVIDER OR SUPPLIER	495250	B. WING	STREET	ADDRESS, CITY, STATE, ZIP CODE	1 00	70072017
NAME OF F	ROVIDER OR SOFFEIER				ENDALE RD PO BOX 229		
GALAXH	EALTH AND REHAB				X, VA 24333		
GALAXII							
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR	BE	(X5) COMPLETION DATE
,,,,		,			DEFICIENCY)		
F 281			F:	281			
	Continued From pa	ge 17 and a copy of a note					
		wn on the surveyor's clinical					Wild states
	record access) titled	•					
		ondition Effective Date:					
	1	tuation: Resident spit out					
	1	95 y/o with CHF, CKD,					
	Dementia with Beha	=	1				
		N, DNR (do not resuscitate),	100				
		AMET, ACE INHIBITORS					
	1	ent spit out all her medication					
		i included ASA (aspirin) 81 mg,					
		oonse: Dr [name] group					
		aware. The surveyor asked					
		ot been visible during clinical					
	-	o LPN #1. The ADON stated					
	they were available	to her.					
	During a summanu	meeting on 6/7/17, the					
	, -	the nursing policy concerning					
4	1	ers. The surveyor was					
		c situations where they would					
		physician and family should be					
		hould be documented. The					
		two times during April 2017					
	,	ew orders and the nurse			·		
		ing the order and notifying the					
		eeting on 6/8/17, the DON					
		was no policy concerning use					
	1 .	The surveyor read the	ŧ.				
		anding orders are as follows "					
		ment E. Dysuria, Foul					
	,	d LOC, or Agitation Obtain					
		. If positive report results to					The same of the sa
		read the urinalysis. The order					
		documented a phone order					
		C&S d/t (urinalysis with					
		ity due to) confusion. The					
		t confusion was not one of the					
		ng orders listed for obtaining a					
	urinalysis. The AD	ON said that the resident spit					

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(X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY PROVIDER/SUPPLIER/CLIA A. BUILDING AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED C 06/08/2017 495250 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 836 GLENDALE RD PO BOX 229 **GALAX HEALTH AND REHAB GALAX, VA 24333** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PRÉFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 281 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. 7/20/2017 F309 D Provide Care Services for F 309 F 309 483.24, 483.25(k)(I) PROVIDE CARE/SERVICES FOR SS=D HIGHEST WELL BEING Highest Well Being. 483.24 Quality of life 1. Facility residents have the Quality of life is a fundamental principle that potential to be affected by this applies to all care and services provided to facility practice. Resident #9 was ordered residents. Each resident must receive and the facility must provide the necessary care and Bactrian bid times 10 days on services to attain or maintain the highest 4/29/17. It was noted that only 19 practicable physical, mental, and psychosocial doses of this antibiotic were well-being, consistent with the resident's administered. Antibiotic was comprehensive assessment and plan of care. discontinued by physician during 483.25 Quality of care facility rounds on 5/9/17. Resident Quality of care is a fundamental principle that #10 was administered 6pm applies to all treatment and care provided to medications twice. Upon physician facility residents. Based on the comprehensive notification, vital signs were assessment of a resident, the facility must ensure ordered, but vital signs were not that residents receive treatment and care in accordance with professional standards of obtained per frequency order.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
					С
		495250	B. WING		06/08/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GALAX H	EALTH AND REHAB			836 GLENDALE RD PO BOX 229 GALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 309			F 30	09	
F 309	and the residents' chelimited to the followin (k) Pain Manage The facility must ensure provided to residents consistent with profess the comprehensive provided to residents' go. (l) Dialysis. The residents who require services, consistent wof practice, the comprehensive proferences. This REQUIREMENT by: Based on staff intervively and clinical refailed to follow physic residents (Resident #Resident #9). The findings included 1. The facility staff farorders for the administ medications. Resident medications. Resident pass on 10/6/16. The clinical record of 6/7/17. Resident #3 in 10/28/14 with diagnost limited to paranoid somellitus, depressive complete.	on-centered care plan, oices, including but not g: ement. ure that pain management is who require such services, ssional standards of practice, erson-centered care plan, als and preferences. e facility must ensure that e dialysis receive such with professional standards rehensive person-centered sidents' goals and is not met as evidenced riew, facility document ecord review, the facility staff cian's orders for 3 of 21 dialysis receive and dialysis receive and ris not met as evidenced riew, facility document ecord review, the facility staff cian's orders for 3 of 21 dialysis receive and dialysis receive and ris not met as evidenced riew, facility document ecord review, the facility staff cian's orders for 3 of 21 dialysis receive and dialysis receive and ris not met as evidenced riew, facility document ecord review, the facility staff cian's orders for 3 of 21 dialysis receive and dialysis receive and ris not met as evidenced	FSI	2. An audit of residents with antibiotic orders was performed Assistant Director of Nursing to identify any other concerns; no concerns were noted. A medication error audit was performed by Assistant Director Nursing to identify physician or post medication error; no other concerns were noted. 3. Director of Nursing/Designe will be reviewing order listing r in morning meeting to identify a new orders post medication error and new antibiotic orders to insithe physician's orders are follow 4. Any deficient practice regard following physicians orders will brought to the QAPI Committee monthly for discussion/resolution 5. Date of Compliance: 7/20/20	oother of of oders eeport ony ors are ved. ing be

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	1	PLETED
					,	С
		495250	B. WING		1	08/2017
NAME OF P	ROVIDER OR SUPPLIER		D. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	1 337	
			l	836 GLENDALE RD PO BOX 229		
GALAX H	EALTH AND REHAB			GALAX, VA 24333		**************************************
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	l	PROVIDER'S PLAN OF CORRECTION	((X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
F 309			F 30	09		
	Continued From page	e 20 secondary				
	parkinsonism, hyperte	-				
	gastroesophageal ref	· ·				
	Resident #3's quarter	ly minimum data set (MDS)				
		ssessment reference date				
		essed the resident with a				
	cognitive summary so	j				
	Section C Cognitive F	atterns.				
	The currover reviews	d the progress notes for				
	•	2016 through June 2017.				
		ted 10/6/16 at 18:25 (6:25		-		
		n error at 1730 Background:				
	69yr (year) old female	9				
	paranoid schizophren	ia, constipation, MDO				
		order), personality disorder,				
		al HTN (hypertension),				
	GERD (gastroesopha					
	Allergies: Banana, sti	•				
		tently administered lamictal				
	100 mg (milligrams), r					
		epam 5 mg, and glipizide s): B/P (blood pressure)			l	
	135/55, P (pulse)-64,					
-		22 (oxygen saturation) 91%.			l	
TO COLUMN TO THE TO THE TO COLUMN TO THE THE TO THE		g tired at this time. No				
Vicinitation		at this time. No noted rash				
***************************************		e: Spoke with on-call MD				
		nitor VS and blood sugar q				
	, , , , , , , , , , , , , , , , , , , ,	imes 16 hrs and monitor for			ļ	
	=	and if this develops then to				
		ospital immediately. May				
	administer Benadryl p	er standing order in			NOTE AND ADDRESS OF THE PARTY O	
	needed."					
	Resident #3's Octobor	2016 physician orders did				
		ations administered above				
	but included Zaditor ey	1			ļ	
		, , , , , , , , , , , , , , , , , , , ,			THE PERSON NAMED IN COLUMN NAM	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	4	(X3) DATE SURVEY COMPLETED	
						С
		495250	B. WING		06	/08/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GALAX H	EALTH AND REHAB			836 GLENDALE RD PO BOX 229 GALAX, VA 24333		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORR		(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG	((EACH CORRECTIVE ACTION SECTION SE		DATE
F 309			F3	809		
	Continued From page	e 21				
		d the administrative staff of				
		istration error that occurred				HADDEN AND AND AND AND AND AND AND AND AND AN
-		orders were not followed in				
-		eeting on 6/7/17 at 4:10 p.m.				
		edication error for 10/6/16.				
	The director of nursin	g stated the nurse handed				
		3 and she took them. The				TO PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY AND ADDRESS OF THE PROPERTY ADDRES
	DON stated the nurse	e received education.				
	The medication error	form dated 10/6/2016 had				is to Ashion common
		ast column titled "Medication				William Parket
	Administration" was o	checked. The first question				
	read "Which of the	following was involved?"				
		patient". "What Procedure				
		Checked was "Resident not				
		"How did this error occur?"				
		med administered to wrong				
		E: Categorize the error: Did				
		ce any negative effects from I were "NO. An error or				manufacture (manufacture manufacture manuf
		but corrective action took				TOTAL PROPERTY AND A STATE OF THE STATE OF T
		lent was negatively harmed.				And the second
	•	sion occurred, but monitoring				**************************************
		e of negative effects. Were				Commence
		nonitored every 15 min after				E. C.
	•	red? No. Was the resident				
	admitted to the hospit					
	No further information	was provided prior to the				
	exit conference on 6/8	•				
	2 232.01.00 011 070					
	2. The facility staff fail	ed to follow physician				
		administration for Resident				
The state of the s	#10. Resident #10 re	ceived medications (Xanax				
and the same and t	and Oxycodone) on 3	/28/17 at 4:45 p.m. and				
	again 1 hour and 15 n	ninutes later at 6:00 p.m.				
a de la companya de l	The clinical record of l	Resident #10 was reviewed				

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X	3) DATE SURVEY COMPLETED
						С
		495250	B. WING			06/08/2017
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GALAX H	EALTH AND REHAB			836 GLENDALE RD PO BOX 229 GALAX, VA 24333		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORE	ECTION	(×5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		HOULD BE	COMPLETION
F 309			F 3	09		
	9/1/16 with diagnose to right shoulder pair obstructive pulmonar disorder, gastroesop (GERD), major depre hyperlipidemia, type hypertension, and nice Resident #10's quart (MDS) assessment was reference date (ARD resident with a cogniout of 15 in Section (with no signs or sympsychoses or behavior Current comprehens and revised 1/16/17 needs pain management chronic back pain. In medication as ordered one for potential for associated with use related to anti-any Interventions: Provide physician and evaluate The clinical record codated 3/28/17 18:30 "Monitor vital signs e hour for 15 administr	o was admitted to the facility is that included but not limited in, atrial fibrillation, chronic by disease (COPD), anxiety hageal reflux disease essive disorder, 2 diabetes mellitus (DM), cotine dependence. erly minimum data set with an assessment of 3/27/17 assessed the tive summary score of 15 cognitive Patterns and proms of delirium, for affecting others. ive care plan initiated 9/2/16 identified that Resident #10 ment and monitoring related to interventions: Administer pain ed. Care plan also included of drug related complications of psychotropic medications diety and antidepressants. He medications as ordered by the the effectiveness. ontained a telephone order (6:39 p.m.) that read wery hour x 15 hours every				
TO THE PROPERTY OF THE PROPERT	note read "SBAR-Ch Nurse administered >	ange of Condition Situation: (anax 0.5 mg (milligrams) g at 1645 (4:45 p.m.). Meds			ndi da wakana awakana a	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
						C	12047
		495250	B. WING_			06/08/	2017
	EALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 836 GLENDALE RD PO BOX 229 GALAX, VA 24333			againn agus aig an air agus air an sinn air an t-air an
(X4) ID	SHMMARYST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	ECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	1	HOULD BE		OMPLÉTION DATE
F 309			F 3	09			
F 309	administered again at old male with a histor anxiety, GERD, DM with hyperglycemia depressive disorder, diabetic neuropathy anemia, Code Status (No Known Allergy) omitted) contacted a very relaxed but will to RP to return call to fa (vital signs) to be che hrs d/t (due to) half-lift Resident #10's March were reviewed and in 0.5 mg by mouth four anxiety Order date 10 HCL 10 mg Give 10 m for pain Order date 9/ The surveyor request Resident #10 from the nursing on 6/7/17. The dated 3/28/17 read "X Oxycodone 10 mg given	due at 6pm. Meds were a 6pm. Background: 80 year ry of atrial fibrillation, COPD, due to underlying condition a, hyperlipidemia, major, HTN, Type 2 DM with ry, autonomic neuropathy, Efull Code. Allergies: NKA. Response: MD (name and stated resident may be needed as the december of the color of the medication error for the medication lincident. When the same and stated resident may be not one of the medication error for the medication error for the assistant director of the "Medication Incident." May 10 and 10 and 10 and 10 and 10 anation: Nurse forgot to taken: Nurse educated on	F3	09			
	No further information exit conference on 6/8 3. For Resident #9, fa	was provided prior to the 3/17.					

