STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 survey was conducted 8/9/16 through 8/11/16. Significant corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. Three complaints were investigated during the survey. The Life Safety Code survey/report will follow. The census in this 90 certified bed facility was 84 at the time of the survey. The survey sample consisted of fourteen current resident reviews (Residents 1 through 14) and three closed record reviews (Residents 15 through 17).	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a	F 157		9/19/16

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

Electronically Signed | 08/26/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 157	Continued From page 1 change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, the facility staff failed to notify the physician of a change in condition for one of 17 residents in the survey sample (Resident # 15). Resident # 15's had a hypoglycemic (low blood sugar) episode on 03/08/16, the resident's blood sugar was 23. The facility staff failed to notify the resident's physician. Findings include: Resident # 15 was admitted to the facility on 03/01/16. Diagnoses for Resident # 15 included, but were not limited to: Stroke with aphasia (inability to speak), seizures, tracheostomy (surgical opening through the neck to provide an airway and remove secretions), DM (diabetes mellitus), and a PEG tube (medical procedure where a tube is passed into a patient's stomach to provide a means of nutrition and hydration when unable to take oral intake). The most recent full MDS (minimum data set) was a 5 day admission assessment dated 03/08/16. This MDS assessed the resident as	F 157	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 483.10 NOTIFY OF CHANGES INJURY/DECLINE/ROOM, ETC) F157: How the correction action will be accomplished for the resident(s) affected. Resident #15 no longer reside at Louisa Health and Rehabilitation Center. How corrective action will be accomplished for those residents with the potential to be affected by the same	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 157	Continued From page 2 having short and long term memory impairment with severe impairment in daily decision making skills. The resident was also assessed as being totally dependent upon staff for all ADL's (activities of daily living) including feeding. The resident was also assessed as receiving insulin injections for the previous 7 days. The resident did trigger in the CAAS (care area assessment summary) section of this MDS for nutrition and the area was marked to address in the resident's comprehensive care plan (CCP). A complaint regarding Resident # 15, was investigated during the survey process on 08/09/16 through 08/11/16. During clinical record review, Resident # 15's facility admission physician orders were reviewed. Resident # 15 was admitted on 03/01/16. The facility admission orders were dated 03/02/16 and included orders for, but were not limited to: NPO (nothing by mouth), Pro-Stat SF (a sugar free ready to drink medical food providing 15 grams of protein) two times a day (no specific amount was indicated in the order), Enteral Feed Order every evening and night shift via pump-osmolite 1.5 at 95 ml/hr, Insulin NPH (intermediate acting) 70 units one time a day, Insulin NPH 70 units at 1800 (6:00 p.m.), SS (sliding scale) insulin Regular (short acting) every 6 hours, and glucophage 1000 mg (milligrams) twice a day. The resident's SS insulin order documented, for a blood sugar 350 + give 18 units of regular insulin. The physician's order did not specify to call or notify the physician if the blood sugar was over or under a certain amount and did not specify any interventions for hypoglycemia. The resident's MARs (medication administration	F 157	practice. The current physician orders will be reviewed to ensure that blood sugar parameters are present for physician notification and interventions for hypoglycemia. Measures in place to ensure practices will not occur. Director of Nursing (DON)/designee will in-service Charge Nurses on the policy and procedure for Significant Change in Condition to include MD notification, blood glucose parameters and interventions for hypoglycemia. The in-service will include the need to report all signs and symptoms of the change in Condition to the Physician and document on the 24-hour shift report, the nursing progress notes and the EMAR. How the facility plans to monitor and ensure the correction is achieved and sustained. The Director of Nursing (DON)/designee will review the 24-Hour Shift Report and EMARs of diabetic residents five (5) times a week for four (4) weeks to identify any resident with blood glucose levels outside the ordered parameters to ensure prompt notification to the physician and documented. Any deficient practice will result in re-education of nursing staff or disciplinary action as indicated. The Director of Nursing(DON) will report findings to the QA committee quarterly for tracking and trending.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 157	Continued From page 3	F 157		

records) were then reviewed and documented on 03/08/16 at 6:00 p.m., the resident's blood sugar was 23.

A nursing note dated 03/08/16 and timed 7:28 p.m. documented, "...blood glucose was 23, prostat med plus and 2 [two] 118 [ml] orange juice with 4 packets of sugar given glucose rechecked after first oange [sic] juice with sugar reading 55 at which time second juice with sugar given and recheck of 77 tube feed started and long acting insulin held..."

No documentation was found within the clinical record to evidence the resident's physician was notified of the extremely low blood sugar.

The resident's CCP (comprehensive care plan) was then reviewed. The CCP dated 03/02/16 documented: "...has altered cardio/cerebrovascular/pulmonary health r/t [related to]...DM [diabetes mellitus]...administer medication as ordered; monitor effect...Provide diet/fluid as ordered..."

The above information was shared with the administrator, DON (director of nursing), and the corporate nurse in a meeting with the survey team on 08/09/16 at 3:00 p.m.

The DON, administrator and corporate nurse were again made aware of concerns in an end of day meeting with the survey team on 08/10/16 at 5:00 p.m., the facility staff were asked if they had standing orders for blood sugar parameters, the corporate nurse voiced that she did not think so, but would check. The facility staff were asked if they thought that the physician should be notified of a blood sugar level of 23, all agreed that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 157	Continued From page 4 physician should be notified. The facility's medical director, also known as physician # 1 was interviewed at 9:45 a.m. on 08/11/16, in a meeting with the survey team. Physician # 1 was asked if he would expect to be notified of a resident's blood sugar of 23, the physician voiced yes. At approximately 11:40 a.m. on 08/11/16, the facility staff again met with the survey team. The facility staff were asked if there was any additional information/documentation for presentation. The facility staff voiced, no. No further information or documentation was presented by facility staff prior to the exit conference on 08/11/16 at 12:30 p.m., to evidence Resident # 15's physician was notified of a critical low blood sugar level.	F 157		
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.	F 164		9/19/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 164	Continued From page 5 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 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 staff interview and clinical record review, the facility staff failed to maintain confidentiality in a clinical record for one of 17 residents in the survey sample. Resident #16's name was included in a nursing note recorded in Resident #5's clinical record. The findings include: Resident #16 was admitted to the facility on 1/14/16 and was discharged on 7/6/16. Diagnoses for Resident #16 included urinary tract infection, history of gastrointestinal bleeding, coronary artery disease, anemia (low hemoglobin levels leading to reduce oxygen to tissues), severe protein calorie malnutrition and high blood pressure. The minimum data set (MDS) dated 6/22/16 assessed Resident #16 with moderately impaired cognitive skills. Resident #5's clinical record was reviewed on 8/9/16. Resident #16's name was included in a nursing note recorded in Resident #5's clinical	F 164	483.10(e), 483.75(l)(4) PERSONALPRIVACY/CONFIDENTIALITY OF RECORDS F164 How the correction action will be accomplished for the resident(s) affected. Resident #16 no longer resides at Louisa Health and Rehabilitation facility. The Nurse responsible was in-serviced and counselled on Resident Rights and the need for maintaining confidentiality in the clinical record. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. The Nursing Progress Notes from 8/11/2016 of current residents will be reviewed to ensure confidentiality was maintained. Involved Nurse will be in-serviced on any areas where confidentiality was not maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 164	Continued From page 6 record. The note in Resident #5's clinical record dated 7/17/16 at 10:45 a.m. stated, "Resident upset/crying, wanting to know about funeral arrangements for her friend [Resident #16's name], Called daughter..." On 8/10/16 at 3:45 p.m. the director of nursing (DON) was interviewed about Resident #16's name listed in Resident #5's clinical record. The DON stated Resident #16's name should not have been written in Resident #5's notes. The DON stated, "We wouldn't normally name another resident in the chart." These findings were reviewed with the administrator, director of nursing and nurse consultant during a meeting on 8/10/16 at 11:30 a.m.	F 164	Measures in place to ensure practices will not occur. The Charge Nurses will be in-serviced on Policy and Procedure for Documentation Summary and Confidentiality to include not listing one Resident□s name in another Resident□s clinical record. How the facility plans to monitor and ensure the correction is achieved and sustained. The DON/designee will perform five (5) random reviews of Nursing Notes five (5) times a week for four (4) weeks to ensure confidentiality is being maintained. Any deficient practice will result in re-education of nursing staff or disciplinary action as indicated. The Director of Nursing(DON) will report findings to the QA committee quarterly for tracking and trending.	
F 271 SS=D	483.20(a) ADMISSION PHYSICIAN ORDERS FOR IMMEDIATE CARE At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, the facility staff failed to ensure immediate physician's orders for diabetic care parameters for one of 17 residents in the survey sample (Resident # 15).	F 271	483.20 (a) ADMISSION PHYSICIAN ORDERS FOR IMMEDIATE CARE F271 How the correction action will be accomplished for the resident(s) affected. Patient/Resident #15 no longer resides at	9/19/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 271	Continued From page 7 The facility failed to ensure Resident # 15 had immediate physician's orders on admission, for the management of hypoglycemia (low blood sugar). Findings include: Resident # 15 was admitted to the facility on 03/01/16. Diagnoses for Resident # 15 included, but were not limited to: Stroke with aphasia (inability to speak), seizures, tracheostomy (surgical opening through the neck to provide an airway and remove secretions), DM (diabetes mellitus), and a PEG tube (medical procedure where a tube is passed into a patient's stomach to provide a means of nutrition and hydration when unable to take oral intake). The most recent full MDS (minimum data set) was a 5 day admission assessment dated 03/08/16. This MDS assessed the resident as having short and long term memory impairment with severe impairment in daily decision making skills. The resident was also assessed as being totally dependent upon staff for all ADL's (activities of daily living) including feeding (nutrition/hydration). The resident was also assessed as receiving insulin injections for the previous 7 days. The resident did trigger in the CAAS (care area assessment summary) section of this MDS for nutrition and the area was marked to address in the resident's comprehensive care plan (CCP). A complaint regarding Resident # 15, was investigated during the survey process on 08/09/16 through 08/11/16. During clinical record review, Resident # 15's	F 271	Louisa Health and Rehabilitation facility. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. The current physician orders will be reviewed to ensure that immediate physician orders are present for diabetic care parameters, orders are present on admission and for the management of hypoglycemia. Measures in place to ensure practices will not occur. The Charge Nurses will be in-serviced on the need for residents to have immediate care orders put in place for diabetic management upon admission including orders for blood glucose parameters for hyper (high) or hypoglycemia (low) blood sugar levels and orders when to notify the physician. How the facility plans to monitor and ensure the correction is achieved and sustained. The DON/designee will review New Admissions five (5) times a week for four (4) weeks to ensure orders are in place for diabetic care parameters and the management of hypoglycemia. The DON/designee will review the 24-hour shift report and the EMAR of residents with diabetes to ensure that orders specify when to notify the physician, the physician was notified appropriately to include documentation related to the management for hyper (high) or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 271	Continued From page 8 facility admission physician orders were reviewed. Resident # 15 was admitted on 03/01/16. The facility admission orders were dated 03/02/16 and included orders for, but were not limited to: NPO (nothing by mouth), Prostat SF (a sugar free ready to drink medical food providing 15 grams of protein) two times a day (no specific amount was indicated in the order), Enteral Feed Order every evening and night shift via pump-osmolite 1.5 at 95 ml/hr, Insulin NPH (intermediate acting) 70 units one time a day, Insulin NPH 70 units at 1800 (6:00 p.m.), SS (sliding scale) insulin Regular (short acting) every 6 hours, and glucophage 1000 mg (milligrams) twice a day. The resident's SS insulin order documented, for a blood sugar 350 + give 18 units of regular insulin. The admission physician's orders did not specify to call or notify the physician and did not include blood glucose parameters for hyper (high) or hypoglycemia (low) blood sugar levels. The resident's MARs (medication administration records) were then reviewed and documented on 03/08/16 at 6:00 p.m., the resident's blood sugar was 23. A nursing note dated 03/08/16 and timed 7:28 p.m. documented, "...blood glucose was 23, prostat med plus and 2 118 [ml] orange juice with 4 packets of sugar given glucose rechecked after first oange [sic] juice with sugar reading 55 at which time second juice with sugar give and recheck of 77 tube feed started and long acting insulin held..." The resident's CCP (comprehensive care plan) was then reviewed. The CCP dated 03/02/16 documented: "...has altered	F 271	hypoglycemia (low) blood sugar levels. Any deficient practice will result in re-education of nursing staff or disciplinary action as indicated. The Director of Nursing(DON) will report findings to the QA committee quarterly for tracking and trending.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 271	Continued From page 9	F 271		

