PRINTED: 08/24/2016 391

		E & MEDICAID SERVICES			FORM APPRO' OMB NO: 0938-0
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495126	B WING		C 08/04/2016
NAME OF	PROVIDER OR SUPPLIER		L S	FREET ADDRESS, CITY, STATE, ZIP CODE	
WADDE	LL NURSING AND RE	HAB CENTER	1	02 PAINTER ST ALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETE
F 000	INITIAL COMMENT	· · · · · · · · · · · · · · · · · · ·	F 000	This Plan of Correction will serve facility's allegation of compliance requirements of 42 CFR, Part 483, B for long term care facilities. Pre	with the Subpart paration
	survey was conduct 08/04/16. Two (2) C Corrections are requ	Medicare/Medicaid Abreviated ted 08/03/16 through Compalints were investigated uired for compliance with 42 direments for Long Term Care		and submission of the plan of corre in response to the CMS 2567 for the and does not constitute an agreeme admission by Waddell Nursing and Center of the truth of the facts alles correctness of the conclusions state statement of deficiencies. This plan correction is prepared and submittee	ection is ne survey ent or I Rehab ged or ed on the n of
	121 at the time of th consisted of three ( (Residents #1 through 483.10(e), 483.75(l)		F 164	because of the requirements under federal laws. Waddell Nursing and Center contends that it was in subscompliance with the requirements CFR, Part 483, Subpart B throught time period stated in the statement deficiencies. In accordance with statement law, however, Waddell Nursian Rederal Rederal law, however, Waddell Nursian Rederal Red	I Rehab tantial of 42 but the of cate and rsing and
	The resident has the	e right to personal privacy and or her personal and clinical		Rehab Center submits this plan of of to address the statement of deficient to serve as it's allegation of complithe pertinent requirements as of the stated in the plan of correction and complete in all areas as of Septemb 2016	acies and ance with dates as fully
	medical treatment, w communications, pe meetings of family ar does not require the	ludes accommodations, vritten and telephone rsonal care, visits, and nd resident groups, but this facility to provide a private		F 164: 1) Resident #1 was intervie the Social Services Dire	•
:	section, the resident	n paragraph (e)(3) of this may approve or refuse the and clinical records to any		and RN Medicare Case Manager to discuss privand confidentiality issu August 3, 2016 at 5:10 Resident #1 was assure privacy would be maint	vacy es on o.m. d that
i i	and clinical records or resident is transferred institution; or record r	o refuse release of personal does not apply when the d to another health care release is required by law.		by knocking on the doo announcing themselves entry into the room. Re #1 was advised to let th Social Services Director if this was not the case.	r or prior to sident e
		o confidential all information dent's records, regardless of		in any was not the case.	
OPATORY	NEETOR'S OF PROVIDE	DISTIDUTED DEDDECENTATIVES SIGNA	THAT	TITLE	(X6) DATE

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

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Facility ID: VA0257

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CENTE	RS FOR MEDICAR	E & MEDICAID SERVICES			OMB NO. 0938-0
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPL A BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495126	B WING		C 08/04/2016
	PROVIDER OR SUPPLIER		20	TREET ADDRESS, CITY, STATE, ZIP CODE D2 PAINTER ST ALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETI
	release is required healthcare institution contract; or the resemble contract and contract	methods, except when by transfer to another on; law; third party payment ident.  NT is not met as evidenced tion and staff interview it was facility staff failed to ensure a Residents in the sample in acility staff person failed to herself prior to entering	F 164	<ul> <li>2) All interviewable residents interviewed about any violations of their rights, privacy or dignity, which completed on 8/4/16. Far members, who visit were instructed on resident's riprivacy and dignity protocoloby the Social Services Director. Non-interviewal residents and those without visiting family members who be monitored daily by the Social Services Director, Managers, ADON, DON Administrator for complia with residents rights, privand dignity.</li> <li>3) All employees were provided service information on 8/3 addressing maintaining of resident's rights.</li> <li>4) Facility Unit Managers will monitor daily the actions of staff to assure for protecting the rights, privacy and dignof the residents as part of assignments.</li> <li>5) At each resident council methe residents will be asked see if there are any issues concerns about any violation of their rights, privacy or dignity by the Council President and staff member attendance.</li> </ul>	was nily ghts, cols ble ut will Unit and ance acy ed in- 5/16 f  of the ng inity their eting to or ons

alarms or mats as safety precautions on Resident

On August 3, 2016 at 10:30 a.m. the surveyor



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		I WIND LIGINIAN SEKAICES				FORM APPROV
CENTE	ERS FOR MEDICARE	E & MEDICAID SERVICES			O	MB NO. 0938-03
	NT OF DEFICIENCIES LOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		495126	B WING			C 08/04/2016
NAME OF	PROVIDER OR SUPPLIER	A	<u> </u>	STREET ADDRESS, CITY	, STATE, ZIP CODE	1 00/0 11.23.2
WADDE	TI MITOSING AND DE	UAD CENTED		202 PAINTER ST		
VVADDE	ELL NURSING AND RE	HAB CENTER		GALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD NCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
	the clinical record pridentified that Resid fractured left femuridentified that Resid Continued review of the Comprehensive surveyor reviewed the comprehensive surveyor reviewed the identified the following Interventions:  "Focus Risk for falls falls, use of psychotobalance, poor coording impairments, poor disorder, Dementia, resident in floor besid (right) arm wedged by (side rail). Sent to Effinjury. Date initiated: 06/13/16. Intervention of bed date initiated: 06/13/16. Inte	#1's clinical record. Review of produced documentation that dent #1 recently had a a and the clinical record also dent #1 was at risk for falls. If the clinical record produced a Care Plan (CCP). The che CCP. Review of the CCP and Focus area and a characterize by history of propic medications, impaired dination, pain, Memory decision making, Psychiatric impaired cognition, 6-12 ide bed facing window. Repow (between) bed and s/r R (Emergency Room). no 03/07/16. Revision on ons Mat in floor on right side 6/14/16. Pressure alarm on 6/20/2016." (sic) at 2 p.m. the surveyor once ident #1 lying in bed. And the left leg. The surveyor ed alarm or a fall mat on the ed bed. In fact a fall mat was	F 1	6) The facility in Director, A will conduct determine in maintaining privacy and concerns it addressed a employee / and correct in an addressed in a correct in the intermined	Social Services ADON and DON act monthly rounds to compliance with ag resident rights, d dignity. Any dentified will be at that time with the / resident involved ted. dervices Director, d DON will report ags to the attor at the monthly gement Meeting. / Administrator will onthly rounds of e facility to observe ance with ag resident rights, d dignity. Any oncerns will be of formulate a plan Risk Management will monitor and report findings erly Quality Committee for	9/7/16