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1	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/GIDENTIFICATION NUMBER:	CLIA (X2) MUL A. BUILD		NSTRUCTION	(X3) DATE COMP	SURVEY LETED
						(
		495250	B. WING			06/	08/2017
	ROVIDER OR SUPPLIER EALTH AND REHAB			836 0	ET ADDRESS, CITY, STATE, ZIP CODE GLENDALE RD PO BOX 229 AX, VA 24333		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	<u> </u>	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG	1	(EACH CORRECTIVE ACTION SHOULD B	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 309			F	309			
	kidney disease, depre failure, diabetes melli On the minimum data assessment reference scored 15/15 on the bestatus. The resident of delirium, psychosis others. During clinical record	per physician orders. nitted to the facility on ncluded traumatic peripheral vascular disease, ession, congestive heart tus, and Crohn's disease. a set assessment with e date 3/21/17, the resident orief interview for mental was assessed with out signs s, or behavior affecting review on 6/7/17, the sician telephone order dated					
	(Sulfamethoxazole-Ti (milligram) by mouth tract infection) for 10 mouth BID (twice per medication administration documented administration times per day 4/30/17 on 5/9/17 for a total of reported the concern nursing on 6/7/17 and concerning the omitted additional information	rimethoprim) Give 1 mg once a day for UTI (urinary days Give 1 tab (tablet) by day) X 10 days. The ation record (MAR) tration of the medication two 7 through 5/8/17 and 1 dose of 19 doses. The surveyor to the assistant director of d requested information and dose of antibiotic. No					
F 312 SS=D	a summary meeting v director of nursing on 483.24(a)(2) ADL	vith the administrator and 6/8/17. CARE PROVIDED FOR ENTS	OR F		F312 D ADL Care Provided fo Dependent Residents.	or	7/20/2017

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BOILDII	10			
						l)
		495250	B. WING			06/	08/2017
NAME OF PF	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CALAVIII	TALTH AND DEHAD				6 GLENDALE RD PO BOX 229		
GALAX HI	EALTH AND REHAB			G	ALAX, VA 24333		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	_	(X5) COMPLETION
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
F 312	R		F3	312			
	Continued From page	e 25			1. Facility residents have the		
		g receives the necessary			potential to be affected by this		
		good nutrition, grooming, and			practice. Resident #1's ADL red	ord	
	personal and oral hyg				did not show that resident recei		
		is not met as evidenced			two shower within a week. Res		
	by:						
		iterview, group interview,			did not show any adverse reacti		
		l record review and in the			such practice. Resident has had		
		t investigation, the facility			showers per week since concern	ı was	
		ADL (activities of daily			identified.		
	living) care to 1 of 21	residents (Resident #1).					
	The findings included	 -			2. A shower audit was perform	ed to	
	The intuitige included				focus on two showers per week		
	The facility staff failed	d to provide ADL care to a		-	resident for the past 30 days; no	-	
		Resident #1). The facility		-	deficient practice was noted. Ur		
	staff failed to provide	showers two times a week			-		
	to Resident #1.			· ·	Manager re-educated certified s		
					on ensuring showers are provide		
		Resident #1 was reviewed			timely and documented accurate	ely.	Maryer of the Parkers
		esident #1 was admitted to					
	but not limited to Park	th diagnoses that included			3. Resident shower records wil	l be	
		weakness and difficulty in			audited by Director of		
		tes mellitus, hyperlipidemia,			Nursing/Designee weekly durin	g	
	heart failure, depress				morning meeting to identify any	_	
		n, and atrial fibrillation.		and the same of th	deficient practice and allow for		
					immediate intervention.		Propression
		ly minimum data set (MDS)			THE PERSON OF TH		
		assessment reference date		-	A Any deficient practice record	ling	
	, ,	essed the resident with a		-	4. Any deficient practice regard	_	
	Section C Cognitive F	ntal status as 15 out of 15 in		Andrew Condessor	shower delivery or documentati	OH	
		or behaviors that affected			will be brought to the QAPI		
		d. Resident #1 needed			Committee monthly for		
		of one person for bed			discussion/resolution.		
		et use; limited assistance of					
	one for personal hygic	ene, and was totally			5. Date of Compliance: 7/20/20	17	
	dependent on one pe	rson for bathing.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		i i	IPLE CONSTRUCTION	1 ' '	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			C
		495250	D MANAG			/08/2017
NAME OF P	ROVIDER OR SUPPLIER	493230	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE		
				836 GLENDALE RD PO BOX 229		
GALAXH	EALTH AND REHAB			GALAX, VA 24333		oraleadittiilaaniinaiteidetailaaaltattelaadidatti et e lote e oota
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 312			F3	12		
	Continued From page	e 26				
		comprehensive careplan				
		d revised 5/3/17 read that the				
	resident had a physic	cal functioning deficit related				
	to self-care managen					
	•	from staff, personal hygiene				
	assistance from sta	aff. The care plan also eurological status related to				
	1	Interventions: Assist in				
	ADL's as needed.					
	angui a					
	-	wed Resident #1 on 6/7/17 It #1 stated she had some				
		taff on the unit and the care				
		esident #1 stated she was				
	-	ath or shower twice a week.				
	The augustan ravious	ad the August 2016				
	The surveyor reviewe	d October 2016 bath/shower				
	sheets. The facility s					
	-	ng) Flow Sheet Log for the				
	requested months.					
	The September 2016	ADI Flow Sheet Log				
	•	did not receive two showers				
		unday) through 9/10/16				
		#1 did not receive a shower				
	-	nber 2016 from 9/3/16				
	through 9/12/16.					
	The surveyor reviewe	ed the progress notes from				
	9/1/16 through 9/14/1					
	_	esident #1 refused a bath or				
		was on a leave of absence				
		:29 p.m. on 9/11/16 until				
	5:00 p.m. 9/11/16.					
	The surveyor intervie	wed certified nursing				
	assistant #3 on 6/7/17	7 at 12:35 p.m. C.N.A. #1				
	stated baths are giver	n 2 times a week as long as				<u> </u>

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STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
1	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED		
		495250	B. WING		06/0	08/2017	
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE			
				836 GLENDALE RD PO BOX 229			
GALAX H	EALTH AND REHAB			GALAX, VA 24333			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETION DATE	
F 312			F 31	2			
	refuse. C.N.A. #3 sta assistants chart wher their baths. C.N.A. # team for the A unit ar The surveyor intervie assistant #4 on 6/7/1 stated baths are give stated she was the bath team worked Mc The surveyor held a gresidents of the facilit The group stated that least 2 times a week. The surveyor informe the failure to provide Resident #1 during S through 9/12/16) durin 6/8/17 at 11:55 a.m. stated they thought the family in September 1.	7 at 9:30 a.m. C.N.A. #4 n 2 times a week. C.N.A. #4 ath team on B unit and the onday through Friday. group meeting with seven y on 6/7/17 at 10:00 a.m. t most got their showers at d the administrative staff of					
	exact days. No further information exit conference on 6/3	n was provided prior to the 8/17.					
F 328 SS=D	This is a complaint de 483.25(b)(2)(f)(g)(5)(l FOR SPECIAL NEED	n)(i)(j) TREATMENT/CARE	F 32	F328 D Treatment Care for Special Needs.	20 00 00 00 00 00 00 00 00 00 00 00 00 0	7/20/2017	
		nsure that residents receive care to maintain mobility the facility must:					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AINDILANO	OOKINEOTION	ISENTI TONTION NONIBER.	, , , , , , , , , , , , , , , , , , , ,			(
		495250	B. WING_			1	08/2017
NAME OF P	ROVIDER OR SUPPLIER		I I	ST	REET ADDRESS, CITY, STATE, ZIP CODE	L	***************************************
					6 GLENDALE RD PO BOX 229		
GALAX H	EALTH AND REHAB			G/	ALAX, VA 24333		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	c	(X5) COMPLETION
TAG	· ·	SC IDENTIFYING INFORMATION)	TAG	^	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
F 328			F3	328	4. E. ilitar ancidente have the		
	Continued From page	e 28			1. Facility residents have the		
		care and treatment, in			potential to be affected by this practice. Resident #2's nebulize	ייי	
	accordance with profe				practice. Resident #2 s neodifice	or not	
	the resident's medica	prevent complications from			tubing was noted by the survey	טו ווטנ	
	the resident's medica	i condition(a) and			to be dated. Nurse immediately		
	(ii) If necessary,	assist the resident in making			identified concern.		
	appointments with a				a de la Calabina tubina	T.700	
		rtation to and from such			2. An audit of nebulizer tubing	was	
	appointments				completed by Regional Clinical	l otod	
	(f) Colostomy, ureter	ostomy, or ileostomy care.			Consultant; no concerns were n	tral	
	The facility must ensu	-			Administrator re-educated Cen	ll d1	
		eterostomy, or ileostomy			Supply Coordinator/Backup to	EE	
	services, receive such				utilize a census sheet and check		
	professional standard				nebulizer tubing as changed an	a	
	the resident's goals a	n-centered care plan, and nd preferences.			dated during weekly rounds.		
	(a)(5) A resident who	is fed by enteral means			3. During morning meeting, th	ıe	
		ate treatment and services			Administrator/Designee will re	quest	
		ations of enteral feeding			that Care Keeper Round Sheets	s be	
		ed to aspiration pneumonia,			submitted by department heads	with	
	diarrhea, vomiting, de	-			any nebulizer tubing concerns	for	
	autiorniailles, and ha	sal-pharyngeal ulcers.			correction.	:	
	(h) Parenteral FI	uids. Parenteral fluids must				:	
		istent with professional			4. Any deficient practice rega	ding	
		and in accordance with			nebulizer tubing will be broug	ht to	
		comprehensive person-			the QAPI Committee monthly	for	
	preferences.	nd the resident's goals and			discussion/resolution.		
	protoronood.						
		care, including tracheostomy			5. Date of Compliance: 7/20/2	2017	
		tioning. The facility must			-		
		t who needs respiratory care,					
	including tracheostom	d such care, consistent with					
	professional standard						
	,	•					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
						С	
		495250	B. WING		00	6/08/2017	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GALAX H	EALTH AND REHAB			836 GLENDALE RD PO BOX 229 GALAX, VA 24333	· · · · · · · · · · · · · · · · · · ·		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	RECTION	(X5)	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)		COMPLETION DATE	
F 328			F3	28			
	and preferences, and (j) Prostheses. The fresident who has a p	e plan, the residents' goals I 483.65 of this subpart. Cacility must ensure that a rosthesis is provided care					
	standards of practice centered care plan, the preferences, to wear prosthetic device. This REQUIREMENT	istent with professional , the comprehensive person- ne residents' goals and and be able to use the is not met as evidenced					
	record review, the nebulizer equipment	n, staff interview and clinical facility staff failed to store in a clean and sanitary 21 residents in the survey 2).					
And the second s	The findings included	l:					
	10/13/16 with the foll- limited to high blood disorder, depression, chronic obstructive pi quarterly MDS (Minin (Assessment Referer resident was coded a Interview for Mental S possible score of 15. extensive assistance dressing and is totally members for personal	dmitted to the facility on owing diagnoses of, but not pressure, dementia, anxiety manic depression and ulmonary disease. On the num Data Set) with an ARD noce Date) of 5/26/17, the is having a BIMS (Brief Status) score of 3 out of a Resident #2 also requires of 2 staff members for y dependent on 2 staff all hygiene and bathing.					
	Resident #2's room a with resident. The su	, the surveyor went into nd was attempting to talk riveyor observed a plastic de the bed that contained a					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULT	TPLE CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY	
3	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG		PLETED
						С
		495250	B. WING		06/	08/2017
NAME OF P	ROVIDER OR SUPPLIER		I I	STREET ADDRESS, CITY, STATE, ZIP CODE		
			i	836 GLENDALE RD PO BOX 229		
GALAX H	EALTH AND REHAB			GALAX, VA 24333		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(×5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG		BE	COMPLETION DATE
F 328			F 3	328		
	On the outside of the 5/6/17 on it. The surveyor the nebulizer tubing of written on the tubing of director of nursing steed tubing was changed for nursing stated "the weekly." The surveyor would know if this had director of nursing stated atteed of the change on bag or put a piece of the date written on it." The could see a date on edirector of nursing stated the could see a date on edirector of nursing stated the could see a date on edirector of nursing stated.	pped in the room and the often the nebulizer mask ged. The assistant director				
F 364 SS=D	documented findings conference room by the No further information surveyor prior to the ed 483.60(d)(1)(2) NPALATABLE/PREFER (d) Food and drink Each resident receive (d)(1) Food prepared in nutritive value, flavor, (d)(2) Food and drink attractive, and at a safe	was provided to the xit conference on 6/8/17. IUTRITIVE VALUE/APPEAR, R TEMP s and the facility provides- by methods that conserve and appearance; that is palatable,	F3	F364 D Nutritive Value/App Palatable/Prefer Temp. 1. Facility residents have the potential to be affected by this practice. Resident #1's lunch patty was noted to be tough a Dietary Manager offered other options to Resident #1; resided denied offer.	s chicken nd dry. r	7/20/2017

