STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING _____ B. WING _____	09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid standard survey was conducted 09/06/16 through 09/09/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.

The census in this 110 certified bed facility was 104 at the time of the survey. The survey sample consisted of 18 current Resident reviews (Residents 1 through 18) and 3 closed record reviews (Residents 19 through 21).

F 279 SS=D 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS — F 279

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

The submission of the Plan of Correction does not constitute agreement on the part of Lee Health and Rehab Center that deficiencies cited with the report represents deficient practices on the part of the center and its staff.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Interim Administrator	9/26/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 279	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to develop a plan of care on cognition for 1 of 21 residents (Resident #11). The findings include: 1. For Resident #11, the facility staff failed to develop a comprehensive plan of care for cognition. Resident #11 was originally admitted to the facility on 4/16/16. Resident #11 ' s diagnoses include but are not limited to, dementia with behaviors, anxiety disorder, depressive disorder, psychotic disorder, and high blood pressure. On 5/07/14, Resident #11 ' s clinical record review revealed his significate change minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/11/16. This assessment was coded an 11. In Section V: Care Area Assessment, Resident #11 "triggered" for cognition and the facility staff documented that cognition would be care planned. The facility staff had no documentation on the corresponding care plan for cognition. On 9/8/16, the MDS nurse, RN #8, was asked to assist in locating the cognition care plan. After reviewing the current care plan, she said, " I don ' t have it. " At the end of the day meeting, the issue of the cognition not being done was discussed. Prior to exit, no further information was provided by the facility staff related to the failure to develop a care plan for cognition	F 279	F Tag 279 Cross reference 12 VAC 5-371-250 (A and C) 1. A care plan to address cognition was put into place in Resident # 11's care plan. 2. 100% of charts will be reviewed to ensure a care plan to address cognition is in place for all Resident's who require a cognition care plan. 3. Education will be provided to clinical team members to complete the triggered CAA and care plan related to cognition. Residents without a cognition care plan that triggered will have one completed immediately. 4. MDS or designee will review 10 comprehensive plans monthly x 3 months to ensure cognition is addressed in the plan of care. All findings will be reported to the QA committee for further review and recommendation. 5. 10/21/16.	

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	495352	A. BUILDING _____ B. WING _____	09/09/2016

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F 280 SS=D	Continued From page 2 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280 F 280	F Tag 280 Cross reference 12 VAC 5-371-250 (A and C)	

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review the facility staff failed to review and revise a CCP (comprehensive care plan) for 1 of 21 Residents, Resident #7.

The findings included:

For Resident #7, the facility staff failed to revise a care plan for foley catheter use.

Resident #7 was admitted to the facility on 02/0516 and readmitted on 03/02/16. Diagnoses

1. Resident #7s care plan was revised immediately, no adverse effects noted.

2. Care plans for Residents who have/had indwelling foley catheters for the last 3 months will be reviewed to ensure accuracy and revision of the care plan. Any negative findings will be corrected immediately.

3. Education to be provided to the nursing staff to revise the care plan when indwelling foley catheters are discontinued.

4. Residents with indwelling foley catheters and those that have been discontinued will be reviewed in am clinical meeting to ensure care plan has been revised weekly x 4 weeks. then monthly for 2 months. All findings will be reported to the QA committee for further review and recommendations.

5. 10/21/16.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING _____ B. WING _____	09/09/2016

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F 280	Continued From page 3	F 280		

included but not limited to hypertension, neurogenic bladder, hyperlipidemia, cerebrovascular accident, coronary artery disease, seizure disorder, anxiety, depression, schizophrenia, chronic obstructive pulmonary disease, dysphagia, hypothyroidism, and gastroesophageal reflux disease.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 07/28/16 coded the Resident as 8 out of 15 in Section C, cognitive patterns. Section H, bowel and bladder, coded the Resident as "2" for urinary continence, which is the equivalent of "frequently incontinent. This is a quarterly MDS.

Resident #7's clinical record was reviewed on 09/07/16. It contained a CCP with a CP with a focus of "...has an indwelling foley catheter r/t (related to) neurogenic bladder". This CP was initiated on 03/16/16 with a revision date of 03/03/16.

Resident #7 was observed by surveyor on 09/07/16 at approximately 1415. No catheter was observed.