cardio/cerebrovascular/pulmonary health r/t [related to]...DM [diabetes mellitus]...administer medication as ordered; monitor effect...Provide diet/fluid as ordered..."

No specific interventions were in the resident's CCP for the management of blood sugar parameters (hyperglycemia or hypoglycemia).

The above information was shared with the administrator, DON (director of nursing), and the corporate nurse in a meeting with the survey team on 08/09/16 at 3:00 p.m.

The DON, administrator and corporate nurse were again made aware of concerns in an end of day meeting with the survey team on 08/10/16 at 5:00 p.m., the facility was asked if they had standing orders for blood sugar parameters, the corporate nurse voiced that she did not think so, but would check. The facility staff were made aware that the resident did not have immediate care orders for diabetic management upon admission.

The facility's medical director, also known as physician # 1 was interviewed at 9:45 a.m. on 08/11/16, in a meeting with the survey team. Physician # 1 was asked if the facility has standing orders, the physician voiced no, 'I don't think so'. The physician was asked about admission orders for residents. The physician voiced, the facility uses the orders that came from the hospital. The physician was then asked if he would expect to be notified of a resident's blood sugar of 23, the physician voiced yes. The physician was asked what type of treatment would you order or expect for a diabetic who may have a low blood sugar, the physician voiced

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 271	Continued From page 10 'glucagon' [injection]. The physician was then made aware that the resident did not have any orders upon admission for diabetic management and no orders for glucagon. The physician voiced, we have glucagon orders now for everyone. The physician was asked when that took place, the physician voiced, 'after that' [after Resident # 15's discharge). No further information or documentation was presented by facility staff prior to the exit conference on 08/11/16 at 12:30 p.m., to evidence Resident # 15 had admission physician's orders for the immediate care and management of diabetic parameters.	F 271		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		9/19/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 279	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and clinical record review, the facility staff failed to develop a comprehensive care plan for two of 17 residents in the survey sample. 1. Resident #4 had no care plan developed regarding a significant weight loss. 2. Resident #5 had no care plan developed regarding grief due to the death of a close friend, a significant weight loss and the daily use of anti-platelet medication (aspirin). The findings include: 1. Resident #4 had no care plan developed regarding a significant weight loss. Resident #4 was admitted to the facility on 12/29/15 with diagnoses that included heart failure, chronic obstructive pulmonary disease (COPD), diabetes, lymphedema (swelling of a body part due to obstructed lymphatic vessels), anxiety and obesity (excessive body weight). The minimum data set (MDS) dated 6/8/16 assessed Resident #4 with moderately impaired cognitive skills. Resident #4's clinical record was reviewed on 8/10/16. The record documented the resident weighed 260 pounds (lbs.) upon admission to the facility. The clinical record documented the resident's weights as follows. 12/29/15 - 260 lbs.	F 279	283.20 (d), (k) (1) DEVELOPCOMPREHENSIVE CARE PLANS F279 How the correction action will be accomplished for the resident(s) affected. Resident #4 has an updated care plan in place for a significant weight loss. Resident #5 has an updated care plan in place regarding grief due to the death of a close friend, a significant weight loss and the daily use of anti-platelet medication (aspirin). How corrective action will be accomplished for those residents with the potential to be affected by the same practice. Current residents will be reviewed to ensure a comprehensive careplan CCP has been developed and/or revised to include weight loss, grief and the use of anti-platelet medications, as needed. Measures in place to ensure practices will not occur. DON/designee will in-service Charge Nurses on the Policy and Procedure for Care Planning to include the initiation and activation of services to meet the resident's highest practicable physical, mental, and psychosocial well-being. In-servicing to include weight loss, nutrition, anti-platelet medications, grief and any other pertinent care areas.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 279	Continued From page 12 2/3/16 - 261.5 lbs. 3/1/16 - 246 lbs. (5.9% loss in one month; 5.4% loss since admission) 4/4/16 - 247.5 lbs. 5/2/16 - 244 lbs. 5/24/16 - 223.2 lbs. (14.2% loss since admission) 6/7/16 - 220.5 lbs. 7/4/16 - 224 lbs. 8/1/16 - 215 lbs. The clinical record documented on 3/1/16 the resident had experienced a significant weight loss of 5.9% in one month going from 261.5 lbs. on 2/3/16 to 246 lbs. on 3/1/16. A nutrition assessment by the registered dietitian (RD) dated 3/24/16 listed the resident with a significant weight loss since admission and a weight goal of 250 lbs. and documented the weight loss was desired. A note written by the dietary manager on 7/22/16 stated, "Trigger for significant loss since 1/6/16 of -30# [lbs.] @ -12.2% weight 225, 4/12/16 -22# @ -8.9%. Weight on 7/4/16 = 224..." The quarterly MDS assessment dated 6/20/16 listed the resident as weighing 221 lbs. with a significant weight loss (loss of 5% or more in the last month or 10% or more in last 6 months) and not on a prescribed weight loss regimen. Resident #4's plan of care (revised 4/22/16) listed no problems, goals and/or interventions regarding the resident's significant weight loss. The care plan listed the resident had a potential for nutritional problems, weight fluctuations due to diuretic therapy, obesity and a therapeutic diet. The care plan goal stated, "Resident will avoid significant weight change through next review." Interventions listed were to administer	F 279	How the facility plans to monitor and ensure the correction is achieved and sustained. The DON/designee will review the 24-hour shift report and new orders five (5) times a week for four (4) weeks to ensure a comprehensive careplan (CCP) is being reviewed and updated. DON/designee will review new admissions five (5) times a week for four (4) weeks to develop a comprehensive on admission. Any deficient practice will result in re-education of nursing staff or disciplinary action as indicated. The Director of Nursing(DON) will report findings to the QA committee quarterly for tracking and trending.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 279	Continued From page 13	F 279		

medications as ordered, perform labs as ordered, weigh as ordered and provide diet as ordered.

The resident's clinical record included no current orders for a diuretic medication. The RD's nutritional assessment dated 3/24/16 listed the weight loss as desired but the care plan goals made no mention of a desired weight loss.

On 8/10/16 at 10:00 a.m. the dietary manager and RD were interviewed about Resident #4's care plan for weight loss. The dietary manager stated Resident #4 was discussed in the weight review committee and was not listed as being on a planned weight loss program. The dietary manager stated she did not know why the care plan did not include weight loss. The RD stated it was the responsibility of the weight committee to develop and add the care plan for weight loss.

On 8/10/16 at 2:55 p.m. the registered nurse (RN #3) MDS coordinator responsible for care plan development was interviewed about Resident #4. RN #3 stated the weight loss was not listed on the care plan. RN #3 stated the resident was obese, on a diabetic diet and would be expected to lose weight. RN #3 stated she was only responsible for care plan updates when annual and comprehensive MDS assessments were completed.

On 8/10/16 at 3:45 p.m. the director of nursing (DON) was interviewed about Resident #4's care plan. The DON stated the care plan development was a nursing responsibility. The DON stated they currently did not have unit managers and this responsibility fell to the MDS coordinator.

These findings were reviewed with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 279	Continued From page 14	F 279		

administrator, director of nursing and nurse consultant during a meeting on 8/10/16 at 4:50 p.m.

2. Resident #5 had no care plan developed regarding grief due to the death of a close friend, a significant weight loss and the daily use of anti-platelet medication (aspirin).

