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ROMAN EAGLE REHABILITATION AND HEALTH CARE CENTER	2526 NORTH MAIN STREET DANVILLE, VA 24540

(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 standard was conducted on 7/18/17 through 7/20/17. Corrections are required for complainance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey report will follow. The census in this 312 bed certified bed facility was 288 at the time of the survey. The survey sample consisted of 27 current Resident Reviews (Resident #'s 1 through 27) and 3 closed record reviews (Resident #'s 28 through 30).	F 000		
F 278 SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly-	F 278		8/14/17

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

Electronically Signed | 08/16/2017

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 278	Continued From page 1 (i) 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 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and clinical record review, the facility staff failed to ensure an accurate minimum data set (MDS) assessment for 1 of 30 residents (Resident #19). Dialysis was not coded in Section O of the admission MDS. The findings included: The facility staff failed to code Resident #19's dialysis on the admission MDS with an assessment reference date of 7/4/17. The surveyor observed and interviewed Resident #19 on 7/19/17 at 4:31 p.m. Resident #19 stated to the surveyor the reasons for her admission to the facility. Resident #19 stated while in the hospital, dialysis had been started and since admitted to the facility, she had received dialysis three times. The clinical record of Resident #19 was reviewed 7/19/17 and 7/20/17. Resident #19 was initially admitted to the facility 6/2/17 and readmitted 6/27/17 with diagnoses that included but not	F 278	A modification was completed on 7/19/17 to show that resident is receiving dialysis. This resident has since been discharged to home. A 100% audit of all residents receiving dialysis has been completed by the Resident Assessment Supervisor to ensure that dialysis is coded in the MDS. Results of audit reviewed by QA Coordinator with no corrective measures necessary. Quarterly, the MDS of all residents receiving dialysis will be audited by the Resident Assessment Coordinator to ensure dialysis is accurately recorded. These audits will be reviewed by the Quarterly Assurance Coordinator with appropriate corrections made if necessary. The DON will ensure compliance. (See attached form)	

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F 278	Continued From page 2 limited to chronic kidney disease stage 4, hypertension, hyperlipidemia, type 2 diabetes mellitus, arteriovenous fistula, and left bundle branch block. Resident #19's admission MDS with an assessment reference date (ARD) of 7/4/17 assessed the resident with a cognitive summary score of 15. Section O Special Treatments, Procedures and Programs was reviewed. Dialysis (O0100J) was not coded for either while not a resident (column 1) or while a resident (column 2) in the facility. Resident #19's current physician orders for July 2017 read in part "6/27/17 May go out for dialysis txt (treatment) 3 x week on Tues, Thurs, and sat (Blairs)." The Departmental Notes were reviewed for June 2017 and July 2017. Departmental Notes written 6/29/17 at 11:18 a.m., 7/1/17 at 11:02 a.m., and 7/4/17 at 10:19 a.m. each read OOH (out of home) with transport via wheelchair to dialysis. The surveyor interviewed registered nurse #1 on 7/20/17 at 9:05 a.m. concerning the coding of dialysis on the admission MDS. After reviewing the clinical record including the documentation in the departmental notes, R.N. #1 stated "it couldn't get any plainer than that. Forgot to code it." The surveyor informed the director of nursing, administrator, registered nurse #2 and the quality assurance coordinator of the above concern with the failure to code dialysis on the admission MDS in a meeting on 7/20/17 at 10:15 a.m. No further information was provided prior to the exit conference.	F 278	These systemic changes will ensure continued compliance with the regulation.	

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F 279	Continued From page 3	F 279		
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1)	F 279		9/1/17

483.20
(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.