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
						١,	c
		405050				06/08/2017	
NAME OF P	ROVIDER OR SUPPLIER	495250	B. WING	STREET AND	PRESS, CITY, STATE, ZIP CODE	1 00/	00/2017
TANKE OF F	NO VIDEN ON SOFFEIEN						
GALAXH	EALTH AND REHAB			GALAX, VA	ALE RD PO BOX 229		
				OALAX, T			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B ROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 364			F 3	34			
,	Continued From page	. 21	. 0	[ındom verbal interviews w	oro	
	Continued From page	: 31		1		ere	
	by:				with residents who had		
		n, group interview, resident		receiv	ved chicken patties on their	r tray	
		ew, and in the course of a		to foc	rus on toughness and dryne	ess of	
		on, the facility staff failed to		the m	eat; no further concerns w	ere	
	,	valatable to 1 of 21 residents		1	d by residents.		
	(Resident #1).			VOICE	a by residents.		
	mmic configuration of the design			2 4			
	The findings included	•		1	in-service was completed	-	
	77) 6 777 1 66 6 7			Dietai	ry Manager with dietary te	am	
	-	to ensure that the food			us on the placement of chi	icken	
	served to Resident #1	i was palatable.		pattie	s on the pans in the steame	er -	
	The olinical passed of	Resident #1 was reviewed			to allow the steam to make		
		esident #1 was reviewed		1			
		th diagnoses that included		i	ct with each patty more ev	emy	
200	but not limited to Park				p prevent toughness and		
9.000		weakness and difficulty in		dryne	ss. A random audit of chic	ken	
		es mellitus, hyperlipidemia,		patties	s will be performed by the		
	heart failure, depressi			-	ry Manager/Designee to ei		
and the same	disorder, hypertension	-		 	r texture and moistness wh	1	
Ballato a company	disorder, riyperterision	i, and athar infiliation.			food item is offered times		
The Property of the Property o	Resident #1's quarter	ly minimum data set (MDS)				one	
		ssessment reference date		month	1.		
		essed the resident with a					
	` '	ntal status as 15 out of 15 in		4. An	y deficient practice regard	ling	
and	Section C Cognitive P			i	and dry chicken patties w		
	•	r behaviors that affected			ht to the QAPI Committee	1	
		I. Resident #1 needed		1		i	
	extensive assistance	of one person for bed		11101111	aly for discussion/resolution	л.	
	mobility, transfers toile	et use; limited assistance of					
	one for personal hygie			5. Dat	te of Compliance: 7/20/20)17	
	dependent on one per	rson for bathing.					
	-	ved Resident #1 on 6/7/17					
		t #1 stated she had some				The state of the s	-
		service at the facility and					
	•	or to eat lunch with her.					
		e boiled eggs were so hard					
<u> </u>	they bounce, the mea	tloaf was a hamburger patty					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495250	B. WING		1	C /08/2017
NAME OF P	ROVIDER OR SUPPLIER	1,00200	T D. WING	STREET ADDRESS, CITY, STATE, ZIP CODE		
GALAX H	EALTH AND REHAB			836 GLENDALE RD PO BOX 229 GALAX, VA 24333		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON O	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	4	D BE	COMPLETION DATE
F 364			F 3	64		
F 364	potatoes were served hamburgers were served and chips. Resident so thin you could see soup had no potatoes. Resident #1's physici resident to receive a. The surveyor conduct 6/7/17 at 10:00 a.m. of acility. These resident they were served were appearance was satisfied group stated the food. Statements made by chew the meat. It's lift it's hot. They don't be They won't toast a pie much rice and noodle. Anything covered with probably tough."	an's order was for the regular diet. Ited a group interview on with seven residents of the nts were asked if the foods re hot and if the flavor and sfactory. The majority of the I was not served hot. Ithe group included: "Can't ke shoe leather. Sometimes elieve in heating cornbread. ecc of white bread. Too es and pinto beans. In gravy is something that's entures were obtained for 115 a.m. by a second eratures were as follows:	F 3			
	Pureed cream corn-1 Chicken patty-163 Cream of chicken sou					
	Pureed bread-165	1 -				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA \ \		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495250	B. WING		06	C 5/08/2017
NAME OF P	ROVIDER OR SUPPLIER	433230	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	1	
GALAX H	EALTH AND REHAB			836 GLENDALE RD PO BOX 229 GALAX, VA 24333		- AND THE RESIDENCE OF THE PARTY OF THE PART
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)		COMPLETION DATE
F 364			F 3	64		
	Continued From page	e 33				
	Noodles-198					
	Rice-200					
	Green beans-175					
	Potatoes-200					The second secon
		ong with a test tray was				
		by the dietary manager and				
		ervice manager. Resident				:
	_	ans, corn, and a chicken ated her family had brought				
	her something to eat					
	•	gional dietary manager				
	-	vo surveyors tasted the		de de la companya de		
	-	nd green beans along with				ne romania
	the regional dietary m	nanager.				
	The first surveyor sut	the chicken patty. The				
		igh and hard to cut and both				
		chicken patty was dry when				
	•	dietary manager agreed the				
		cut and dry to the taste. All				
	agreed the temperatu	re was warm enough.				
TO THE PARTY OF TH	•	the regional dietary manager				
No. a Accommonation and	,	the dining room on 6/7/17 st tray completed in the				
		d to be warm and palatable				
	-	eans, liver and onions, and				
	corn).	sario, inter aria ornario, aria				
	·					
	•	d the administrative staff of				
		palatability of the test tray				
	served to Resident #1	-				
	meeting on 6/7/17 at	4. IO p.III.				The state of the s
	No further information	was provided prior to the				
	exit on 6/8/17.	1				
The state of the s	This is a complaint de	eficiency.				
	a complaint de					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	.E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
						С
		495250	B. WING		06	6/08/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 836 GLENDALE RD PO BOX 229 GALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 372 SS=C	(i)(4)- Dispose of gard This REQUIREMENT by: Based on observation determined that the fit that the dumpster are maintained. The Findings Include On June 6, 2017 at 1 an initial tour of the k Manager (DM). The the dumpster area. I kitchen and exited the surveyor observed the surveyor observed the littered with straws, e mayonnaise, plastic milk cartons, regular "sugar" packets, used crush medications in, surveyor also noted to was open. The surveyor asked the for keeping the dumpster area clean control of the dumpster area was little door to the dumpster asked the MD who was well as the dumpster area was little of the dumpster are	d: :30 p.m. the surveyor made itchen with the Dietary surveyor requested to view The surveyor and DM left the e back of the building. The e dumpster area. The at the dumpster area was impty packets of medicine cups, chocolate milk cartons, sweet and low diplastic envelopes-used to and drink tabs. The hat the door to the dumpster everyor pointed out the trash and surrounding the dumpster or door was open to the DM. The DM who was responsible ester area clean. The DM was responsible for keeping ean. :30 a.m. the surveyor nce Director (MD) that the trash and that the was left open. The surveyor	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 import of keeping dumpster area clean During morning meeting, Dieta Manager/Designee will report of sanitary conditions of dumpster via Care Keeper Round Sheets. 4. Any deficient practice regard the sanitation an overall appears of the dumpster area will be broto the QAPI Committee monthly discussion/resolution. 5. Date of Compliance: 7/20/20	ance ary on area ding nce ought y for	7/20/2017

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(X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING COMPLETED С 06/08/2017 495250 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 836 GLENDALE RD PO BOX 229 **GALAX HEALTH AND REHAB GALAX, VA 24333** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 372 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. 7/20/2017 F 425 483.45(a)(b)(1) **PHARMACEUTICAL** SVC 425 E Pharmaceutical SVC SS=E ACCURATE PROCEDURES, RPH **Accurate Procedures.** Procedures. A facility must provide 1. Facility residents have the pharmaceutical services (including procedures potential to be affected by this that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and practice. Residents #1, #14, #7, #8, biologicals) to meet the needs of each resident. #2, and #5 were noted to have missed medication doses due to Service Consultation. The facility must (b) medications not being available/not employ or obtain the services of a licensed delivered timely by pharmacy. 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

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AND FLAN OF CORRECTION A95250 BANKE OF PROVIDER OR ESPACE GALAX, VA. 24333 STREET ADDRESS. CITY, STATE, 2P CODE SIGNAL ROLL FRO PO BOX 229 GALAX, VA. 24333 PRESIDENCY OR LIST EXPRENSITION OF DEPLEMENTS BEACH DEPLEMENT OR OBSTRANGE PROCEDED BY FLIL, BEACH CORRECTION STREET, 2P CODE BEACH CORRECTION ACTION OR LIST EXPRENSITION OF DEPLEMENTS FACE Continued From page 36 ordered medications were available for administration for 5 of 21 residents (Resident #1, Resident #1, Resident #2, and Resident #6). The findings included: 1. The facility staff failed to ensure Resident #1's medication for Parkinson disease was 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 4/20/14 with diagnoses that included but not limited to Parkinson's disease, constipation, muscle weakness and difficulty in walking, type 2 disbete maillist, hyperflipidemia, heart failure, depressive disorder, anxiety disorder, hypertension, and atrial fibrillation. Resident #1's quarretry minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/29/17 seasessment reference date extensive assistance of one person by placen, and was totally dependent on one person for bathing. Resident #1's current comprehensive care plan initiated 100/22/14 and revised 5/3/17 included impaired neurological status related to Parkinson's disease. Interventions, Medication as	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
NAME OF PROVIDER OR SUPPLIER GALAX HEALTH AND REHAB 794) 0 SIRMANY STATEMENT OF DEPICIENCES (STATE AND RESS. OTTY, STATE, 2PT CODE 285 GLENDALE RD PO BOX 229 GALAX, VA. 2433. 10 PRETIX (SANDALE ALTH AND REHAB) F 425 Continued From page 36 ordered medications were available for administration for 5 of 21 residents (Resident #1, Resident #2, Resident #3, Resident #4, Resident #7, Resident #8, Resident #2, and Resident #6. 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 11/2/16 and 11/22/16. The clinical record of 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, hyperfipidemia, heart failure, depressive disorder, ambity disorder, hyperension, and atrial fibrillation. Resident #1's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 929/17 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 bathing. Resident #1's current comprehensive care plan minitiated 10/22/14 and revised 5/3/17 included impaired neurological status related to				A. BUILDII	NG		1 '	
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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						E Date of Compliance, 7/20/20	17	
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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								
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								
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								
initiated 10/22/14 and revised 5/3/17 included impaired neurological status related to								
impaired neurological status related to								
Parkinson's disease Interventions: Medication as								
ordered by physician.					A Comment			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
, 110 / 2/ 110						С
		495250	B. WING _		06/	08/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GALAX H	EALTH AND REHAB			836 GLENDALE RD PO BOX 229 GALAX, VA 24333		and the second s
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5) COMPLETION
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)		DATE
F 425			F4	25		
	Continued From page	e 37				
	The surveyor intervie	wed Resident #1 on 6/7/17				
	•	at #1 stated she had some				
		cation administration. She				
	· · · · · · · · · · · · · · · · · · ·	a notebook where she nt information. Resident #1				
	•	016 on 11/20/16, 11/21/16				
	and 11/22/16, the sta					
	Parkinson's patch to p	put on.				
	The surveyor reviewe	ed the November 2016				
	, ,	lovember 2016 electronic				
	medication administra	ation records (eMAR) on				
	The November 2016	electronic medication				
		(eMAR) had entries for				
	· ·	r 2 mg/24 hr. The first entry 29 a.m.) and the second				
	· ·	830). The boxes for apply				
		2/16 had "7" in both boxes.				
	•	tom read "7=Other/See				
	Nurse's Notes".					
		r 11/21/16 8:47 a.m. read				
	· · · · · · · · · · · · · · · · · · ·	ur 2 mg (milligram)/24 HR				
		transdermally one time a day sidisease and remove per				
	schedule Awaiting arr					
	The progress note for	11/22/16 8:05 a.m. read				
		ur 2 mg (milligram)/24 HR				
	(hour) Apply 1 patch t	ransdermally one time a day				
		disease and remove per				
	schedule Awaiting arr	ivai.				
		11/22/16 14:55 (2:55 p.m.)				
		a and spoke with (name				
	omitted) at alixa relate	ed to neupro patch. Patch				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			G		E SURVEY PLETED	
					1	C
		495250	B. WING		06	/08/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GALAX H	EALTH AND REHAB			836 GLENDALE RD PO BOX 229 GALAX, VA 24333		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECT	ON	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION DATE
F 425			F 4:	25		
, ,,,,,	Cautinual Francisco	- 20iii				
	Continued From page					
	be on next pharmacy	run."				
	the above concern dumeeting on 6/7/17 at nursing stated that the the issue of medication 2017. The DON state running out of medical started. The DON state daily struggle. The Dhave a back-up pharm. The surveyor reviewer "Unavailable Medication read in part "Medication read in part "Medication read in part "Medication was be due to the phonout of stock of a particular manufacturer's short a situation may be permolonger being made every effort to ensure	ed the facility policy titled ions" on 6/8/17. The policy ons used by residents in the e unavailable for dispensing a occasion. The situation armacy being temporarily cular product, a drug recall, age of an ingredient, or the nanent because the drug is e. The facility must make				
		ng staff shall: 1) Notify the				
		f the situation and explain				
	· ·	spected availability and				
		that are available. A. If the				
	•	e to obtain a response from				
	0. ;	an, the nurse should notify				
	• .	r and contact the Facility				
		rders and/or direction. 2)				
		nd cancel/discontinue the				
		ilable medication. 3) Notify				
	the pharmacy of the r	еріасетіені отцег.				
	No further information exit conference on 6/8	was provided prior to the 3/17.				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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SATEMENT OF DEFICIENCES AND PLANO F CORRECTION AND PRICE SECURITY STATE, 2P CODE 88 GLERDALE RD PO BOX 222 AND PLAN THE CORRECTION F CORRECTION AND PRICE SECURITY STATE, 2P CODE 88 GLERDALE RD PO BOX 222 AND PLANO F CORRECTION AND PRICE SECURITY STATE, 2P CODE 88 GLERDALE RD PO BOX 222 AND PLANO F CORRECTION AND PRICE SECURITY STATE, 2P CODE 88 GLERDALE RD PO BOX 222 AND PLANO F CORRECTION AND PRICE SECURITY STATE, 2P CODE 88 GLERDALE RD PO BOX 222 AND PLANO F CORRECTION AND PRICE SECURITY STATE, 2P CODE 88 GLERDALE RD PO BOX 222 AND PLANO F CORRECTION AND PRICE SECURITY STATE, 2P CODE 88 GLERDALE RD PO BOX 222 AND PLANO F CORRECTION AND PRICE SECURITY STATE, 2P CODE 88 GLERDALE RD PO BOX 222 AND PLANO F CORRECTION AND PRICE SECURITY STATE, 2P CODE 88 GLERDALE RD PO BOX 222 BALL X LAY 22 ASSETTED AND PRICE SECURITY STATE, 2P CODE 88 GLERDALE RD PO BOX 222 BALL X LAY 22 ASSETTED AND PRICE SECURITY STATE, 2P CODE 88 GLERDALE RD PO BOX 222 BALL X LAY 22 ASSETTED AND PRICE SECURITY STATE, 2P CODE 88 GLERDALE RD PO BOX 222 BALL X LAY 22 ASSETTED BALL X LAY 22 ASSETTED AND PRICE SECURITY STATE, 2P CODE 88 GLERDALE RD PO BOX 222 BALL X LAY 22 ASSETTED BA	CENTERS	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	. 0938-0391
NAME OF PROVIDER OR SUPPLIER GALAX HEALTH AND REBAB STREET ADDRESS, CITY, STATE, ZIP CODE 386 GLENDALE RD PO BOX 229 GALAX, VA 24333 CALAX, VA 24333 CALAX, VA 24333 CALAX, VA 24333 CALAX, VA 24333 FREGULATORY OR LSC IDENTIFYING INFORMATION) FREST REGULATORY OR LSC IDENTIFYING INFORMATION) F 425 Continued From page 39 2. The facility staff failed to ensure Resident #14's medications were available for administration on 5/26/17, Calcium Acetate 667 mg (milligram) was not available for administration on 5/26/17, Calcium Acetate 667 mg (milligram) was not available for administration on 5/27/17, 6/17, 6/17, 6/17, and 6/17/1. Distyvite was not available for administration on 5/27/17, Calcium Acetate 667 mg (milligram) was not available for administration on 5/17/17, 6/17/1, 6/17, 6/17, and 6/17/1. Resident #14 was admitted to the facility 5/6/17 resident #14 was admitted to the facility 6/6/17 resident #14 was admitted to the facility 6/6/17 resident #14 was admitted to the facility 6/6/17 resident #14 receiving hemodality assessed the resident #				` ′				
ALAX, VA. 2433 BREAT ADDRESS, CITY, STATE, JP CODE See GLENDALE RD. PO BOX 229 GALAX, VA. 24333 CONTINUED FROM MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. Calcium Acetate 667 mg (milligram) was not available for administration on 6/3/11, 3/6/17, 6/6/17, and 6/7/17, Dialytive aws not available for administration on 6/3/17. The clinical record of Resident #14 was reviewed 6/3/17. Resident #14 was admitted to the facility 5/3/17. Resident #14 was admitted to the facility 5/3/17 with diagnoses that included but not limited to Type 1 Diabetes Melitus, chronic kidney disease, level for being the facility of the facility 5/3/17 with diagnoses that included but not limited to Type 1 Diabetes Melitus, chronic kidney disease, level facility of the facility o								
GALAX HEALTH AND REHAB SIAMAKY STATEMENT OF DEPICIENCES 10 PREPRIX REGULATORY OR ISC IDENTIFYING INFORMATION F 425 Continued From page 39 2. The facility staff failed to ensure Resident #14's medications were available for administration on 5/26/17, Calcium Acctate 667 mg (miligram) was not available for administration on 5/26/17, Calcium Acctate 667 mg (miligram) was not available for administration on 6/3/17, 6/4/17, 6/5/17, 8/6/17, and 6/7/17, Dialyvite was not available for administration on 6/3/17, Resident #14 was enviewed 6/6/17. Resident #14 was admitted to the facility 5/6/17 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, hypertipidemia, 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) assessement 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 atteration in kidney disease) current receiving hemodiayis. Interventions: Administer medications as ordered collaborating with Physician and/or pharmacist for			495250	B. WING			06/0	08/2017
GALAX HEALTH AND REHAB O(4) ID REPORT FOR THE PROPERTY TARGET AND THE PROPERTY TAGE REACH DETRICION MIST BE PRECEDED BY TULL REGULATORY OR LSC DENTIFYING INFORMATION) 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 6/3/17, 16/4/17, 6/5/17, 6/6/17, and 6/7/17, Dalyvite was not available for administration on 6/3/17, 10/4/17, and Gabapentin 300 mg was not available for administration on 6/3/17. The clinical record of Resident #14 was reviewed 6/8/17. Twith diagnoses that included but not limited to Type 1 Diabetes Mellitus, chronic kidney disease, because (stage 4 severe), ESRD (end stage renal diseases on won dislyss), hyperhension, hyperlipidemia, acute respiratory failure, anemia in chronic kidney disease, petural 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 afteration in kidney disease, current receiving hemodallysis. Interventions: Administer medications as ordered collaborating with Physician andorp harmacist for	NAME OF PE	ROVIDER OR SUPPLIER	•		STR	REET ADDRESS, CITY, STATE, ZIP CODE		
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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, Caclaium Acetate 667 mg (miligram) was not available for administration on 5/26/17, Caclaium Acetate 667 mg (miligram) was not available for administration on 6/3/17, 6/4/17, 6/4/17, 6/6/17, and 67/17/ Dialyvite was not available for administration on 6/3/17, 6/4/17, 6/6/17, and 67/17/ Dialyvite was not available for administration on 6/4/17. The clinical record of Resident #14 was reviewed 6/6/17. Resident #14 was admitted to the facility 5/8/17 with diagnoses that included but not limited to Type 1 Diabetes Melitius, chronic kidney disease, (stage 4 severe), ESRD (end stage renal disease now on dialysis), hypertension, hypertipidemia, acute respiratory faiture, 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	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI	- 1	COMPLETION
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; Cacium Acetate 667 mg (militgram) was not available for administration on 5/26/17; Cacium Acetate 667 mg (militgram) was not available for administration on 6/3/17, 6/4/17, 6/6/17, 6/6/17, and 6/7/17; Dialyvite was not available for administration on 6/3/17; and Gabapentin 300 mg was not available for administration on 6/4/17. The clinical record of Resident #14 was reviewed 6/6/17. Resident #14 was reviewed 6/6/17. Resident #14 was admitted to the facility 5/6/17 with diagnoses that included but not limited to Type 1 Diabetes Melitius, 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. Interventitons: Administer medications as ordered collaborating with Physician and/or pharmacist for	F 425			F	425			***************************************
#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 6/26/17. Calcium Acetate 667 mg (milligram) was not available for administration on 6/3/17, 5/6/17, 6/6/17, and 6/7/17, 10/19/te was not available for administration on 6/4/17; and Gabapentin 300 mg was not available for administration on 6/6/17. 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). ESRO (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 carepian 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	1 420	Continued From page	e 39	•	120			
(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		#14's medications we administration. Cyar (micrograms) was no on 5/26/17; Rena-Vit administration on 5/2 mg (milligram) was nadministration on 6/3 and 6/7/17; Dialyvite administration on 6/4 was not available for The clinical record of 6/8/17. Resident #14 5/8/17 with diagnose to Type 1 Diabetes Misease, (stage 4 sex disease now on dialy hyperlipidemia, acute in chronic kidney disease.	ere available for nocobalamin 1000 mcg of available for administration e tablet was not available for 16/17; Calcium Acetate 667 of available for 1/17, 6/4/17, 6/5/17, 6/6/17, was not available for 1/17; and Gabapentin 300 mg administration on 6/5/17. Fresident #14 was reviewed 4 was admitted to the facility is that included but not limited fellitus, chronic kidney were), ESRD (end stage renal visis), hypertension, e respiratory failure, anemia ease, pleural effusion, der of scholastic skills, and gastroesophageal reflux					
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		(MDS) assessment v reference date (ARD resident with a cogni	vith an assessment) of 5/16/17 assessed the tive summary score of 9 out					
		initiated 5/11/17 inclufunction evidenced by disease) current receilnterventions: Admir collaborating with Ph	uded alteration in kidney y CKD (chronic kidney eiving hemodialysis. nister medications as ordered nysician and/or pharmacist for					