Resident #7's clinical record contained a "physician's telephone order" which read in part "Created date: 04/14/16 02:14. Communication method: phone. Order summary: 16 FR (french) 5CC balloon change every 28 days every night shift every 28 days related to Neuromuscular dysfunction of bladder unspecified (N31.9). Discontinue: 04/14/16 02:14".

Surveyor spoke with MDS coordinator on 09/08/16 at approximately 0939 regarding the CP for foley catheter use. MDS coordinator stated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING _____ B. WING _____	09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

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F 280	Continued From page 4 CP should have been discontinued when the catheter was discontinued, and that she had just overlooked it. The concern of the unrevised CP was brought to the attention of the administrative staff during a meeting on 09/08/15 at approximately 1800. No further information regarding this issue was provided prior to exit.	F 280		
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission--	F 285		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING _____ B. WING _____	09/09/2016

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F 285	Continued From page 5 (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to obtain a PASRR (preadmission screening and Resident review) for 1 of 21 Residents, Resident #17. The findings included: For Resident #17, the facility staff failed to locate a PASRR to demonstrate that one had been completed. Resident #17 was admitted to the facility on 11/11/15. Diagnoses included but not limited to Down Syndrome, anemia, hyperlipidemia, cerebrovascular accident, hemiplegia, dysphagia and hypothyroidism. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 07/25/16	F 285	F Tag 285 Cross Reference 12 VAC 5-371-140 (D.2) 1. The original PASRR has been requested for resident #17. If it is available it will be added to the medical record. 2. 100% of charts of residents with MI or MR will be reviewed to ensure PASSR is present in the medical record. 3. Education to be provided to the admissions staff regarding PASRR to be obtained prior to admission on all residents/patients with MI or MR. 4. New admissions with diagnosis of MR or MI will be reviewed prior to admissions to ensure all required screenings are complete and are part of the medical record. All findings to be reported to the QA committee for further review and recommendations. 5. 10/21/16.	

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	495352	A. BUILDING _____ B. WING _____	09/09/2016

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F 285	Continued From page 6 coded the Resident as 11 out of 15 in Section C, cognitive patterns. Resident #17's clinical record was reviewed on 09/09/16. The surveyor could not locate the PASRR form in the record. Surveyor spoke with SW (social worker) on 09/09/16 at approximately 1030 regarding the missing PASRR form and SW stated that she had obtained the form, but did not know where it was at. She stated that it was possibly in the business office. SW stated that when she located the form, she would bring it to the surveyor. Surveyor spoke with SW again at approximately 1445 regarding the PASRR form. SW stated that the form could not be located at the facility, and she had called .....(name omitted) at Resident #17's previous day support, and was told that the PASRR could not be released to her due to HIPPA laws. The concern of the missing PASSR was discussed during a meeting with the administrative staff on 09/09/16 at approximately 1545. No further information was provided prior to exit.	F 285		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING _____ B. WING _____	09/09/2016

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LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

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F 309	Continued From page 7	F 309	F Tag 309 Cross reference 12 VAC 5-371-220 (C)	

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, the facility staff failed to follow physician ' s orders related to Tylenol administration for 1 of 21 residents, (Resident #4).
The Findings Included:
Resident #4 was admitted to the facility on 5/28/15; her admitting diagnoses included, but were not limited to: heart failure, acute and chronic respiratory failure, diabetes mellitus, anxiety, angina, and cerebral infarction.
The most current Minimum Data Set (MDS) assessment located in the clinical record was a quarterly MDS assessment with an Assessment Reference Date (ARD) of 6/22/16. The facility staff coded Resident #4 with short and long term memory loss. The facility staff also coded Resident #4 to require assistance with Activities of Daily Living (ADL's).
Review of Resident #4 ' s clinical record revealed a physician ' s order that read as follows:
" Tylenol tablet 325 mg (acetaminophen) give 650 mg via G-tube every 6 hours as needed for elevated temperature dated 7/29/2016. "
Continued review of the clinical record revealed the medication administration record (MAR). The MAR evidenced the September 2016 schedule for Resident #4 ' s medications. In the list was " Tylenol tablet 325 mg (acetaminophen) give 650 mg via G-tube every 6 hours as needed for elevated temperature with the order date 7/29/2016. " Documentation on 9/6/16 indicated that the Tylenol had been administered for an elevated temperature.
Review of the nurse ' s notes revealed the

1. Resident #4's orders have been changed to reflect when Tylenol is given for a fever and when it is given for pain. No adverse effects noted.