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the CCP identified Resident #1 was at risk for falls and that the nursing interventions of a bed

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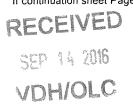
	& MEDICAID SERVICES			OMB NO. 0938-03
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
	495126	B WING		08/04/2016
NAME OF PROVIDER OR SUPPLIER  WADDELL NURSING AND REH	IAB CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 202 PAINTER ST GALAX, VA 24333	
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
should have been in On August 3, 2016 a asked RN# 1 to accord Resident #1's room to interventions of a beinght side of the bed interventions of a beinght side of the surveyor walked RN (#1) entered Resident growth in the side of t	the right side of the bed place. It 2:05 p.m. the surveyor down to to determine if the nursing d alarm and a fall mat on the were in place. RN (#1) and down to Resident #1's room. Sident #1's room without any herself. Resident #1 was not #1's roommate was not the room. It 2:10 p.m. the surveyor she (RN #1) had entered without knocking or RN (#1) stated, "Yes maim, I or focused on what you had to 3:45 p.m. the surveyor ator (Adm) and Director of RN (#1) had entered without knocking or to entering the room. Intion was provided as to why to ensure and provide #1.  Exercise 1.	F 16		and itored ms it. with e is igns

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Event ID: NU1211

Facility ID: VA0257

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CENTERS FOR MEDIC	ADE & MEDICAID SERVICES			OMB NO. 0938-039
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ` ′	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
	495126	B WING	,	08/04/2016
NAME OF PROVIDER OR SUPPL	JER		STREET ADDRESS, CITY, STATE, ZIP	CODE
			202 PAINTER ST	
WADDELL NURSING AND	REHAB CENTER		GALAX, VA 24333	
PREFIX (EACH DEFICI	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE COMPLÉTION E APPROPRIATE DATE
F 225 - 0 - 1 - 1 - 1 - 1			2) Social Services Directo	or and RN
F 225 Continued From			MDS Director have	
	ss for service as a nurse aide o		interviewed all currer	nt
	ff to the State nurse aide registi	ry	residents starting 8/4/	
or licensing auth	norities.		any issues of abuse a	
7907A - 717A			incidents of unknowr	n origin
	t ensure that all alleged violation	ns	and found none.	
<u> </u>	atment, neglect, or abuse,		3) All staff have been in-s	
	s of unknown source and	tod	completed on 8/12/16	
	n of resident property are report he administrator of the facility a		provided a copy of th	
	in accordance with State law	iiia	resident's rights polic	
	hed procedures (including to th	e	and neglect policy an	
•	d certification agency).	Ü	Virginia Mandated R	
Otate survey and	a continuation agency).		requirements, for imr	
The facility must	have evidence that all alleged		reporting, along with procedures for report	
	proughly investigated, and mus	t	injuries of unknown	
	ootential abuse while the		their immediate supe	<del>-</del>
investigation is i			In-0services will be h	
·			throughout the year a	
The results of al	I investigations must be reporte	ed	annually. All newly	
	itor or his designated		employees will be in-	
	nd to other officials in accordan	ice	at the time of hire on	
with State law (ir	ncluding to the State survey and	t	policies addressed.	W.I.
	ncy) within 5 working days of the		4) Risk Management Con	nmittee
incident, and if the	ne alleged violation is verified		will meet daily to rev	
appropriate corre	ective action must be taken.		address all facility ev	
			will complete an Eve	
			Tracking Form for	
			investigation and will	l submit
	IENT is not met as evidenced		their finding to the Q	
by:			Quality Assurance Co	ommittee
	nterview, facility document		for review and necess	- 1
review, clinical re	ecord review, interview with the		actions. All determin	
	n and in the course of a		injuries from the Risk	1
	igation, it was determined that		Management Commi	
	ailed to implement facility policy		unknown origin will	
and procedure re	egarding reporting an injury of	<i>C)</i>	immediately reported	l and
unknown origin to	Adult Protective Services (AP	<i>3)</i>	investigated by the	

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and to the State Agency. The Findings Included:

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Facility ID: VA0257

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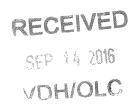
PRINTED: 08/24/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495126	B. WING		C
NAME OF	PROVIDER OR SUPPLIEF		B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	08/04/2016
	LL NURSING AND RI			202 PAINTER ST GALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOUNDER CORREST TO THE APPROPRICE OF THE APPROPR	JLD BE COMPLETIC
	regarding Residen received in the Sta 7/28/16. The Comp who will be identified an injury of unknown whether the injury of reported to the Star On August 3, 2016 reviewed the policy. Neglect, and Misap Reporting Policy. The part "It is the be withheld) Nursing Fighther the right to be free than and misappropriations seeks to prevent vertice mental abuse, corporting against abuse (name thome has developed components: screen identification, invest reporting/responsed event of suspicious patterns, and trends nurse will complete addition, the family a C. The Administrator Director of Social Seethe event VII. Resoft investigation will be agencies within 5 word administrator or designation agency 2 icensing authority. 3 4. Resident and/or Resident #1 was an according to the side of the	received two Complaints t #1. The Complaints were te Agency on 6/24/16 and plaints alleged that a Resident, ed as Resident #1, sustained who origin and questioned of unknown origin had been	F 2		g s s