Resident #5 was admitted to the facility on 1/16/12 with a re-admission on 3/29/14. Diagnoses for Resident #5 included depression, high blood pressure, diabetes, hypothyroidism (deficiency of thyroid gland activity), chronic obstructive pulmonary disease (COPD) and insomnia (inability to sleep). The minimum data set (MDS) dated 6/20/16 assessed Resident #5 as cognitively intact.

On 8/9/16 at 2:45 p.m. an interview was conducted with Resident #5 about quality of life in the facility. During this interview Resident #5 was tearful and stated she was still upset about the recent death of a close friend. The resident stated she did not have much appetite and did not feel like participating in activities because of the death of her friend. The resident stated that staff members had been very supportive since the death.

Resident #5's clinical record documented a physician's order dated 10/10/14 for aspirin 81 milligrams daily for anti-platelet therapy. The medication administration record documented aspirin was administered each day as ordered.

Resident #5's clinical record documented a MDS assessment dated 6/20/16 listing the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 279	Continued From page 15	F 279		

weighed 122 lbs. (pounds) and had experienced a significant weight loss of 5.4% in one month.

A mental health progress note dated 7/12/16 documented the resident presented with anger, poor coping skills and depression symptoms related to the recent death of her significant other. The clinical record documented a nursing note dated 7/17/16 stating, "Resident upset/crying, wanting to know about funeral arrangements for her friend..." A note dated 7/18/16 stated, "Resident has had a decreased appetite the past week d/t [due to] recent loss in family, she did not eat much of the facility provided meal..."

Resident #5's plan of care (revised 6/21/16) included no problems, goals and/or interventions regarding grief associated with the recent loss of her friend, the significant weight loss noted on 6/20/16 or the daily anti-platelet therapy (aspirin). The care plan listed the resident had a potential for nutritional problems but made no mention of any weight loss.

On 8/10/16 at 9:55 a.m. the registered nurse (RN #3) MDS coordinator responsible for care plans was interviewed about Resident #5. RN #3 stated she was only involved with care plans during annual or comprehensive MDS assessments.

On 8/10/16 at 11:00 a.m. the social worker was interviewed about a care plan regarding Resident #5's grieving process. The social worker stated staff members were providing frequent visits with Resident #5 due to the death of her friend. The social worker stated the resident also had been assessed and treated by psychiatric services due to her grief. When asked why this grief issue for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 279	Continued From page 16 the resident was not part of the care plan, the social worker stated the plan already listed the topic of mental health. The social worker stated the MDS coordinator was responsible for adding the care plan interventions. On 8/10/16 at 3:45 p.m. the director of nursing (DON) was interviewed about Resident #5's care plan. The DON stated the grief, weight loss and aspirin therapy should have been included in the plan of care. The DON stated she reviewed the care plan and did not find goals or interventions for these topics. The DON stated concerning the care plan, "Everything was very generic." The DON stated care plan development was a nursing responsibility and without unit managers that responsibility fell to the MDS coordinator. These findings were reviewed with the administrator, director of nursing and nurse consultant during a meeting on 8/10/16 at 4:50 p.m.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and review of facility documents, the facility staff failed for two of 17 residents in the survey sample (Residents # 2 and 15) to maintain acceptable standards of nursing practice. For Resident # 2, the facility staff failed to perform neuro checks after the resident fell and sustained a head injury.	F 281	483.20 (k) (3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS F281 How the correction action will be accomplished for the resident(s) affected. 1. Patient/Resident #15 no longer resides at Louisa Health and	9/19/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 281	Continued From page 17 For Resident # 15, the facility staff failed to immediately develop a plan of care to address diabetic management. The findings included: 1. The facility staff failed to perform neuro checks after Resident # 2 fell and sustained a head injury. Resident # 2 in the survey sample, an 89 year-old female, was admitted to the facility on 3/10/14, and most recently readmitted on 6/12/14 with diagnoses that included chronic obstructive pulmonary disease, generalized muscle weakness, hypertension, and Alzheimer's Disease. According to an Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/20/16, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 12 out of 15. According to the most recent Quarterly MDS, with an ARD of 8/5/16, the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with a Summary Score of 3 out of 15. Review of Resident # 2's Electronic Health Record (EHR) revealed the following entry: 4/26/16 - 0045 "Res. fell while ambulating in room, hitting head...Resident alert oriented at baseline. Hematoma remains on back of head. Dressing intact on skin tear right forearm...." Review of the Incident Report regarding the fall revealed the following:	F 281	Rehabilitation facility. 2. Nurse responsible for completion of the Post Fall assessment and completing the neuro checks is no longer employed at the facility. The Nurses responsible for the Post Fall Documentation will be in-serviced on completing a neurological assessment for unwitnessed falls /hitting head and comprehensive assessment for the next 24hours. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. Current Residents who have fallen since 8/11/2016 will be reviewed to ensure neurological assessment and comprehensive assessment was completed per policy. Any missing assessments will result in in-servicing of involved nurses. Current diabetic residents will be reviewed to ensure they have an updated Comprehensive Careplan (CCP) for immediate care and management of diabetes. Measures in place to ensure practices will not occur. Charge Nurses will be educated on the Fall Management Program including Fall Occurrence/ Immediate Responsibilities, including the evaluation, monitoring, and documentation of patient response for the first 24 hours (3 consecutive shifts) post fall, including a neurological assessment if the fall was unwitnessed and/or the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 281	Continued From page 18 "This nurse was passing medication to the room next to this resident room. The resident's daughter came to this nurse and stated her mother had fallen. Upon entering the room the resident was found lying flat on her back beside the closet...She has a grape-sized lump on the back of her scalp with some dark purple bruising...." At the request of the surveyor, the Director of Nursing (DON) furnished a copy of the facility's Fall Management Program Policy. Review of the policy noted the following: "Fall Occurrence Immediate Responsibilities: Evaluate, monitor, and document patient response for the first 24 hours (3 consecutive shifts) post fall, include a neurological assessment if the fall was unwitnessed and/or the patient hit his/her head. For the next 48 hours a comprehensive assessment will be documented daily." A thorough review of the resident's paper clinical record as well as her EHR failed to reveal any documentation of a neurological assessment. At approximately 2:10 p.m. on 8/10/16, the surveyor asked the DON if she could locate a neurological assessment for the resident's fall. At approximately 4:30 p.m. on 8/10/16, during a meeting with the survey team and the administrative staff, the facility's Nurse Consultant notified the surveyor that they had been unable to find a neurological assessment, and that apparently it was not done.	F 281	patient hit his/her head. For the next 48-hours a comprehensive assessment will be documented daily." The Charge Nurses will be in-serviced on the need for residents to have immediate care orders for diabetic management upon admission and Comprehensive Careplan developed and updated with interventions for care and management of their diabetes. How the facility plans to monitor and ensure the correction is achieved and sustained. The DON/designee will review the 24-hour shift report and Risk Management five (5) times a week for four (4) weeks to ensure completion of neurological assessment as indicated and completion of comprehensive assessment for the next 48 hours. Any missing assessments will be completed. The DON/designee will review two diabetic residents weekly for four (4) weeks to ensure plan of care was developed to address diabetic management. Any deficient practice will result in re-education of nursing staff or disciplinary action as indicated. The Director of Nursing(DON) will report findings to the QA committee quarterly for tracking and trending.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 281	Continued From page 19	F 281		

2. The facility staff failed to ensure an immediate plan of care was developed for diabetes management/parameters for Resident # 15.

Resident # 15 was admitted to the facility on 03/01/16. Diagnoses for Resident # 15 included, but were not limited to: Stroke with aphasia (inability to speak), seizures, tracheostomy (surgical opening through the neck to provide an airway and remove secretions), DM (diabetes mellitus), and a PEG tube (medical procedure where a tube is passed into a patient's stomach to provide a means of nutrition and hydration when unable to take oral intake).

The most recent full MDS (minimum data set) was a 5 day admission assessment dated 03/08/16. This MDS assessed the resident as having short and long term memory impairment with severe impairment in daily decision making skills. The resident was also assessed as being totally dependent upon staff for all ADL's (activities of daily living) including feeding (nutrition/hydration). The resident was also assessed as receiving insulin injections for the previous 7 days. The resident did trigger in the CAAS (care area assessment summary) section of this MDS for nutrition and the area was marked to address in the resident's comprehensive care plan (CCP).

A complaint regarding Resident # 15, was investigated during the survey process on 08/09/16 through 08/11/16.

During clinical record review, Resident # 15's facility admission physician orders were reviewed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 281	Continued From page 20	F 281		

Resident # 15 was admitted on 03/01/16. The facility admission orders were dated 03/02/16 and included orders for, but were not limited to: NPO (nothing by mouth), ProStat SF (a sugar free ready to drink medical food providing 15 grams of protein) two times a day (no specific amount was indicated in the order), Enteral Feed Order every evening and night shift via pump-osmolite 1.5 at 95 ml/hr, Insulin NPH (intermediate acting) 70 units one time a day, Insulin NPH 70 units at 1800 (6:00 p.m.), SS (sliding scale) insulin Regular (short acting) every 6 hours, and glucophage 1000 mg (milligrams) twice a day. The resident's SS insulin order documented, for a blood sugar 350 + give 18 units of regular insulin. The physician's order did not specify any specific blood sugar parameters for Resident # 15.

The resident's MARs (medication administration records) were then reviewed for the month of March 2016. Resident # 15 had a very low blood sugar reading of 23 on one occasion (03/08/16) and several high blood sugar readings over 350.

The resident's CCP (comprehensive care plan) was then reviewed. The CCP dated 03/02/16 documented: "...has altered cardio/cerebrovascular/pulmonary health r/t [related to]...DM [diabetes mellitus]...administer medication as ordered; monitor effect...Provide diet/fluid as ordered..."

The CCP did not have interventions or parameters for the care and management of diabetes for Resident # 15.