2. 100% of Residents with orders for Tylenol will be reviewed to ensure there is an order to give for a fever and a seperate order to give for pain. All negative findings will be corrected immediately.

3. Education to be provided to the nursing staff on the need to specify if Tylenol is given for fever or pain.

4. DON/Designee will review 10 records of Resident's with orders for Tylenol monthly to ensure the indication for administration is clear monthly x 3 months. All findings to be reported to the QA committee for further review and recommendations.

5. 10/21/16.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING _____ B. WING _____	09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 8 corresponding note dated 9/6/16 at 14:12, related to the administration of the Tylenol on the MAR. The note read: " Tylenol tablet 325 mg; give 650 mg via G-tube every 6 hours as needed for elevated temperature. " Review of the vital sign record did not reveal the resident had a temperature on 9/6/16. On 9/9/16, LPN #7 was asked if Resident #4 ' s temperatures had been documented. She said, " No, that ' s my fault. She didn ' t have a temperature. She had leg pain is why I gave it. " LPN #7 was then asked if the order allowed for it to be given for pain. She said, " Technically, no. It says for elevated temperature. " On 9/9/16 at the end of the day meeting, the above concern was discussed with the administrator, director of nurses, and the administrator in training. No further discussion was held prior to the exit conference on 9/9/16.	F 309		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING _____ B. WING _____	09/09/2016

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F 425	Continued From page 9	F 425		

a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, Resident interview and clinical record review the facility staff failed to ensure a medication was available for administration for 1 of 21 Residents, Resident #14.

The finding included:

For Resident #14, the facility staff failed to ensure the medication Lidoderm patches were available for administration.

Resident #14 was admitted to the facility on 08/17/16 and readmitted on 08/24/16. Diagnoses included but not limited to anemia, atrial fibrillation, congestive heart failure, hypertension, peripheral vascular disease, gastroesophageal reflux disease, end stage renal disease, diabetes mellitus, arthritis, hyperlipidemia, and depression.

The most recent MDS (minimum data set) with and ARD (assessment reference date) of 08/24/16 coded the Resident as 13 of 15 in Section C, cognitive patterns. This is the initial MDS.

Surveyor observed Resident #14 taking medications during a routine medication pass and pour observation on 09/07/16 at approximately 0830. No Lidoderm patch was administered at

F Tag 425 Cross reference 12 VAC 5-371-300 (A)

1. Resident # 14's Lidoderm patch was immediately obtained from the back up pharmacy and applied.
2. Resident's with orders for Lidoderm patches will be reviewed to ensure Lidoderm patch is present and have been received from the pharmacy in a timely manner. All negative findings will be corrected immediately.
3. Education will be provided to the nursing staff on the procedure for obtaining meds from the pharmacy and the back up pharmacy.
4. DON/Designee will observe one med pass weekly x 4 weeks then one med pass monthly x 2 months to ensure all meds are available. All findings will be reported to the QA committee for further review and recommendations.
5. 10/21/16.

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	495352	A. BUILDING _____ B. WING _____	09/09/2016

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F 425	Continued From page 10	F 425		

this time.

Resident #14's POS (physician's order summary) was reviewed on 09/07/16 for medication reconciliation. The POS contained an order which read in part "Lidoderm Patch 5% (Lidocaine) Apply per additional directions topically in the morning for pain apply patch to skin daily remove patch within 12 hrs".

Resident #14's MAR (medication administration record) was reviewed and contained an entry which read in part "Lidoderm Patch 5% (Lidocaine) Apply per additional directions topically in the morning for pain apply patch to skin daily remove patch within 12 hrs". This entry had x's in the boxes for 09/03, 09/04, 09/05 and 09/06. The entries for 09/04 and09/05 had been coded with "9". Chart codes indicated "9" as "other/see nurses notes". Nurse ' s notes for 09/04/16 were reviewed and contained an entry which read in part "09/04/16 17:55 Type: eMar Administration Note. Note Text: Lidoderm Patch 5% Apply to per additional directions topically in the morning for pain apply patch to skin daily remove patch within 12 hrs. No patches in house". The nurse ' s notes for 09/05/16 were reviewed and contained an entry which read "09/05/16 16:26 Type: eMAR-Medication Administration Note. Note Text: Lidoderm Patch 5% Apply to per additional directions topically in the morning for pain apply patch to skin daily remove patch within 12 hrs. No patches in house".

