STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495126	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADDELL NURSING AND REHAB CENTER	202 PAINTER ST GALAX, VA 24333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid Abreviated survey was conducted 08/03/16 through 08/04/16. Two (2) Compalints were investigated. Corrections are required for compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities. The census in this 130 certified bed facility was 121 at the time of the survey. The survey sample consisted of three (3) current Resident reviews (Residents #1 through #3).	F 000	This 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. Preparation and submission of the plan of correction is in response to the CMS 2567 for the survey and does not constitute an agreement or admission by Waddell Nursing and Rehab Center of the truth of the facts alleged or correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements under state and federal laws. Waddell Nursing and Rehab Center contends that it was in substantial compliance with the requirements of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, however, Waddell Nursing and Rehab Center submits this plan of correction to address the statement of deficiencies and to serve as it's allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully complete in all areas as of September 7, 2016	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of	F 164	F 164: 1) Resident #1 was interviewed by the Social Services Director and RN Medicare Case Manager to discuss privacy and confidentiality issues on August 3, 2016 at 5:10p.m. Resident #1 was assured that privacy would be maintained by knocking on the door or announcing themselves prior to entry into the room. Resident #1 was advised to let the Social Services Director know if this was not the case.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
James B Waddell	administrator	9/7/16

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

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F 164	Continued From page 1	F 164	2) All interviewable residents were interviewed about any violations of their rights, privacy or dignity, which was completed on 8/4/16. Family members, who visit were instructed on resident's rights, privacy and dignity protocols by the Social Services Director. Non-interviewable residents and those without visiting family members will be monitored daily by the Social Services Director, Unit Managers, ADON, DON and Administrator for compliance with residents rights, privacy and dignity. 3) All employees were provided in-service information on 8/5/16 addressing maintaining of resident's rights. 4) Facility Unit Managers will monitor daily the actions of the staff to assure for protecting the rights, privacy and dignity of the residents as part of their assignments. 5) At each resident council meeting the residents will be asked to see if there are any issues or concerns about any violations of their rights, privacy or dignity by the Council President and staff member in attendance.	

the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview it was determined that the facility staff failed to ensure the privacy of 1 of 3 Residents in the sample survey, Resident #1.
For Resident #1 a facility staff person failed to knock or announce herself prior to entering Resident #1's room.
The Findings Included:
Resident #1 was an 85 year old female who was originally admitted on 5/26/15. Admitting diagnoses included, but were not limited to: dysphagia, dehydration, urinary tract infection, falls, fractured left femur, dementia without behaviors, anxiety, diabetes mellitus and being Bipolar.
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).
On August 3, 2016 at 10:15 a.m. the surveyor observed Resident #1 lying in bed. Resident #1 was turned to the left side. A brace was observed on her left leg. The surveyor did not observe any alarms or mats as safety precautions on Resident #1.
On August 3, 2016 at 10:30 a.m. the surveyor

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F 164	Continued From page 2	F 164	6) The facility Social Services Director, ADON and DON will conduct monthly rounds to determine compliance with maintaining resident rights, privacy and dignity. Any concerns identified will be addressed at that time with the employee / resident involved and corrected. 7) The Social Services Director, ADON and DON will report their findings to the Administrator at the monthly Risk Management Meeting. The facility Administrator will conduct monthly rounds of 100% of the facility to observe for compliance with maintaining resident rights, privacy and dignity. Any identified concerns will be discussed to formulate a plan of action. Risk Management Committee will monitor compliance and report findings to the quarterly Quality Assurance Committee for action and follow up as necessary.	9/7/16

reviewed Resident #1's clinical record. Review of the clinical record produced documentation that identified that Resident #1 recently had a fractured left femur. The clinical record also identified that Resident #1 was at risk for falls. Continued review of the clinical record produced the Comprehensive Care Plan (CCP). The surveyor reviewed the CCP. Review of the CCP identified the following Focus area and Interventions:
"Focus Risk for falls characterize by history of falls, use of psychotropic medications, impaired balance, poor coordination, pain, Memory impairments, poor decision making, Psychiatric disorder, Dementia, impaired cognition, 6-12 resident in floor beside bed facing window. R (right) arm wedged b/w (between) bed and s/r (side rail). Sent to ER (Emergency Room). no injury. Date initiated 03/07/16. Revision on 06/13/16. Interventions Mat in floor on right side of bed date initiated: 6/14/16. Pressure alarm on bed Date initiated: 06/20/2016." (sic)
On August 3, 2016 at 2 p.m. the surveyor once again observed Resident #1 lying in bed. Resident #1 was propped to the right side. A brace was in place on the left leg. The surveyor did not observed a bed alarm or a fall mat on the right hand side of the bed. In fact a fall mat was not observed in Resident #1's room.
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 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