The above information was shared with the administrator, DON (director of nursing), and the corporate nurse in a meeting with the survey

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 281	Continued From page 21 team on 08/09/16 at 3:00 p.m. The DON, administrator and corporate nurse were again made aware of concerns in an end of day meeting with the survey team on 08/10/16 at 5:00 p.m., that Resident # 15 was on multiple hypoglycemic medications and there were no interventions on the resident's CCP for the care and management of his diabetes. No information was given, as to why a CCP was not developed for Resident # 15 for diabetes. No further information or documentation was presented by facility staff prior to the exit conference on 08/11/16 at 12:30 p.m., to evidence Resident # 15 had comprehensive care plan for the immediate care and management of diabetes.	F 281		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, facility staff failed to assess and attempt non-pharmacological interventions prior to the administration of pain medication for one of 17 residents (Resident #4) and failed to follow physician orders for one of 17 residents in the	F 309	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING F309 How the corrective action will be accomplished for the resident(s) affected. A pain assessment will be completed for	9/19/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 309	Continued From page 22 survey sample (Resident #5). 1. Resident #4 was administered nine doses of the medication Oxycodone in August 2016 without a documented assessment and/or prior attempts at non-pharmacological interventions to reduce pain. 2. Nurses failed to follow physician orders regarding notification for six high blood sugar readings for Resident #5 from 7/1/16 through 8/10/16. The findings include: 1. Resident #4 was administered nine doses of the medication Oxycodone from 8/1/16 through 8/10/16 without a documented assessment and/or prior attempts at non-pharmacological interventions to reduce pain. Resident #4 was admitted to the facility on 12/29/15 with diagnoses that included heart failure, chronic obstructive pulmonary disease (COPD), diabetes, lymphedema (swelling of a body part due to obstructed lymphatic vessels), anxiety and obesity (excessive body weight). The minimum data set (MDS) dated 6/8/16 assessed Resident #4 with moderately impaired cognitive skills. Resident #4's clinical record documented a physician's order dated 12/31/15 for the medication Oxycodone 5 mg (milligrams) to be administered every 4 hours as need for pain. The record also documented a physician's order dated 2/19/16 for the medication Tylenol 650 mg (milligrams) to be administered every 8 hours as needed for pain.	F 309	Resident # 4 to include pain, pain rating, location, medication selection, non-pharmacological interventions, and response. The Comprehensive Care Plan (CCP) will be reviewed and revised for pain management regarding Resident #4. Physician was notified for six high blood sugar readings between 7/01/2016 and 8/10/2016 for Resident # 5. How the correction action will be accomplished for those residents with the potential to be affected by the same practice. Current residents who have received pain medications in the last 24 hours will be reviewed to ensure pain assessment has been completed, non-pharmacological interventions have been attempted and interventions are careplanned. Any residents identified without pain management or interventions will be corrected. EMAR of current diabetic residents will be checked to ensure complete and accurate documentation of blood sugar checks, physician notification per orders and parameters. MD will be notified of any outstanding findings. Measures in place to ensure practices will not occur. The DON/designee will in-service the Charge Nurses on the policy and procedure for Pain Management to include the physician orders, assessment of chronic and acute pain, pain on admission, new pain, interventions for pain, non-pharmacological interventions	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 309	Continued From page 23 Resident #4's medication administration record (MAR) from 8/1/16 through 8/10/16 documented the resident was administered 11 doses of Oxycodone for pain rated from 2 to 6 (on a scale with 0 as no pain, 10 as worst pain). Nine of the 11 doses of Oxycodone administered to Resident #4 included no assessment of the resident's pain other than the numeric pain rating and included no mention of any attempts of non-pharmacological interventions. The August MAR documented no doses of Tylenol administered to Resident #4. Nursing notes documented the following concerning the Oxycodone administered from 8/1/16 through 8/10/16. 8/1/16 at 9:43 a.m. - "Needed for pain 2/10." 8/3/16 at 9:37 a.m. - "Needed for pain 2/10." 8/4/16 at 9:14 a.m. - "Needed for pain 2/10." 8/4/16 at 9:05 p.m. - "req [requested] for (L) [left] knee pain unrelieved by repo [repositioning] 8/5/16 at 10:35 a.m. - "Given per resident request for 6/10 left leg pain." 8/5/16 at 5:02 p.m. - "given for c/o [complaint of] 6/10 left knee pain." 8/6/16 at 8:41 p.m. - "req for (L) knee pain unrelieved by repo." 8/7/16 at 8:32 a.m. - "Needed for pain 2/10." 8/8/16 at 8:54 a.m. - "Given per resident request for 5/10 left leg pain." 8/9/16 at 9:37 a.m. - "Needed for pain 2/10." 8/10/16 at 1:30 a.m. - no notes listed Five of the 11 doses included no location of the resident's pain. The notes describing leg/knee pain included no assessment of the resident's leg or knee including appearance, skin color, skin	F 309	and documentation of pain. Charge Nurses will also be in-serviced on the administration and effectiveness of pain medication, and specific interventions based on individual resident needs. Nurses will be in-serviced on following physician orders, physician notification of blood sugar reading outside the parameters and maintaining complete and accurate documentation. How the facility plans to monitor and ensure correction is achieved and sustained. The DON/designee will review two residents five (5) times a week for four weeks to ensure residents were assessed for pain, non-pharmacological interventions were implemented and the physician orders were followed. The DON/designee will review the EMAR for two(2) diabetic residents five (5) times a week for four new admissions to ensure appropriate orders are in place, parameters for blood sugars are being followed and documented, and the physician is notified per order. Any deficient practice will result in re-education or disciplinary action. The DON will report the findings to the QA committee quarterly for tracking and trending.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 309	Continued From page 24	F 309		

temperature, presence of edema or any limits on range of motion. The record documented no parameters of when to administer Tylenol versus the Oxycodone. Nursing notes made no mention of why Tylenol was not administered to Resident #4 during August 2016.

The resident's care plan (revised 4/22/16) listed the resident had pain due to lymphedema, obesity and impaired mobility. The care plan goal for pain stated, "She [Resident #4] will have no/decreased complaints of pain through next review." Interventions for pain included, "Encourage relaxation techniques and provide diversional activities...Medicate as ordered; monitor effect...Position resident for comfort."

On 8/9/16 at 9:15 a.m. the registered nurse (RN #2) administering medications to Resident #4 was interviewed about the pain assessment and medicines. RN #2 stated she was filling in as a floor nurse and did not know for sure why the resident was administered the Oxycodone instead of the Tylenol. RN #2 reviewed the MAR for August and stated the resident had received only Oxycodone for pain and no Tylenol. RN #2 stated RN #1 was more familiar with Resident #4.

On 8/10/16 at 9:20 a.m. RN #1 was interviewed about Resident #4's pain assessments and medicines. RN #1 stated the as needed pain medications were administered based upon the pain scale. RN #1 stated the Tylenol could have been offered for pain rated as 2. RN #1 stated the resident was able to make her needs knows and will say, "Can you give me my pain pill." RN #1 stated the resident had ongoing leg pain due to edema in her legs. RN #1 stated the resident's legs were normally wrapped with a support

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 309	Continued From page 25	F 309		

dressing when out of bed but the resident preferred to stay in bed most days. When asked how the nurses know when to give Tylenol and when to give Oxycodone, RN #1 stated she did not see any documented parameters. When asked about non-pharmacological interventions for pain, RN #1 stated she did not see anything documented other than the repositioning. RN #1 stated there should be an assessment listed when the pain medications were administered including the location of the pain.

On 8/10/16 at 3:45 p.m. the director of nursing (DON) was interviewed about pain management for Resident #4. The DON stated nurses should be documenting the location, pain rating and include a full assessment of the pain at the time as needed medications were administered. The DON stated nurses should document if the resident was offered Tylenol and she refused. The DON stated the assessments for August (2016) were lacking and there was no recent documentation indicating the Tylenol was ineffective. The DON stated non-drug interventions were supposed to be attempted and the goal was for the resident to have pain managed with the least amount of medication.

The Drug Information Handbook for Nursing 13th edition on pages 912 through 914 describes Oxycodone and an opioid analgesic used for the management of moderate to severe pain, usually in combination with non-opioid analgesics. Page 913 of this reference states Oxycodone "is indicated for around-the-clock management of moderate-to-severe pain when an analgesic is needed for an extended period of time" and states under warnings, "Healthcare provider should be alert to problems of abuse, misuse and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 309	Continued From page 26	F 309		

diversion." Page 914 of this reference states Oxycodone may cause physical and/or psychological dependence. (1)

The Drug Information Handbook for Nursing 13th edition on pages 25 and 26 describes Tylenol as an analgesic used for the management of mild to moderate pain and fever. (1)

These findings were reviewed with the administrator, director of nursing and nurse consultant during a meeting on 8/10/16 at 4:50 p.m.

(1) Turkoski, Beatrice B., Brenda R. Lance and Elizabeth A. Tomsik. Drug Information Handbook for Nursing. Hudson, Ohio: Lexi-Comp, 2011.

2. Nurses failed to follow physician orders regarding notification for six high blood sugar readings for Resident #5 from 7/1/16 through 8/10/16.

Resident #5 was admitted to the facility on 1/16/12 with a re-admission on 3/29/14. Diagnoses for Resident #5 included depression, high blood pressure, diabetes, hypothyroidism (deficiency of thyroid gland activity), chronic obstructive pulmonary disease (COPD) and insomnia (inability to sleep). The minimum data set (MDS) dated 6/20/16 assessed Resident #5 as cognitively intact.

Resident #5's clinical record documented a physician's order dated 8/30/14 for Novolog insulin to be administered before meals with the dosage based upon the resident's blood sugar reading (sliding scale). The order included

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 309	Continued From page 27	F 309		

instructions to notify the physician of any blood sugar readings of 451 or higher. The record also documented a physician's order dated 9/29/14 for the resident's blood sugar level to be checked at bedtime with instructions to notify the physician of any blood sugar readings greater than 400.

The resident's medication administration records (MARs) from 7/1/16 through 8/10/16 were reviewed. The MAR documented six blood sugar readings above the physician ordered parameters without notification to the physician.

The following blood sugar readings assessed as part of the sliding scale Novolog insulin order were above the physician ordered parameter of 451 or higher and were without notification to the physician.

