

202 Painter Street Galax, VA 24333 PHONE (276) 236-5164 FAX (276) 236-0699 www.autumnnursingrehab.com

April 25, 2016

Rodney L. Miller Long Term Care Supervisor Office of Licensure and Certification Division of Long Term Care Services 9960 Mayland Drive, Suite 401 Henrico, Virginia 23233-1485

Re: Waddell Nursing & Rehab Center SNF/NF 49-5126 Plan of Correction

Mailed: 4/25/16

Dear Mr. Miller:

Please find enclosed the Plan of Correction submitted by Waddell Nursing and Rehab Center for the Standard Survey ending on March 31, 2016. The facility received the 2567 Statement of Deficiencies on April 18, 2016 via E-Mail.

The submitted Plan of Correction will serve as the facility's allegation of compliance with the requirements of 42 CFR, Part 483, Subpart B for long term care facilities.

Please feel free to contact me if you have any questions or need any additional information at 276-236-5164.

E-Wroffled

Respectfully,

James R. Wooddell Administrator

RECEIVED

APR 27 2016

VDH/OLG

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Printed: 04/14/2016 ED 91

CENT	ERS FOR MEDICARE	& MEDICAID SERV	ICES ICES			FO OMB I	NO. C		
	ENT OF DEFICIENCIES IN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		1	E CONSTRUCTION	(X3) DATI COM	E SURV		
		495126		B. WING		0;	3/31/2	2016	
1	PROVIDER OR SUPPLIER ELL NURSING AND I	REHAB CENTER	202 PAI	RESS, CITY, STA INTER ST I, VA 24333	NTE, ZIP CODE				and dispension of the
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE T BE PRECEDED BY FULL F ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	С	(X5 COMPLE DAT	TION
F 252 SS=E	survey was conduct 03/31/16. Correction compliance with 42 Term Care requirent survey/report will for The census in this 122 at the time of the consisted of 21 cure (Residents #1 throus reviews (Residents #2 483.15(h)(1) SAFE/CLEAN/COMENVIRONMENT The facility must procomfortable and hore the resident to use the tothe extent possible. This Requirement is Based on observation determined the facility safe, clean, comfortate environment in indivisualts. Findings: During the initial tour day onsite survey encidentified. The survey rooms were clean on 2 & 3. Resident rooms were debris build up on the	ledicare/Medicaid stated 03/29/16 through ons are required for CFR Part 483 Feder nents. The Life Safety llow. 135 certified bed facilities survey. The survey rent Resident reviews gh #21) and 3 closed #22 through #24). FORTABLE/HOMELI vide a safe, clean, nelike environment, a sis or her personal between, and staff interviews ty staff failed to maintable and homelike dual resident rooms of the subsequent vironmental issues wors observed the resumit 1, but not clean to observed to have die floors and around the subsequent of the subsequent wors observed to have die floors and around the subsequent of the subsequent of the subsequent wors observed to have die floors and around the subsequent of the subseq	al Long y Code ity was y sample s record KE allowing longings ed by: it was ain a on 2 of 3 three ere ident on units rt and e	F 000	This Plan of Correction will serve as facility's allegation of compliance wir requirements of 42 CFR, Part 483, Su B for long term care facilities. Prepar and submission of the plan of correction response to the CMS 2567 for the sand does not constitute an agreement admission by Waddell Nursing and Recenter of the truth of the facts alleged correctness of the conclusions stated of statement of deficiencies. This plan of correction is prepared and submitted because of the requirements under stated federal laws. Waddell Nursing and Recenter contends that it was in substant compliance with the requirements of 4 CFR, Part 483, Subpart B throughout time period stated in the statement of deficiencies. In accordance with state federal law, however, Waddell Nursing Rehab Center submits this plan of corrodadress the statement of deficiencies to serve as it's allegation of compliance the pertinent requirements as of the dat stated in the plan of correction and as f complete in all areas as of May 13, 201 F 252: 1) Bathrooms and resident reading the pertinent requirements as of the dat stated in the plan of correction and as f complete in all areas as of May 13, 201 F 252: 1) Bathrooms and resident reading the pertinent requirements as of the dat stated in the plan of correction and as f complete in all areas as of May 13, 201 F 252: 1) Bathrooms and resident reading the floors and at the base of floor vinyl tile in the bathrooms and resident room floor vinyl tile in the bathrooms and resident room floor vinyl tile in the bathrooms and resident room floor vinyl tile in the bathrooms and resident room floor vinyl tile in the bathrooms and resident room floor vinyl tile was repaired and reattacher rooms 103, 104, 105, 106, 114, 115, 117, 119, 120, 20, 202, 203, 204, 205, 206, 20, 202, 203, 204, 205, 206, 20, 202, 203, 204, 205, 206, 20, 202, 203, 204, 205, 206, 20, 202, 203, 204, 205, 206, 20, 203, 204, 205, 206, 20, 203, 204, 205, 206, 20, 203, 204, 205, 206, 20, 203, 204, 205, 206, 20, 203, 204, 205, 206, 20, 203, 2	th the abpart ration ion is survey or ehab for the and ehab tial 42 the and rection is and rection in a sand rection is and rection in a sand rection in a s	SIOC		The state of the s
ABORATOF	Y DIRECTOR'S OR PROVIDE			TURE	TITLE		(X6) DA	ATE	

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.

Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			(X3) DATE SURVEY COMPLETED		
		495126		B WING		03/31/2016
I	NAME OF PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	
	WADDELL NURSING AND R	REHAB CENTER	Į.	NTER ST , VA 24333		
	PREFIX (EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL F NTIFYING INFORMATION)	ES REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETIC
	bathrooms. The viny to be warping and prooms and bathroon	evinyl baseboards in yl baseboards were eulling away from the ns. Paint was scrapes of bedrooms and no ions were observed 103, 104, 105,106, 1120, 201, 203, 202, 2011, 213, 212, 214, 2011, 213, 212, 214, 2011, 213, 212, 214, 2011, 213, 212, 214, 2011, 213, 212, 214, 2011, 213, 212, 214, 2011, 213, 212, 214, 2011, 213, 212, 214, 2011, 213, 212, 214, 2011, 213, 212, 214, 2011, 213, 212, 214, 2011, 213, 212, 214, 2011, 213, 212, 214, 2011, 213, 212, 214, 2011, 213, 212, 214, 2011, 213, 212, 214, 2011, 213, 212, 214, 2011, 213, 212, 214, 2011, 214, 214, 214, 214, 214, 214, 214, 2	observed walls in ed and eeded in varying 07, 114, 204, 206, 222, & ed on eent. iodically it s the ecified de at n;	F 252	104, 105, 106, 107, 117, 119, 120, 201, 204, 205, 206, 207, 211, 212, 213, 214, 222 were repaired ar This was completed 22, 2016. 2) All facility bathroom resident rooms were for dirt and debri on and at the base of the vinyl tile, loose basel vinyl tile, wall scrap chipped paint and was mopped, cleaned, rearepaired and painted necessary. Complete 4/18/16. 3) The Housekeeping S and Maintenance Dirwith their departmen 4/8/16 to implement cleaning and repair p 4) The Housekeeping S and Maintenance Dirwith their departmen 4/8/16 to implement cleaning and repair p 4) The Housekeeping S and Maintenance Dirwinspect the bathrooms resident rooms daily that the resident's bath and rooms will be main a sanitary, orderly a comfortable condition. Identified areas will be addressed and correct. 5) The facility administration management team will a daily facility inspect assigned and selected floors, which will coverentire facility at least each and covered the selected floors, which will covered the selected floors and selected floors and selected floors and selected floors which will covered the selected floors and selected floors and selected floors which will covered the selected floors and selected floors which will covered the selected floors which will covered the selected floors and selected floors which will covered the	202, 203, 208, 209, 220, and and painted. on April as and inspected the floors of floor coard as and as attached, as ed on a facility-rogram. Approximate the sand as a facility-rogram. Approximate the floors intained and and as a facility-rogram. Approximate the floors of floor and a facility-rogram. Approximate the floors of floors o
	Activity pursuit; Medications;				month to maintain a sa	initary,