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F 164	Continued From page 3 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. RN (#1) entered Resident #1's room without knocking or identifying herself. Resident #1 was lying in bed. Resident #1's roommate was standing at the sink in the room. On August 3, 2016 at 2:10 p.m. the surveyor notified RN (#1) that she (RN #1) had entered Resident #1's room without knocking or announcing herself. RN (#1) stated, "Yes maim, I didn't knock. I was so focused on what you had asked me." On August 3, 2016 at 3:45 p.m. the surveyor notified the Administrator (Adm) and Director of Nursing (DON) that RN (#1) had entered Resident #1's room without knocking or identifying herself prior to entering the room. No additional information was provided as to why the facility staff failed to ensure and provide privacy for Resident #1.	F 164		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would	F 225	1) Resident #1 was interviewed on 8/4/16 about the incident and Resident #1 is being monitored for any signs and symptoms resulting from the incident. The administrator spoke with the Responsible Party on 8/5/16 by phone about the incident and Resident #1 is being monitored for any signs and symptoms resulting from the incident.	

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F 225	Continued From page 4 indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, interview with the local Ombudsman and in the course of a Complaint investigation, it was determined that the facility staff failed to implement facility policy and procedure regarding reporting an injury of unknown origin to Adult Protective Services (APS) and to the State Agency. The Findings Included:	F 225	2) Social Services Director and RN MDS Director have interviewed all current residents starting 8/4/16 about any issues of abuse and incidents of unknown origin and found none. 3) All staff have been in-serviced, completed on 8/12/16 and provided a copy of the resident's rights policy, abuse and neglect policy and Virginia Mandated Reporting requirements, for immediate reporting, along with procedures for reporting injuries of unknown origin to their immediate supervisors. In-0services will be held throughout the year and at least annually. All newly hired employees will be in-serviced at the time of hire on all policies addressed. 4) Risk Management Committee will meet daily to review and address all facility events and will complete an Event Tracking Form for investigation and will submit their finding to the Quarterly Quality Assurance Committee for review and necessary actions. All determined injuries from the Risk Management Committee of unknown origin will be immediately reported and investigated by the	

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The State Agency received two Complaints regarding Resident #1. The Complaints were received in the State Agency on 6/24/16 and 7/28/16. The Complaints alleged that a Resident, who will be identified as Resident #1, sustained an injury of unknown origin and questioned whether the injury of unknown origin had been reported to the State Agency.
On August 3, 2016 at 10:30 a.m. the surveyor reviewed the policy and procedure titled, "Abuse, Neglect, and Misappropriation of Property Reporting Policy." The policy and procedure read in part ... "It is the belief of (name of facility withheld) Nursing Home that every resident has the right to be free from mistreatment, neglect and misappropriation of property. This policy seeks to prevent verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. In order to safeguard against abuse (name of facility withheld) Nursing Home has developed policies that focus on seven components: screening, training, prevention, identification, investigation, protection, and reporting/response .... IV. Identification: A. In the event of suspicious bruising, occurrences, patterns, and trends that may be abusive, the nurse will complete an initial Incident Report. B. In addition, the family and physician will be notified. C. The Administrator, Director of Nursing and Director of Social Services will be made aware of the event .... VII. Reporting/Response: A. Results of investigation will be reported to the appropriate agencies within 5 working days in writing by the administrator or designee. 1. State survey and certification agency 2. State nurses aid registry or licensing authority. 3. Adult Protective Services. 4. Resident and/or Responsible Party. (sic)
Resident #1 was an 85 year old female who was originally admitted on 5/26/15. Admitting Administrator and DON. The Administrator will assure that all alleged violations involving abuse, neglect, exploitation, including injuries of unknown origin will be reported following the Facility Reportable Incident guidelines immediately and to the appropriate outside agencies according to state law.

5) Any identified employees alleged to be involved will be removed and suspend immediately, pending a thorough internal / external investigation, with appropriate final action depending on the outcome of the investigation.

6) Social Services Director will attend the Risk Management Committee and will monitor compliance and report findings to the Quarterly Quality Assurance Committee for action and follow-up as necessary.