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SUR COMPLETE		
					С	
		495250	B. WING		06/08/2	2017
NAME OF P	ROVIDER OR SUPPLIER		Ī	STREET ADDRESS, CITY, STATE, ZIP CODE		
GALAX H	EALTH AND REHAB			836 GLENDALE RD PO BOX 229 GALAX, VA 24333		
(VA) (C)	CHMMADV CT	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRI	CTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		OULD BE CC	OMPLETION DATE
F 425			F4	25		
F 420				20		
	Continued From page					
	notes from May 2017 progress note dated ! "Cyanocobalamin Ta	ed Resident #14's progress through June 2017. The 5/26/17 at 10:22 a.m. read blet Give 1000 mg by mouth d to anemia in chronic	A CALLED TO STATE OF THE STATE			
		vailable pharmacy called."				
	a.m. read "Rena-Vite	so dated 5/26/17 at 10:22 Tablet Give 1 tablet one chronic kidney disease Drug acy called."		·		
	"Calcium Acetate Ca by mouth before mea Gastro-esophageal re					
	read "Calcium Acetat capsule by mouth be Esophageal Reflux D	ated 6/3/17 17:40 (5:40 p.m.) te Capsule 667 mg Give 1 fore meals related to Gastro- disease Without med from pharmacy."				
	The 6/4/17 7:44 a.m. Calcium Acetate Cap by mouth before mea Gastro-esophageal reesophagitis Not arrive	osule 667 mg Give 1 capsule als related to eflux disease without				
	p.m.) read "Calcium /					
		ated 6/6/17 16:54 (4:54 p.m.) te Capsule 667 mg Give 1 fore meals related to				

Event ID:IXUB11

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
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		495250	B. WING _		1	08/2017
	ROVIDER OR SUPPLIER EALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 836 GLENDALE RD PO BOX 229 GALAX, VA 24333		MINISTERIO IN THE STATE OF STA
				PROVIDEDIO DI ANI OF COR	DECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION DATE
F 425			F4	25		
, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Continued From page	9.41				
	Gastro-esophageal re esophagitis Pharmac	eflux disease without by notified and still waiting."				
	The progress note da	ated 6/7/17 16:54 (11:02)				
		te Capsule 667 mg Give 1				
		fore meals related to Gastro-				
		sease without esophagitis				
	Pharmacy notified ar	nd still waiting."				
	The progress note da	ated 6/4/17 10:58 read				
		1 tablet by mouth one time a				
	day for supplement h	lave not received from				
	pharmacy."					
	The progress note da	ated 6/5/17 17:38 (5:38 p.m.)				
	read "Gabapentin ca	psule 300 mg Give 1 capsule				
		s a day related to Type 1				
		th Hyperglycemia for 1 week				
	not available called p					
	The surveyor informe	ed the assistant director of				
		ent #14's medications were				
		ninistration on 5/26/17 and				
	6/3-6/7 on 6/8/17 at 3	2:40 p.m.				
	The surveyor informs	ed the administrative staff of				
		n 6/8/17 at 4:00 p.m. The				
		ated that the facility had self-				
		of medications not available in				
		N stated they found they were				The second second
		ations so a count sheet was				
		tated the issue had been a				
		OON stated the facility does				
	have a back-up phar					
	-	and the facility policy titled				
		ed the facility policy titled itions" on 6/8/17. The policy				
	read in part "Medica	tions used by residents in the				
	nursing facility may b	pe unavailable for dispensing				
L	Training facility may i	oo anaranana ia diapanang			······································	

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OMB NO. 0938-0391

A95250 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 836 GLENDALE RD PO BOX 229 GALAX HEALTH AND REHAB (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PROFILE OF THE PROVIDER OF THE PROFILE OF	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 836 GLENDALE RD PO BOX 229 GALAX, VA 24333 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	1/2017
GALAX HEALTH AND REHAB 836 GLENDALE RD PO BOX 229 GALAX, VA 24333 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	
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CONTRACTOR OF THE CONTRACTOR O	(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLÉTION DATE
F 425	y y taraktan kiyas kirak aliaya kirakiriya kirakir
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	