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Facility ID: VA0257

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			(	OMB NO	O. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '		CONSTRUCTION		ATE SURVEY OMPLETED
		495126	B WING	MANO TO PROGRAMME TO STREET		08	C 8/04/2016
NAME OF	PROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
WADDEL	L NURSING AND RE	HAD CENTED		202 [	PAINTER ST		
AAMDDLL	L NORSING AND RE	HAD CENTER		GAL	AX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 225	Continued From pa	ge 6	F 2:	25			
	· ·	, but were not limited to:					
		tion, urinary tract infection,					
		emur, dementia without					
		diabetes mellitus and being					
	Bipolar.						
	The most current Minimum Data Set (MDS)						
	assessment located						
	30 Day Medicare MDS assessment with an Assessment Reference Date (ARD) of 7/15/16.						
		ed that Resident #1 had a					
	Cognitive Summary Score of 11. The facility staff						
	also coded that Resident #1 required extensive						
		care (4/2) with Activities of					
	Daily Living (ADL's).						
		y staff coded that Resident					
		CIFIED FRACTURE OF LEFT					
	FEMUR, SEQUELA	it 10:15 a.m. the surveyor					
		#1 lying in bed. Resident #1					
		t side. A brace was observed					
	on her left leg.						
		it 10:30 a.m. the surveyor					
		1's clinical record. Review of	,				
		oduced nursing notes dated					
		The notes read in part					
		45 a.m.) Note Text: Heard					
		! Will you come here! CAN sistant) entered room and					
		ith her upper torso still on the					
		dy hanging off of R (right)					
		s holding on to side rail. No					
	injury noted. Assisted	d back to bed. Stated, "How					
		r? She is dead and I must					
		t to her." One-on-one time					l
		Attempted to redirect her					
		for distraction. Call light					
	within reach." '5/28/16 14:11 (2:11)	p.m.) placed resident on					
	JIZOI 10 14. 11 (Z. 11	p.m., piaceu resident on					1

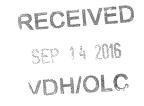
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rounds list for left leg and foot pain."

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					IO. 0938-03
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			CONSTRUCTION	(X3) [	DATE SURVEY COMPLETED
		495126	B WING		er ook on die Ooste ombooks die daar die ook on die Japanese in 1900 van de projekt van die Ooste		C 08/04/2016
NAME OF	PROVIDER OR SUPPLIER		************	STR	REET ADDRESS, CITY, STATE, ZIP CODE		
WADDE	LL NURSING AND RE	HAB CENTER			PAINTER ST LAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
	am "my leg is broke left leg and when Reattempted resident syellow bruise observappears to be slight any fall or recent injunonambulatory and transfers. VSS (vital resident to be transf withheld) ER (emergevaluation. Report withheld) ER nurse. (responsible person leave a voicemail, woontact."  "5/30/16 1113 (11:13 medical services (Entransport resident to ER. Bed hold policy "5/30/16 1622 (4:22 of hospital withheld) EMS. Fx (fracture) and has Immobilizer to be wo removed for bathing need to be scheduled doctor withheld) or (resoon as possible, as was on call today. Renurse at hospital with received Tylenol #3 at 1235 (12:35 p.m.) an Returned with NO (netab (tablet) po (by motion of the service of the services) and the services of the servic	55 a.m.) Resident stating this in". Resident gauarding the OM (range of motion) acreams out in pain. Light wed over knee and knee by swollen. Resident denies uries. Resident is requires use of lift for signs). 911 notified and derred to (name of hospital gency room) for further called to (name of hospital Unable to reach RP) at this time and can not ill continue to try and S a.m.) (name of emergency MS) withheld) EMS arrived to (name of hospital withheld)	F 2	25			

bed at this time. Call light within reach. Still unable to reach Family, (mane of family members withheld). Left another voice mail on Cell phone



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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	D. 0938-039
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	PROVIDER OR SUPPLIER	HAB CENTER		202 PAIN	ADDRESS, CITY, STATE, Z INTER ST X, VA 24333		material de la companya de la compa
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	X C	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	member withheld) to possible." (sic) Further review of the document titled After hospital dated 5/30 that Resident #1 has sent back to the nur immobilizer. Continued review of a physician Progress note read "06/02/Demented WF (white (fracture). Pt (patient appropriately treated leg pain progressed to the ER where xrawas initially no swell became more localized decision to get the Ethere was a yellow of left knee. There was 5/20/16 staff document had upper torso on the extremities hanging She was assisted back to She was more confut tho. Our assessment osteoporosis may have occurred where the sessentially spontane may have occurred when the sessentially spontane may have occurred while there was no face while there was no face possible t	umbers for (name of family o contact family as soon as e clinical record produced a er Care Instruction from a local 1/16. The document identified d a fracture and was being rsing home with a knee of the clinical record produced is Note dated 6/2/16. The 2016 12:31 (12:31 p.m.) the female) with left distal fx. In the contributed to the expectation of the contributed to the expectation. The pain is no fall or clear injury. But on the bed but lower body and off the right side of the bed. For injury, none found, and the bed but lower body and off the right side of the bed. For injury, none found, and the bed but lower body and off the right side of the bed. For injury, none found, and the bed but lower body and off the right side of the bed. For injury, none found, and the bed but lower body and off the right side of the bed. For injury, none found, and the bed but lower body and off the right side of the bed. For injury, none found, and the bed but lower body and off the right side of the bed. For injury, none found, and the bed but lower body and off the right side of the bed. For injury, none found, and the bed but lower body and off the right side of the bed. For injury, none found, and the bed but lower body and off the right side of the bed. For injury, none found, and the bed but lower body and off the right side of the bed. For injury, none found, and the bed but lower body and off the right side of the bed. For injury, none found, and the bed but lower body and off the right side of the bed. For injury, none found, and the bed but lower body and off the right side of the bed. For injury, none found, and the bed but lower body and off the right side of the bed. For injury, none found, and the bed but lower body and off the right side of the bed. For injury, none found, and the bed but lower body and off the bed but lower bo	F 2	25			

a bit more confused than normal, her leg is in an immobilizer. Cor-rr pulm-abd- soft (coronary/heart