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

K48R11 If continuation sheet Page 2 of 28

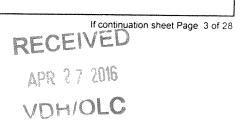


DEPARTMENT OF HEALTH AND HUMAN SERVICES

Printed: 04/14/201 Έ[391

CENTERS FO	R MEDICARE	E & MEDICAID SERV	/ICES /ICES				FOR OMB N	M APPROV O. 0938-03
STATEMENT OF DE AND PLAN OF COR	EFICIENCIES	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	ER/CLIA	i	LE CONSTRUCTI		(X3) DATE S	SURVEY
		495126	į	B. WING	West residence of the second s		03/	31/2016
NAME OF PROVIDE			1	RESS, CITY, ST	ATE, ZIP CODE		1	V 1/4
		REHAB CENTER	GALAX,	NTER ST , VA 24333				
TAG	DEFICIENCY MUST OR LSC IDE	TATEMENT OF DEFICIENCIE T BE PRECEDED BY FULL R ENTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	(EACH COR	ER'S PLAN OF CORRECT RRECTIVE ACTION SHOU ERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
Speci Disch Docui the ac areas Data S	narge potential imentation of s dditional asses s triggered by t Set (MDS); an	and procedures; I; summary information ssment performed on the completion of the nd	n the care Minimum	F 272	be di Hous Main	ior. Identified issues iscussed with the sekeeping Supervisor tenance Director for ection.	and	5/13/16
Doour	mentation or p	participation in assess	iment.	J	F 272			
Based it was	d on staff intervidented the	s not met as evidence view and clinical recor ne facility staff failed to comprehensive, accu	ord review to ensure		1) Reside 4, 5, 6 19 CA assessi were u where, the loc inform CAA c	ents numbers 1, 2, 3, 5, 7, 9, 10, 11, 13, and As (care area ment) summaries update to reflect, in the clinical record cation and date of lation related to the can be found and for		
CAA (0 functio	Care Area Ass onal capacity fo	sessment) of each res or 13 of 24 residents. 4, 10, 14, 1, 3, 9, 11, 2	sident's		was acc 4/8/16. 2) A 100% residen	% audit of all its CAAs was		
Finding	-	the complete on good	• -		4/22/16 team an	eted and concluded on by the care plan and the location and	1	
CAA (C Reside	Care Area Asse	to complete an accur essment) summary fo sident's clinical record at 10:30 AM.	or		to the C correcte clinical	information related CAAs was found in or ed at that time in the record for each	:	
10/23/1 diabete: vascula	12. The diagno es, coronary ar	mitted to the facility or oses included dement rtery disease and cere nd-stage renal disease on.	tia, ebral		3) In-servi provide team on the docu	ed CAA for each resident. ice education was d to the care plan 4/13/16 addressing umentation		
assessr with slig	ment dated 06 ghtly impaired	I MDS (minimum data 6/18/15 coded the resi cognitive ability. Resi nce for all ADL (activit	sident ident #5		assessm support making	nents concerning tent information in of clinical decision relevant to the		

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



making relevant to the CAA, documentation

K48R11

Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE	& MEDICAID SERV	ICES	Week granden and a second a second and a second a second and a second a second and a second and a second and			OMB NO. 0938-03
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		(X2) MULTIPLE A BUILDING			(X3) DATE SURVEY COMPLETED
	495126		B WING			03/31/2016
NAME OF PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CO	ODE	
WADDELL NURSING AND I	REHAB CENTER	1	NTER ST , VA 24333			
PREFIX (EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE T BE PRECEDED BY FULL F ENTIFYING INFORMATION)		ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRECT I CORRECTIVE ACTION SHOU REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
07/01/15. The locate V) of the CAA docu incomplete for local summarized materia. This information was administrator on 3/3 additional info was personal staff faile CAA (Care Area Assesident #13. The reviewed on 3/30/16. Resident # 13 was a 09/16/14. The diagn injury, paraplegia, at anxiety and psychos. The resident's annual assessment dated 0 with unimpaired cognized staff assistated aily living.) The MDS contained 09/03/15. The location V) of the CAA documincomplete for location	d CAA's signed and orion and date section mentation was obsertion and dates of the all for CAA documents as shared with the DCB0/16 at 4:45 PM. No provided. In the complete an accessment and sessment are sessment, summary fresident's clinical record at 9:00 AM. In the complete an accessment and date section (Some and dates of the 1 for CAA documentation was observed and dates of the 1 for CAA documentation was accessment at 9:00 AM. In the complete an accessment at 9:00 AM.	(Section ved to be ation. ON and curate for ord was on atic brain tension, ta set) sident trainites of ated section ed to be tion.	F 272	5)	regarding where, in the clinical record, the locat and date of information related to the CAA can be found for each triggered CAA. The facility has implemented a new Electronic Health Record effective March 1, 2016 which will assist with accurately documenting location and date section (Section V) of the CAA location and date of the summarized material for CAA documentation. The facility administrate will attend 25% of the monthly interdisciplinary care plan team meetings monitor for compliance of the CAA summaries with containing the location and date of information in the clinical record for eatriggered CAA.	the in for to of the in
3. For Resident #4, th	ne facility staff failed t	:O				

K48R11

16 D 1

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	AND HUMAN SERV & MEDICAID SERV	/ICES /ICES			FOR	d: 04/14/20: MAPPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER		(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE S COMPL	
	495126	;	B WING		03/:	31/2016
NAME OF PROVIDER OR SUPPLIER WADDELL NURSING AND R	REHAB CENTER	202 PAII	RESS, CITY, STA NTER ST VA 24333	TE, ZIP CODE		
PREFIX (EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL I NTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
section V (care area	of the CAA document assessment (CAA) sidents annual MDS assessment. mitted to the facility but were not limited utritional deficiency, irbances, hypertensing patterns) of the Resment with an ARD ce date) of 10/22/15 hary score of 5 out of the directions under ate in the Location and column where infan be found"	11/23/15. If to, dementia on, and sident included if a section V and Date formation	F 272			

CAA documentation" the facility staff had documented see CAA summary 10/23/15 and 10/26/15. The actual location(s) had not been documented.

On 03/30/16 at approximately 1:20 p.m. LPN (licensed practical nurse) #1 was asked about the missing documentation in section V. LPN #1 verbalized to the surveyors that she had been taught to do it that way when she attended training on the computer system.

The administrator, DON (director of nursing), ADON (assistant director of nursing), and staff development coordinator were notified of the missing information in section V of the Residents annual MDS assessment in a meeting with the survey team on 03/30/16 at approximately 4:35 p.m.

If continuation sheet Page 5 of 28

RECEIVED AFR 27 2016 VDH/OLC

Printed: 04/14/2016 ORM APPROVED NO. 0938-0391

> COMPLETION DATE

CENTERS FOR MEDICARE	& MEDICAID SERV	ICES ICES		O	FORM APPR MB NO. 0938
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTIPLE A BUILDING	i.	B) DATE SURVEY COMPLETED
	495126		B. WING		03/31/2016
NAME OF PROVIDER OR SUPPLIER WADDELL NURSING AND REHAB CENTER			RESS, CITY, STA	TE, ZIP CODE	
WADDLEL NORSING AND P	CENAR CENTER		NTER ST , VA 24333		
PREFIX (EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE T BE PRECEDED BY FULL F ENTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLI

F 272 Continued From page 5

F 272

No further information regarding this issue was provided to the survey team prior to the exit conference.