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OMB NO. 0938-0391

		(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	A. BUILDIN	NG	COMPLETED
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		495250	B. WING	OTDEET ADDRESS SITY STATE 7/2 CON	06/08/2017
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	=
041.49.55	PAI THE AND DELLA			836 GLENDALE RD PO BOX 229 GALAX, VA 24333	
GALAX H	EALTH AND REHAB			GALAA, VA 24333	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	l countries
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	DATE
F 425			F4	125	
	Continued From pag	0.43			
	Continued From pag				
		so coded that Resident #7			
	required set up (1/1) with Activities of Dail	to total nursing care (4/2) y Living (ADL's).			
	On June 7, 2017 a	t 9:30 a.m. the surveyor			
		7's clinical record. Review of			
		oduced signed physician			
	orders dated 5/10/17	7. Signed physician orders			
		ot limited to: "Benicar Tablet			
		Medoxomil) Give 1 tablet by			
		y related to ESSENTIAL		no.	
	(PRIMARY) HYPER	TENSION (I10)." (sic)			
	Continued review	of the clinical record			
	produced the May 2				
		rds (MAR's). Review of the			
	May 2017 MAR's do	cumented that the Benicar			
		administration on May 5th,			
	6th, 8th, 24th, 26th,	and 31st of 2017.			
		t 10:30 a.m. the surveyor	And a second		
	notified the Unit Mar	nager (UM), who was a			
		lurse (LPN #1), that Resident			
		sician ordered medications			
	available for adminis	stration in May 2017. The Resident #7's clinical record	· sa statement		
	with the LIM / DN #	1). The surveyor reviewed	and the same of th		
	the signed physician	orders and pointed out the	TO A COLOR		
	specific order for the	Benicar. The surveyor then			
	reviewed the May 20	017 MAR's with the UN (LPN			
	#1). The surveyor p	ointed out that the physician			
	ordered Benicar was	s not available on May 5th,			
	6th, 8th, 24th, 26th a	and 31st of 2017. The			
	surveyor asked if the	e facility had a back-up		***************************************	
	pharmacy and the U	IM (LPN #1) named a local			
	pharmacy. The surv	eyor requested the facility			
	policy and procedure	e for obtaining medications.			
	On June 7, 2017 at	11:05 a.m. the Assistant			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
					C 06/08/2017
		495250	B. WING	OTDEET ADDRESS SITY STATE 719 CODE	00/00/2017
	ROVIDER OR SUPPLIER EALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 836 GLENDALE RD PO BOX 229 GALAX, VA 24333	
GALANTI	CALITI AND NEITAD				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SECTION SEC	HOULD BE COMPLETION
F 425	Continued From page	- 14	F۷	125	
F 425	facility policy and pro Unavailable Medicati procedure read "Policy Medications nursing facility may b from the pharmacy o may be due to the ph out of stock of a parti manufacturer's shorts situation may be per no longer being made every effort to ensure available to meet the Procedure A. The ph notify the nursing sta	ADON) hand delivered the cedure for "Obtaining ons." The facility policy and sused by residents in the pe unavailable for dispensing in occasion. This situation harmacy being temporarily icular product, a drug recall, age of an ingredient, or the manent because the drug is e. The facility must make that medications are needs of each resident. Parmacy staff shall: 1) Call of that the ordered product (2) Notify nursing when it is	F	125	
	available. 3) Suggest drug (s) and dosage available, which is consurance. B. The number of the attending physicities explain the circumstate and optional therapy the facility nurse if urfor the attending phynotify the nursing supporting the facility Medical Direction. 2) Obtain a cancel/discontinue the medication. 3) Notify replacement order." On June 8, 2017 a met with the Administ Nurses (DON), ADO Corporate Compliance	t alternative, comparable of drug (s) that is/are overed by the resident's ursing staff shall: 1) Notify an of the situation and ances, expected availability (ies) that are available. a. If hable to obtain a response sician, the nurse should pervisor and contact the ctor for orders and/or a new order and he order for the non-available by the pharmacy of the (sic) t 4:10 p.m. the survey team strator (Adm), Director of N, Social Workers (SW) and			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С	
		495250	B. WING _		06	6/08/2017	
	ROVIDER OR SUPPLIER EALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 836 GLENDALE RD PO BOX 229 GALAX, VA 24333			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)	
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETION DATE	
F 425			F4	25			
	Continued From page	e 45					
	ordered Benicar was	ailed to ensure that physician available for administration 24th, 26th and 31st of 2017.					
	surveyor and stated that she/the facility st the primary pharmacy pharmacy and have t	e DON approached the hat she had not been aware aff could call and request y to call the back-up he back-up pharmacy as that were unavailable.					
	exiting the facility as to ensure that physiciavailable for administ 4. For Resident # 5,	nation was provided prior to to why the facility staff failed ian ordered medication was tration for Resident #7. facility staff failed to ensure asidone and macrobid were tration.					
	behavior disturbance tract infection, and hy minimum data set ass reference date 5/10/1 on the brief interview	included dementia with , bipolar disorder, urinary					
	a nurse's note dated Medication Administration HCI capsule 20 mg G times a day related to [affective] disorder Ta 100 mg not available today and 4/23/17 09 Administration Note	ation Note for Ziprasidone live 1 capsule by mouth two					

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OMB NO. 0938-0391

	FOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/ DE CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
ANDION	OOM CEONON				С
		495250	B. WING		06/08/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GALAX H	EALTH AND REHAB			836 GLENDALE RD PO BOX 229 GALAX, VA 24333	
	***			·	RECTION (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 425			F4	25	
	Continued From page	o 46		to control of the con	
	· -	d mood [affective] disorder			
	1	ng to total 100 mg not			
		effective date 4/24/17			
	21:05 documented e-				
	Administration Note of	documented medication	Company of the Compan		
	1	5/17. A nurse's note dated			
	1	R Medication Administration			
		apsule 100 mg Give 1 o times a day related to			
	,	, site not specified for 5 days	Lanco		
	1	. There was no evidence,	Auditory Control of the Control of t		
		on administration record or			
	in the nurse's notes,	that the medications were			
		ered after arriving from the			
		staff on site were unable to			
	•	dent received the ordered			
	number of doses of the	ne antibiotic.			110.7
	Surveyors discussed	documented lack of			
	1 -	tions for multiple residents in			
	the survey sample w	ith the administrator, director			
	of nursing, and assis	tant director of nursing			
		etings on 6/8/17. They			
	1 '	as no way for the facility to			
	activate the backup p				
	the primary pharmac	ey were not available from			
		ailed to ensure physician			
	ordered medication v				
	administration to Res	sident #5.			
	Resident #5 was roa	dmitted to the facility on			
-		wing diagnoses of, but not			
		rol, Alzheimer's disease,			d and a second s
	aphasia, stroke, depr				
	weakness. On the q	uarterly MDS (Minimum Data			
		ssessment Reference Date)			
		nt was coded as having a			
	RIMS (Ruet Interview	v for Mental Status) score of			

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	4G		COMPLETED
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		495250	B. WING		l	06/08/2017
NAME OF P	ROVIDER OR SUPPLIER		T	STREET ADDRESS, CITY, STATE, ZIP CODE		ales years han the telephone the section of the section of the section of the section is a section of the secti
			1	836 GLENDALE RD PO BOX 229		
GALAX H	EALTH AND REHAB			GALAX, VA 24333		
(X4) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX			COMPLETION DATE
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F 425	Continued From page	e 4 7	F 4	25		
		score of 15. The resident				
	•	equiring extensive assistance				
	of one staff member t					
		tally dependent on one staff				
	member for bathing.	•				***************************************
		cord review of Resident #5's				
	i	7/17, the surveyor noted the				
		umented in the nurses' notes				
		wing:3/11/17 19:24 (7:24				
		e 300 mg Give 1 capsule by				
	i .	ay for pneumonia for 7 days				
		Acetylcysteine Solution 20% e orally two times a day for				
		s Awaiting on medication to				
		/" On 4/7/17 at 19:09				
		ng was also documented in				
		follows: "Hydrea Capsule				
		am) by mouth in the evening				
	Awaiting from phar					
	The assistant directo	r of nursing was notified of				
		ed findings on 6/7/17 at				
		. The assistant director of				According
		surveyor "The staff has a				
	backup pharmacy tha					
	1	e readily available to obtain				
	medications from. I d	ch I these cases this was				
	1	cn i these cases this was The assistant director of				
	not followed upon.		en proposition			
	0 .	tions" which stated the				
	following:	William Stated the				
		shall call the attending				
	physician of the situa					
		cted availability and optional				
	therapies that are ava	ailable. Obtain a new order				
		ue the order for the non-				
		Notify the pharmacy of the				
	replacement order."					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIF	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
ANDIEANO	CONTROL				С
		495250	B. WING		06/08/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GALAXH	EALTH AND REHAB			836 GLENDALE RD PO BOX 229 GALAX, VA 24333	
GALAAII	LALIII AND IVEIIAP				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE COMPLETION
F 425			F 42	25	
1 425	Continued From page	e 48			
		am was notified of the above on 6/7/17 at 4:10 pm in the the surveyor.			
F 431 SS=D	483.45(b)(2)(3)(g)(h)	exit conference on 6/7/17. DRUG RECORDS,	F 43	431 D Drug records, Label Drugs & Biological	/Store 7/20/2017
	drugs and biologicals them under an agree §483.70(g) of this pa unlicensed personne law permits, but only supervision of a licer (a) Procedures. pharmaceutical servithat assure the accurdispensing, and admibiologicals) to meet to the pharmacist who (b) Service Confemploy or obtain the pharmacist who (2) Establishes and disposition of all detail to enable an account maintained and period (g) Labeling of Drugs (g) Labeling of Drugs (p) (g) Labeling of Drugs (g) Labeling of Drugs (g)	rt. The facility may permit I to administer drugs if State under the general ised nurse. A facility must provide ces (including procedures rate acquiring, receiving, inistering of all drugs and the needs of each resident. sultation. The facility must services of a licensed a system of records of receipt controlled drugs in sufficient ccurate reconciliation; and that drug records are in order of all controlled drugs is odically reconciled.		1. Facility residents have the potential to be affected by the practice. Upon zinc-oxide not be in the unlocked cabinet, is immediately removed by the Assistant Director of Nursin audit was immediately performing with no other issues noted. 2. An audit of medication st was done and found to be appropriate. No further defice practice was noted. Unit Maneducated staff regarding prostorage of medications. 3. Unit Manager/Designee is perform daily checks in shor rooms to ensure medications properly stored and be brough morning meeting for review.	is oted to t was g. An ormed corage cient nager re- per will wer s are ght to

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NAME OF PROVIDER OR SUPPLIER GALAX HEALTH AND REHAB SUMMARY STATEMENT OF DESCRIBACIES (EACH DESIGNATIVE STATE, ZIP CODE as GLENDALE RD PO BOX 229 GALAX, VA 24333 (X44) D SUMMARY STATEMENT OF DESCRIBACIES (EACH DESIGNATIVE REGULATORY OR LOC INTERPRETATION OF CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY STATE (EACH DESIGNATIVE ACTION SHOULD BE DEFICIENCY) F 4.31 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 feeliths and fields to ordinal texts prediction to a 1.4.	`		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
AAME OF PROVIDER OR SUPPLIER GALAX HEALTH AND REHAB (XA) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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						С		
GALAX HEALTH AND REHAB (CALID PREFIX TAG (CALID REGULATORY OR LSC IDENTIFYING INFORMATION) 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 stored when 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			495250	B. WING		06/08/201	17	
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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			-		medication storage will be	brought		
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		•			to the OAPI Committee me	onthly for		
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(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								
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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		(2) The facility m	nust provide separately	and the same of th				
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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		the						
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be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the								
This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the			illiai and a missing dose can					
by: Based on observation and staff interview, the		1	is not met as evidenced					
Based on observation and staff interview, the						***************************************		
facility staff failed to cafely store modication on 1		· -	n and staff interview, the					
facility staff failed to safely store medication on 1		-						
of 2 units in the facility (Unit 2).		of 2 units in the facilit	y (Unit 2).					
The findings included:		The findings included	:	And the second s				
The facility staff failed to safely store a medication		The facility staff failed	to safely store a medication					
on Unit 2.		-	a to during diore a medication	Abbitote manufacture and the second of the s				
On 6/6/17 at 2:45 pm, the surveyor went into the		On 6/6/17 at 2:45 pm	, the surveyor went into the			Version in a contract of the co		
shower room that is used for resident care on		•	_					
Unit 2. There was a cabinet on the wall facing		1						
the door in which a lock was in the hole in the								
cabinet but was not securely locked. The lock						The second secon		
remained opened at the time of this observation.		remained opened at t	ne time of this observation.				ality trade all Alman manager	

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OLIVIEN	CENTERO FOR MEDIO/ME & MEDIO/MD GETV. GET		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY	
-	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
MADIEMAOF	CONTROLL				С	
		495250	B. WING		06/08/2017	
NAME OF PE	ROVIDER OR SUPPLIER		T	STREET ADDRESS, CITY, STATE, ZIP CODE		
				836 GLENDALE RD PO BOX 229		
GALAX HI	EALTH AND REHAB			GALAX, VA 24333	em ajaranda hajama angara sa Majama pempanjan pempanda dalambar adalah 1900-1907 (1907) A. 1907 M.	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	I	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 431			F 43	1		
	Continued From page	e 50				
	In this cabinet, the su	urveyor observed (1) 15				
	ounce container of Zi	inc Oxide Ointment Skin				
		ocked cabinet. Licensed				
) #1 entered the shower				
	room and the survey	or showed the unit manager found to be unlocked. On				
		ed the above mentioned Zinc				
		Protectant. The surveyor				
		was considered to be				
	medication and LPN	#1 stated "yes, it is. It is				
		ed up at all times either in the				
	medication room or o	on the medication carts."				
	The assistant directo	or of nursing was notified of				
		ed findings at 3:10 pm at				
		cation was taken out of the			Vi.	
	shower room by LPN	l #1.				
	The administrative te	eam was notified of the above	***************************************			
	documented findings	on 6/7/17 at 4:10 pm by the				
	surveyor in the confe	erence room.				
	No further information	n was provided to the				
	surveyor prior to the	exit conference on 6/8/17.			7/20/2017	
F 441	483.80(a)(1)(2)(4)(e)	(f) INFECTION CONTROL,	F 44	441 D Infection Control, Prev	ent 7/20/2017	
SS=D		, LINENS	The state of the s	Spread, Linens		
	(a) Infection preventi	ion and control program.	And the control of th	1. Facility, recidents have the		
				1. Facility residents have the		
		ablish an infection prevention		potential to be affected by this	nd on	
		(IPCP) that must include, at		practice. Resident #5 was place	eu Oli	
	a minimum, the follow	wing elements:		contact isolation for ESBL in u	rine,	
	(4) A quater for	conting identifying reporting		PPE was not readily accessible	. INO	
	investigating and co	venting, identifying, reporting, ontrolling infections and		other residents were identified		
	communicable disea	ises for all residents, staff,		on isolation precautions at that	time.	
	volunteers, visitors, a				and the second s	
	providing services ur					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
-	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
						С	
		405350				1	08/2017
NAME OF DE	ROVIDER OR SUPPLIER	495250	B. WING	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/0	
NAME OF FE	CONDEN ON OUT FIELD				6 GLENDALE RD PO BOX 229		
GALAX H	EALTH AND REHAB				ALAX, VA 24333		
							/VE)
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	ιE	(X5) COMPLETION
TAG	•	SC IDENTIFYING INFORMATION)	TAG	`	CROSS-REFERENCED TO THE APPROPRI		DATE
					DEFICIENCY)		
F 441	Continued From page	e 51 arrangement based	F4	141			
	upon the facility asse				2. An isolation precautions aud	lit	
	•	(e) and following accepted			was performed. No further defi	cient	
	national standards (fa				practice was noted. Infection C	ontrol	
	implementation is Ph	-			Nurse re-educated licensed staf	f	
	•	, ·					
		, policies, and procedures		-	regarding isolation precautions	unu	
	, -	h must include, but are not		-	making PPE readily accessible	•	
	limited to:					•	
	(*) A				3. Infection Control Nurse/De	signee	
		surveillance designed to			will identify residents who are	on	
		municable diseases or can spread to other persons			isolation precautions for the ne	ed of	
	in the	can spread to other persons			PPE and will ensure PPE is rea	idily	
	facility;				available.		
	raomey,				dvullable.		
	(ii) When and to	whom possible incidents of			4. Any deficient practice regard	rding	
	communicable diseas	se or infections should be	isolation precautions/PPE will			he	
	reported;				isolation precautions/FFE win	20	
			and the state of t		brought to the QAPI Committee		
	V	d transmission-based			monthly for discussion/resolut	10n.	
	•	owed to prevent spread of					
	infections;				5. Date of Compliance: 7/20/2	2017	
	(iv) When and ho	ow isolation should be used for					
	a resident; including l						111111111111111111111111111111111111111
	a resident, moldaling i	out not mined to.					
	(A) The type and	d duration of the isolation,					
		nfectious agent or organism					
	involved, and	- -					
	(B) A requirement	nt that the isolation should be					
		ossible for the resident under					
	the circumstances.						
	(u) The singuistration	tances under which the					
	(v) The circumst facility must prohibit of						
		se or infected skin lesions					
		ith residents or their food, if					and an artist and a state of the state of th
		nsmit the disease; and					
	and do not trin trui						
	(vi) The hand hy	giene procedures to be					
	followed						
L							