9/7/16

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diagnoses included, but were not limited to: dysphagia, dehydration, urinary tract infection, falls, fractured left femur, dementia without behaviors, anxiety, diabetes mellitus and being Bipolar.
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 I.Active Diagnoses the facility staff coded that Resident #1 had an "UNSPECIFIED FRACTURE OF LEFT FEMUR, SEQUELA." (sic)
On August 3, 2016 at 10:15 a.m. the surveyor observed Resident #1 lying in bed. Resident #1 was turned to the left side. A brace was observed on her left leg.
On August 3, 2016 at 10:30 a.m. the surveyor reviewed Resident #1's clinical record. Review of the clinical record produced nursing notes dated 5/20/16 and 5/30/16. The notes read in part ...
"5/20/2016 04:45 (4:45 a.m.) Note Text: Heard resident holler, "Hey! Will you come here! CAN (Certified Nursing Assistant) entered room and observed resident with her upper torso still on the bed but her lower body hanging off of R (right) side of bed. She was holding on to side rail. No injury noted. Assisted back to bed. Stated, "How do I get to my mother? She is dead and I must find my brother to get to her." One-on-one time spent with resident. Attempted to redirect her several times. TV on for distraction. Call light within reach."
"5/28/16 14:11 (2:11 p.m.) placed resident on rounds list for left leg and foot pain."

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"5/30/16 10:55 (10:55 a.m.) Resident stating this am "my leg is broken". Resident gauarding the left leg and when ROM (range of motion) attempted resident screams out in pain. Light yellow bruise observed over knee and knee appears to be slightly swollen. Resident denies any fall or recent injuries. Resident is nonambulatory and requires use of lift for transfers. VSS (vital signs). 911 notified and resident to be transferred to (name of hospital withheld) ER (emergency room) for further evaluation. Report called to (name of hospital withheld) ER nurse. Unable to reach RP (responsible person) at this time and can not leave a voicemail, will continue to try and contact."
" 5/30/16 1113 (11:13 a.m.) (name of emergency 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

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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 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

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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)

On August 3, 2016 at 3:45 p.m. the surveyor notified the Administrator (Adm) and Director of Nursing (DON) of the Complaints. The surveyor requested to see the investigative details related to Resident #1's left femur fracture. The surveyor asked if the facility staff had reported the injury of unknown origin to the State Agency. The Adm stated that they had done and investigation and believed the fracture was caused by the event on 5/20/16 when Resident #1 was found hanging out of the bed. The surveyor notified the Administrative Team (AT) the fracture was not discovered until 5/30/16, a full ten days after the incident that occurred on 5/20/16. The surveyor notified the AT that the facility could not definitively prove that the fracture was caused by the incident on 5/20/16. Therefore it was an injury of unknown origin and should have been reported to the APS and the State Agency. The surveyor located the regulations regarding reporting injuries of unknown origin and attempted to clarify the expectations regarding injuries of unknown origin with the Adm. The Adm stated that he knew what the regulation was as far as reporting injures of unknown origin. The surveyor informed the AT that once the injury of unknown origin was determined it should have been reported to the State Agency and that in the investigation follow up the facility could have identified the physician notes, staff interviews and the incident on 5/20/16 and of their belief that the femur fracture was the result of the occurrence on 5/20/16. The surveyor notified the AT that the Complaints would be substantiated with deficient practice.

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F 225	Continued From page 10 On August 4, 2016 at 8:55 a.m. the local Ombudsman met with the surveyor. The Ombudsman stated that she had received complaints from family members regarding the left femur fracture on Resident #1. The Ombudsman stated she had not received any documentation/reports from the facility related to the left femur fracture. No additional information was provided as to why the facility staff failed to implement facility policies and procedures and State and Federal regulations regarding reporting injuries of unknown origin to APS and the State Agency. For additional information regarding Resident #1 refer to F Tag 164, 278 and 323. THIS IS A COMPLAINT DEFICIENCY.	F 225		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who	F 278	1) Resident #1 MDS coding to reflect the accurate limitations in the lower extremities was corrected on 8/4/16. Resident #2 MDS coding to reflect accurate fall with major injury was corrected on 8/4/16. 2) All residents with limitations in the extremities and / or injury statues after falls MDS records were reviewed was completed on 8/4/16 by the MDS coordinators and found to be accurately coded with no corrections necessary. 3) The DON and DSD provided in-service education to the members of the care planning team on the MDS and care planning requirements and accurate assessments on 8/9/16.	