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CENTE	ERS FOR MEDICARE	E & MEDICAID SERVICES				VO. 0938-039
	NT OF DEFICIENCIES LOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	LTIPLE CONSTRUCTION DING		DATE SURVEY COMPLETED
	,	495126	B WING	***************************************		C 08/04/2016
NAME OF	F PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP COD		JU/U-TILU IU
-414 (2) (2) (2)	······································	The state of the s	1	202 PAINTER ST		
WADDE	ELL NURSING AND REI	HAB CENTER		GALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		OULD BE	(X5) COMPLETION DATE
F 225	Continued From pag	age 9	F 2:	25	*	
	rate regular, pulmor negative and soft) n Left spontaneous di (name of physician (sic) On August 3, 2016 a notified the Administ Nursing (DON) of th requested to see the to Resident #1's left asked if the facility sunknown origin to th stated that they had believed the fracture 5/20/16 when Reside of the bed. The surv Administrative Team discovered until 5/30 incident that occurrenotified the AT that the definitively prove that the incident on 5/20/of unknown origin and to the APS and the Slocated the regulation injuries of unknown of the expectations regaorigin with the Adm. knew what the regular injures of unknown of the AT that once the idetermined it should State Agency and that up the facility could hotes, staff interviews	nary/lungs negative, abdomen not left leg in immobilizer. A/P: listal femur fracture. To see Dr withheld) for definitive care."  at 3:45 p.m. the surveyor strator (Adm) and Director of the Complaints. The surveyor e investigative details related to femur fracture. The surveyor staff had reported the injury of the State Agency. The Adm if done and investigation and the was caused by the event on dent #1 was found hanging out the veyor notified the (AT) the fracture was not 0/16, a full ten days after the ed on 5/20/16. The surveyor				

result of the occurrence on 5/20/16. The surveyor notified the AT that the Complaints would be substantiated with deficient practice.



PRINTED: 08/24/201 FORM APPROVEI OMB NO. 0938-039

CENTE	CKS FOR MEDICARE	& MEDICAID SERVICES				OMB NO. 0938-03
1	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	TIPLE CONSTR	UCTION	(X3) DATE SURVEY COMPLETED
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F 225	Ombudsman met woombudsman stated complaints from far left femur fracture of Ombudsman stated documentation/reporthe left femur fracture. No additional inform the facility staff faile and procedures and regulations regarding unknown origin to A	at 8:55 a.m. the local rith the surveyor. The I that she had received rily members regarding the n Resident #1. The I she had not received any orts from the facility related to receive to implement facility policies I State and Federal g reporting injuries of PS and the State Agency. The part of the state Agency and the state Agency and the state Agency and the State Agency and 1278 and 323.	F 2	25		
	483.20(g) - (j) ASSE ACCURACY/COOR The assessment muresident's status. A registered nurse meach assessment with participation of healt A registered nurse massessment is comp	SSMENT DINATION/CERTIFIED  ast accurately reflect the  nust conduct or coordinate th the appropriate h professionals.  nust sign and certify that the leted.	F 27	2)	the accurate limitations in the extremities was corrected on 8/4/16. Resident #2 MDS c to reflect accurate fall with a injury was corrected on 8/4/All residents with limitation extremities and / or injury stafter falls MDS records were reviewed was completed on 8/4/16 by the MDS coordinated and found to be accurately c with no corrections necessar	the lower n coding major /16. as in the tatues re ators coded ry.
	assessment must sig that portion of the as Under Medicare and willfully and knowing false statement in a r	completes a portion of the gn and certify the accuracy of sessment.  Medicaid, an individual who y certifies a material and esident assessment is ey penalty of not more than		3)	The DON and DSD provide service education to the me of the care planning team o MDS and care planning requirements and accurate assessments on 8/9/16.	embers

\$1,000 for each assessment; or an individual who

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE					FOR	ED: 08/24/20 RM APPROV O: 0938-03
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRI		(X3) D	ATE SURVEY OMPLETED
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to certify a material resident assessment penalty of not more assessment.  Clinical disagreement material and false store This REQUIREMEN by: Based on observation record review it was staff failed to ensure Minimum Data Set (If the sample survey, Fine Findings Included 1. Resident #1 was	gly causes another individual and false statement in a at is subject to a civil money than \$5,000 for each at does not constitute a atement.  This not met as evidenced on, staff interview and clinical determined that the facility a complete and accurate MDS) for 2 of 3 Residents in desident #1 and Resident #2.	F 2	78 4)	The DON and Administrat attend at least a monthly caplanning conference and wreview the MDS / care plan information for accuracy. identified areas will be disc with the interdisciplinary cateam and Risk Management Committee.  Risk Management Commitmonitor compliance and refindings to the quarterly Quassurance Committee for a and follow up as necessary.	are vill n Any cussed are plan nt tee will port uality	9/7/16

The most current Minimum Data Set (MDS) assessment located in the clinical record was a 30 Day Medicare MDS assessment with an Assessment Reference Date (ARD) of 7/15/16. The facility staff coded that Resident #1 had a Cognitive Summary Score of 11. The facility staff also coded that Resident #1 required extensive (3/3) to total nursing care (4/2) with Activities of Daily Living (ADL's). In Section G.004 the facility

diagnoses included, but were not limited to: dysphagia, dehydration, urinary tract infection, falls, fractured left femur, dementia without behaviors, anxiety, diabetes mellitus and being

staff coded that Resident #1 had functional limitations in her lower extremities. In Section I.Active Diagnoses the facility staff coded that Resident #1 had an "UNSPECIFIED FRACTURE OF LEFT FEMUR, SEQUELA." (sic)

If continuation sheet Page 12 of 25

Event ID: NU1211

Bipolar.