Surveyor spoke with LPN (licensed practical nurse) #4 on 09/07/16 at approximately 1000 regarding Resident #14's Lidoderm patches. LPN #4 stated that the order was not specific about a

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	495352	A. BUILDING _____ B. WING _____	09/09/2016

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F 425	Continued From page 11	F 425		

time for administration, just that they were to be placed on Resident in the morning. Surveyor asked LPN #4 where on Resident they were to be placed, and LPN #4 stated "wherever he wants them, he uses them instead of pain pills, because he doesn't like to take them". Surveyor then asked to see the patches, and LPN #4 accompanied surveyor to Resident's room and asked if she could look at the patches. Resident #14 stated "I don't have any on, haven't had any for 4-5 days. They told me they were out and couldn't get anymore." Surveyor then asked LPN #4 to see patches in the medication cart. LPN #4 could not locate patches in the cart.

Surveyor spoke with Resident #14 on 09/07/16 at approximately 1040 regarding the use of Lidoderm patches. Surveyor asked Resident #14 if the patches helped with pain and Resident stated that they did. Surveyor asked Resident how long it had been since he had had any patches and Resident stated "2-3 days, probably 3 days for sure".

A copy of pharmacy policy "Regular Hours of Operation" on 09/07/16 which read in part "Policy: ...(name omitted) provides pharmacy services 7 days a week, 24 hours a day, and 365 days a year in order to assure timely availability of medications for its customers. Procedure: A ...pharmacist is available 24 hours a day and is able to dispense needed medications from the pharmacy or arrange dispensing from a back-up pharmacy to meet the needs of the customer".

The concern of the availability of the Lidoderm patches was discussed with the administrative team during a meeting on 09/07/16 at approximately 1630.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING _____ B. WING _____	09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 12 No further information was provided prior to exit.	F 425		
F 468 SS=D	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure handrails were free of chipped rough edges on 1 of 3 units. The findings included: During a facility walk through on 9/8/16 beginning at 2:00 p.m., the surveyor observed chipped and rough handrails at the corner of the west wing hall. The wall paper below the hand rail was also torn and loose. As the surveyor continued down the hall more rough edges were observed. The service hall outside of the laundry department revealed more chipped and rough edged handrails. The surveyor informed the maintenance director of the rough handrails on 9/9/16 at 9:00 a.m. He stated, " They are rough and we have glued the wall paper back. " The administrator and the director of nurses were informed of the above findings on 9/9/16 at 4:00p.m. No further information was provided prior to the exit conference on 9/9/16.	F 468	1. The identified areas were smoothed out and rounds were made to inspect all hand rails throughout the facility. No adverse effects are noted. 2. All hand rails have the potential to be affected. All were inspected on 9/12/16 and any questionable areas were repaired on this date. 3. Education will be provided to all staff to complete a work order when hand rails are noted to be in need attention. 4. Maintenance will round weekly to ensure all hand rails are smooth and in good repair. Negative trends will be reported to the QA committee for f further review and recommendations. 5. 10/21/16.	
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness	F 502		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING _____ B. WING _____	09/09/2016