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS	OMB NO. 0938-039	91					
ł .	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	1 ' '	
		495250	רואוואו מ		C 06/08/2017		
NAME OF PE	ROVIDER OR SUPPLIER	490200	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE			
GALAX HEALTH AND REHAB				836 GLENDALE RD PO BOX 229 GALAX, VA 24333	and the second s	A	
(X4) ID	SHAWWARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	ECTION (X5)		
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)		Ν	
F 441			F 4	41			
	Continued From page	2.52					
	Continued From page by staff involved in di						
		ording incidents identified CP and the corrective facility.					
		sonnel must handle, store, ort linens so as to prevent the					
	annual review of its I program, as necessa This REQUIREMENT by: Based on observation document review and facility staff failed to its	r is not met as evidenced on, staff interview, facility diclinical record review, the implement an effective eline for 1 of 21 residents in Resident #5).					
	For Resident #5, the personal protective e accessible to staff who contact isolation. Resident #5 was rea	facility staff failed to stock equipment that was readily nen caring for Resident #5 in dmitted to the facility on					
	limited high choleste aphasia, stroke, depi Spectrum Beta Lacta weakness. On the q Set) with an ARD (As of 3/28/17 the reside BIMS (Brief Interview 15 out of a possible s	wing diagnoses of, but not rol, Alzheimer's disease, ression, EBSL (Extended amases) in urine and muscle uarterly MDS (Minimum Data ssessment Reference Date) nt was coded as having a v for Mental Status) score of score of 15. The resident equiring extensive assistance					

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROV		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	COMPLETED	
	•				С	
					1	
		495250	B. WING		06/08/2017	
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				836 GLENDALE RD PO BOX 229		
GALAX HEALTH AND REHAB			GALAX, VA 24333			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRI	ECTION (X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX		HOULD BE COMPLETION	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE AP	PROPRIATE DATE	
				DEFICIENCY)		
F 441			F4	41		
		e 53 of one staff member				
	for bathing, personal	hygiene and being totally			30 Miles	
	dependent on one sta	aff member for bathing.				
	During the initial tour	on 6/6/17 at approximately				
	1:15 pm, the surveyo	r noted a sign on =Resident				
	#5's door that stated	"Stop and go to the nurses'				
	station before enterin	g." The surveyor did not				
	observe an isolation	cart which contained				
	personal protective e	quipment (PPE) for staff or		4	Or make a report	
		g into the resident's room.				
	At 1:40 pm, the surve	eyor stopped Registered			a voca	
		hallway and asked what the				
	sign meant on Reside	=			*****	
		eyor that the resident was in				
	· •	ause she had ESBL in her				
		did not observe an isolation				
	1	itside of the resident's room				
	1	ntained the PPE for staff to			44 44 44 44 44 44 44 44 44 44 44 44 44	
		ritained the FFE for stan to				
	use.				WATER AND THE STATE OF THE STAT	
	On 6/7/17 of 7:20 om	, the surveyor went to			non-november 1	
		and did not observe an				
		the resident's door due to the			un a a a a a a a a a a a a a a a a a a a	
	-	tact isolation as the surveyor				
		evious day by RN #1. The			WAR AND	
		le the resident's room due to				
		and there was no isolation				
	cart inside of the roor	m eitner.				
					The second of	
		cord review of Resident #5's				
		noted a physician order			-	
		d timed for 10:51 am which				
	stated "Contact Isola	tion".				
		r made another round to				
	Resident #5's room a					
	isolation cart in the h	allway or just inside of the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL		(X1) PROVIDER/SUPPLIER/CLIA	LIA (X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
1	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COMPI		
						1	
		495250	B. WING		06/0	08/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
				836 GLENDALE RD PO BOX 229			
GALAX H	EALTH AND REHAB			GALAX, VA 24333	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5) COMPLETION	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		DATE	
F 441			F4	41			
T 441	0 1 15	. 64					
	Continued From pag	e 54					
	resident's door.						
	A	injetrative team was notified					
		inistrative team was notified ented findings with dates and					
		s that were made by the					
		aled the resident was in					
		to having ESBL in her urine					
		ler. The surveyor asked for					
		ity concerning infection					
	control and isolation.						
		mately 10 am, the assistant					
		rovided a copy of the policy ective Equipment" which					
	stated the following:	ective Equipment which					
	"All employees wil	Il have access to the					
		equipmentEquipment will					
		that provide quick access in	The same of the sa				
		nable anticipated exposure	7				
		ed the assistant director of	The state of the s				
		PE should be kept if you					
	have a resident in co						
		nursing stated, "We have					
		ght outside of the resident's					
	-	e resident's room at the door					
	for easy access."						
	No further information	on was provided to the					
		exit conference on 6/8/17.					
F 514			F 5	514 E Resident Records-		7/20/2017	
SS=E	RECORDS-COMPLI	ETE/ACCURATE/ACCESSIB		Complete/Accurate/Accessi	ible	- Documentaries	
	LE			_			
	(2) 11 - 11 - 1						
	(i) Medical records.	th annuated professional					
	(1) In accordance will standards and practi	th accepted professional					
		cords on each resident that					
	are-	Solds on edon resident that					
	<u></u>						
L				i .			

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OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER SALAX HEALTH AND REHAB STREET ADDRESS, CITY, STATE, 2P CODE 885 GLEMOLAE RD PO BOX 229 GALAX NA LASALAY. A 24333 Political Conference of Suppliers of Continued From page 55 Continued From page 55 Continued From page 55 (ii) A Courately documented; (iii) A courately documented; (iv) Systematically organized (iv) Systematically organized (iv) Systematically organized (iv) Sufficient information to identify the resident; (iii) A record of the resident's assessments; (iv) The comprehensive plan of care and services provided: (iv) Physician's, nurse's, and other licensed professional's progress notes; and (iv) Laboratory, radiology and other diagnostic services reports as required under 6435.50. 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 review the facility staff failed to maintain a complete and accurate clinical record for Resident # 4. 17. 6. 9 and 15). The facility staff failed to maintain a complete and accurate clinical record for Resident # 4. 17. 6. 9 and 15). The facility staff failed to maintain a complete and accurate clinical record for Resident # 4. 17. 6. 9 and 15). The facility staff failed to maintain a complete and accurate clinical record for Resident # 4. 17. 6. 9 and 16. 10. 10. 10. 10. 10. 10. 10. 10. 10. 10	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
STREET ADDRESS CHY STATE ZIP CODE SOCIEDATE PRODUCES GALAX HEALTH AND REHAB DATA SOCIEDATE PRODUCES (EACH DEPLEMENT WILST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) F 514 Continued From page 55 (i) Complete: (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (iv) Systematically organized (iv) 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; (iv) Physican's, nurse's, and other licensed professional's progress notes; and (iv) Laboratory, radiology and other diagnostic services reports as required under \$483.50. This REQUIREMENT is not met as evidenced by: Based on staff introview, facility document review and clinical record review, the facility staff failed to maintain a complete and accurate clinical record to reflect that medications were of 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. Review and resident review evaluations and determinations conducted by the State; (iv) Physician's, nurse's, and other licensed professional's progress notes; and (iv) Laboratory, radiology and other diagnostic services reports as required under \$483.50. This REQUIREMENT is not met as evidenced by: Based on staff introview, facility document review and clinical record review, the facility staff failed to maintain a complete and accurate clinical record to reflect that medications were administrated on 5-10-17. Resident #15 was ordered. Not the surveyor that reflects the administration of the previous provided to the surveyor that reflects the administration of the provided to the surveyor that reflects the administration of the provided to the surveyor that reflects the administration of the pr							С	
SALAX HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (SALAX, VA 24333 CASCAM, V			495250	B. WING		06	/08/2017	
GALAX, VA 24333 GALAX, VA 24333 FROMDERS PLAN OF CORRECTION PROCESSATE PRODUCTION ACTION SHOULD BE PROCESSATE PROCE	NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
F 514 Continued From page 55 (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (iv) Physician's, nurse's, and other licensed professional's progress notes; and (iv) 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 the surveyor that reflects the administration of the surveyor that reflects the administration of this practice. Resident # 9 was found to have undocumented 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 UT1 and treatment was ordered. Resident # 9 was found to have undocumented medications on MAR on 5-6, 9, 10 and 14; no 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 practice.	GALAX H	EALTH AND REHAB						
F514 Continued From page 55 (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (iv) Systematically organized (iv) Sufficient information to identify the resident; (iii) 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; (iv) 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 for 5 of 21 residents in the survey sample (Resident #54, 17, 6, 9 and 15). The findings included: 1. The facility staff failed to maintain a complete							COMPLETION	
Continued From page 55 (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (iv) Systematically organized (iv) Systematically organized (iv) Systematically organized (iv) 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 #3 4, 17, 6, 9 and 15). The findings included: 1. The facility staff failed to maintain a complete	ł	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		OPRIATE	DATE	
Continued From page 55 (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (iv) Systematically organized (iv) Systematically organized (iii) A record of the resident's assessments; (iii) 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	F 514			F 5	1. Facility residents have th			
(ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (iv) Systematically organized (iv) Systematically organized (iv) Sufficient information to identify the resident; (iii) A record of the resident's assessments; (iii) 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; (iv) 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 rot of of 21 residents in the survey sample (Resident #\$ 4, 17, 6, 9 and 15). The findings included: 1. The facility staff failed to maintain a complete		Continued From page	e 55		potential of being affected b	this vas		
medical record. Nesterit #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 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 #5 4, 17, 6, 9 and 15). The findings included: 1. The facility staff failed to maintain a complete		(i) Complete:			removed and filed in the cor	ect		
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 (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 #5 4, 17, 6, 9 and 15). The findings included: 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 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 of this practicent solutions. 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 undocum					medical record. Resident # 1	7's ented as		
(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 to 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		(ii) Accurately docun	nented;		given on the MAR for 5-10-	17.		
(ii) Sufficient information to identify the resident; (iii) 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; (iv) 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 to the surveyor that reflects the administration of 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 #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		(iii) Readily accessib	le; and		Initial notification of this pr	ictice Paper		
(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). 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 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		(iv) Systematically or	ganized		MARs were located in the r	esidents		
(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 for 5 of 21 residents in the survey sample (Resident #\$ 4, 17, 6, 9 and 15). The findings included: (iii) A record of the resident's assessments; 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 #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 #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 4-28-17. Urinalysis was positive for UTI and treatment was ordered. 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 4-28-17. Urinalysis was positive for UTI and treatment was ordered. 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 4-28-17. Urinalysis was positive for UTI and treatment was ordered. Resident #6 had results from saminal proved the resident spitting out medications on 14-28-17. Urinaly		(5) The medical reco	rd must contain-		clinical record and all medic	ations		
(iii) A record of the resident's assessments; (iiii) 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; (iv) Physician's, nurse's, and other licensed professional's progress notes; and (ivi) 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). Refollings included: 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 residention.		(i) Sufficient info	formation to identify the resident;		administration of such med	cations.		
(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: The facility staff failed to maintain a complete 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 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 on 4-28-17. Urinalysis was positive for UTI and treatment was ordered. Resident # 9 was found to have undocumented medications 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 on 4-28-17. It is not was provided to the survey or that reflects the administration of the resident spitting out medications on 4-28-17. Urinalysis was positive for UTI and treatment was ordered. Resident # 9 was found to have undocumented medications were administration. Paper MARs were located in this resident's clinical record to ref		(ii) A record of t	he resident's assessments;		Resident #6 had results fror	ı a		
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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 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			- ·					
was not signed. However a nurse's note was provided to the surveyor that reflects the administration of		record for 5 of 21 res	idents in the survey sample		OII 5-10-17. Resident #15 (.17 ΜΔD		
The findings included: note was provided to the surveyor that reflects the administration of this medication		(Resident #'s 4, 17, 6	6, 9 and 15).		ordered solumedroi on 5-3	T/. MITIN		
that reflects the administration of					was not signed. However a	nuise s		
1. The facility staff failed to maintain a complete		The findings included	1:		note was provided to the s	rveyor		
1. The facility staff failed to maintain a complete		4 70 5 10 6 55			that reflects the administra	ion of		
and accurate clinical record for resoluting.								
	L	and accurate cirilcal	record for resident #4.					