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CENTERS FOR MEDICARE	E & MEDICAID SERVICES			OMB NO. 0938-03
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observed Resident was turned to the leg on her left leg. On August 3, 2016 reviewed Resident; the clinical record p 5/20/16 and 5/30/16 "5/20/2016 04:45 (4 resident holler, "Hey (Certified Nursing A observed resident whed but her lower be side of bed. She was injury noted. Assisted of get to my mother find my brother to get spent with resident. several times. TV or within reach." "5/28/16 14:11 (2:11 rounds list for left leg "5/30/16 10:55 (10:5 am "my leg is broker left leg and when RC attempted resident syellow bruise observed appears to be slightly any fall or recent injuresident to be transfers. VSS (vital resident to be transfer withheld) ER (emerged)	at 10:15 a.m. the surveyor #1 lying in bed. Resident #1 eft side. A brace was observed at 10:30 a.m. the surveyor #1's clinical record. Review of produced nursing notes dated 5. The notes read in part 4:45 a.m.) Note Text: Heard y! Will you come here! CAN assistant) entered room and with her upper torso still on the ody hanging off of R (right) as holding on to side rail. No ed back to bed. Stated, "Hower? She is dead and I must et to her." One-on-one time. Attempted to redirect her in for distraction. Call light.  p.m.) placed resident on g and foot pain." 55 a.m.) Resident stating this in". Resident gauarding the DM (range of motion) acreams out in pain. Light ared over knee and knee y swollen. Resident denies uries. Resident is requires use of lift for signs). 911 notified and erred to (name of hospital ency room) for further stalled to (name of hospital)		DETICION	
(responsible person)	at this time and can not			
leave a voicemail, wil	Il continue to try and			

"5/30/16 1113 (11:13 a.m.) (name of emergency

contact."



PRINTED: 08/24/2016 FORM APPROVEE OMB NO. 0938-0391

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#### F 278 Continued From page 13

medical services (EMS) withheld) EMS arrived to transport resident to (name of hospital withheld) ER. Bed hold policy sent with resident." "5/30/16 1622 (4:22 p.m.) Returned from (name of hospital withheld) ER at this time via (name of EMS withheld) EMS. Diagnosis of Distal Femur Fx (fracture) and has knee immobilizer in place. Immobilizer to be worn at all times but may be removed for bathing purposes. Follow up will need to be scheduled with either Dr. (name of doctor withheld) or (name of doctor withheld) as soon as possible, as neither MD (medical doctor) was on call today. Report received from (name of nurse at hospital withheld) ER nurse, resident received Tylenol #3 at approx. (approximately) 1235 (12:35 p.m.) and Ativan approx. 2pm. Returned with NO (new order) for Norco 5/325 1 tab (tablet) po (by mouth) q4h (every 4 hours) prn (as needed) for pain. Resident resting quietly in bed at this time. Call light within reach. Still unable to reach Family, (mane of family members withheld). Left another voice mail on Cell phone and Home phone numbers for (name of family member withheld) to contact family as soon as possible." (sic)

Further review of the clinical record produced a document titled After Care Instruction from a local hospital dated 5/30/16. The document identified that Resident #1 had a fracture and was being sent back to the nursing home with a knee immobilizer.

Continued review of the clinical record produced a physician Progress Note dated 6/2/16. The note read ... "06/02/2016 12:31 (12:31 p.m.) Demented WF (white female) with left distal fx. (fracture). Pt (patient) was chronic pain, appropriately treated for same, but when her left leg pain progressed over 4-5 days she was sent to the ER where xray found femur fracture. There

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

Event ID: NU1211

Facility ID: VA0257

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PRINTED: 08/24/2016 FORM APPROVED OMB NO: 0938-0391

CENTERS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-039
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### F 278 Continued From page 14

was initially no swelling or discoloration. The pain became more localized, which contributed to the decision to get the ER evaluation. By 5/30/16 there was a yellow discoloration superior to the left knee. There was no fall or clear injury. But on 5/20/16 staff documented pt called for help and had upper torso on the bed but lower body and extremities hanging off the right side of the bed. She was assessed for injury, none found, and was assisted back to bed, with no complaints. She was more confused than normal that day. tho. Our assessment is that her chronic osteoporosis may have contributed to an essentially spontaneous left distal fracture that may have occurred when she was hanging off the bed, but did not fall. The manic phase of her restlessness, which occurs frequently, may have contributed to her getting out of place in bed, and while there was no fall, it probably contributed/caused the fracture. At present she is a bit more confused than normal, her leg is in an immobilizer. Cor-rr pulm-abd- soft (coronary/heart rate regular, pulmonary/lungs negative, abdomen negative and soft) nt left leg in immobilizer. A/P: Left spontaneous distal femur fracture. To see Dr (name of physician withheld) for definitive care." (sic)

Continued review of the clinical record produced a Significant Change MDS assessment with an ARD of 6/24/16. The MDS assessment coded that Resident #1 had a Cognitive Summary Score of 8. The facility staff also coded that Resident #1 required extensive (3/3) to total nursing care (4/2) with ADL's. In Section G. G0400. Functional Limitations the facility staff coded that Resident #1 did not have any functional limitations in upper or lower extremities.