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F 502	Continued From page 13 of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to obtain a physician ordered lab for 1 of 21 Residents, Resident #7. The findings included: For Resident #7 the facility staff failed to obtain a physician ordered Dilantin level and lipid panel. Resident #7 was admitted to the facility on 02/0516 and readmitted on 03/02/16. Diagnoses included but not limited to hypertension, neurogenic bladder, hyperlipidemia, cerebrovascular accident, coronary artery disease, seizure disorder, anxiety, depression, schizophrenia, chronic obstructive pulmonary disease, dysphagia, hypothyroidism, and gastroesophageal reflux disease. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 07/28/16 coded the Resident as 8 out of 15 in Section C, cognitive patterns. This is a quarterly MDS. Resident #7's clinical record was reviewed on 09/07/16. It contained a signed POS (physician's order summary) dated 07/30/16 which read in part "Dilantin level Q (every) 3 months (April/July/Oct/Jan)". This order originated 03/20/16. The surveyor could not locate results for any Dilantin levels. The POS also contained an order which read in part "Lipid panel Q 6 months (April/Oct)." This order originated 03/02/16. The surveyor could not locate the	F 502	F Tag 502 Cross reference 12 VAC 5-371-310 (A) 1. Resident #7's order for the Dilantin level was discontinued on 9/8/16. The MD was notified with no new orders. The MD was also notified the ordered Lipid panel was not obtained and the order was changed to obtain the lipid panel every 6 months. 2. Labs for the last 30 days will be reviewed on all Residents to ensure orders for labs are present and all ordered labs are obtained. 3. Nursing staff will be educated on obtaining orders for labs and obtaining labs and will be educated on the procedure to record the order and the lab results. 4. DON/Designee will review 10 medical records per week x 4 weeks then 10 medical records per month x 2 months. All findings will be reported to the QA committee for further review and recommendations. 5. 10/21/16.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING _____ B. WING _____	09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

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F 502	Continued From page 14 results of a lipid panel. Surveyor spoke with the administrator regarding the missing lab results on 09/07/16 at approximately 1330. The administrator provided the surveyor with a copy of an order dated 07/30/16 which read in part "Discontinue Dilantin Infatabs Tablet chewable 50mg". The administrator stated the lab order should have been discontinued when the medication was discontinued, but was overlooked. The administrator could not locate a result for the lipid panel. The concern of the missing lab reports was discussed with the administrative team during a meeting on 09/08/16 at approximately 1800. No further information was provided prior to exit.	F 502		
F 504 SS=D	483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to obtain and order prior to obtaining a lab test for 1 of 21 Residents, Resident #7. The findings included: For Resident #7, the facility staff obtained a lipid panel without a physician's order.	F 504		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING _____ B. WING _____	09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

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F 504	Continued From page 15 Resident #7 was admitted to the facility on 02/0516 and readmitted on 03/02/16. Diagnoses included but not limited to hypertension, neurogenic bladder, hyperlipidemia, cerebrovascular accident, coronary artery disease, seizure disorder, anxiety, depression, schizophrenia, chronic obstructive pulmonary disease, dysphagia, hypothyroidism, and gastroesophageal reflux disease. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 07/28/16 coded the Resident as 8 out of 15 in Section C, cognitive patterns. This is a quarterly MDS. Resident #7's clinical record was reviewed on 09/07/16. It contained a signed laboratory report for a lipid panel dated 03/08/16. The surveyor could not locate a physician's order for this lab test. The surveyor spoke with the administrator regarding the missing physician's order on 09/07/16 at approximately 1330. The administrator could not locate an order for the test. The concern of the missing physician's order was discussed with the administrative team during a meeting on 09/08/16 at approximately 1800. No further information was provided prior to exit.	F 504	F Tag 504 Cross reference 12 VAC 5-371-310 (A) 1. Resident #7's physician was notified a lipid panel was obtained without an order. On 9/8/16 a new order was obtained to do a lipid panel every 6 months. 2. Labs for the last 30 days will be reviewed on all Residents to ensure labs that have been obtained have an appropiate, complete order. 3. Nursing staff will be educated on procedure for obtaining order prior to obtaining lab and making sure the order is entered into the medical record. 4. DON/Designee will review 10 medical records per week x 4 weeks then 10 records monthly x 2 months to ensure all labs that were obtained have a complete order. All findings will be reported to the QA committee for further review and recommendations. 5. 10/21/16.	
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING _____ B. WING _____	09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

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F 514	Continued From page 16	F 514		

resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for 4 of 21 Residents, Residents #1, #3, #8, and #11

The findings included:

1. For Resident #1, the facility staff failed to ensure a complete Virginia Department of Health DDNR (durable do not resuscitate) form.

Resident #1 was admitted to the facility on 01/30/14 and readmitted on 06/20/16. Diagnoses included but not limited o hypertension, uropathy, diabetes mellitus, hyperlipidemia, cerebrovascular accident, psychotic disorder, dysphagia, hypothyroidism, gastroesophageal reflux disease, and benign prostatic hyperplasia.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 06/29/16 coded the Resident as 1/1/3 in Section C, cognitive patterns, which is the equivalent of both long and short term memory loss with impairment

1. Resident #1, #3, #8 and #11 code status have been verified, the DDNRs have been corrected and Resident's physician notified.