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F 278	Continued From page 11 willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review it was determined that the facility staff failed to ensure a complete and accurate Minimum Data Set (MDS) for 2 of 3 Residents in the sample survey, Resident #1 and Resident #2. The Findings Included: 1. Resident #1 was an 85 year old female who was originally admitted on 5/26/15. Admitting diagnoses included, but were not limited to: dysphagia, dehydration, urinary tract infection, falls, fractured left femur, dementia without behaviors, anxiety, diabetes mellitus and being Bipolar. 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 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)	F 278	4) The DON and Administrator will attend at least a monthly care planning conference and will review the MDS / care plan information for accuracy. Any identified areas will be discussed with the interdisciplinary care plan team and Risk Management Committee. 5) Risk Management Committee will monitor compliance and report findings to the quarterly Quality Assurance Committee for action and follow up as necessary.	9/7/16

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On August 3, 2016 at 10:15 a.m. the surveyor observed Resident #1 lying in bed. Resident #1 was turned to the left side. A brace was observed on her left leg.

On August 3, 2016 at 10:30 a.m. the surveyor reviewed Resident #1's clinical record. Review of the clinical record produced nursing notes dated 5/20/16 and 5/30/16. The notes read in part...

"5/20/2016 04:45 (4:45 a.m.) Note Text: Heard resident holler, "Hey! Will you come here! CAN (Certified Nursing Assistant) entered room and observed resident with her upper torso still on the bed but her lower body hanging off of R (right) side of bed. She was holding on to side rail. No injury noted. Assisted back to bed. Stated, "How do I get to my mother? She is dead and I must find my brother to get to her." One-on-one time spent with resident. Attempted to redirect her several times. TV on for distraction. Call light within reach."

"5/28/16 14:11 (2:11 p.m.) placed resident on rounds list for left leg and foot pain."

"5/30/16 10:55 (10:55 a.m.) Resident stating this am "my leg is broken". Resident gauarding the left leg and when ROM (range of motion) attempted resident screams out in pain. Light yellow bruise observed over knee and knee appears to be slightly swollen. Resident denies any fall or recent injuries. Resident is nonambulatory and requires use of lift for transfers. VSS (vital signs). 911 notified and resident to be transferred to (name of hospital withheld) ER (emergency room) for further evaluation. Report called to (name of hospital withheld) ER nurse. Unable to reach RP (responsible person) at this time and can not leave a voicemail, will continue to try and contact."

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

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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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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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#1 and #2), who were the MDS Nurse's, that Resident #1's Significant Change MDS assessment with the ARD of 6/24/16 was inaccurate. The surveyor reviewed the MDS with the MDS Nurse's (LPN #1 and #2). The surveyor pointed out that the MDS did not code Resident #1's limitations in the lower extremities. The surveyor notified the MDS Nurse's (LPN #1 and #2) that Resident #1 had been in a knee since 5/30/16. LPN (#2) stated, "You are correct. Thank you for pointing that out to us."

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 ensure a complete and accurate MDS assessment. The surveyor notified the Administrative Team (AT) that the facility staff had coded that Resident #1 did not have any limitations in upper or lower extremities on a Significant Change MDS assessment with the ARD of 6/14/16. The surveyor notified the AT that Resident #1 had a fractured femur and had been in a knee brace since 5/30/16.

No additional information was provided as to why the facility staff failed to ensure a complete and accurate MDS assessment for Resident #1.

2. For Resident #2 the facility staff inaccurately coded a fall as a fall with minor injury, when in fact, the fall resulted in a subdural hematoma and should have been coded a fall with major injury.

Resident #2 was an 80 year old female who was originally admitted on 2/26/16 and readmitted on 5/9/16. Admitting diagnoses included, but were not limited to: falls, dysphagia, chronic pain, pneumonia, contusion of the lung, respiratory failure, congenital mitral insufficiency, fractured humerus and a subdural hematoma.

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

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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.