On August 3, 3016 at 2:25 p.m. the surveyor notified the two Licensed Practical Nurse's (LPN

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

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Facility ID: VA0257

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PRINTED: 08/24/2016 FORM APPROVED OMB NO 0938-0391

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	Resident #1's Signi assessment with the inaccurate. The sure the MDS Nurse's (I pointed out that the #1's limitations in the surveyor notified the #2) that Resident #2 5/30/16. LPN (#2) so Thank you for pointing On August 3, 2016 anotified the Administ Nursing (DON) that ensure a complete a assessment. The sold that Resident limitations in upper coded that Resident limitations in upper coded that Resident #1 had a from a knee brace since No additional information additional information and the facility staff failed accurate MDS assess 2. For Resident #2 coded a fall as a fall fact, the fall resulted should have been consignally admitted or 5/9/16. Admitting diamot limited to: falls, doneumonia, contusion	ficant Change MDS e ARD of 6/24/16 was rveyor reviewed the MDS with LPN #1 and #2). The surveyor MDS did not code Resident le lower extremities. The le MDS Nurse's (LPN #1 and 1 had been in a knee since stated, "You are correct. ling that out to us." lat 3:45 p.m. the surveyor trator (Adm) and Director of the facility staff failed to land accurate MDS urveyor notified the le (AT) that the facility staff had le #1 did not have any lor lower extremities on a lower extremities on a lower extremities on a lower extremities on a lower extremities lower extremi	F 278		

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

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#### F 278 Continued From page 16

Quarterly MDS assessment with an Assessment Reference Date (ARD) of 7/15/16. The facility staff coded that Resident #2 had a Cognitive Summary Score of 15. The facility staff coded that Resident #2 required extensive assistance (3/3) with Activities of Daily Living (ADL's). In Section J. 1900 Number of falls the facility staff coded that Resident #2 had a fall with a minor injury.

On August 3, 2016 at 12:30 p.m. the surveyor reviewed Resident #2's clinical record. Review of the clinical record produced Nursing Progress Notes dated 6/25/16. The notes read in part ... "06/25/06 02:23 (2:23 a.m.) Overview: Occurrence details: Resident was lying in the floor on her left side but had turned herself over because she had a bruise and hematoma to the right temple, bruise to rig elbow, and was complaining of right hip pain 8 our of 10 on a pain scale 0-10. She got up without using her call bell and fell on the floor. Immediate Intervention: Checked resident out and called 911 and sent to ER (emergency room) for evaluation. Vitals: BP (blood pressure) 100/47 02:15 (2:15 a.m.) Position: Lying r/arm (right arm) P (pulse) 112-6-25/16 02:15 Pulse Type: Regular R (rate) 20.0-6/25/16 02:15 T (temperature) 97.8-6/9/16 18:15 (6:18 pm.) Route Oral O2 98.0%-6/21/16 16:50 (4:50 P.M.) Method: Oxygen via nasal cannula. Resident A&OX3 (alert and oriented times 3). Resident is Pleasant. Resident is Cooperative. Resident has full range of motion to all extremities. Eyes did not react to light but has had cataract surgery. Evidence of pain notedRight hipPlan level is 8out of 10. The pain is constantpain frequency is unknown. Resident skin tone is normal. Skin is warm and dry. Respirations are unlabored. Respirations are normal. Lung sounds are clear on inspiration.

F 278

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

Event ID: NU1211

Facility ID: VA0257

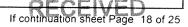
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		THE OCH LEI		GALA	AX, VA 24333			
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F 278	Continued From page	ige 17	E 2	70			***************************************	
	pa	_	ГΖ	170				
	Apical rate and rhyt	hm is regular Resident has no						
	edema. Right pedal	I pulses N/A (non-applicable).						
	Resident is continer	nt of bladder. Resident has						
	voided this shift. Res	esident is continent of bowel.						
		vement) 06/23/16 Stool						
	appearance is soft a	and formed. Bowel sounds are						
	present X (times) all	I four Quadrants. Residents						
	family/responsible pa	arty was notified o						
	occurrence. Called (	(name of family member						
	withheid) and left a r	message to call. Sent to EK						
	at 0230 (2:30 a.m.) t	inis morning." (sic)						
	the Comprehensive	Coro Plan (CCP) for				•		
	Resident #2 The CC	Odle Flatt (OUF) 101						
	Focus (problem) "	'Actual fall with continued risk						
	for falls characterize	ed by history of falls, recent						
	fall with fracture, imp	paired balance, poor						
		dy gait, pain, Functional						
	problem, med (medic	cation) use, abnormal labs.						
	Good safety awarene	ess. 6-25 lying Left side, fell						
	on R (right) side and	rolled over.Large						
	bruise/Hematoma R	temporal region and right						
	elbow." (sic)							
	The surveyor noted to	that a fall with a subdural						
	nematoma snould be	coded as a fall with major						
	ARD of 7/15/16.	ly MDS assessment with the						
:	On August 3, 3016 at	t 2:25 p.m. the surveyor						
i	notified the two Licen	nsed Practical Nurse's (LPN						
i	#1 and #2), who were	e the MDS Nurse's, that						
1	Resident #2's Quarter	rly MDS assessment with						
	the AKD of //15/16 W	vas inaccurate. The surveyor						
ſ	reviewed the MDS with	ith the MDS Nurse's (LPN #1						

and #2). The surveyor pointed out that the MDS was coded inaccurately. The surveyor pointed out that the fall on 6/25/16 had been coded as a fall with minor injury, when in fact; the fall was a fall with major injury, as Resident #2 had a subdural





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	bringing the issue to On August 3, 2016 with the Administrat Nursing. The surve Team (AT) that Resident #2's 07/15/16 coded the facility staff faile accurate MDS asse 483.25(h) FREE OF HAZARDS/SUPERV	t2) thanked the surveyor for their attention. at 3:45 p.m. the surveyor met for (Adm) and Director of eyor notified the Administrative ident #2 had a fall with major. The surveyor notified the AT Quarterly MDS with the ARD of all as a fall with minor injury, nation was provided as to why d to ensure a complete and ssment for Resident #2.	F 2	23 1)	Resident #1 had their bed al activated and in place along right side floor mat on 8/3/1 Resident #2 had their pressualarm activated on 8/3/16. The professional nursing state conducted a 100% room revall residents with bed alarms pressure bed alarms and / or mats and found all in place 68/3/16. Daily rounds will be conducted.	with 6. are bed aff riew of s, floor on	
	by: Based on observation interview and clinical determined that the frame an environment free 3 Residents in the saland Resident #2. For Resident #1 to apply nursing interright side floor mat, to Comprehensive Care 2. For Resident #2	T is not met as evidenced on, staff interview, Resident I record review it was facility staff failed to ensure of accident hazards for 2 of ample survey, Resident #1 the facility staff person failed ventions, bed alarm and a hat were identified in the e Plan (CCP). the facility staff failed to ntions, a pressure alarm		-,	the charge nurse along with management staff to assure compliance with the daily assignments. In-service edu has been conducted and confor nursing staff on 8/24/16 assessing, reviewing and implementation of the daily assignment information for balarm placement and floor material placement and following nur interventions.	facility for  cation cluded on  ped	