2. All Residents with DNR orders have the potential to be affected.
Residents with a DNR order will be reviewed to ensure a DDNR sheet is complete and accurate.

3. Education will be provided to admissions, nursing and social service staff on completion of the DDNR.

4. DON/Designee will review all new admission weekly x 4 weeks then monthly x 2 months to ensure accurate completion of the DDNR form. All findings will be submitted to the QA committee for further review and recommendations.

5. 10/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING _____ B. WING _____	09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

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F 514	Continued From page 17	F 514		

to decision making for daily living. This is a significant change MDS.

Resident #1's clinical record was reviewed on 09/08/16. It contained a Virginia Department of Health DDNR form which read as follows:
"I further certify [must check 1 or 2]:
[] 1. The patient is CAPABLE of making an informed decision....
[] 2. The patient is INCAPABLE of making an informed decision...."
Neither box had been checked on the form.

The incomplete DDNR form was brought to the attention of the administrative team during a meeting on 09/08/16 at approximately 1800.

No further information was provided prior to exit.

2. For Resident #3, the facility staff failed to ensure a complete Virginia Department of Health DDNR (durable do not resuscitate) form.

Resident #3 was admitted to the facility on 05/31/16 and readmitted on 05/02/14. Diagnoses included but not limited to anemia, congestive heart failure, hypertension, dementia, psychotic disorder, asthma, atrial fibrillation, chronic kidney disease, gastroesophageal reflux disease, and arthritis.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 07/03/16 coded the Resident as 4 out of 15 in Section C, cognitive patterns. This is a quarterly MDS.

Resident #3's clinical record was reviewed on 09/07/16. It contained a Virginia Department of Health DDNR form which read as follows:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING _____ B. WING _____	09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

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F 514	Continued From page 18 "I further certify [must check 1 or 2]: [] 1. The patient is CAPABLE of making an informed decision.... [] 2. The patient is INCAPABLE of making an informed decision...." Box 2 had been checked in this section. DDNR form continued to read as follows: "If you checked 2 above, check A, B or C below: [] A. While capable of making an informed decision, the patient has executed a written advanced directive which directs that life-prolonging procedures be withheld or withdrawn. [] B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a 'Person Authorized to Consent of the Patients Behalf'..... [] C. The patient had not executed a written advanced directive....." No box had been checked. The incomplete DDNR form was discussed with the administrator on 09/07/16 at approximately 1630. The administrator stated that this form was not considered a part of the clinical record and the facility used the signed physician's order as the DNR. Resident #3's clinical record was reviewed again on 09/08/16. It contained an "Advanced Directives Acknowledgement" which read as follows: "[] I understand that a DDNR form signed by the Resident or Resident Designee is not in effect until a physician has signed the DDNR form and has included the DDNR as part of my medical record."	F 514		

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	495352	A. BUILDING _____ B. WING _____	09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

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F 514	Continued From page 19	F 514		

The concern of the incomplete DDNR form was discussed with the administrative staff during a meeting on 09/08/16 at approximately 1800.

No further information was provided prior to exit.

3. For Resident #8, the facility staff failed to ensure a complete Virginia Department of Health DDNR (durable do not resuscitate) form.

Resident #8 was admitted to the facility on 02/12/13. Diagnoses included but not limited to dementia, depression, and psychotic disorder.

The most recent MDS (minimum data set) with and ARD (assessment reference date) of 07/20/16 coded the Resident as 02 out of 15 in Section C, cognitive patterns. This is an annual MDS.

Resident #8's clinical record was reviewed on 09/08/16. It contained a Virginia Department of Health DDNR form which read as follows:
"I further certify [must check 1 or 2]:
[] 1. The patient is CAPABLE of making an informed decision....
[] 2. The patient is INCAPABLE of making an informed decision....
"If you checked 2 above, check A, B or C below:
[] A. While capable of making an informed decision, the patient has executed a written advanced directive which directs that life-prolonging procedures be withheld or withdrawn.
[] B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a 'Person

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	495352	A. BUILDING _____ B. WING _____	09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

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F 514	Continued From page 20	F 514		

Authorized to Consent of the Patients Behalf.....
[] C. The patient had not executed a written advanced directive....."
No boxes had been checked in either section of the form.