4. For Resident #10, the facility staff failed to include the location of the CAA documentation in section V (care area assessment (CAA) summary) of the Residents annual MDS (minimum data set) assessment.

Resident #10 was admitted to the facility 03/14/14. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease. respiratory failure, sleep apnea, hypertension, and hyperglycemia.

Section C (cognitive patterns) of the Residents annual MDS assessment with an ARD (assessment reference date) of 06/24/15 included a documented summary score of 14 out of a possible 15 points. The directions under section V read in part "3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found..."

Under the column labeled "Location and Date of CAA documentation" the facility staff had documented see CAA summary and had documented the dates of 06/05/15, 06/08/15, and 06/09/15. The actual location(s) had not been documented.

On 03/30/16 at approximately 1:20 p.m. LPN (licensed practical nurse) #1 was asked about the missing documentation in section V. LPN #1 verbalized to the surveyors that she had been taught to do it that way when she attended training on the computer system.

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

If continuation sheet Page 6 of 28

RECEIVED APR 27 2016 VUH/OLC

Printed: 04/14/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING_ COMPLETED 495126 B. WING 03/31/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE WADDELL NURSING AND REHAB CENTER 202 PAINTER ST **GALAX, VA 24333** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY COMPLETION

F 272 Continued From page 6

TAG

The administrator, DON (director of nursing), ADON (assistant director of nursing), and staff development coordinator were notified of the missing information in section V of the Residents annual MDS assessment in a meeting with the survey team on 03/30/16 at approximately 4:35 p.m.

OR LSC IDENTIFYING INFORMATION)

No further information regarding this issue was provided to the survey team prior to the exit conference.

5. For Resident #14, the facility staff failed to include the location of the CAA documentation in section V (care area assessment (CAA) summary) of the Residents annual MDS (minimum data set) assessment.

Resident #14 was admitted to the facility 12/04/14. Diagnoses included, but were not limited to, anemia, dementia, mood disorder, depression, hypertension, and chronic pain.

Section C (cognitive patterns) of the Residents annual MDS assessment with an ARD (assessment reference date) of 11/19/15 included a documented summary score of 8 out of a possible 15 points. The directions under section V read in part "3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found..."

Under the column labeled "Location and Date of CAA documentation" the facility staff had documented see CAA summary and had documented the dates of 11/20/15 and 11/23/15. The actual location(s) had not been documented.

On 03/30/16 at approximately 1:20 p.m. LPN (licensed practical nurse) #1 was asked about the F 272

PREFIX

TAG

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

DATE

Printed: 04/14/2016 11

CENTERS FOR MEDICARE & MEDICAID SERVICES					FORM APPROVE OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495126		B. WING		03/31/2016
NAME OF PROVIDER OR SUPPLIER STREET A			RESS, CITY, STA	ATE, ZIP CODE	4
WADDELL NURSING AND R	REHAB CENTER		NTER ST VA 24333		
PREFIX (EACH DEFICIENCY MUST	NTEMENT OF DEFICIENCIE BE PRECEDED BY FULL F NTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 272 Continued From pa	ge 7		F 272		

missing documentation in section V. LPN #1 verbalized to the surveyors that she had been taught to do it that way when she attended training on the computer system.

The administrator, DON (director of nursing), ADON (assistant director of nursing), and staff development coordinator were notified of the missing information in section V of the Residents annual MDS assessment in a meeting with the survey team on 03/30/16 at approximately 4:35 p.m.

No further information regarding this issue was provided to the survey team prior to the exit conference.

6. For Resident #1 the facility staff failed to ensure an accurate comprehensive MDS (minimum data set) assessment. Resident #1 was admitted to the facility on 04/17/14 and readmitted on 01/21/16. Diagnoses included but not limited to anemia, congestive heart failure, hypertension, peripheral vascular disease, gastroesophageal reflux disease, urinary tract infection, diabetes mellitus, hyperlipidemia. anxiety, depression, bipolar disorder, chronic obstructive pulmonary disease, and dysphagia. The most recent comprehensive MDS with and ARD (assessment reference date) of 01/28/16 coded the Resident as 14 of 15 in Section C, cognitive patterns. Section V, Care Area Assessment (CAA) Summary was also reviewed. The facility staff had not identified the date and location of the CAA information used to determine the care plan. The only documentation was " see CAA summary 02/02/16 ". The MDS coordinator was interviewed on

03/30/16 at approximately 1320. She stated that is how they were taught during MDS training.

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

If continuation sheet Page 8 of 28

RECEIVED APR 27 2016 VOH/OLG

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Printed: 04/14/2016

CENTERS FOR MEDICARE	& MEDICAID SERV	/ICES			FORM APP OMB NO. 093	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	ER/CLIA		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495126	3	B. WING		03/31/201	16
NAME OF PROVIDER OR SUPPLIER		1	DRESS, CITY, STA	ATE, ZIP CODE		
WADDELL NURSING AND I	REHAB CENTER	3	INTER ST (, VA 24333			
PREFIX (EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCI T BE PRECEDED BY FULL ENTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE COM E APPROPRIATE	(X5) IPLETION DATE
coordinator, and star of the findings during team on 03/30/16 at No further information. For Resident #3 ensure an accurate assessment. Resident #3 was accurate assessment. Resident #3 was accurate assessment. Resident #3 was accurate assessment and readmincluded but not limit multi drug resistant malnutrition, deep vortice of the most recent ME coded the Resident accurate patterns. So Assessment (CAA). The facility staff had location of the CAA is the care plan. The of CAA summary 10/30. The MDS coordinate 03/30/16 at approximate administrator, diccoordinator, and staff of the findings during team on 03/30/16 at	director of nursing, Maff development were at 1640. It is a meeting with the at 1640 it is a meeting with the at 1640. It is a meeting with the facility staff failed to comprehensive MDS dmitted to the facility in ited to anemia, hyperorganism, seizure divenous thrombosis, a postructive pulmonary dysphagia, gastroeso and stage renal disease of the stage	re informed e survey or to exit. d to S on siagnoses ertension, isorder, enxiety disorder, ophageal ease. 1/13/16 ction C, reviewed. ate and determine was " see on sied that ning. DS informed survey or to exit.	F 272			

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

Resident #9 was admitted to the facility on 02/09/15. Diagnoses included but not limited to anemia, congestive heart failure, hypertension,

> If continuation sheet Page 9 of 28 K48R11

> > RECEIVED

APR 2.7.2016

Printed: 04/14/2016

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	AND HUMAN SERV & MEDICAID SERV	ICES ICES			FOR	M APPROVI 0. 0938-03
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		1`'	E CONSTRUCTION	(X3) DATE S COMPL	SURVEY
	495126		B. WING		03/:	31/2016
NAME OF PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		Management of the second secon
WADDELL NURSING AND F	REHAB CENTER		NTER ST , VA 24333			
PREFIX (EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI T BE PRECEDED BY FULL I ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 272 Continued From pa	age 9		F 272			
•	eflux disease, end s	tage renal				
	order, osteoporosis,					
	se, dementia, anxiety	/ ,				
depression, and psy						
	DS with an ARD of 0					
	as 0 of 15 in Section					
	Section V, Care Area					
	Summary was also					
	d not identified the da					
	information used to					
CAA summary 01/2	only documentation w	vas see				
	or was interviewed o	n				
	mately 1320. She sta					
	ught during MDS trai					
	lirector of nursing, M					
coordinator, and sta	iff development were	informed				
	g a meeting with the	survey				
team on 03/30/16 at						
No further information	on was provided prior	r to exit.				
9. For Resident #11	the facility staff failed	d to				
ensure an accurate	comprehensive MDS	3				
assessment.						
	dmitted to the facility					
	itted on 05/26/15. Di					
	ted to anemia, hyper					
	perlipidemia, demen					
	disorder, gastroesopl					
	nic kidney disease, co oporosis, and psycho					
disorder.	pporosis, and psycho	illo				
	S with an ARD of 03	//03/16				
coded the Resident						
cognitive patterns. S						

K48R11

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

CAA summary 09/18/15 ".