483.21
(b) Comprehensive Care Plans

(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will

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F 279	Continued From page 4 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to develop a CCP (comprehensive care plan) for 3 of 30 Residents, Resident #9, #10, and #12. The findings included: 1. For Resident #9 the facility staff failed to develop care plans for cognition and falls Resident #9 was admitted to the facility on 09/28/08. Diagnoses included but not limited to Alzheimer's disease, Parkinson's disease, anxiety and gastroesophageal reflux disorder.	F 279	Resident #9's care plan has been revised to include problems for cognition and falls. Resident #10's care plan has been revised to include the problem for cognition. Resident #12's care plan has been revised to include problems for cognition and falls. Education will be provided to the care planning team on specifics related to developing a comprehensive care plan by the Resident Assessment Coordinator	

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F 279	Continued From page 5 The most recent comprehensive MDS (minimum data set) with an ARD (assessment reference date) of 0817/16 coded the Resident as 12 of 15 in section C, cognitive patterns. Section V, care area assessment summary, triggered the Resident for "cognitive" and "falls", and indicated that CCP's would be developed. This is an annual MDS. Resident #9's CCP was reviewed on 07/19/17. The surveyor could not locate CP's (care plan) for cognition or falls. Surveyor spoke with the DON (director of nursing) on 07/20/17 at approximately 0900 regarding the missing care plans. DON stated that the information was included in other areas of the care plan, but no specific care plan for these triggered areas had been developed. Surveyor asked DON to review the CP. DON could not locate any information in the care plan regarding cognition or falls. The concern of the missing care plans was discussed with the administrative team on 07/20/17 at approximately 1010. No further information was provided prior to exit. 2. For Resident #10 the facility staff failed to develop a care plan for cognition. Resident #10 was admitted to the facility on 09/14/16 and readmitted on 09/16/16. Diagnoses included but not limited to Alzheimer;s disease, anxiety, hypothyroidism and chronic kidney disease. The most recent comprehensive MDS with an ARD of 04/12/17 coded the Resident as 15 out of	F 279	supervisor. The Director of Nursing will ensure compliance. A 100% audit of all care plans of residents who triggered cognition and falls will be completed by the Resident Assessment Coordinator and her team to ensure cognition and falls have been addressed. This audit will be completed by the Resident Assessment Coordinator and assistants. The results of this audit will be reviewed by the QA Coordinator and Resident Assessment Supervisor with revisions made as necessary. Quarterly, 10% of resident's care plans who triggered cognition and/or falls will be audited by the Resident Assessment Coordinator Supervisor and her team. Results will be reviewed by the QA Coordinator and RAC Supervisor with appropriate action taken. The Director of Nursing will ensure compliance. These systemic changes will ensure continued compliance with the regulation.	

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F 279	Continued From page 6	F 279		

15 in section C, cognitive patterns. Section V, care area assessment summary, triggered the Resident for "cognitive" and indicated that a care plan would be developed. This is a significant change MDS.

Resident #10's CCP was reviewed on 07/19/17. The surveyor could not locate a CP for cognition. Surveyor spoke with the DON (director of nursing) on 07/20/17 at approximately 0900 regarding the missing care plans. DON stated that the information was included in other areas of the care plan, but no specific care plan for cognition had been developed. Surveyor asked DON to review the CP. DON could not locate any information in the care plan regarding cognition.

The concern of the missing care plan was discussed with the administrative team on 07/20/17 at approximately 1010.

No further information was provided prior to exit.
3. For Resident #12, the facility staff failed to develop a comprehensive plan of care for Cognition and falls.

Resident #12 was originally admitted to the facility on 11/3/14. Resident #12's diagnoses include but are not limited to: heart failure, gout, obesity, anemia, depression, anxiety disorder, and high blood pressure.

On 7/19/17, Resident #12's clinical record review revealed her significant change minimum data set (MDS) assessment with an assessment reference date (ARD) of 6/19/17. Resident #12 was coded in section C (cognitive patterns) with a score of 14.
In Section V: Care Area Assessment, Resident

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F 279	Continued From page 7 #12 "triggered" for cognition in section C, and the facility staff documented that cognition would be care planned. The facility staff had no documentation on the corresponding care plan for cognition. No cognitive care plan had been developed. Resident #12 also "triggered" in section V for falls. Falls was coded in section J. There was no care plan developed for falls. On 7/19/17, the MDS nurse, RN #1, was asked to assist in locating the fall and cognition care plans. After reviewing the current care plan, she said, "As much as I hate to say it, it's not there." 0n 7/19/17 at the end of the day meeting with the administrative staff, the failure to develop a cognition or a fall care plan was discussed. Prior to exit, no further information was provided by the facility staff related to the failure to develop a care plan for cognition or falls.	F 279		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.	F 280		9/1/17

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F 280	Continued From page 8 (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 280		