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (C		(X1) PROVIDER/SUPPLIER/CLIA	CLIA (X2) MULTIPLE CONSTRUCTION		CONSTRUCTION	(X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		COMPLETED	
		495250	B. WING			06/	08/2017
NAME OF P	ROVIDER OR SUPPLIER		Ī	ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
				83	6 GLENDALE RD PO BOX 229		
GALAX H	EALTH AND REHAB			G/	ALAX, VA 24333		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	I D		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	1	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 514			F :	514	2. A chart audit was performed	by	
		o 56			Medical Records Coordinator to	-	
	Continued From page 56 Resident #4 was readmitted to the facility on						
					focus on correct filing of reside		
		-			information; no further concern	was	
	limited to blood clot,	ring diagnoses of, but not			noted.		
	· ·	order, seizure disorder,			An audit was performed by Uni	t	
		chotic disorder. On the			Manager to focus on residents		
		DS (Minimum Data Set) with			receiving medications during th	e	
		t Reference Date) of 5/9/17			time frame in question; no furth		
		ed as having short and long			concern was noted.		
		ns and being severely			An audit of residents with urinal	vsis	Table Andrews
		aily decisions. Resident #4			for the past 30 days for proper	y 515	AAAAAAATTI TII TII TAAAAAAAAATTI TII TAAAAAAAA
		equiring extensive assistance or dressing and being totally				20	n voteronamen
	dependent on 1 staff				indication per standing orders w		
	aoponasin sir i sian				performed by Assistant Director		
	The surveyor perform	ned a clinical record review			Nursing; no further concerns we	re	
	on 6/6/17 of Residen	t #4's medical record.			noted.		
		surveyor noted a urinalysis			An audit was performed by Uni	t	
		itivity report of another			Manager to focus on proper		
	resident filed on Resi	ident #4's clinical record.			documentation of medication		
	At 3 pm on 6/6/17, th	e assistant director of			administration for the past 30 da	iys,	-
		of the above documented			no further concern was noted.		
	•	ant director of nursing stated					
	she would take care	of this.	COLOR PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS				
	On 6/7/17 at 4:10 pm	, the administrative team	DOMESTIC STATE OF STA				
	•	pove documented findings by					
	the surveyor in the co		A Company				
	the surveyor in the se	Sinordine reali.					
	No further information	n was provided to the					
		exit conference on 6/8/17.					
	2. The facility staff fa						
	administration of med	dications for Resident #17.	and the second s				
	Resident #17 was re-	admitted to the facility on					
		wing diagnoses of, but not					
	.,,	J J	<u> </u>				***************************************

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V. N. S.	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		CONSTRUCTION	(X3) DATE SURVEY			
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	NG		COMPL	
						C	1
		495250	B. WING			06/0	8/2017
NAME OF PE	OVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
GALAX HI	ALTH AND REHAB				6 GLENDALE RD PO BOX 229 ALAX, VA 24333		A SAME IN THE PARTY OF T
		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	1	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 514	tract infection, diabet pain and chronic kidr (Minimum Data Set) completed but the sig an ARD (Assessmen was still in progress: A clinical record reviesurveyor on 6/8/17. surveyor noted the feleft blank on the (MARecord for the date of as follows: Celexa 20 po (by mouth) daily, tablet po one time a capsule po one time a po BID (two times a four times a day. The assistant director the above document 10 am. The assistant can't tell if these wer supposed to initial the administered to the interpretation of the above document 10 am. The administrative to	heart failure, chronic gh blood pressure, urinary es, atrial fibrillation, chest ney disease. The entry MDS dated for 4/13/17 had been gnificant change MDS with at Reference Date) of 6/22/17 at the time of this survey. The was performed by the During this review, the collowing medications were at the time of this survey. The was performed by the During this review, the collowing medications were at the time of this survey. The was performed by the During this review, the collowing medications were at the time of this survey. The was performed by the During this review, the collowing medications were at the direction Administration of 5/10/17 at 8 am which are to mg (milligram) one tablet the day, Colace 100 mg 1 and the day, Vitamin C 500 mg 1 and day, Vitamin C 500 mg 1 and day, Miralax Give 17 grams day) and Baclofen 20 mg po the findings by the surveyor at the director of nursing stated "I be given or not. They are the box when the medication is resident." The am was notified at 4 pm of the ted findings by the surveyor. The was provided to the exit conference on 6/8/17, facility staff failed to	F	514	3. Medical Records Coordinat will audit and report findings or proper filing of resident inform on the clinical record during morning meeting for two week then weekly times one month. Assistant Director of Nursing/Designee will utilize missed documentation report to ensure medications are documentation. Assistant Director of Nursing/Designee will run an listing report to focus on propindication for urinalysis per storder and will report during meeting. 4. Any deficient practice regainproper filing of labs in resicular record, missed MAR documentation, and improper indications of urinalysis per sorders will be brought to the Committee monthly for discussion/resolution. 5. Date of Compliance: 7/20	on nation as and the co ented orning order er anding norning dent tanding QAPI	
	notification of physic		Village and the second				
	Resident #6 was ad	mitted to the facility on 9/6/14.		·			-

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OMB NO. 0938-0391

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. DOILDII			ĺ
		40-0-0			C 06/08/2017	
NAME OF D	VOLUMED OD CLIMATICA	495250	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE		\dashv
NAME OF PROVIDER OR SUPPLIER GALAX HEALTH AND REHAB			836 GLENDALE RD PO BOX 229 GALAX, VA 24333		~	
				PROVIDER'S PLAN OF COR	RECTION (X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		SHOULD BE COMPLETIO	ıN
F 514			F 5	514		
, 0.,	Caratina and France many	- 50				
	Continued From page					
	Diagnoses included of	-				
	, , ,	kidney disease (CKD),				
	dementia, and hypert					
		sessment with assessment				
		7, the resident scored 3 of				
		ew for mental status and				
	was assessed as with					
		ors affecting others. Section I				
	2300 was coded for u	urinary tract infection (UTI).				
	During clinical record	review, the surveyor noted				
		a urinalysis from the clinical			and the state of t	
	-	date 4/28/17 and fax stamp			The Management of the State of	
	•	noted faxed to the physician		and several		
		the lab results was "Noted				
	1	Ceftin 500 mg po BID X 3				
		"[physician initials] 5/3/17".	en a company		Table in the state of the state	
		able to locate evidence of			s ;	
	•	d with urinary tract infection				
		th a physician concerning				
	į	rsing notes did not indicate				
	1 .	ordered the test. On 6/7/17,				
		ed the issue with LPN #1.				
	,	ad written the order on the			- dispersion	
	i .	ers. The surveyor asked if				
	there should have be				A. C.	
		er had been written, the				
	basis for the order, a					
		sident's responsible party.			1	
	, ·	nought she had written a				
		asked the assistant director				
	-	r a copy of the standing		***************************************		
		provided the standing orders				
		(which had not shown on				
	the surveyor's clinical			**************************************		
	SBAR-Change of cor					
		ation: Resident spit out				
	med's Background: 9					
	Dementia with Behav					
	Dementia with Deliav	noral Disturbance,	<u></u>			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULT	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NONDER.	50.25		С
		495250	B. WING		06/08/2017
NAME OF PI	ROVIDER OR SUPPLIER	1	1	STREET ADDRESS, CITY, STATE, ZIP COD	E
				836 GLENDALE RD PO BOX 229	
GALAX H	EALTH AND REHAB			GALAX, VA 24333	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION	RRECTION (X5) COMPLETION
PREFIX TAG		NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	PREFI TAG	CROSS-REFERENCED TO THE DEFICIENCY)	DATE
F 514			F	514	
1 314	Caratiana d From n	ago 50			A municipal control of the control o
	Continued From pa		A Company		
		TN, DNR (do not resuscitate), GAMET, ACE INHIBITORS			
	Assessment: Posi	dent spit out all her medication			
	this AM Medication	on included ASA (aspirin) 81 mg,			
		sponse: Dr [name] group			
	awarelfamily name	e] aware. The surveyor asked			
	why the note had	not been visible during clinical			
	record review and	to LPN #1. The ADON stated			
	they were availabl	e to her.			
	deliana della dell				
	During a summary	meeting on 6/7/17, the			
	surveyor asked to	r the nursing policy concerning			
	use of standing of	ders. The surveyor was ific situations where they would			
	ho used when the	e 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 con	cerning use of standing orders.			
	The surveyor read	the standing orders. Standing			
	orders are as follo	ws " IV. Symptom Treatment E.			
	Dysuria, Foul Sme	elling, decreased LOC, or			
	Agitation Obtai	n urinalysis with C&S. If			
	positive report res	sults to MD". The surveyor read			
	the urinalysis. The	e order dated 4/27/17 10:20 one order from Dr [name] UA			
	C&S d# (urinalysis	s with culture and sensitivity			
	due to) confusion	n. The surveyor stated that			
	confusion was no	t one of the reasons the			
	standing orders lis	sted for obtaining a urinalysis.			
	The ADON said the	nat the resident spit out			
	medications (on the	he morning of 4/26/17) and that			
	was a sign of agit	ation. The surveyor observed		En proposition	
	that the order for	the urinalysis was written 24			
	hours later and a	different reason stated. The			
		ed that the physician could have			
	been contacted d	uring that time.			
	During the finel of	ummary meeting with facility			
	administrative eta	off on 6/8/17, the surveyor			
L	aurinistrative Sta	an on oron 11, and dan rojo.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULT	TIPLE CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII	NG	1 ' '	PLETED
AND FLAN OF	CONTECTION				1	c
					1	
		495250	B. WING			/08/2017
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	=	
			I	836 GLENDALE RD PO BOX 229		
GALAX HI	EALTH AND REHAB			GALAX, VA 24333		
	0.11111177/07	FATENCIAL OF DEFINITIONS	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	PREFI	X (EACH CORRECTIVE ACTION	SHOULD BE	COMPLETION DATE
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE A	APPROPRIATE	DATE
				DEFICIENCY)		
C 544			E	514		
F 514						
	Continued From pag	e 60 reiterated concerns				
	with nursing docume	entation.				
			THE PERSONNEL PROPERTY OF THE PERSONNEL PROP			
	4. For Resider	nt #9, facility staff failed				
		tration of medications.				
	togocament adminio	manori or modications.				
	Resident #9 was ad	mitted to the facility on				
	6/21/15. Diagnoses					
		, peripheral vascular disease,				
		ression, congestive heart				
		litus, and Crohn's disease.				
	l .	a set assessment with				
	1					
		ce date 3/21/17, the resident				
		brief interview for mental				
		t was assessed with out signs				
		is, or behavior affecting		·		
	others.					
		d review on 6/7/17, the				
	surveyor noted unex					
		ne May 2017 medication				
		d on May 6, 9, 10, and 14.				
		ed the concern to the				
		nursing on 6/8/17. No				
	additional information	n was available.				
		sed the concern again during				
	a summary meeting	with the administrator and				
	director of nursing o		ALCOHOL STREET			
	5. The facility	staff failed to document when				
	medications were ac	dministered to Resident #15				
	on the May 2017 ele					
	administration recor					
	The clinical record of	of Resident #15 was reviewed				
		5 was admitted to the facility				
		ed 3/27/17 with diagnoses				
		t limited to Alzheimer's				E communication of the communi
		ency anemia, hypertension,				
		rombosis, gastroesophageal				
L	CHIOTIC emponsiti/(nombosis, gastrocsopriagear				

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		495250	B. WING		C 06/08/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE
				836 GLENDALE RD PO BOX 229	
GALAX H	EALTH AND REHAB			GALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION DATE
F 514			F 5	514	
1 314	Cantinued From page	o 61 roflux diseasee nain			
		e 61 reflux disease, pain,			
	and chronic kidney d	isease.			
	(MDS) assessment w reference date (ARD)) of 4/4/17 assessed the tive summary score of 10			
	dated 5/3/17 that rea mg (milligrams) IM (in for wheezing."	evealed a physician order d in part "Solumedrol 62.5 ntramuscular) x1 at bedtime			
	medication administr order for the Solume the May 2017 eMAR documentation that the administered. Each	ed the May 2017 electronic ation record (eMAR). The drol had been entered onto , however; there was no he medication had been entry for the month of May had an "X" in the block.			
	notes. The5/3/17 pro	ed the May 2017 progress ogress note read "Received cal doctor) earlier with new and cough reported.			
	Solumedrol and (responsible party) Solumedrol given per well. Continues extremity) 2+ edemored and warm with 3-resident reports hx thrombosis) in leg. (reason. Will monitor	Albuterol ordered. RP made aware via phone. er order IM left hip, tolerated with BLE (bilateral lower a, right lower ext (extremity) + edema. Negative Homans, (history) of DVT (deep vein Dn Coumadin therapy for this :"			
	director of nursing ar nurse of the above c	ed the administrator, the and the corporate registered concern in documentation on the surveyor asked the			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS	FOR MEDICARE &	MEDICAID SERVICES			UNID INO	. 0938-0391
	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	LETED
		495250	B. WING		06/	08/2017
	OVIDER OR SUPPLIER	455250		STREET ADDRESS, CITY, STATE, ZIP CO 836 GLENDALE RD PO BOX 229 GALAX, VA 24333	DE	anagamana akananan merengan sebagai dan 1 A m
GALAX NE				PROVIDER'S PLAN OF CO	ODDECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI	N SHOULD BE E APPROPRIATE	COMPLÉTION DATE
F 514			F 51	4		
	Continued From pa	ne 62				
	document medication	r expectations of nurses to ons administered on the tated she would expect medications administered on				
	medication adminis meeting on 6/8/17 a administrative staff. The policy titled "Sp Administration Prace Procedures for All I After administration medication contain remain), and docur					
F 526 SS=D	if indicated." No further informat exit conference on 483.70(o)(1)-(4) Ho (o) Hospice service	ospice	F 5.	26 526 D Hospice		7/20/201
	(1) A long-term car the following:	re (LTC) facility may do either of				
	(i) Arrange for services through a Medicare-certified	or the provision of hospice n agreement with one or more hospices.				
	services at the fac a Medicare-certified	ge for the provision of hospice ility through an agreement with hospice and assist the resident facility that will arrange for				