Assessment (CAA) Summary was also reviewed. The facility staff had not identified the date and location of the CAA information used to determine the care plan. The only documentation was " see

If continuation sheet Page 10 of 28

RECEIVED

APR 27 2016

Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

03/31/2016

STATEMENT OF	E DEFICIENCIES
AND PLAN OF	
	39111E311011

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
A BUILDING_		COMPLETED

495126

5126 B WING _____

WADDELL NURSING AND REHAB CENTER

202 PAINTER ST GALAX, VA 24333

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY
OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 272 Continued From page 10

The MDS coordinator was interviewed on 03/30/16 at approximately 1320. She stated that is how they were taught during MDS training. The administrator, director of nursing, MDS coordinator, and staff development were informed of the findings during a meeting with the survey team on 03/30/16 at 1640.

No further information was provided prior to exit. 10. The facility staff failed to document the location of where the documentation could be found in Resident #2 's clinical record for Section V of the Care Area Assessment (CAA) Summary of the Minimum Data Set (MDS).

of the Minimum Data Set (MDS). Resident #2 was readmitted to the facility on 5/22/15 with the following diagnoses of, but not limited to anemia, high blood pressure, diabetes, dementia, anxiety, dysphagia and insomnia. The most recent MDS was a quarterly assessment with an ARD (Assessment Reference Date) of 12/31/15 scored the resident of having a BIMS (Brief Interview of Mental Status) score of 3 out of a possible score of 15. The resident was also coded as requiring extensive assistance of 2 or more staff members for bathing and personal hygiene.

The surveyor reviewed the clinical record of Resident #2 on 3/30/16. The surveyor noted that on the annual MDS with an ARD of 10/8/15 in Section V of the CAA Summary the location of the documentation to support the triggered area for the following were missing: Cognitive Loss/Dementia, Visual Function, Communication, Urinary Incontinence/Indwelling Catheter, Falls, Nutritional Status, Dental Care, Pressure Ulcer and Psychotropic Drug Use.
The MDS nurse was interviewed on 3/30/16 at approximately 3 pm in the conference room and

approximately 3 pm in the conference room and was notified of the above documented findings. The MDS nurse stated "We were told as long as we put See CAA Summary with a date, that it was

F 272

STREET ADDRESS, CITY, STATE, ZIP CODE

R - (f continuation sheet Page 11 of 28

Printed: 04/14/2016 FORM APPROVED MB NO. 0938-0391

CENTERS FOR MEDICARE	A MEDICAID SERV	ICES	-		OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495126		B WING		03/31/2016
NAME OF PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	+-
WADDELL NURSING AND F	REHAB CENTER	202 PAI	INTER ST		
		1	X, VA 24333		
PREFIX (EACH DEFICIENCY MUST TAG OR LSC IDE	TATEMENT OF DEFICIENCIE T BE PRECEDED BY FULL F ENTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ULD BE COMPLETION
F 272 Continued From pa	age 11		F 272		
alright, "	•				
The administrator, o	director of nursing an				
	f nursing was notified				
above documented	findings in the end o	of the day			
conference on 3/30	1/16 at approximately	4pm.			
No further information	ion was provided to th	he			
surveyor prior to the	e exit conference on 3	3/31/16.			
11 The facility staff	een oo ah	• •			
	f failed to document to				
	e documentation cou				
	6 ' s clinical record fo Assessment (CAA) S				
of the Minimum Data	ASSESSINGLIC (UMM) U	Ummary			
	a set (MDS). Imitted to the facility o	on			
	owing diagnoses of, b				
	igh cholesterol, major				
	r, general anxiety, pai				
	. The most recent M				
a quarterly assessm	ent with an ARD				
	ence Date) of 1/21/16	scored			
	ng a BIMS (Brief Inter				
	e of 9 out of a possibl				
of 15. The resident	was also coded as re	equiring			
total dependent on th	he assistance of 2 or	more			
staff members for ba	athing and personal h	nygiene.			
	o coded as being alw	vays			
incontinent of bowel					
	red the clinical record				
	/16. The surveyor no				
	with an ARD of 10/29				
	A Summary the location				:
	pport the triggered ar	ea for			
the following were mi	0 0	41			
	ial Function, Commun				
	abilitation Potential, U	,			
	ing Catheter, Psychological States				
	ctivities, Falls, Nutrition	onal			
Status, Dental Care,	Pressure Dicer,				I

Psychotropic Drug Use and Pain.

The MDS nurse was interviewed on 3/30/16 at

Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

CLIVILIO POR MEDICARE	A MEDICAID SERV	ICES			<u>OMB NO. 0938-039</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		l .	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495126		B. WING		03/31/2016
NAME OF PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
WADDELL NURSING AND	REHAB CENTER	202 PA	INTER ST		
		GALAX	, VA 24333		
PREFIX (EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCI T BE PRECEDED BY FULL I ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 272 Continued From p	age 12		F 272		
approximately 3 pm was notified of the The MDS nurse state we put See CAA Stalright. " The administrator, assistant director of above documented conference on 3/30 No further informatis surveyor prior to the surveyor prior to the 12. The facility staff location of where the found in Resident #V of the Care Area of the Minimum Date Resident #7 was restained to coronary a high blood pressure asthma, low potassis. The annual MDS with Reference Date of the score of 15 out of a resident was also consupervision of one start was a	in the conference reabove documented fiated. "We were told a summary with a date, if director of nursing and finursing was notified findings in the end of 16 at approximately ion was provided to the exit conference on a failed to document the documentation court is clinical record for Assessment (CAA) Star Set (MDS). admitted to the facility allowing diagnoses of the exit conference on the failed to the facility and respiratory for the ARD (Assessment 1/28/16 scored the rest Interview of Mental possible score of 15. The surveyor not the clinical record of 15. The surveyor not the clinical record of 16. The surveyor not the clinical record of the clinical rec	ndings. as long as that it was ad I of the If the day Apm. ae 3/31/16. The Id be or Section ummary y on but not failure, esterol, failure. ent esident of Status) The I of Oted that Section V rea for	F 272		
Status, Dental Care,	Pressure Ulcer, and interviewed on 3/30/	Pain.			

approximately 3 pm in the conference room and was notified of the above documented findings.

Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

03/31/2016

STATEMENT	OF	DEFICIENCIES	
AND DLAN O	FC	ODDECTION	

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER

(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY	
A. BUILDING	COMPLETED	

495126

B WING

STREET ADDRESS, CITY, STATE, ZIP CODE

Α

WADDELL NURSING AND REHAB CENTER

202 PAINTER ST GALAX, VA 24333

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID **PREFIX** TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

F 272 Continued From page 13

The MDS nurse stated "We were told as long as we put See CAA Summary with a date, that it was alright. "

The administrator, director of nursing and assistant director of nursing was notified of the above documented findings in the end of the day conference on 3/30/16 at approximately 4pm. No further information was provided to the surveyor prior to the exit conference on 3/31/16. 13. The facility staff failed to document the location of where the documentation could be found in Resident #19's clinical record for Section V of the Care Area Assessment (CAA) Summary of the Minimum Data Set (MDS). Resident #19 was readmitted to the facility on 1/27/16 with the following diagnoses of, but not limited to anemia, high blood pressure, anxiety, depression, respiratory failure, heart failure, muscle weakness and Stage III kidney disease. The most recent MDS was a quarterly assessment with an ARD (Assessment Reference Date) of 2/4/16 scored the resident of having a BIMS (Brief Interview of Mental Status) score of 15 out of a possible score of 15. The resident was also coded as requiring limited assistance of 1 staff member for transfers, and ambulation. The resident is coded as needing the assistance for set up only with eating. The surveyor reviewed the clinical record of Resident #19 on 3/31/16. The surveyor noted that on the significant change MDS with an ARD of 10/30/15 in Section V of the CAA Summary the location of the documentation to support the triggered area for the following were missing: ADL Functional/Rehabilitation Potential, Urinary Incontinence/Indwelling Catheter, Mood State, Falls, Nutritional Status, Dehydration/Fluid Maintenance, Dental Care, Psychotropic Drug Use and Pain. The MDS nurse was interviewed on 3/31/16 at