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F 280	Continued From page 9 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to review and revise the comprehensive care plan for 1 of 30 residents (Resident #17). The findings include: The facility staff failed to review and revise the comprehensive care plan for Resident #17 to reflect the resident was not on contact precautions and the family preferred the resident continue to use paper products for meals. Resident #17 was admitted to the facility on 1/23/17 with diagnoses of dysphagia, hypertension, anemia, and multi drug resistant	F 280	Resident #17's care plan has been reviewed and revised to show contact precautions are no longer needed and paper products are preferred for meals. The care plans of all residents who are currently on contact precautions will be audited upon completion of contact precautions to ensure the care plan is revised to show the completion of contact precautions. This audit will be performed by the Resident Assessment Coordinator and assistants. The care plans of all resident receiving paper products for meals by choice will be	

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F 280	Continued From page 10 organism. The current quarterly Minimum Data Set (MDS) with a reference date of 5/1/17 assessed the resident with a cognitive score of "14" of "15". The resident was assessed requiring extensive assistance of 1-2 persons for bed mobility, transfers,dressing, toileting, bathing, and hygiene. The resident was observed eating breakfast from all paper products on 7/19/17. The staff nurse (LPN#3) was asked about the use of the paper and if the resident was on isolation precautions. LPN#3 stated the resident was not on isolation any longer and the family had requested the resident continue to eat from paper products because they felt he would eat better. The clinical record was reviewed. The physician had written a telephone order to discontinue the contact precautions on 5/27/17. The comprehensive care plan was reviewed. The care plan included under the nutrition plan that the resident was actively on contact precautions. There was no mention the family preference for paper products. The administrator, director of nursing, and assistant director of nursing were informed of the findings during an end of the day meeting with the survey team on 7/19/17.	F 280	audited to ensure this is care planned by the Resident Assessment Coordinator and assistants. The results of these audits will be reviewed by the Resident Assessment Coordinator Supervisor and Quality Assurance Coordinator with revisions made as necessary. Quarterly, 10% of all resident care plans who have had contact precautions discontinued during the quarter or who use paper products for meals by choice will be audited by the Resident Assessment Coordinator and assistants. Results of these audits will be reviewed by the Resident Assessment Coordinator Supervisor and Quality Assurance Coordinator with revisions made as necessary. (See attached sheet) The Director of Nursing will ensure compliance. These systemic changes will ensure continued compliance with the regulation.	
F 502 SS=D	ADMINISTRATION CFR(s): 483.50(a)(1) (a) Laboratory Services (1) The facility must provide or obtain laboratory	F 502		7/20/17

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F 502	Continued From page 11 services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain a laboratory test as ordered by the physician for 1 of 30 residents in the survey sample (Resident #3). The findings included: The facility staff failed to obtain a Pre-Albumin laboratory test as ordered by the physician for Resident #3. Resident #3 was admitted to the facility on 1/25/17 with the following diagnoses of, but not limited to urinary tract infection, Alzheimer's disease, pressure ulcer to left buttock, depression, retention of urine and delusional disorders. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 4/24/17 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 00 out of a possible score of 15. Resident #3 was also coded as being totally dependent on 1 staff member for eating, personal hygiene and bathing. A clinical record review was performed by the surveyor on 7/19/17. At that time, it was noted by the surveyor that on 2/6/17, the physician had ordered a Pre-Albumin level to be obtained the next day lab. The surveyor could not find the results for the Pre-Albumin level. At 1:30 pm, the surveyor notified the director of nursing (DON) of the above documented findings.	F 502	The physician was notified that a pre-albumin evaluation was not obtained in February on Resident #3. No further orders were received. All residents with current orders for a pre-albumin level will be audited by the RN Supervisors to ensure a pre-albumin was drawn and resulted. This audit will be completed by the RN Supervisors. Results will be reviewed by the QA Coordinator and DON with appropriate corrections made if necessary. Quarterly, the medical records of 10% of residents with physician orders for pre-albumin levels will be audited by the RN Supervisors to ensure pre-albumin levels were obtained. Results will be reviewed by the QA Coordinator and DON with corrections made if necessary. (See attached form) The DON will ensure compliance. These systemic changes will ensure continued compliance with the regulation.	