7/3/16 at 4:00 p.m. - blood sugar reading of 472
7/28/16 at 4:00 p.m. - blood sugar reading of 467
7/29/16 at 6:00 a.m. - blood sugar reading of 461
7/29/16 at 4:00 p.m. - blood sugar reading of 460
8/6/16 at 12:00 p.m. - blood sugar reading of 528

In addition the resident's blood sugar on 7/10/16 at 8:00 p.m. was assessed as 441. The physician's order for bedtime blood sugar check required notification for sugar readings above 400. The clinical record documented no notification to the physician of the elevated blood sugar.

On 8/10/16 at 3:45 p.m. the director of nursing (DON) was interviewed about the lack of notification to the physician of the elevated blood sugars for Resident #5. The DON stated she reviewed the record and did not find notification to the physician. The DON stated nurses should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 309	Continued From page 28 follow the physician's order and promptly notify the physician of elevated blood sugars and also document the notification in the clinical record. These findings were reviewed with the administrator, director of nursing and nurse consultant during a meeting on 8/10/16 at 11:30 a.m.	F 309		
F 322 SS=G	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and during the course of a complaint investigation, the facility staff failed to ensure	F 322	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS	9/19/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 322	Continued From page 29 appropriate care and services for a gastrostomy tube to prevent dehydration and significant metabolic changes for one of 17 residents in the survey sample (Resident # 15), which resulted in actual harm. The facility failed to ensure Resident # 15 received adequate nutrition/hydration via a gastrostomy tube for the prevention of dehydration, as a result Resident # 15 was sent out emergently to the hospital via 911. Resident # 15 was admitted to the facility on 03/01/16 and discharged on 03/014/16, at which time he was admitted to the hospital MICU (medical intensive care unit), where the resident was diagnosed with severe dehydration. Findings include: Resident # 15, (a 76 year old African American man) was admitted to the facility on 03/01/16. Diagnoses for Resident # 15 included, but were not limited to: Ischemic stroke (damage to the brain from an interruption of blood supply), aphasic (unable to speak), flaccid right side hemiplegia (complete paralysis of right side) and spastic left sided hemiparesis (weakness of left side with involuntary movements), seizures, tracheostomy (surgical opening through the neck to provide an airway and remove secretions), DM (diabetes mellitus), PEG tube (medical procedure where a tube is passed into a patient's stomach to provide a means of nutrition and hydration when unable to take oral intake) and cognitive communication deficit. The most recent full MDS (minimum data set) was a 5 day admission assessment dated 03/08/16. This MDS assessed the resident as	F 322	F322 How the corrective action will be accomplished for the resident(s) affected. Resident # 15 no longer resides in Louisa Health and Rehabilitation Facility. How the correction action will be accomplished for those residents with the potential to be affected by the same practice. Current residents with a naso-gastric or gastrostomy tube will be assessed by RD to ensure residents are receiving appropriate care and services, adequate nutrition/hydration to prevent dehydration and metabolic changes. The current Resident orders and the intake and output records will be reviewed to ensure that the current orders are matching the RD recommendations for the fluid and feeding. Measures in place to ensure practices will not occur. Charge Nurses will be in-serviced on the policy and procedures for Feeding Tubes, Care of the Resident with a feeding tubes, Change of Condition, and Nursing Documentation. Charge Nurses also will be in-serviced on I&O (intake and output) documentation to monitor the amount of feeding and/or hydration ordered by the physician for fluid and feeding. Charge Nurses will notify RD of all new admissions with tube feeding orders. How the facility plans to monitor and ensure correction is achieved and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 322	Continued From page 30 having short and long term memory impairment with severe impairment in daily decision making skills. The resident was also assessed as being totally dependent upon staff for all ADL's (activities of daily living) including feeding (nutrition/hydration). The resident was additionally assessed on this MDS to have a feeding tube (abdominal peg). In section K0700. Percent Intake by Artificial Route A. Proportion of total calories the resident received through tube feeding was documented as, "51% or more" and for B. Average fluid intake per day by IV (intravenous) or tube feeding was documented as, "501 cc/day (cubic centimeters) or more." The resident was also assessed as receiving insulin injections for the previous 7 days and as receiving diuretics (medication that induces excretion of fluid from the body) for the previous 6 days. The resident did trigger in the CAAS (care area assessment summary) section of this MDS for nutrition, feeding tube, and dehydration; all of these areas were marked to address in the resident's comprehensive care plan (CCP). A complaint regarding Resident # 15, was investigated during the survey process on 08/09/16 through 08/11/16. The complaint alleged that Resident # 15 was transferred to the hospital on 03/14/16 where he was found to be severely dehydrated, with hypernatremia (high sodium level). During clinical record review, Resident # 15's facility admission physician orders were reviewed. The orders included, but were not limited to, keep the resident NPO (nothing by mouth), and to have tube feeding (Osmolite 1.5) at 95 cc/hour for 14	F 322	sustained. DON/designee will review Resident feeding tubes orders on admission and three (3) times a week for four (4) weeks to ensure weights and labs will be obtained as ordered, I&O□s recorded per shift and MD notified of Change in Condition or omissions. Any deficient practice will result in re-education or disciplinary action. The DON will report the findings to the QA committee quarterly for tracking and trending.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 322	Continued From page 31	F 322		

hours via PEG tube to start at 6:00 p.m. and stop at 10:00 a.m., and to flush feeding tube with 100 cc of water every 6 hours. The resident was also order hydrochlorothiazide (a diuretic) 25 mg (milligrams) every morning. A BMP (Basic Metabolic Panel) was also ordered to be drawn on 03/03/16. All of the above orders had an order date of 03/02/16.

The resident's CCP (comprehensive care plan) was then reviewed. The CCP dated 03/02/16 documented: "...PEG TF [tube feed], risk for aspiration/dehydration r/t CVA/ICH [cerebrovascular accident/intracranial hemorrhage], NPO [nothing by mouth] status, trach in place, dependence on staff for nourishment/hydration...Provide diet/fluid as ordered. Monitor intake and record..., weekly weights..."

A Nutritional Assessment dated 03/02/16 and timed 2:51 p.m. documented, "...76 year old male...tracheostomy and peg place on 2/6/16...Diet: NPO...ProStat SF BID [twice daily], provides 220 kcal [kilo calories]...labs: none since admission...Per hospital records Na+ [sodium] downtrending to most recent level 131...Pertinent Meds: Hydrochlorothiazide [diuretic], hydralazine, Insulin, Metformin...Height: 67 inches [5'6]...Weight: 213 (97 kg)...adjusted weight 180 (82 kg)...Estimated nutritional needs...2300-2450 kcal...2300-2450 ml fluid, 28-30 ml/kg...1013 ml fluid + 600 ml flush = 1613 ml fluid...Suspect fluid restricted d/t [due to]...hyponatremia [low sodium]. will follow labs and adjust flushes as needed...signature of RD [Registered Dietitian]."

The physician's order for fluid and the RD note

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 322	Continued From page 32	F 322		

above did not match, as far as the resident's fluid/hydration needs.

The resident's I&O (intake and output) records in the clinical record were then reviewed and no information was documented.

The corporate nurse was asked on 08/10/16 at approximately 10:30 a.m., where I&O records are kept and/or documented. The corporate nurse voiced that the information was on enteral flow sheet, which is part of the MARs (medication administration records) where the tube feeding is listed.

The resident's MARs and TARs (treatment administration records) for the entire month of March 2016 were reviewed.

The following feeding and fluid intake records for Resident # 15 documented what the resident had on the following days.

03/02/16 = 855 ml of intake.
03/03/16 = 190 ml of intake.
03/04/16 = 855 ml of intake.
03/05/15 = no information found.
03/06/16 = 1040 ml of intake.
03/07/16 = 1000 ml of intake.
03/08/16 = 650 ml of intake.
03/09/16 = 650 ml of intake.
03/10/16 = 650 ml of intake.
03/11/16 = 650 ml of intake.
03/12/16 = 560 ml of intake.
03/13/16 = 940 ml of intake.

The above documentation indicated that the resident did not receive an adequate amount of feeding and/or hydration on the above days and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 322	Continued From page 33	F 322		

never met the minimum requirement that was ordered by the physician for fluid and feeding. No other information was located throughout the clinical record regarding intake for Resident # 15.

Weight records were then reviewed for Resident # 15 from admission (03/01/16) through discharge (03/14/16), the last recorded weight was on 03/08/16, which documented a weight of 174.5. No weight records were located from 03/09/16 through 03/14/16, to evidence that Resident # 15 was getting daily weights as directed by the resident's CCP.

A BMP (basic metabolic panel) laboratory test was drawn on 03/03/16 for Resident # 15. The BMP was reviewed and documented, the resident had a high glucose level of 427 (reference range: 65-99), BUN (blood urea nitrogen-used to determine kidney function) was high at 39 (reference range: 8-27), the resident's eGFR (if African American) is a test to estimate glomerular filtration rate for African Americans and is used to detect early kidney damage, the resident's reading was 100 (reference range: greater than 59) a normal value, the resident's BUN/Creatinine Ration, which is used to assess kidney function was 49 (reference range: 10-22), well above normal, the resident's sodium level was slightly low at 133 (reference range: 134-144).

No documentation could be located throughout the clinical record to evidence that the above lab results were reported to the physician or that the RD had reviewed.

A nursing note dated 03/05/16 and timed 5:44 a.m., documented: "vomited large amount of TF [tube feeding] appearing curdled with a brownish

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 322	Continued From page 34	F 322		

colored mucus and hiccups...low grade temp 99.2...no residual TF obtained. TF held at this time, suction via yonker [sic] and trach [sic] to ensure no aspiration...MD [medical doctor] notified...[signature of LPN (Licensed Practical Nurse) # 3]."

No information or documentation was found to evidence the physician was actually made aware of the above. No physician's orders were found to hold the TF for any time. The above nursing note did not document how long the TF was actually held.

The resident's MARs for 03/05/16 (evening/night shift) was reviewed and no information and/or documentation at all was documented to indicate how much enteral feeding/fluid the resident received, if any.