The concern of the incomplete DDNR form was discussed with the administrative staff during a meeting on 09/08/16 at approximately 1800.

No further information was provided prior to exit.
4. For Resident #11, the facility staff failed to accurately complete a DDNR (durable do not resuscitate) order form.
Resident #11 was admitted to the facility on 1/2/13. Diagnoses included, but were not limited to: diabetes, Bipolar, edema, atrial fibrillation, stroke, hypertension, anxiety, and depression.

A review of Resident #11 ' s MDS (minimum data set) assessment with an ARD (assessment reference date) of 8/11/16, scored the resident to be a 3 in section C for his cognitive pattern.

The clinical record included a DDNR form dated 4/15/16. This form had been signed by the physician and the Resident ' s responsible party.

This DDNR read in part, "I further certify [must check 1 or 2]:
1. " The patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment. (Signature of patient is required).
2. "The patient is INCAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment because he/she is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING _____ B. WING _____	09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

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F 514	Continued From page 21	F 514		

unable to understand the nature, extent or probable consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision." Neither of the two had been checked for Resident #11.
Section 2 of the DDNR stated, "If you checked 2 above, check A, B, or C below."

The B box had been checked.

On 9//16 at approximately 3:05p.m., a meeting was held with the director of nurses, the administrator, and other administrative staff. The incomplete DDNR was discussed during this meeting.
Prior to exit, no further information was provided related to the incomplete DDNR.

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING _____ B. WING _____	09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

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F 000	Initial Comments An unannounced Medicare/Medicaid standard survey and biennial State Licensure Inspection was conducted 09/06/16 through 09/09/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. The census in this 110 certified bed facility was 104 at the time of the survey. The survey sample consisted of 17 current Resident reviews (Residents 1 through 17) and 3 closed record reviews (Residents 18 through 21).	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: Policies and Procedures 12 VAC 5-371-140 (D.2)- cross reference to F285 Nursing Services 12 VAC 5-371-220 (C)- cross reference to F309 Resident Assessment 12 VAC 5-371-250 (A and C)- Cross reference to F279 and 280 Pharmaceutical Services 12 VAC 5-371-300 (A)-Cross reference to F425 Diagnostic Services 12 VAC 5-371-310 (A)- Cross reference to F502 and 504 Clinical Records	F 001	12 VAC 5-371-140 (D.2) Please cross reference to Plan of Correction for F-285 12 VAC 5-371-220 (C) Please cross reference to Plan of Correction for F-309 12VAC 5-371-300 (A and C) Please cross reference to Plan of Correction for F-279 and F-280 12 VAC 5-371-310 (A) Please cross reference to Plan of Correction for F-425 12 VAC 5-371-310 (A) Please cross reference to F-502 and F-504	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Interim Administrator (X6) DATE: 9/26/16

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING _____ B. WING _____	09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 001	Continued From Page 1 12 VAC 5-371-360 (A, E4, 6)- Cross reference to F514	F 001		

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING _____ B. WING _____	09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 000	Initial Comments	F 000		

An unannounced Medicare/Medicaid standard survey and biennial State Licensure Inspection was conducted 09/06/16 through 09/09/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow.

The census in this 110 certified bed facility was 104 at the time of the survey. The survey sample consisted of 17 current Resident reviews (Residents 1 through 17) and 3 closed record reviews (Residents 18 through 21).

F 001 Non Compliance — F 001

The facility was out of compliance with the following state licensure requirements:

This RULE: is not met as evidenced by:
Policies and Procedures
12 VAC 5-371-140 (D.2)- cross reference to F285

Nursing Services
12 VAC 5-371-220 (C)- cross reference to F309

Resident Assessment
12 VAC 5-371-250 (A and C)- Cross reference to F279 and 280

Pharmaceutical Services
12 VAC 5-371-300 (A)-Cross reference to F425

Diagnostic Services
12 VAC 5-371-310 (A)- Cross reference to F502 and 504

Clinical Records

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

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING _____ B. WING _____	09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 001	Continued From Page 1 12 VAC 5-371-360 (A, E4, 6)- Cross reference to F514	F 001		