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F 502	Continued From page 12 The DON stated "Let me go look and see if I can find it for you." The DON returned to the surveyor at 2:30 pm and stated, "They did not obtain this lab." At 3:30 pm on 7/19/17, the administrative team was notified of the above documented findings by the surveyor. No further information was provided to the surveyor prior to the exit conference on 7/20/17.	F 502		
F 504 SS=D	LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN CFR(s): 483.50(a)(2)(i) (a) Laboratory Services (2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain a physician order prior to obtaining a laboratory test for 1 of 30 residents in the survey sample (Resident #3). The findings included: The facility staff failed to obtain a physician order prior to obtaining an Albumin level for Resident #3.	F 504	Resident #3 did have a physician's telephone order dated 2/6/17 for a CMP (Comprehensive Metabolic Profile), which includes an albumin level. See attached physician's telephone order and back of lab slip showing what is included in a CMP. (See Attached)	7/21/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495015	A. BUILDING _____ B. WING _____	07/20/2017

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F 504	Continued From page 13 Resident #3 was admitted to the facility on 1/25/17 with the following diagnoses of, but not limited to urinary tract infection, Alzheimer's disease, pressure ulcer to left buttock, depression, retention of urine and delusional disorders. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 4/24/17 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 00 out of a possible score of 15. Resident #3 was also coded as being totally dependent on 1 staff member for eating, personal hygiene and bathing. A clinical record review was performed by the surveyor on 7/18/17. At that time, the surveyor noted that an Albumin level result was in the electronic clinical record dated for 2/7/17. The surveyor could not find a physician order for this laboratory test. On 7/19/17 at 1:30 pm, the surveyor notified the director of nursing (DON) of the above documented findings. The DON stated "Let me go look and see if I can find it for you." The DON returned to the surveyor at 2:30 pm and stated "They did not obtain an order this lab." At 3:30 pm on 7/19/17, the administrative team was notified of the above documented findings by the surveyor. No further information was provided to the surveyor prior to the exit conference on 7/20/17.	F 504		
F 514 SS=D	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5)	F 514		9/1/17

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F 514	Continued From page 14 (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for 1 of 30 residents (Resident #18).	F 514	Resident #18's weight record has been corrected to show a weight of 128 instead of 138.	

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F 514	Continued From page 15 The findings include: The facility staff failed to maintain a complete and accurate clinical record for Resident #18. Resident #18 was admitted to the facility on 10/31/07 and re-admitted on 5/11/13 with diagnoses of congestive heart failure, dementia, urinary tract infection, breast cancer, depression, osteoporosis, and Parkinson's disease. The current Minimum Data Set (MDS) with a reference date of 5/13/17 assessed the resident with a cognitive score of "6" of "15". The resident was assessed requiring total assistance of 1-2 persons for bed mobility, transfers, dressing, eating, toileting, bathing, and hygiene. The clinical record was reviewed. The physician recertification orders contained an order to weigh daily. The weight record was reviewed and the resident was weighed daily as ordered. The weight recorded on 7/8/17 was 129 pounds. The weight recorded on 7/9/17 was recorded as 138.6 pounds. The weight recorded on 7/10/17 was 129 pounds. The nursing staff on the unit were interviewed about the discrepancy in weights on 7/19/17 at 7:30 a.m. LPN#4 stated she would have done a reweigh because of the change from 129 to 138.6. LPN#5 stated she thought the nurse had entered the amount wrong on the computer and did not notice the difference. The administrator, director of nursing, and assistant director of nursing were informed of the findings during an end of the day meeting with the	F 514	The Staff Development Coordinator will provide education on the importance of comparing daily weights for accuracy. This education will be provided to all LPNs and RNs. A 100% audit of all daily weight records will be conducted by the RN Supervisors. Results will be reviewed by the QA Coordinator and DON with appropriate action taken. Each day the RN Supervisors will check daily weights for accuracy with appropriate action taken if necessary. The DON will ensure compliance. Quarterly, the RN Supervisors will conduct a 10% audit of all daily weight records to ensure accuracy. Results will be reviewed by the QA Coordinator and DON with appropriate action taken. (See attached form) The DON will ensure compliance. These systemic changes will ensure continued compliance with the regulation.	

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F 514	Continued From page 16 survey team on 7/19/17.	F 514		