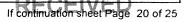
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	was originally admit diagnoses included dysphagia, dehydra falls, fractured left fe behaviors, anxiety, or Bipolar.  The most current Massessment located 30 Day Medicare Mid Assessment Referent The facility staff cod Cognitive Summary also coded that Res (3/3) to total nursing Daily Living (ADL's). On August 3, 2016 a observed Resident #was turned to the left on her left leg. The salarms or mats as salarms dentified that Reside fractured left femur. dentified that Reside Continued review of the Comprehensive Courveyor reviewed the dentified the following dentified the fol	as identified in the re Plan (CCP). led: s an 85 year old female who ited on 5/26/15. Admitting but were not limited to: tion, urinary tract infection, emur, dementia without diabetes mellitus and being inimum Data Set (MDS) in the clinical record was a DS assessment with an ince Date (ARD) of 7/15/16. led that Resident #1 had a Score of 11. The facility staff ident #1 required extensive care (4/2) with Activities of the 10:15 a.m. the surveyor lying in bed. Resident #1 t side. A brace was observed surveyor did not observe any afety precautions on Resident to 10:30 a.m. the surveyor lys clinical record. Review of coduced documentation that ent #1 recently had a The clinical record also int #1 was at risk for falls. The clinical record produced Care Plan (CCP). The le CCP. Review of the CCP	F 3:	5)	The DON, ADON and DSD monitor daily the electronic larecord for assessing 100% compliance with daily assign The RN Unit Supervisor will monitor daily all residents fo application of personal alarm mats and nursing intervention identified issues will be addreat that time by the RN Unit Supervisor and reported to th DON for follow up.  The DON, ADON and DSD present findings to the Quality Assurance Committee for necessary monitoring and folloup.	ments r s floor ns. All essed e	•

by history of falls, use of psychotropic

pain, Memory impairments, poor decision

medications, impaired balance, poor coordination,





D 91

		AND HUMAN SERVICES  MEDICAID SERVICES			FORM APPROVE
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	TIPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		495126			C 08/04/2016
	NAME OF PROVIDER OR SUPPLIER  WADDELL NURSING AND REHAB CENTER			STREET ADDRESS. CITY, STATE, ZIP CODE 202 PAINTER ST GALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		JLD BE COMPLETION
F 323	making, Psychiatric cognition, 6-12 residual c	disorder, Dementia, impaired dent in floor beside bed facing m wedged b/w (between) bed ent to ER (Emergency Room). ted 03/07/16. Revision on the base of the floor on right side 6/14/16. Pressure alarm on	F 3.	23	

alarm and fall mat on the right side of the bed should have been in place. On August 3, 2016 at 2:05 p.m. the surveyor asked RN# 1 to accompany the surveyor down to Resident #1's room to determine if the nursing interventions of a bed alarm and a fall mat on the right side of the bed were in place. RN (#1) and the surveyor walked down to Resident #1's room. Resident #1 was lying in bed. RN (#1) was unable to locate a bed alarm or a fall mat on the right hand side on the bed. On August 3, 2016 at 3:45 p.m. the surveyor notified the Administrator (Adm) and Director of

Nursing (DON) that the facility staff failed to

right hand side of the bed. In fact a fall mat was

On August 3, 2016 at 2:05 the surveyor observed a Registered Nurse (RN #1) sitting at the nurses station. The surveyor informed RN (#1) that Resident #1's CCP identified that Resident #1 was at risk for falls and that a bed alarm and a fall

not observed in Resident #1's room.

mat on the right hand side of the bed were nursing interventions on the CCP. The surveyor opened the clinical record and pointed out that the CCP identified Resident #1 was at risk for falls and that the nursing interventions of a bed

Facility ID: VA0257

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STATEMEN	TEMBER FOR MEDICARE & MEDICAND SERVICES  (A) PROVIDER OR SUPPLIER  ADDELL NURSING AND REHAB CENTER  ADDELL REGULATORY OR LSC IDENTIFYING INFORMATION)  ARE EVER LEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  FOR RESIDENCY AND ADDED AN	(X3) DATE SU COMPLE	JRVEY				
MANIE V SOMMONTON AND SOME SOME SOME SOME SOME SOME SOME SOME	NO SO Soles of Adville Personage and Advilled	495126	B WING			C 08/04/	2016
NAME OF	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		Metalitatura entratúcio com
WADDE	LL NURSING AND RE	HAB CENTER					
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	applied safety intended to the composition of the c	ventions as identified in the 1. The surveyor notified the in (AT) that the CCP identified is at risk for falls and that a shit sided fall mat were lace as nursing interventions. It is intervention was provided as to why idea to ensure an environment ards. The facility staff failed in and a right sided fall mat as interventions. The facility staff failed in and a right sided fall mat as interventions, a pressure alarm on entified in the Comprehensive and 278. The facility staff failed to entions, a pressure alarm on entified in the Comprehensive and 2/26/16 and readmitted on agnoses included, but were sysphagia, chronic pain, and of the lung, respiratory tral insufficiency, fractured ural hematoma. The insufficiency in the clinical record was a sesment with an Assessment D) of 7/15/16. The facility dent #2 had a Cognitive 5. The facility staff coded aired extensive assistance in Daily Living (ADL's). In the coffalls the facility staff	F 32	23			
(	On August 3, 2016 at	12:30 p.m. the surveyor					

the clinical record produced Nursing Progress Notes dated 6/25/16. The notes read in part ...