F 272

Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

OLIVILI	10 I ON WEDIOANE	G WILDION IID OLIV	1000				T	<u> </u>
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED		
		495126		B. WING			03/31/2016	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CO	DE		
WADDE	LL NURSING AND F	REHAB CENTER	202 PAI	INTER ST				
			GALAX	i, VA 24333				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI T BE PRECEDED BY FULL I ENTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	(EACH	VIDER'S PLAN OF CORRECTIVE ACTION SHOUR CORRECTIVE ACTION SHOUR REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 278	was notified of the a The MDS nurse sta we put See CAA Su alright. " The administrator, assistant director of above documented conference on 3/31 conference. No further informati surveyor prior to the 483.20(g) - (j) ASSI	m in the conference above documented filted. "We were told aummary with a date, director of nursing arf nursing was notified findings in the end of /16 prior to the exit on was provided to the exit conference on	indings. as long as that it was ad d of the of the day he 3/31/16.	F 272	F 278:	Resident #3 MDS codi	nσ	
	The assessment maresident's status. A registered nurse reach assessment with participation of health A registered nurse reassessment is complete assessment is complete. Each individual who assessment must see that portion of the action of	must conduct or coor with the appropriate th professionals. must sign and certify pleted. o completes a portion ign and certify the ac	t the rdinate that the that the of the ccuracy of dual who al and it is ore than idual who adividual in a money		2)	to reflect the accurate height statues was adde and corrected on 4/1/16 Resident #11 MDS code to reflect accurate range motion was added and corrected on 4/1/16. All residents with height and functional range of motion MDS records were viewed was complete on 4/8/16 by the MDS coordinators and found be accurately coded with no corrections necessare The DON and DSD provided in-service education to the memb of the care planning team on the MDS and care planning requirements accurate assessments of 4/13/16.	ed 5. ding e of hts f vere ed S d to ith ry. ers am	

Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERV	ICES				OMB	NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED
		495126		B. WING			03	3/31/2016
NAME OF	PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CC	DDE	***************************************	
WADDE	LL NURSING AND	REHAB CENTER	1	NTER ST , VA 24333				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIE T BE PRECEDED BY FULL I ENTIFYING INFORMATION)		ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRECT I CORRECTIVE ACTION SHOL REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	This Requirement Based on staff inter review the facility s and accurate MDS assessment for 2 o and #11. The findings include 1. For Resident #3 accurately record th Resident #3 was ac 10/20/15 and readn included but not lim multi drug resistant malnutrition, deep v disorder, chronic ob respiratory failure, of reflux disease, and The most recent qua 01/13/16 coded the Section C, cognitive swallowing/nutrition recorded the Reside most recent compre 10/27/15 recorded th in Section K. The MDS coordinate 03/31/16 at approxim she did not know wh different, but she wo (registered dietitian) 03/31/16 at approxim surveyor with a list th measurements per el admission, 14-day, a recorded the Reside	ent does not constitut statement. is not met as evidence rview and clinical doc taff failed to ensure a (minimum data set) f 24 Residents, Resid	to to to agnoses tension, sorder, phageal ase. URD of 15 in wed. It The ARD of tas 62 " ed that ght was e RD yor on ded height at The all while	F 278	5)	The DON and Administrator will atter at least a monthly care planning conference an will review the MDS / care plan information for accuracy. Any identificareas will be discussed with the interdisciplinar care plan team and Risk Management Committee Risk Management Committee will monitor compliance and report findings to the quarterly Quality Assurance Committee for action ar follow up as necessary.	d or ed ry k ee.	5/13/16

Printed: 04/14/2016 FORM APPROVED OMB NO 0938-0391

[TENOT ON WEDIOANE	A MEDICAID SERV	TOLO				OMR M	<u>0. 0938-039</u>
	MENT OF DEFICIENCIES LAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495126	;	B. WING			03/	31/2016
NAME	OF PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, ST.	ATE, ZIP	CODE	1	
WAD	DELL NURSING AND F	REHAB CENTER	202 PAI	NTER ST				
			GALAX	, VA 24333				
(X4) II PREF TAG	X (EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI F BE PRECEDED BY FULL ENTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	(EA	ROVIDER'S PLAN OF CORREC' CH CORRECTIVE ACTION SHOI S-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 30	60 " . RD stated the team was responsit heights. Surveyor s nursing) regarding hobtained, and she s she would have been to the attention of the to the attention of the meeting on 03/31/18 No further information. For Resident #11 ensure an accurate to " range of motion Resident #11 was according to the state of the s	led the Resident 's reconstruction of the facility staff faile MDS assessment in the facility littled on 05/26/15. Distented to anemia, hyper perlipidemia, demendisorder, gastroesophic kidney disease, coporosis, and psychological well-being, in the facility distented to the facility littled on 05/26/15. Distented to anemia, hyper perlipidemia, demendisorder, gastroesophic kidney disease, coporosis, and psychological well-being in the facility littled on 05/26/15. Distented to anemia, hyper perlipidemia, demendisorder, gastroesophic kidney disease, coporosis, and psychological well-being in the facility of the MDS coded the Resident as no impairment the MDS coded the Resident	e 's aide) ident director of s were ent #3, own. s brought if during a 230. or to exit. d to regards on iagnoses rtension, hageal oronary otic ARD of of 15 in function ient to ost esident pper and R y must to attain ial,	F 278		The attending physicians residents #2 was contacted on 3/30/16 and advised the blood pressure was not obtained and recorded for the week of 3/1/316 — 3/17/16. The attending physician for resident #2 did not provide any additional orders or change of orders. A 100% review of resident charts was conducted by the professional nursing staff	ed hat ot r ge t he	

RECEIVED

116 ED 91

	TMENT OF HEALTH					FOR	d: 04/14/20 MAPPROVE O: 0938-039	
STATEME		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	R/CLIA	1	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495126		B WING		03/	31/2016	
NAME OF	PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE			
WADDI	ELL NURSING AND F	REHAB CENTER		NTER ST , VA 24333				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI TBE PRECEDED BY FULL NTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 30	Based on staff inter review, the facility s physician ordered by residents. (Resider The findings included The facility staff failed blood pressures we Resident #2 was resident #2 with an ARD (Assess 12/31/15 scored the (Brief Interview of Ma possible score of coded as requiring emore staff members hygiene. During the clinical resident properties was noted the weekly blood pressured to 12/4/16 to 3/3/16 from 2/4/16 to 3/3/16	is not met as evidence view and clinical recutaff failed to follow on blood pressures for 1 at #2) and the facility of the fac	ord btaining of 24 n ordered ity on but not diabetes, nnia. The sment ate) of a BIMS of 3 out of s also of 2 or sonal esident 's d ordered uary 4, e obtained On	F 309	completed on 4/5/1 found no residents without obtained By appropriate and the attending physician notified of this on 4 3) In-service education provided by the Dir Staff Development professional nursing on 4/20/16 and 4/21 covering proper profer processing and following physician and notifications to attending physician missed orders. 4) The DON, ADON, a DSD will monitor donew physician and physician orders in physician orders in physician order sect the electronic health and will monitor 20 resident records for verification and monof compliance with physician orders by professional nursing and accurate reflect.	were /Ps as s were //S/16. a was rector of for the g staff //16 recedures a orders the of any and aily renewed the cion of a records % of nitoring the g staff		
	pressures obtained. weekly blood pressu The administrator, d	ire obtained and doc	umented.		the MARs and TAR DON will present fi to the Administrator	ndings		

F 314 483.25(c) TREATMENT/SVCS TO SS=D PREVENT/HEAL PRESSURE SORES

of the day at approximately 4 pm.

surveyor prior to the exit conference.

assistant director of nursing was notified of the

No further information was provided to the

above documented findings on 3/30/16 in the end

F 314

K48R11

RECEVED 18 of 28

5/13/16

APX 27 2016

monthly and will provide a

summary to the Quality Assurance Committee for

necessary monitoring and

follow up.