A nursing note dated 03/06/16 and timed 6:01 a.m. documented, "...pain, hiccups and vomiting...temp 100.0, hiccups at same time as yesterday with vomiting to follow. MD returned call [no time] with new orders to decrease tf [tube feeding] to 80 cc hour and extending hang time to 1700 [5:00 p.m.] to 1100 [11:00 a.m.]...monitor for any changes...signature of LPN # 3."

A physician's order dated 03/06/16 (no time) documented to change the tube feeding to 80 cc per hour for 16 hours and gave a start time of 5:00 p.m. and stop at 11:00 a.m.

NOTE: oth physician's orders for the tube feeding were not clear and concise the first tube feeding order was ordered to run at 95 ml/hr for 14 hours, but had a start time of 6:00 p.m. and stop time of 10:00 a.m., which is actually 16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 322	Continued From page 35	F 322		

hours (not 14). The second physician's order for the tube feed was ordered to run at 80 ml/hr for 16 hours, but had a start time of 5:00 p.m. and stop time of 11:00 a.m., which is 18 hours (not 16). Neither orders were clarified.

A physician's progress note dated 03/08/16 (1 week after the resident's admission) was reviewed and documented: "...Nurses report patient had an episode of vomiting 03/5/16 and now with thick green sputum from trach tube...otherwise continue present care plan..."

The physician's progress note did not address or acknowledge the resident's BMP (Basic Metabolic Panel) laboratory test results from 03/03/16.

A physician's order dated 03/02/16 (order date) for a "Swab trach for MRSA [methicillin-resistant Staphylococcus aureus] one time only for 1 day" was reviewed. The start date for this order was 03/04/16.

A nursing note dated 03/09/16 and timed 2:09 a.m. documented: "...100.4 [temp]...Noted trach culture results positive for MRSA. Lab results sent to MD...[signature of LPN # 3]."

The above lab result was not reported to the physician until 5 days after lab test was completed, Resident # 15 was started on antibiotics for the above infection on 03/11/16.

A physician's order dated 03/09/16 (no time) for laboratory tests, including a CMP (comprehensive metabolic panel), CBC (complete blood count), UA (urinalysis) C/S (culture and sensitivity) "STAT" to rule out infection was found in the clinical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 322	Continued From page 36	F 322		

The CMP dated 03/09/16 for Resident # 15 was reviewed. The collection time was documented as 10:45 a.m., with a result time of 5:35 p.m.

The CMP lab results documented that the resident had an HH [High Alert] BUN of 125 (reference range: 8-27), this was a significant increase from the BUN of 39 on 03/03/16; the resident's eGFR had significantly decreased from 100 (a normal value) on 03/03/16 to 54 a low, below normal value (reference range: greater than 59), the resident's BUN/Creatinine ratio was significantly higher at 87 (reference range: 10-22) compared to the result on 03/03/16, which was 49. The resident's sodium level was 150 on 03/09/16 in comparison to the 03/03/16 labs where the resident's sodium level was 133 (reference range: 134-144).

No evidence could be located throughout the clinical record to evidence that the physician was actually notified of the CMP critical lab values dated 03/09/16. No physician's orders were found to evidence that any type of action had been taken to address the critical CMP lab results for Resident # 15 and no physician correspondence of any kind could be located to evidence that the physician was informed/notified and/or received the CMP critical lab information for Resident # 15.

A nursing note dated 03/10/16 and timed 4:03 a.m. documented, that the resident was on antibiotic for MRSA infection (sputum).

Resident # 15's antibiotic for the MRSA infection did not actually start until 03/11/6 at 8:00 a.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 322	Continued From page 37	F 322		

A Nutrition Assessment dated 03/10/16 and timed 9:10 a.m. documented, "...updated with current weight...76 year old male...tracheostomy and peg place on 2/6/16...NPO...labs: none since admission...Per hospital records Na+ [sodium] downtrending to most recent level 131...Pertinent Meds: Hydrochlorothiazide [diuretic], hydralazine, Insulin, Metformin...Height: 67 inches...Weight: 3/8/16=174.5 (79 kg)...adjusted weight 161 (73 kg)...Estimated nutritional needs...2000-2200 kcal...2300-2450 ml fluid, 28-30 ml/kg...1013 ml fluid + 600 ml flush = 1613 ml fluid...Suspect fluid restricted d/t [due to]...hyponatremia [low sodium]. will follow labs and adjust flushes as needed...signature of RD [Registered Dietitian]."

There was no evidence throughout the clinical record that the RD reviewed the resident's laboratory test results from 03/03/16 or 03/09/16, no evidence was found that the physician and/or RD communicated or collaborated in response to Resident # 15's critical lab results or that the resident's nutritional and hydration needs were confirmed.

A nursing note dated 03/10/16 and timed 2:46 p.m. documented, "...Resident...lethargic...CMP returned with alert BUN level of 125...Creatinine 1.44...MD made aware via nurse, awaiting new order...started on Levaquin yesterday...presumed UTI [urinary tract infection]..."

A nursing note dated 03/10/16 and timed 11:08 p.m. documented, that the resident was being treated with Levaquin for infection and Bactrim was started on 03/11/6 for MRSA in the trach, the nursing note also documented, that the resident's free water was increased to 150 ml every 6 hours.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 322	Continued From page 38	F 322		

No other interventions or physician's orders were found or located to indicate that the resident's critical CMP lab results were addressed.

It could not be evidenced by the resident's clinical record or by the intake records, that Resident # 15 received the increase in fluids.

An order was identified on the resident's POS (physician's order sheet) dated 03/11/6 (no time) for a CBC and CMP one time only for 1 day, the order date was documented as 03/11/16, the start date was documented as 03/17/16 (3 days after the resident had been discharged to the hospital). No other lab test were drawn on Resident # 15 until 03/14/16.

The CMP lab results dated 03/14/16, with a time collection of 1:00 a.m. and a result time of 2:10 p.m. were reviewed. The CMP was marked and flagged as critical. The resident's BUN was now 219, the eGFR was now 21, the Creatinine was now at 3.20, the BUN/Creatinine was now 68, and the Sodium was now 166.

A nursing note dated 03/14/16 and timed 5:04 p.m., documented, "...Change of Condition...Abnormal lab results...this started on 03/07/16 during the afternoon...notified [Physician # 2 on] 03/13/16 6:00 p.m.. Orders obtained: Blood tests...[signature of RN # 1]."

A nursing note dated 03/14/16 and timed 6:04 p.m. documented, "...MD notified of lab result: ...MD orders to send resident out 911 to ER [emergency room]...signature of RN # 1."

All of the above concerns were shared with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 322	Continued From page 39	F 322		

administrator, DON (director of nursing), and the corporate nurse in a meeting with the survey team on 08/09/16 at 3:00 p.m. The facility staff were informed of the complaint investigation and any and all assistance was requested for any additional information or documentation to evidence that the resident received adequate fluids and nutrition and that the physician was actually notified, and/or notified in a timely manner regarding the critical labs results and any further information to evidence that the lab results were acted upon appropriately.

The facility staff were also made aware of concerns regarding the resident's CCP, which included interventions for daily weights and for monitoring/recording the resident's intake. No evidence of daily weights were found after 03/08/16, which was the last recorded weight for Resident # 15. Limited evidence was found regarding Resident # 15's nutrition/hydration monitoring and recording. The staff were made aware that the resident's fluid intake did not ever meet the minimum requirements, as ordered by the physician or recommended by the RD and that the resident's lab values were showing signs of decline (dehydration) from admission up to the time of discharge without adequate and/or appropriate intervention from facility staff.

The DON, administrator and corporate nurse were again made aware of serious concerns in a end of day meeting with the survey team on 08/10/16 at 5:00 p.m., again the facility staff were ask to provide any additional information or documentation to evidence the resident received adequate fluids and/or nutrition for the prevention of dehydration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 322	Continued From page 40	F 322		

On 08/11/16 at 8:50 a.m., RN (Registered Nurse) # 1 was interviewed in a meeting with the survey team. The RN was asked about the note written on 03/14/16 and timed 5:04 p.m. (the date of discharge for Resident # 15), the RN voiced that she could not remember what exactly happened on 03/14/16. The RN was asked about the change in condition note that was written, and asked specifically what was the change. RN # 1, voiced that she didn't remember and asked to see a copy of the note. RN #1 viewed a copy of the note and voiced the labs, that is why I notified the physician (physician # 2).

It was pointed out to the RN that she notified physician #2 on 03/13/16 at 6:00 p.m. and was asked how she could notify physician # 2 of critical lab results that had not been drawn yet (referring to labs drawn on 03/14/16 1:00 a.m.). RN # 1 voiced that she notified the physician of the Resident's critical lab work from 03/09/16 and further voiced that the results were abnormal. RN # 1 voiced that it is documented in her note (dated 03/14/16) that she notified physician # 2 on 03/13/16 at 6:00 p.m. and as a result of that notification, that physician ordered blood tests (for 03/14/16) to be drawn, those labs were drawn at 1:00 a.m. on 03/14/16. The RN voiced noticing everything going down starting on 03/07/16 (referring to resident and labs). The RN voiced the 03/14/16 lab results were documented to have been drawn at 10:45 a.m. and reported to the facility at 5:35 p.m. RN #1 voiced that after the labs came back from 03/14/16 and the best she could remember was that she contacted the physician around 6:00 p.m. and the doctor gave an order to send out to hospital by 911. The RN was made aware that according to the lab results dated 03/14/16, that the results had been called

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 322	Continued From page 41	F 322		

back to LPN # 5 at 3:23 p.m. and was asked why it took 2 1/2 hours for physician #2 to be notified of those results. RN #1 voiced uncertainty and went on to say the resident was sent to the hospital via 911 at 6:20 p.m.