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CENTER	S FOR MEDICARE	& MEDICAID SERVICES		(	OMB NO. 0938-039
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altra constituta di socia con anche del socia con		495126	B WING		C 08/04/2016
NAME OF PR	NOVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	work shall be also a second as the second as a second
WADDELL	NURSING AND REI	HAB CENTER		202 PAINTER ST GALAX, VA 24333	
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#### F 323 Continued From page 22

"06/25/06 02:23 (2:23 a.m.) Overview: Occurrence details: Resident was lying in the floor on her left side but had turned herself over because she had a bruise and hematoma to the right temple, bruise to rig elbow, and was complaining of right hip pain 8 our of 10 on a pain scale 0-10. She got up without using her call bell and fell on the floor. Immediate Intervention: Checked resident out and called 911 and sent to ER (emergency room) for evaluation. Vitals: BP (blood pressure) 100/47 02:15 (2:15 a.m.) Position: Lying r/arm (right arm) P (pulse) 112-6-25/16 02:15 Pulse Type: Regular R (rate) 20.0-6/25/16 02:15 T (temperature) 97.8-6/9/16 18:15 (6:18 pm.) Route Oral O2 98.0%-6/21/16 16:50 (4:50 P.M.) Method: Oxygen via nasal cannula. Resident A&OX3 (alert and oriented times 3). Resident is Pleasant. Resident is Cooperative Resident has full range of motion to all extremities. Eyes did not react to light but has had cataract surgery. Evidence of pain notedRight hipPlan level is 8out of 10. The pain is constantpain frequency is unknown. Resident skin tone is normal. Skin is warm and dry. Respirations are unlabored. Respirations are normal. Lung sounds are clear on inspiration. Lung sounds are clear on expiration. Apical112 Apical rate and rhythm is regular Resident has no edema. Right pedal pulses N/A (non-applicable). Resident is continent of bladder. Resident has voided this shift. Resident is continent of bowel. Last BM (bowel movement) 06/23/16 Stool appearance is soft and formed. Bowel sounds are present X (times) all four Quadrants. Residents family/responsible party was notified o occurrence. Called (name of family member withheld) and left a message to call. Sent to ER at 0230 (2:30 a.m.) this morning." (sic) Continued review of the clinical record produced

F 323

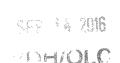
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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MED

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		& MEDICAID SERVICES				D. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A BUILDI	TIPLE CONSTRUCTION NG	1 ' '	ATE SURVEY OMPLETED
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NAMEOFP	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
WADDELI	L NURSING AND RE	HAB CENTER	202 PAINTER ST			
				GALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE

### F 323 Continued From page 23

the Comprehensive Care Plan (CCP) for Resident #2. The CCP identified the following Focus (problem) and Intervention (s) ... "Actual fall with continued risk for falls characterized by history of falls, recent fall with fracture, impaired balance, poor coordination, unsteady gait, pain, Functional problem, med (medication) use, abnormal labs. Good safety awareness. 6-25 lying Left side, fell on R (right) side and rolled over.Large bruise/Hematoma R temporal region and right elbow. Interventions Pressure alarm on bed. Initiated on 6/27/16." (sic) On August 3, 2116 at 1:50 p.m. the surveyor observed Resident #2 sitting in a wheelchair at the side of the bed. The surveyor observed Resident #2's bed. The surveyor did not observe a bed alarm. The surveyor interviewed Resident #2. The surveyor asked what happened when she fell on 6/25/16. Resident #2 stated that earlier in the day she had gone on an outing to Walmart. Resident #2 stated that the trip had worn her out. Resident #2 stated that she had gotten up from the bed to go to the bathroom and had fallen, hitting her head. On August 3, 2016 at 2:30 p.m. the surveyor observed Resident #2 lying in bed. The surveyor did not observe a bed alarm. On August 3, 2016 at 2:40 p.m. the surveyor notified a Licensed Practical Nurse (LPN 3) that Resident #2 was at risk for falls and that the CCP identified that a pressure alarm/bed alarm was supposed to be applied when in bed as a nursing intervention. The surveyor reviewed Resident #2's CCP with LPN (#3). The surveyor notified LPN (#3) that the pressure alarm/bed alarm was not observed. LPN (#3) left the nurses' desk and walked to Resident #2's room. LPN (#3) then walked back to the nurses' station and informed

the surveyor and that the pressure alarm/bed

F 323

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			(X3) DATE SURVEY COMPLETED	
		495126	B WING		C 08/04/2016	
NAME OF PROVIDER OR SUPPLIER  WADDELL NURSING AND REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 202 PAINTER ST GALAX, VA 24333		
(X4) ID PREFIX (E TAG RE	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL)	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  OCCUPANTION (X5)  COMPLETIC DATE	
F 202 0	and the second s	oddddionianu y f rhaefnawnon o fyr yr ddiodd aweirion arwyd arweddion y ddiodd ar ynhaefn y a mae yn rh y fefniaddiolyniae arw	Michigan program a responsable for the second secon			

F 323 Continued From page 24 alarm was not on the bed.

On August 3, 2016 at 3:45 p.m. the surveyor met with the Administrator (Adm) and Director of Nursing. The surveyor notified the Administrative Team (AT) that Resident #2 had a history of falls and that the CCP identified that a pressure alarm/bed alarm was supposed to be applied as a safety/nursing intervention. The surveyor notified the AT that the pressure alarm/bed alarm was not applied to Resident #2.

No additional information was provided as to why the facility staff failed to ensure an environment free of accident hazards. The facility staff failed to apply a pressure alarm/bed alarm for Resident. F 323

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