Printed: 04/14/2016 ED 91

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				FORM APPROVE OMB NO: 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495126	B WING		03/31/2016
NAME OF PROVIDER OR SUPPLIER		RESS, CITY, STA	ATE, ZIP CODE	
WADDELL NURSING AND		NTER ST , VA 24333		
PREFIX (EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
resident, the facility who enters the faci does not develop provided individual's clinical they were unavoided pressure sores reconservices to promote prevent new sores. This Requirement Based on observation interview and clinical staff failed to follow pressure ulcer prevent and the findings included For Resident #3 The findings included For Resident was weard boots. Resident #3 was and 10/20/15 and readmincluded but not liming multiful drug resistant malnutrition, deep verified disease, and the most recent quantity of the findings included the Section C, cognitive	orehensive assessment of a must ensure that a resident lity without pressure sores pressure sores unless the condition demonstrates that able; and a resident having eives necessary treatment and enhealing, prevent infection and from developing. It is not met as evidenced by: ion, Resident interview, staff all record review the facility physician's orders for ention for 1 of 24 Residents,	F 314	F314 1) Protective padded were placed on res and the residents h floated off the bed bed on 3/30/16. 2) 100% of residents orders for protective booties were review 4/1/16 by profession nursing staff and a found to have protective padded booties in padded booties in padded booties in provided to all nurs on the procedure for application and more of residents with one protective padded and this was conducted and this was conducted on 4/6/1 4) In-service education been conducted and concluded for nursion 4/22/16 on assess reviewing and implementation of assignment informations. 5) The DON, ADON will monitor daily the tracking and trending section of the electron health record for as 100% compliance wassignments. The Eupervisor will more daily all residents for	idents #3 eels were when in with we padded wed on onal ll were ective olace. on was sing staff or onitoring rders for oooties cted and 6. on has d ing staff ssing, the daily ation. and DSD he alert ong oonic sessing with daily RN Unit nitor

If continuation sheet Page 19 of 28

RECEIVED APR 27 2016 VDH/OLC

applications of protective

padded booties.

developing pressure ulcers.

Resident #3's CCP (comprehensive care plan) was reviewed on 03/30/16. It contained a care

Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICANE	A MILDIOAID OLIV	IOLO				T		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		(X2) MULTIP			(X3) DATE COMF	SURVEY PLETED	
	495126		B WING			03/31/2016		
NAME OF PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	TATE, ZIP C	CODE			
WADDELL NURSING AND F	REHAR CENTER	202 PAI	NTER ST					
WADDELL HOROMO AND	(mi);	i .	, VA 24333	}				
			.,				(X5)	
PREFIX (EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES THE PRECEDED BY FULL I ENTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	(EAC	ROVIDER'S PLAN OF CORRECT CH CORRECTIVE ACTION SHOU S-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	COMPLETION DATE	
F 314 Continued From page	ane 19		F 314	6)	The DON will present			
,	-	tions	,	,	findings to the Quality			
	rity Needs". Interven				Assurance Committee for	•		
under this care plar	n were "Bunny boots	qsniit.			necessary monitoring and		5/13/16	
					•	*		
	cal record was reviev				follow up.			
03/30/16. It contain	ed a physician' order	r summary						
for March 2016 whi	ich read in part "bunr	ny boots q						
shift every shift".								
·								
Surveyor observed	Resident #3 on 03/3	0/16 at						
approximately 1240). Resident was sittin	g up in						
bed, eating lunch, S	Surveyor asked Resid	dent #3 if						
she had her boots o	on and Resident state	ed "no I						
	there" and pointed to							
wardrohe Surveyor	r then went to unit nu	irse and						
	npany surveyor to Re							
	or asked unit nurse to							
Resident had her bi	unny boots on Resid	ient did						
not have bunny boo	ots on, and unit nurse	was						
unable to locate the	em in Resident's roor	n. Unit						
nurse stated that bo	oots were most likely	in the						
laundry, and she wo	ould call and get ano	ther pair						
sent.								
The concern of the	missing bunny boots	s was		F 315				
brought to the atten	tion of the administra	auve Statt						
	า 03/31/15 at approxi	mately		1)	The attending physicians i	for		
1230.					residents #3 was contacted	d		
No further information	on was provided prio	or to exit.			on 3/30/16 and advised th	at		
F 315 483.25(d) NO CATH	HETER, PREVENT L	JTI,	F 315		the urinary output was not	t		
SS=D RESTORE BLADDE	FR				obtained and recorded on			
33-D REGIONE DE 1001					multiple occasions in the			
Rased on the reside	ent's comprehensive				TAR. The attending			
accessment the fac	cility must ensure tha	nt a			physician for resident #3			
assessment, the lac	the facility without a	n			did not provide any			
					additional orders or chang	re.		
	is not catheterized ur				of orders.	,•		
	ondition demonstrates			2)	A 100% review of resident	.		
catheterization was	necessary, and a res	sident		4)				
who is incontinent o	of bladder receives ar	opropriate			charts was conducted by the	ie		
	ces to prevent urinar				professional nursing staff			
infactions and to res	store as much norma	ı bladder			completed on 4/4/16 and			

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

K48R11

If continuation sheet Page 20 of 28



DEPARTMENT OF HEALTH AND HUMAN SERVICES.

Printed: 04/14/2016 FORM APPROVED

CENTERS FOR MEDICARE	E & MEDICAID SERVICES			OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495126	B. WING		03/31/2016	
NAME OF PROVIDER OR SUPPLIER WADDELL NURSING AND	REHAB CENTER 2	ET ADDRESS, CITY, ST 02 PAINTER ST GALAX, VA 24333			
PRÉFIX (EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REGUL ENTIFYING INFORMATION)	ID ATORY PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION	
Based on staff inter the facility staff fail output for 1 of 24 for The findings included. For Resident #3 the foley catheter output the Resident #3 was a 10/20/15 and reading included but not liming multi drug resistant malnutrition, deep disorder, chronic orespiratory failure, reflux disease, and The most recent que 01/13/16 coded the Section C, cognitive and bladder coded indwelling foley cated. Resident #3's CCP was reviewed on 05 plan for "Urinary Details care plan include amount q shift (even Resident #3's clinic 03/30/16. It contain for March 2016 white output every shift for TAR (treatment address reviewed and contains the rev	is not met as evidenced by erview and clinical record reed to record foley catheter Residents, Resident #3. Ied: e facility staff failed to record to the facility on mitted on 11/11/15. Diagnostic organism, seizure disorder venous thrombosis, anxiety betructive pulmonary disor	eview rd ses on, er, der, eal of el	found no residents were without obtained urinary output as appropriate and the attending physicians were notified of this on 4/4/16. 3) In-service education was provided by the Director of Staff Development for the professional nursing staff on 4/20/16 and 4/21/16 covering proper procedure for processing and following physician orders and notifications to the attending physician of any missed orders. 4) The DON, ADON, and DSD will monitor daily new physician and renewe physician orders in the physician orders in the physician order section of the electronic health record and will monitor 20% of resident records for verification and monitoring of compliance with physician orders by the professional nursing staff and accurate reflection in the MARs and TARs. The DON will present findings to the Administrator monthly and will provide a summary to the Quality Assurance Committee for necessary monitoring and follow up.	es s d ds	

Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A BUILDING		(X3) DATE SURVEY COMPLETED		
		495126		B WING		nemankakan dari dari dari dan masaya sa sa kara dari dari daharan dari.	03/3	1/2016
	PROVIDER OR SUPPLIER LL NURSING AND F	REHAB CENTER	202 PA	DRESS, CITY, STA LINTER ST K, VA 24333	ATE, ZIP CODI	=		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCII T BE PRECEDED BY FULL I ENTIFYING INFORMATION)		ID PREFIX TAG	(EACH C	DER'S PLAN OF CORRECT ORRECTIVE ACTION SHOU FERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 323	areas where nothin shown to the DON development nurse 1430. DON stated to some problems with changed echarting program had only be everyone was still lead to the concern over the brought to the attenduring a meeting or 1230. No further information 483.25(h) FREE OF HAZARDS/SUPER' The facility must encenvironment remain as is possible; and eadequate supervision prevent accidents. This Requirement is Based on observation determined the facility states.	ntry contained multip ig was recorded. The (director of nursing) a on 03/30/16 at appro- the nurses had been h documenting since programs. She state been in use 30 days, a earning it. The missing foley outposition of the administra- in 03/31/16 at approxi- on was provided priors.	e TAR was and staff oximately having they had do the new and the staff mately or to exit. It hazards es vices to ed by: It was o the	F 315	F323 1)	Disinfectant and skin was removed and place into a locked cabinet i shower room on 3/30/containers of Clorox v 70 clean razors, 6 moi barrier creams, and 1 skin prep were remove from the main floor clutility room and store lock. This was done of 3/30/16. The Housekeeping Supervisor inspected a shower rooms on 3/31	n the 16. 6 vipes, sture box of ed ean under on	
		0 PM the following nade in the Unit II sho und to be unlocked w				and found none with a unlocked disinfectant Clorox wipes, razors, moisture barriers creat skin prep and did not any items deemed hazardous.	or ms or	
	a. A one gallon plas	tic jug of "Betco Disir	nfectant					

Printed: 04/14/2016

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	AND HUMAN SERV & MEDICAID SERV	/ICES /ICES				. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	R/CLIA	1' '	CONSTRUCTION	(X3) DATE SI COMPLE	
	495126	;	B. WING		_ 03/3	1/2016
NAME OF PROVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE		
WADDELL NURSING AND F	REHAB CENTER	1	NTER ST , VA 24333			
PREFIX (EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCE THE PRECEDED BY FULL ENTIFYING INFORMATION	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
shower floor undernlabel indicated "Dar irreversible eye dar Harmful if inhaled b. A one gallon bot "Derma Science" si the floor of the show label cautioned "exc. An unidentified y spray bottle hangin next to the tub was CNA I was found at the showers were of they are done "for rewould be doing son CNA I was asked to the shower room to CNA I told the surve bottle was PH7Q cleaner contained in said they were supply gallon containers we shower roombut the bottle on the hook with these findings at 3/3 2. The facility staff room on the main fleat hazardous materials On 3/30/16 at 10:20 assistant of nursing on the main floor in used by residents under the staff of the said they residents under the said they were supply gallon containers we shower roombut the bottle on the hook with the said they were supply gallon containers we shower roombut the said they were supply gallon containers we shower roombut the bottle on the hook with the pool of the main floor in used by residents under the pool of the main floor in used by residents under the pool of the	PH7Q) was found on neath an overbed tain neath a void contact title of D kin care lotion was a wer by staff member ternal use only." Yellow liquid containing about four feet off also found. If the nursing desk are done for the day. CN now" but said second ne later in the evenire accompany the sure identify the items for eyor the fluid in the set on the disinfectant and in the large gallon both oposed to lock up the iden they were not in they generally left the where it was found.	ble. The ses with skin. Ilso left on s. The ed in a the floor and asked if A I said d shift ed. Iso left on s. The ed in a the floor and there. Expray floor ttle. CNA I large a the espray ened of ean Utility and the ty room is being m the	F 323	3) In-service ed been conduct concluded for on 4/15/16 of proper storal materials with 4) The Mainten has placed le cabinets in a shower room locked storal in all clean upon the shower room utility rooms storage of district other items of hazardous 6) The DON, Reference of Manager and Supervisor upon the shower room utility rooms storage of district other items of hazardous 6) The DON, Reference of Manager and Supervisor upon the storage of district of the storage of the storage of district of the storage of the storage of the storage of district of the storage	ducation has cted and for nursing staff concerning ge of hazardous ithin the facility nance Director ocked storage full facility ns and placed age wall cabinets futility rooms. It Manager and fung Supervisor or daily all funs and clean for proper fisinfection and deemed RN Unit d Housekeeping will present	5/13/16

stored on the shelves: 6 containers of Clorox wipes, 70 clean razors and 6 moisture barrier

)16 ED

		AND HUMAN SERV & MEDICAID SERV						Printed: 04/14/20 FORM APPROVI MB NO: 0938-03
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		(X2) MULTIPLE A. BUILDING _			(X3) DATE SURVEY COMPLETED
		495126		B. WING		kanasankaydan eresik him mikki lihal dissipa didekki aya dissipa kiril kiril kiril kiril kiril kiril kiril kir		03/31/2016
NAME OF F	PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CO	DE		
WADDE	LL NURSING AND F	REHAB CENTER	1	NTER ST , VA 24333				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE FBE PRECEDED BY FULL I NTIFYING INFORMATION)	ES REGULATORY	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRECTIVE ACT REFERENCED TO T DEFICIENCE	TON SHOULD I	BE COMPLETIO
F 323	products that was a out of the reach of the warning that state amounts of water. The assistant direct if this door should rehad the above document that the above document that the above document that the above document that the assistant direct An observation was and the door to this floor was locked. The surveyor on the assigned the task on otified of each of the were made by this so the day conference of nursing was notified findings. The direct door has never bee No further information.	of skin prep. On these warning that stated children ". Also, not ated " If ingested, dri Call Physician. " tor of nursing was assemain locked if these amented warnings or tor stated " No I gue a made on 3/31/16 at clean utility room on the survey team that we fenvironmental Rounds assurveyor. Eximately 4 pm in the atministrator arised of the above doctor of nursing stated	" Keep ed was nk large sked about e products n them ss not." 10 am n the main as inds were s they e end of nd director umented " That	F 323				
F 504 SS=D	483.75(j)(2)(i) LAB 3 ORDERED BY PHY The facility must pro services only when physician.	SVCS ONLY WHEN 'SICIAN ovide or obtain labora ordered by the atten s not met as evidence	atory ding ed by:	F 504	F 504 1)	The attending resident #10 ar contacted on 3 advised that an (hemoglobin a hematocrit) wa resident #10 ar digoxin level v	nd #14 was /30/16 and i H & H nd as obtained on that a was obtained	n
	Based on staff interview and clinical record review, the facility staff obtained unnecessary lab					on resident #14 digoxin was di		

No new orders or change of

orders were provided by the attending physician.

The findings included.

#14.

tests for 2 of 24 Residents, Residents #10 and

1. For Resident #10, the facility staff obtained the

Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

03/31/2016

STATEMENT	OF	DEFICIENCIES
AND DUANCO		

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER

(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
A. BUILDING	COMPLETED

495126

B. WING

WADDELL NURSING AND REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

202 PAINTER ST **GALAX, VA 24333**

(X4) ID PRFFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

F 504

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

F 504 Continued From page 24

lab test H & H (hemoglobin and hematocrit) without a physicians order.

Resident #10 was admitted to the facility 03/14/14. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, respiratory failure, sleep apnea, hypertension, and hyperglycemia.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 02/11/16 included a documented summary score of 14 out of a possible 15 points.

The Residents clinical record included a copy of the lab test H & H that was dated 02/01/16. During the record review the surveyor was unable to locate a physicians order for this lab test.