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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 the Comprehensive Care Plan (CCP) for Resident #2. The CCP identified the following Focus (problem). ..."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." (sic)
The surveyor noted that a fall with a subdural hematoma should be coded as a fall with major injury on the Quarterly MDS assessment with the ARD of 7/15/16.
On August 3, 3016 at 2:25 p.m. the surveyor notified the two Licensed Practical Nurse's (LPN #1 and #2), who were the MDS Nurse's, that Resident #2's Quarterly MDS assessment with the ARD of 7/15/16 was inaccurate. The surveyor reviewed the MDS with 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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F 278	Continued From page 18 hematoma. LPN (#2) thanked the surveyor for bringing the issue to their attention. 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 fall with major injury on 6/25/16. The surveyor notified the AT that Resident #2's Quarterly MDS with the ARD of 7/15/16 coded the fall as a fall with minor injury. No additional information was provided as to why the facility staff failed to ensure a complete and accurate MDS assessment for Resident #2.	F 278		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, Resident interview and clinical record review it was determined that the facility staff failed to ensure an environment free of accident hazards for 2 of 3 Residents in the sample survey, Resident #1 and Resident #2. 1. For Resident #1 the facility staff person failed to apply nursing interventions, bed alarm and a right side floor mat, that were identified in the Comprehensive Care Plan (CCP). 2. For Resident #2 the facility staff failed to apply nursing interventions, a pressure alarm	F 323	1) Resident #1 had their bed alarm activated and in place along with right side floor mat on 8/3/16. Resident #2 had their pressure bed alarm activated on 8/3/16. 2) The professional nursing staff conducted a 100% room review of all residents with bed alarms, pressure bed alarms and / or floor mats and found all in place on 8/3/16. 3) Daily rounds will be conducted by the charge nurse along with facility management staff to assure for compliance with the daily assignments. In-service education has been conducted and concluded for nursing staff on 8/24/16 on assessing, reviewing and implementation of the daily assignment information for bed alarm placement and floor mat placement and following nursing interventions.	

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F 323	Continued From page 19	F 323	4) The DON, ADON and DSD will monitor daily the electronic health record for assessing 100% compliance with daily assignments. The RN Unit Supervisor will monitor daily all residents for application of personal alarms floor mats and nursing interventions. All identified issues will be addressed at that time by the RN Unit Supervisor and reported to the DON for follow up. 5) The DON, ADON and DSD will present findings to the Quality Assurance Committee for necessary monitoring and follow up.	9/7/16

when in bed, that was identified in the Comprehensive Care Plan (CCP).
The Findings Included:
1. Resident #1 was an 85 year old female who was originally admitted on 5/26/15. Admitting diagnoses included, but were not limited to: dysphagia, dehydration, urinary tract infection, falls, fractured left femur, dementia without behaviors, anxiety, diabetes mellitus and being Bipolar.
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).
On August 3, 2016 at 10:15 a.m. the surveyor observed Resident #1 lying in bed. Resident #1 was turned to the left side. A brace was observed on her left leg. The surveyor did not observe any alarms or mats as safety precautions on Resident #1.
On August 3, 2016 at 10:30 a.m. the surveyor reviewed Resident #1's clinical record. Review of the clinical record produced documentation that identified that Resident #1 recently had a fractured left femur. The clinical record also identified that Resident #1 was at risk for falls. Continued review of the clinical record produced the Comprehensive Care Plan (CCP). The surveyor reviewed the CCP. Review of the CCP identified the following Focus area and Interventions: "Focus Risk for falls characterize by history of falls, use of psychotropic medications, impaired balance, poor coordination, pain, Memory impairments, poor decision

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making, Psychiatric disorder, Dementia, impaired cognition, 6-12 resident in floor beside bed facing window. R (right) arm wedged b/w (between) bed and s/r (side rail). Sent to ER (Emergency Room). no injury. Date initiated 03/07/16. Revision on 06/13/16. Interventions Mat in floor on right side of bed date initiated: 6/14/16. Pressure alarm on bed Date initiated: 06/20/2016." (sic)

On August 3, 2016 at 2 p.m. the surveyor once again observed Resident #1 lying in bed. Resident #1 was propped to the right side. A brace was in place on the left leg. The surveyor did not observed a bed alarm or a fall mat on the right hand side of the bed. In fact a fall mat was not observed in Resident #1's room.

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 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 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

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applied safety interventions as identified in the CCP on Resident #1. The surveyor notified the Administrative Team (AT) that the CCP identified that Resident #1 was at risk for falls and that a bed alarm and a right sided fall mat were supposed to be in place as nursing interventions. 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 bed alarm and a right sided fall mat as identified in the CCP.
For additional information regarding Resident #1 refer to F Tag 164, 225 and 278.
2. For Resident #2 the facility staff failed to apply nursing interventions, a pressure alarm on the bed, that was identified in the Comprehensive Care Plan (CCP).
Resident #2 was an 80 year old female who was originally admitted on 2/26/16 and readmitted on 5/9/16. Admitting diagnoses included, but were not limited to: falls, dysphagia, chronic pain, pneumonia, contusion of the lung, respiratory failure, congenital mitral insufficiency, fractured humerus and a subdural hematoma.
The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 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 ...

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495126	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADDELL NURSING AND REHAB CENTER	202 PAINTER ST GALAX, VA 24333

(X4) ID 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 323	Continued From page 22	F 323		

"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

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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

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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.