The facility's medical director, also known as physician # 1 was interviewed at 9:45 a.m. on 08/11/16, in a meeting with the survey team. Physician #1 voiced that he is the medical director and has a partner, who is physician #2. The physician was asked if he was familiar with Resident #15 and the physician voiced, yes. The physician was made aware of the above concern regarding Resident #15 and was asked if he was notified of the resident's lab work on 03/03/16 or 03/09/16. The physician voiced that he did not remember. The physician was given the labs results from both dates to review. The physician voiced, clearly there was a change in his labs and voiced the resident's BUN and Creatinine were high. Physician #1 voiced that the labs could have been reported to the physician's office, that facility staff send them via fax, physician #1 voiced that he was not sure if he was notified directly, but voiced physician #2 was probably the one notified, since his name was on the lab results.

Physician #1 was asked how the facility ensures that lab results are in fact reported by fax, phone or in person, and if the nurse documented that the physician was notified, how is it ensured that the labs are actually being validated to ensure that the physician has actually received results. Physician #1 voiced that when he comes into the facility he will initial (the labs) as having checked them and I call back to address if they come to the office and then initial when he comes back to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 322	Continued From page 42	F 322		

the facility. Physician #1 asked this surveyor if the labs in question were initialed. The surveyor let physician #1 look at the copies of the lab results, none of which had any initials. Physician #1 voiced that he could not speak for physician #2, and could not answer whether the labs were seen, but when the 03/14/16 labs were drawn and I was notified, it was obvious there was a significant change and immediately sent him to the hospital. The physician voiced that he would expect the nurses to contact and alert the physicians with all lab results.

Hospital records for Resident #15 were reviewed and documented, "...DEPARTMENT OF MEDICINE MICU [medical intensive care unit] - History and Physical Examination...03/14/16 [Name of Resident # 15]...the ambulance picked him up and since then he has had labored breathing...concerned that the nursing home may not have been giving him his tube feeds and that is why he is dehydrated...chronically ill appearing...dry mucous membranes, tracheostomy in place...peg in place...4 L [liters] NS [normal saline] given in ED [emergency department]...Hypernatremia 166 on admission...Free water deficit calculated to 7 L [liters]...No indication for urgent HD [hemodialysis] currently...admitted with hypoglycemia to 38...of imminent or life threatening deterioration...severe hypernatremia...septic shock which is refractory to aggressive volume resuscitation and requires multiple pressors for hemodynamic stabilization...Continue aggressive volume resuscitation...overall prognosis is incredibly grave.."

The facility staff were again met with in a meeting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 322	Continued From page 43 with the survey team on 08/11/16 at approximately 11:40 a.m., and were asked if any additional information or documentation was found regarding the major concerns related to Resident # 15's fluid/nutrition/hydration status. The facility staff voiced that they (facility) did not have any additional information to present. No further information or documentation was presented by facility staff prior to the exit conference on 08/11/16 at 12:30 p.m., to evidence Resident # 15 received adequate nutrition and/or hydration for the prevention of dehydration and failed to evidence that the physician was notified, with appropriate intervention for lab work that was showing significant change with decline of the resident.	F 322		
F 325 SS=D	Complaint Deficiency 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record	F 325	483.25(i) MAINTAIN NUTRITION	9/19/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 325	Continued From page 44 review, facility staff failed to implement interventions regarding a significant weight loss for one of 17 residents in the survey sample. Resident #4 had no interventions or follow up concerning a 5.9% weight loss assessed in March 2016. In addition, no interventions were implemented for 15 days after an assessed weight loss of 14.2% in May 2016. The findings include: Resident #4 was admitted to the facility on 12/29/15 with diagnoses that included heart failure, chronic obstructive pulmonary disease (COPD), diabetes, lymphedema (swelling of a body part due to obstructed lymphatic vessels), anxiety and obesity (excessive body weight). The minimum data set (MDS) dated 6/8/16 assessed Resident #4 with moderately impaired cognitive skills. Resident #4's clinical record was reviewed on 8/10/16. The record documented the resident weighed 260 pounds (lbs.) upon admission to the facility. The clinical record documented the resident's weights as follows. 12/29/15 - 260 lbs. 2/3/16 - 261.5 lbs. 3/1/16 - 246 lbs. (5.9% loss in one month; 5.4% loss since admission) 4/4/16 - 247.5 lbs. 5/2/16 - 244 lbs. 5/24/16 - 223.2 lbs. (14.2% loss since admission) 6/7/16 - 220.5 lbs. 7/4/16 - 224 lbs. 8/1/16 - 215 lbs. The clinical record documented on 3/1/16 the	F 325	STATUS UNLESS UNAVOIDABLE F325 How the corrective action will be accomplished for the resident(s) affected. Resident #4 had a full assessment completed by the RD addressing weight change with interventions in place on 8/11/2016. How the correction action will be accomplished for those residents with the potential to be affected by the same practice. Current residents with significant weight change will be reviewed to ensure timely interventions are in place, careplan updated and MD will be notified. Measures in place to ensure practices will not occur. The Interdisciplinary Weight Variance Committee will be educated on the Policy and Procedure for Weight Monitoring and Tracking to include implementing interventions to address weight loss and careplan updated. How the facility plans to monitor and ensure correction is achieved and sustained. DON/designee will review two (2) residents weekly times four (4) weeks to ensure that significant weight loss has been identified, timely interventions are implemented, MD notified and careplan updated. Any deficient practice will result in re-education or disciplinary action. The DON will report the findings to the QA	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 325	Continued From page 45 resident had experienced a significant weight loss of 5.9% in one month going from 261.5 lbs. on 2/3/16 to 246 lbs. on 3/1/16. A nutrition assessment by the registered dietitian (RD) dated 3/24/16 listed the resident with a significant weight loss since admission, a weight goal of 250 lbs. and documented the weight loss as desired. Resident #4's weight records documented a weight loss of 36.8 lbs. (14.2%) on 5/24/16. Interventions regarding the 14.2% loss were not implemented until fifteen days later on 6/9/16 when the physician was notified. On 8/10/16 at 10:00 a.m. the dietary manager and RD were interviewed about Resident #4's weight loss and any interventions implemented or assessments of the resident in response to the significant weight loss. The dietary manager stated Resident #4 was discussed in the weight review committee and was not listed as being on a planned weight loss program. The RD stated she did not recall reviewing a significant weight loss for Resident #4. The RD stated she only reviewed residents referred to her by the weight committee. The RD stated she would review Resident #4's record and advise. On 8/10/16 at 3:30 p.m. the RD was interviewed again about Resident #4's significant weight loss since admission. The RD stated the resident was assessed with a significant weight loss in March 2016 when her weight went from 261.5 lbs. on 2/3/16 to 246 lbs. on 3/1/16 (5.9%). The RD stated they questioned the accuracy of the 246 lb. weight. The RD stated Resident #5 was re-weighed on 3/1/16 and her weight remained at 246 lbs. When asked what further assessments and/or interventions were done at this time concerning the weight loss, the RD stated, "It	F 325	committee quarterly for tracking and trending.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 325	Continued From page 46 [weight loss] was not re-visited." The RD stated there were no interventions put in place regarding the 5.9% weight loss. The RD stated the resident's weights were "stable" until June 2016 when the resident was assessed with 36.8 lb. weight loss (14.2%) since admission. The RD stated on 6/9/16 the resident's medications were reviewed with several discontinued. The RD stated the resident was also diagnosed and treated for a urinary tract infections and upper respiratory infection in June 2016. Resident #4's plan of care (revised 4/22/16) listed no problems, goals and/or interventions regarding a significant weight loss. The care plan listed the resident had a potential for nutritional problems, weight fluctuations due to diuretic therapy, obesity and a therapeutic diet. The care plan goal stated, "Resident will avoid significant weight change through next review." Interventions listed were to administer medications as ordered, perform labs as ordered, weigh as ordered and provide diet as ordered. There was no mention the resident was on a prescribed weight loss plan or that the significant weight loss was desired. The care plan referenced use of a diuretic. The clinical record documented no current physician orders for a diuretic. There was no further information presented prior to the end of the survey regarding Resident #4's weight loss. These findings were reviewed with the administrator, director of nursing and nurse consultant during a meeting on 8/10/16 at 4:50 p.m.	F 325		
F 425	483.60(a),(b) PHARMACEUTICAL SVC -	F 425		9/19/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425 SS=D	Continued From page 47 ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on staff interview, and clinical record review, facility staff failed to ensure medications were available for administration for one of 17 residents in the survey sample, Resident #12. Resident #12 did not receive 6 doses of physician ordered Methylphenidate because medication had not been reordered and was not available for administration. Findings included: Resident #12 was admitted to the facility on	F 425	483.60(a),(b) PHARMACEUTICAL SVC-ACCURATE PROCEDURES, RPH F425 How the corrective action will be accomplished for the resident(s) affected. Resident #12 is currently receiving medications as ordered. How the correction action will be accomplished for those residents with the potential to be affected by the same practice. An audit of current Residents will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 48 09/30/2014 with diagnoses including, but not limited to: Chronic fatigue syndrome. The most recent MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 05/23/2016. Resident #12 was assessed as cognitively intact with a total cognitive score of 12 out of 15. Review of Resident #12's clinical record revealed a physician order, originally written 10/24/14 and included on the current POS (physician order sheet) stating, "Methylphenidate HCL [hydrochloride] Tablet 5 MG [milligrams] Give 1 tablet via PEG-Tube one time a day related to CHRONIC FATIGUE SYNDROME." (This medication is more commonly known as Ritalin and is classified as a stimulant). Resident #12's medication administration record (MAR) was then review for verification that medications were being given. According to the MAR for the month of July 2016, resident #12 did not receive Ritalin on July 20th, 23rd, 24th, 25th, 26th, and 27th. Nursing progress notes for Resident #12 were then reviewed for the dates above and evidenced that the medication in question was not given due to being unavailable to give. On 8/10/16 at 3:00 p.m. a license practical nurse (identified as LPN #2) was interviewed (as this nurse was identified on the nursing notes and MAR that Ritalin was unavailable). LPN #2 verbalized that Ritalin was a medication that needed a hard copy prescription from the physician to the pharmacy. LPN #2 verbalized that a request was made to the physician, but the	F 425	conducted to ensure that ordered medications are available. Measures in place to ensure practices will not occur. Charge Nurses will be in-serviced on the procedure to obtain medications from pharmacy in a timely manner, reorder medications, use of the Stat Box, the back-up Pharmacy and the procedure to follow if medications are not available. How the facility plans to monitor and ensure correction is achieved and sustained. DON/designee will review two (2) Resident (EMAR)Medication Administration Records for residents five (5) times a week for four (4) weeks to assure that medications are available. Any deficient practice will result in re-education or disciplinary action. The DON will report the findings to the QA committee quarterly for tracking and trending.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 49 physician did not respond, so without an actual hand written prescription the medication could not be filled. On 8/10/16 at 3:20 p.m. the above finding was presented to the director of nursing (DON). The DON verbalized that she is aware that the physicians sometimes do not respond to nursing request and has been working with the physicians to determine who is on call on weekends and after hours, so that the nurses know who to contact. On 8/10/16 at 4:10 p.m. the administrator was interviewed concerning the above finding. The administrator verbalized that it appears the physicians were not writing for prescriptions when requested. No other information concerning the above finding was provided prior to exit conference on 8/11/16.	F 425		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and in the course of a complaint investigation, the facility failed to provide a safe environment for residents and staff.	F 465	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON F465 How the corrective action will be	9/19/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 465	Continued From page 50 The facilities exit doors were not secured during the evening and night hours. The Findings Include: On 8/10/16 at 9:10 a.m. this surveyor observed a bus driver enter the facility to pick up a resident for transport. The driver opened the door near to nursing station on unit 2 (named residential unit), no alarms sounded. At 9:20 a.m. (same day) the bus driver was seen going out the same door he entered, this time sounding the alarm. A certified nursing aide (identified as CNA #3) went to the door punched in code numbers on a key pad and the alarm stopped. This surveyor interviewed CNA #3 regarding the alarm system. CNA #3 verbalized that the building can be entered day or night by pushing a button on the outside of the door and entering the facility and the alarm will only sound when leaving the facility. This surveyor asked if any doors were locked at night. CNA #3 verbalized that all doors except for the two doors closest to the nursing stations were locked at night, but the two doors at the nursing stations were not locked and can be entered by pushing a button and entering without an alarm sounding. On 8/10/16 at 10:10 a.m. another CNA (identified as CNA #2) was interviewed and corroborated what CNA #3 had said and went onto verbalize that she has come into the facility early in the morning around 5:30 a.m. and has entered the facility as it was not locked and without an alarm sounding.	F 465	accomplished for the resident(s) affected. Door Lock on Unit #2 Nursing Station was repaired on August 10, 2016 to provide a safe environment for residents and staff. How the correction action will be accomplished for those residents with the potential to be affected by the same practice. All facility doors were checked by Maintenance Director and noted to be functioning properly to ensure a safe environment for residents and staff. Measures in place to ensure practices will not occur. Administration will in-service Maintenance Director on completion of work orders to ensure a safe environment. Charge Nurses will be in-serviced on the process for completing work orders. How the facility plans to monitor and ensure correction is achieved and sustained. Maintenance Director will conduct preventative maintenance rounds weekly for four (4) weeks to ensure facility doors are functioning properly. Any nonfunctioning doors will be serviced at that time. Any deficient practice will result in re-education or disciplinary action. The Maintenance Director will report the findings to the QA committee quarterly for tracking and trending.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 465	Continued From page 51	F 465		