On 03/30/16 at approximately 10:30 a.m. LPN (licensed practical nurse) #2 was asked about the lab test.

On 03/3-16 at approximately 1:50 p.m. LPN #2 verbalized to the surveyor that she was unable to find a physicians order for this lab.

On 03/30/16 at approximately 4:35 p.m., during a meeting with the survey team, the administrator, DON (director of nursing), ADON (assistant director of nursing), and staff development coordinator were notified that the lab test H & H was obtained on Resident #10 without a physicians order.

No further information regarding this issue was provided to the survey team prior to the exit conference.

- A 100% review of resident charts was conducted by the professional nursing staff completed on 3/31/16 and found no residents with nonphysician ordered laboratory tests.
- The facility has 3) implemented a new Electronic Health Record which will provide daily alert and scheduled tracking information for laboratory testing. The unit secretary will monitor the tracking information daily and will prepare the appropriate laboratory paper work to be acknowledged by the charge nurse. The RN Unit Supervisor will monitor 100% of resident charts for completion of scheduled and physician ordered laboratory tests.
- 4) The DON and ADON will monitor daily the alert tracking and trending section of the electronic health records and will monitor 100% of resident records for necessary laboratory results. The DON will present findings to the Quality Assurance Committee for necessary monitoring and follow up.

5/13/16

K48R11

If continuation sheet Page 25 of 28

RECEIVED APR 27 2016

VOH/OLG

Printed: 04/14/2016

DEPART CENTER	MENT OF HEALTH.	AND HUMAN SERV & MEDICAID SERV	ICES ICES				M APPROVEI O. 0938-039	
		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	DER/SUPPLIER/CLIA		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495126		B. WING		03/	31/2016	
	PROVIDER OR SUPPLIER LL NURSING AND F	REHAB CENTER	202 PAI	RESS, CITY, STA	ITE, ZIP CODE			
				, VA 24333		POPOTION	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCII BE PRECEDED BY FULL I NTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETION DATE	
F 504	Continued From pa	age 25		F 504				
	digoxin level lab tes	1, the facility staff obt st on 02/26/16. The F had been discontinu	Residents					
	12/04/14. Diagnose limited to, anemia, o	admitted to the facility es included, but were dementia, mood disc ension, and chronic p	not order,					
	quarterly MDS (min with an ARD (asses	e patterns) of the Re imum data set) assessment reference data documented summable 15 points.	essment te) of					
	The Residents clinical record included the results of a digoxin lab test obtained on 02/26/15. The results were documented as < (less than) 0.20. The reference range on this lab was documented as 0.9-2.0.		l5. The n) 0.20.					
	lab test. After review verbalized to the su medication digoxin	2 was asked about twing the clinical reconveyor that it did lool had been discontinuted the lab test had be	rd LPN #2 k like the ed and					
	meeting with the su DON (director of nu	roximately 4:35 p.m. rvey team, the admin rsing), ADON (assis and staff development otified of the above.	nistrator, tant					

F 514 483.75(I)(1) RES SS=D RECORDS-COMPLETE/ACCURATE/ACCESSIB

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

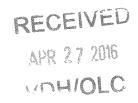
conference.

No further information regarding this issue was provided to the survey team prior to the exit

K48R11

F 514

If continuation sheet Page 26 of 28



Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION	STATEMENT AND PLAN O			
------------------------	-------------------------	--	--	--

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

495126

(X2) MULTIPLE CONSTRUCTION	(X3) D
A. BUILDING	C
B. WING	

(X3) DATE SURVEY COMPLETED

03/31/2016

NAME OF PROVIDER OR SUPPLIER

WADDELL NURSING AND REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

202 PAINTER ST GALAX, VA 24333

(X4) ID SUMMARY STATEMENT OF DEFICIENCIES
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

F 514

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 514 Continued From page 26

LE

The facility must maintain clinical records on each 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 observation, Resident interview and clinical record review the facility staff failed to ensure a complete and accurate clinical record for 1 of 24 Resident's, Resident #3.

The findings included:

For Resident #3 the facility staff failed to ensure complete and accurate MAR (medication administration record) and TAR (treatment administration record).

Resident #3 was admitted to the facility on 10/20/15 and readmitted on 11/11/15. Diagnoses included but not limited to anemia, hypertension, multi drug resistant organism, seizure disorder, malnutrition, deep venous thrombosis, anxiety disorder, chronic obstructive pulmonary disorder, respiratory failure, dysphagia, gastroesophageal reflux disease, and end stage renal disease. The most recent quarterly MDS with an ARD of 01/13/16 coded the Resident as 9 out of 15 in Section C, cognitive patterns.

F 514:

- 1) Resident #3's MAR record was reviewed and corrected to reflect the actual physician order "ensure one time a day for Protein Calorie Malnutrition" and "maintain catheter drainage bag below the bladder level" on the TAR was reviewed and corrected by the floor nurse. This was completed on 3/31/16 as late entry noted in the medical records.
- 2) Resident MAR and TAR records were reviewed by the licensed professional nurse on each floor and by the ADON completed on 4/6/16 and found all MAR and TAR records matched physician orders and signed by the nurse. No corrections were necessary.
- In-service education
 concerning the policy for
 medication administration and
 testament administration
 records and accuracy per
 physician orders and a
 completed accurate medical
 record was conducted on
 4/20/160and 4/21/16 by the
 DON and DSD.
- 4) The Unit Managers will monitor the resident's MAR and TAR record daily and review the electronic health record to-do list for accuracy and completion of the resident's medical record.

RECEI confinential sheet Page 27 of 28

APR 27 2016

VDH/OLC

Printed: 04/14/2016 FORM APPROVED OMB NO: 0938-0391

CENTE	ERS FOR MEDICARE	: & MEDICAID SERV	ICES			OMB NO. 0938-0391
STATEME	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	ER/CLIA	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495126	;	B. WING		03/31/2016
	PROVIDER OR SUPPLIER ELL NURSING AND F	REHAB CENTER	202 PAI	DRESS, CITY, STA LINTER ST K, VA 24333	ATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIENT OF DEFICIENCIENT OF DEFICIENCIENT OF THE PROPERTY OF	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION DATE
F 514	03/30/16. It contains for March 2016 whistime a day for Prote "maintain catheter of level". Resident #3's MAR 03/30/16. It contains "Ensure on time a d Malnutrition". This e 03/25/16. Resident administration recor 03/30/16. It contains "maintain catheter of level". This entry ha 03/25/16. Surveyor observed approximately 1240 bed, eating her lunc of Ensure with a stratray. Surveyor asked Ensure with her lunc day". Surveyor observed trainage bag hanging the Resident's bed for level. The concern over the brought to the attent during a meeting on 1230.	age 27 cal record was review hed a physician' order ich read in part "Ensuein Calorie Malnutritic drainage bag below be a for March were reviewed an entry which ready for Protein Calorie entry had not been signed an entry which ready for March was revied an entry which read an entry which read an entry which read an entry which read and not been signed or Resident #3 on 03/30. Resident was sitting the Resident if she alword and Resident if she alword and Resident state erved Resident's cathing in privacy bag attaframe, placing it below the missing document attorn of the administration of the administration of was provided prior on was provided prior on was provided prior in the missing document and 03/31/16 at approximation on was provided prior on was provided prior in the part of the provided prior in	r summary ure one on" and bladder ewed on ead in part ie igned on ead in part bladder on	F 514	5) The DON, ADON and will conduct daily reviet the electronic health reand conduct monthly reof 25% of the resident for compliance with phorders and medication administration. Results shared with the Risk Management Committee. 6) Risk Management Conwill monitor compliance weekly and report finds the quarterly Quality Assurance Committee action and follow up as necessary.	ew of cord eviews records hysician s will be ee. mmittee ce lings to for