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUC		(X3) DATE SURVEY COMPLETED		
					С
		495250	B. WING_		06/08/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GALAX H	EALTH AND REHAB			836 GLENDALE RD PO BOX 229 GALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE
F 526	transfer. (2) If hospice care is through an agreemer (o)(1)(i) of this section facility must meet the (i) Ensure that the professional standard to individuals providing and to the timeliness. (ii) Have a written hospice that is signed representative of the hospice and an author LTC facility before hospice and an author LTC facility before hospice and the following: (A) The services. (B) The hospice the appropriate hosping §418.112 (d) of this control of the provide based on each communication will be facility and the hospice needs of the resident per day.	furnished in an LTC facility It as specified in paragraph In with a hospice, the LTC If following requirements: Ithe hospice services meet Its and principles that apply Ing services in the facility, In of the services. In agreement with the If by an authorized In orized representative of the Inspired represen	F 5:	1. Facility residents on hospic the potential to be affected by practice. Resident #13's clinical record lacked substantial information regarding services provided by hospice and lack of documentate to show coordination of care between hospice agency and factor Upon notification of such practice was contacted by faciliand hospice was contacted by faciliand 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 focus on documentation of serprovided; no further concerns 3. Hospice company is now reto deliver documentation will be placed medical record, and exit/debric Director of Nursing/Designee visiting the patient. 4. Any deficient practice regal coordination of hospice care whought to the QAPI Committed monthly for discussion/resolutes.	this al mation ration acility. tice, ity rector s to vices noted. equired cly on atients, in ef with after rding vill be ee ion.

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OMB NO. 0938-0391

1	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING		4	E SURVEY PLETED
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BOILDII			C
		495250	B. WING_			/08/2017
NAME OF PE	ROVIDER OR SUPPLIER	453230	B. WING	STREET ADDRESS, CITY, STATE, ZIP COD		
				836 GLENDALE RD PO BOX 229		
GALAX H	EALTH AND REHAB			GALAX, VA 24333		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COI X (EACH CORRECTIVE ACTION		(X5) COMPLETION
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI: TAG	CROSS-REFERENCED TO THE		DATE
			A commence of the commence of	DEFICIENCY)		
F 526			F :	526		
	Continued From page	e 64 notifies the				
	hospice about the fol					
	•	, and the second				
		change in the resident's				
	physical, mental, soc	sial, or emotional status.				
	(2) Clinical comp	plications that suggest a need				
	to alter the plan of ca					
	(0) A 11-1-	and the second section of the second				
	(3) A need to tra facility for any conditi	ansfer the resident from the ion.				
			THE RESIDENCE OF THE PROPERTY			
	(4) The resident	rs death.				
		stating that the hospice				
		ity for determining the				
		f hospice care, including the nge the level of services		12.00		
	provided.					
	(G) An agreeme	nt that it is the LTC facility's				
	` ,	sh 24-hour room and board				us monatories and
		ent's personal care and				
		ordination with the hospice ensure that the level of care				or control of the con
		ately based on the individual				
	resident's needs.					de prisone
		CO - Landarda				
		n of the hospice's ding but not limited to,				
	providing medical dir	ection and management of				
	the patient; nursing;	counseling (including spiritual,				
		ment); social work; providing				
		rable medical equipment, and the palliation of pain and				
	symptoms associated	d with the terminal illness and				
	related conditions; ar	nd all other hospice services				
		or the care of the resident's				
	terminal illness and r	related conditions.				

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
AND FLAN UF	OOM RECTION	DETTI TO CHOR HOWDER.			С	
		495250	B. WING		06/08/2017	
NAME OF PE	ROVIDER OR SUPPLIER		T	STREET ADDRESS, CITY, STATE, ZIP CODE		
GALAX HI	EALTH AND REHAB			836 GLENDALE RD PO BOX 229 GALAX, VA 24333		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DATE	
F 526			F 5	26		
	Continued From page	e 65				
		hat when the LTC facility sible for the administration				
		es, including those therapies				
		ate by the hospice and				
		pice plan of care, the LTC				
		y administer the therapies	Parameter State St			
	the LTC facility.	State law and as specified by				
	-		And the second s			
		stating that the LTC facility				
	must report all allege	it, or verbal, mental, sexual,				
	-	including injuries of unknown				
	source, and misappro	opriation of patient property				
	by hospice personne					
	administrator immedi becomes aware of th	iately when the LTC facility				
	pecomes aware or un	e aneged violation.				
	(K) A delineation	n of the responsibilities of the				
	hospice and the LTC					
	bereavement service	es to LTO facility staff.				
	(3) Each LTC facility	arranging for the provision of				
		written agreement must				
	designate a member					
		n who is responsible for				
	working with hospice	e resident provided by the				
	LTC facility staff and		And the second s			
	•	n member must have a				
		function within their State				
	· ·	, and have the ability to	Andrew Control of Control			
		or have access to someone d capabilities to assess the	all control and the second			
	resident.	a capabilities to account inc			A	
	The designated inter	disciplinary team member is				
			<u> </u>			

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OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
AND FLAN OF	CORRECTION	ISENTI ON TONNOLIS.			С
		495250	B. WING		06/08/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 836 GLENDALE RD PO BOX 229 GALAX, VA 24333	
GALAXIII	LALIII AND REIIAD				NA.
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 526	Continued From page	e 66	F 5	26	
	responsible for the fo				
	and coordinating LTC	g with hospice representatives C facility staff participation in nning process for those nese services.			
	representatives and oparticipating in the prillness, related condit	ing with hospice other healthcare providers ovision of care for the terminal cions, and other conditions, to be for the patient and family.			
	communicates with the patient's attending practitioners participathe patient as needed	at the LTC facility the hospice medical director, g physician, and other ating in the provision of care to d to coordinate the hospice I care provided by other			
	(iv) Obtaining the the hospice:	e following information from			
	(A) The most red specific to each patie	cent hospice plan of care ent.			
	(B) Hospice elec	ction form.			
		ertification and recertification of pecific to each patient.			
		contact information for hospice n hospice care of each patient.			
	(E) Instructions of hospice's 24-hour on	on how to access the r-call system.			

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STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE	(X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMF	LETED	
						C	
		495250	B. WING		06/	08/2017	
NAME OF PE	ROVIDER OR SUPPLIER		Ī	STREET ADDRESS, CITY, STATE, ZIP CODE			
				836 GLENDALE RD PO BOX 229			
GALAX H	EALTH AND REHAB			GALAX, VA 24333			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	TION	(X5)	
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX			COMPLETION DATE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE		
F 526			F 5	526			
	Continued From page	e 67					
	(F) Hospice med	dication information specific to					
	each patient.	·					
	·						
		sician and attending physician					
	(if any) orders specifi	c to each patient.					
	() m	LTO to allity at aff war side -					
		LTC facility staff provides					
		cies and procedures of the ent rights, appropriate forms,					
	, , , , , , , , , , , , , , , , , , ,	equirements, to hospice staff					
	furnishing care to LT						
	rarriorning control = 1						
	(4) Each LTC facility	providing hospice care under					
		must ensure that each					
		n of care includes both the					
	most recent hospice						
		vices furnished by the LTC					
	-	aintain the resident's highest				A STATE OF THE STA	
		mental, and psychosocial				The state of the s	
	well-being, as require	F is not met as evidenced					
	by:	1 13 Hot met as evidenced					
		view, clinical record review				error sales sales	
		t review it was determined				A CONTRACTOR OF THE CONTRACTOR	
		ailed to coordinate Hospice				NAME OF THE PROPERTY OF THE PR	
		Residents in the sample				7	
	survey, Resident #13	3.					
	The Findings Include	ed:					
	Desident #12 was a	98 year old female who was				AL IN CONTROL	
		n 1/13/13 and readmitted on				procure months and an annual state of the st	
		agnoses included, but were					
	not limited to: demen		THE PROPERTY OF THE PROPERTY O				
		ire of the right hand, bullous					
		nsion and diabetes mellitus.					
	F G 2 , 1.7 F						
		nimum Data Set (MDS)	and the same of th			and the second s	
	assessment located	in the clinical record was a					

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1	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E SURVEY PLETED
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		495250	B. WING		06	/08/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	······································	
CALAYH	EALTH AND REHAB			836 GLENDALE RD PO BOX 229 GALAX, VA 24333		
GALAXII	LALITIAND NETIAB			GALAA, VA 24333		terbiorante administrativa e consensa e cons
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		-
F 526			F 5	26		
	Continued From page	e 68				ALL PROPERTY AND ALL PR
		sment with an Assessment				Assertances
		o) of 5/25/17. The facility				-
	•	dent #13 had short and long				a or control of the c
		nent (1/1) and was severely				
	impaired with daily de	ecision making regarding				the approximate the second sec
		ng (ADL's). In Section P.				
	•	Procedures, and Programs				rija je na zakona na n
	-	I that Resident #13 was				
	receiving Hospice Se	rvices.				
	On June 6, 2017 at 1	n m the survey team				
		d the surveyor requested				
		contracts with Hospice				
	Services.	•				
		30 p.m. the Administrator				
		the facility's contracts with				
	4 local Hospice Agend	cy s.				
	On June 8, 2017 at 10	0 a.m. the surveyor				
		3's clinical record. Review				
		produced signed physician				
		Signed physician orders				
	*	t limited to: "Admit to (name				
	of nospice agency wit	hheld) as of 2/16/17." (sic)				
	Continued review of the	he clinical record produced				
		Contract dated 2/23/17.				
		ment identified that Resident				
	_	peech Therapy and that				
		ations were reviewed. The				
1		identified in their care plan				
1		s were declined and the				
1		I visit 1-2 times a month,				
		ices would visit 1-2 times a documentation of nursing				
1		ed, or documentation that a				
		stant would provide any				
i	services or any type o					
<u></u>			***************************************			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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		495250	B. WING		06/08/201	7
	EALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 836 GLENDALE RD PO BOX 229 GALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPL	LETION
F 526			F 5:	26		****
1 320	Continued From page	e 69	1 0.			
	provided for the end					
	produce any addition Hospice Services bei	the clinical record failed to al documentation of the ng provided or when the in to see Resident #13.				
	observed a Licensed sitting at the nurses sethe LPN (#2) if the factorial containing Hospice nurseceiving Hospice Sethospice binder/folder	r for Resident #13. LPN (#2) Hospice Agency withheld)				
	notified the Assistant that Resident #13 was Services and that Holocated since 2/23/17 would look and see if additional documenta ADON and delivered 5/17/17 and 5/31/17. found the Hospice No additional Hospice provided. The Hospic identified that Reside check and see how h #13's end of life supp #13's son stated that Resident #13 as he whad a kidney transplanot specify any additiprovided by the Hospi	spice notes could not be 7. The ADON stated she 5 she could find any ation. Within 30 minutes the Hospice notes dated The ADON stated she had otes at the nurses' station. e notes/documentation was				

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OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
AND FLAN OF	CORRECTION	IDENTIFICATION NOMBER.				С
		495250	B. WING		06	/08/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GALAX H	EALTH AND REHAB			836 GLENDALE RD PO BOX 229 GALAX, VA 24333		yaya y - dadandadaha dan dahahasine dahihirahidahininkin oleh 1 o
		ATTAINED OF DEFLOYABLES	15	PROVIDER'S PLAN OF CORRE	CTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI; TAG		OULD BE	COMPLÉTION DATE
F 526	Continued From page	e 70	F :	526		
F 526	that the Hospice Age and that the facility state time. The survey what services was Howard and the facility contract was supposed to be to Resident #13. The 8/4/08. The Hospice "Plan of Care. a. Ear receive Services here individualized care placcordance with 42C on an assessment of and living situation in designate a registere implementation of the time a Facility resident program or a patient Facility, Hospice shall in the admission procand implementation of The parties will collabile the implementation, as needed, of the Plabasis 5. Services Hospice shall communensure coordination of (sic)	cations were reviewed and ncy spoke to the facility staff taff declined any needs at ror asked the ADON exactly ospice providing to Resident	F	526		
	met with the Adm, Di Corporate Compliand Worker (SW) and Ho	rector of Nursing, ADON, ce Nurse (CCN), Social				

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	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		G	(X3) DATE SURVEY COMPLETED C
		495250	B. WING		06/08/2017
NAME OF PR	ROVIDER OR SUPPLIER	433230	I	STREET ADDRESS, CITY, STATE, ZIP CODE	
GALAX H	EALTH AND REHAB			836 GLENDALE RD PO BOX 229 GALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
F 526	Services with the Ho notified the AT that Hocated in the clinical had hand delivered sometified the AT that Homelia the AT that Homelia the surveyor was Hospice services were Resident #13. The some of the notes idension had been contact However, no additional seeing provided to Hospice Agency. No additional information and the facility and Hospice coordinate and committed the surveyor that the survey or the surveyor that	ailed to coordinate Hospice spice Agency. The surveyor Hospice notes could not be I record and that the ADON several notes. The surveyor Hospice Services had been The surveyor notified the AT is unsure exactly what are being provided to surveyor notified the AT that intified that Resident #13's coted for end of life support. In all services were identified at Resident #13 by the mation was provided as to why	F 5		