On 8/10/16 at 11:30 a.m. this surveyor observed two men working on an exit door leading to a courtyard. This surveyor asked what they were doing to the doors. One of the men identified himself as the regional director of maintenance (Other staff, OS #5), verbalized that the door was not latching all the way and they were trying to repair it.

At this time this surveyor asked both men to observe the two doors that can be accessed at anytime and without an alarm sounding. Both doors were operated by OS #5 and both doors did not alarm when being entered. OS #5 verbalized understanding that without doors being properly locked at night or not sounding an alarm could pose a problem with concern to the staff and residents. OS #5 verbalized he would be looking into this situation to come up with a better system.

On 8/10/16 at 3:30 p.m. License practical nurse, working the evening shift (LPN #2) was interviewed concerning accessibility to the facility at night. LPN #2 verbalized that the two doors near to the nursing stations are accessible at all times throughout the night, by pushing a button and entering the facility without an alarm sounding. LPN #2 verbalized that she was unaware of a key that may be used to physically lock the doors.

On 8/11/16 at 9:15 a.m. the facilities maintenance director (OS #4) was interviewed concerning the above finding. OS #4 verbalized that he did not realize that the two doors in question was set up like that. OS #4 also verbalized that he has the only key to the two doors in question so the staff could not physically lock the doors.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 465	Continued From page 52 On 8/11/16 at 11:00 a.m. the above finding was brought to the attention of the director of nursing and administrator. The administrator verbalized that she was unaware of the finding and the nurses should be able to lock the doors. This surveyor verbalized that according to the maintenance director, he was the only person with a key. No other information was provided prior to exit conference on 8/11/16. This is a complaint deficiency.	F 465		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness 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 physician ordered laboratory tests for one of 17 residents in the survey sample. Resident #5 did not have a complete blood count (CBC) or thyroid stimulating hormone level (TSH) performed as ordered by the physician. The findings include: Resident #5 was admitted to the facility on 1/16/12 with a re-admission on 3/29/14. Diagnoses for Resident #5 included depression, high blood pressure, diabetes, hypothyroidism	F 502	483.75(j)(1) ADMINISTRATION F502 How the corrective action will be accomplished for the resident(s) affected. MD notified that Resident #5 did not have CBC and TSH drawn as ordered. New orders received to have CBC and TSH labs redrawn. How the correction action will be accomplished for those residents with the potential to be affected by the same practice. Current Residents will be reviewed to	9/19/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 502	Continued From page 53 (deficiency of thyroid gland activity), chronic obstructive pulmonary disease (COPD) and insomnia (inability to sleep). The minimum data set (MDS) dated 6/20/16 assessed Resident #5 as cognitively intact. Resident #5's clinical record documented a physician's order dated 11/12/15 for a CBC and TSH to be obtained every 3 months. The most recent CBC and TSH were documented on 2/4/16. The record did not include the CBC and TSH due in May 2016. On 8/10/16 at 3:45 p.m. the director of nursing (DON) was interviewed about Resident #5's missing labs that were due in May 2016. The DON stated she did not find any record of the CBC or TSH due in May 2016. These findings were reviewed with the administrator, director of nursing and nurse consultant during a meeting on 8/10/16 at 4:50 p.m.	F 502	ensure CBC and TSH were obtained as ordered since 8/1/2016. Measures in place to ensure practices will not occur. Charge Nurses will be in-serviced on the Policy and Procedures for lab tracking to include obtaining labs as ordered. How the facility plans to monitor and ensure correction is achieved and sustained. The DON/designee will review lab log book to ensure labs are obtained as ordered and MD notified five (5) times a week for four (4) weeks. Any deficient practice will result in re-education or disciplinary action. The DON will report the findings to the QA committee quarterly for tracking and trending.	
F 505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, the facility staff failed to ensure the physician was promptly notified of significant laboratory changes, and failed to ensure laboratory changes were acted upon for one of 17 residents in the survey sample (Resident # 15).	F 505	483.75 (j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS F505 How the corrective action will be accomplished for the resident(s) affected. Resident #15 no longer resides in Louisa	9/19/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 505	Continued From page 54 The facility failed to ensure Resident # 15's lab results were reported to the physician in a timely manner to ensure prompt, appropriate action was taken for the resident. Resident # 15 had several laboratory test drawn including a BMP (Basic Metabolic Panel) on 03/03/16 (2 days after admission), which showed areas of concern. A CMP (comprehensive metabolic panel) on 03/09/16, which evidenced a significant change/decline from the 03/03/16 labs. A swab for MRSA (methicillin-resistant Staphylococcus aureus) on 03/04/16 and was not reported to the physician until 03/09/16, and another CMP was drawn on 03/14/16, which evidenced critical labs values for Resident # 15, as a result the resident was immediately sent out to the hospital via 911. Findings include: Resident # 15, (a 76 year old African American man) was admitted to the facility on 03/01/16. Diagnoses for Resident # 15 included, but were not limited to: Ischemic stroke (damage to the brain from an interruption of blood supply), aphasic (unable to speak), flaccid right side hemiplegia (complete paralysis of right side) and spastic left sided hemiparesis (weakness of left side with involuntary movements), seizures, tracheostomy (surgical opening through the neck to provide an airway and remove secretions), DM (diabetes mellitus), PEG tube (medical procedure where a tube is passed into a patient's stomach to provide a means of nutrition and hydration when unable to take oral intake) and cognitive communication deficit. The most recent full MDS (minimum data set) was a 5 day admission assessment dated	F 505	Health and Rehabilitation Facility. How the correction action will be accomplished for those residents with the potential to be affected by the same practice. Current Residents will be reviewed to ensure MD was promptly notified of BMP, CMP and culture results with follow-up. How the corrective action will be accomplished for the resident(s) affected. DON/designee will in-service Charge Nurses on Policy and Procedures for lab tracking to include prompt MD notification of significant lab changes and ensuring lab changes were acted upon. How the facility plans to monitor and ensure correction is achieved and sustained. The DON/designee will review two (2) lab draw orders, results, MD notification, follow-up and documentation two (2) times a week for four (4) weeks. Any deficient practice will result in re-education or disciplinary action. The DON will report the findings to the QA committee quarterly for tracking and trending.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 505	Continued From page 55	F 505		

03/08/16. This MDS assessed the resident as having short and long term memory impairment with severe impairment in daily decision making skills. The resident was also assessed as being totally dependent upon staff for all ADL's (activities of daily living) including feeding (nutrition/hydration). The resident was additionally assessed on this MDS to have a feeding tube (abdominal peg). In section K0700. Percent Intake by Artificial Route A. Proportion of total calories the resident received through tube feeding was documented as, "51% or more" and for B. Average fluid intake per day by IV (intravenous) or tube feeding was documented as, "501 cc/day (cubic centimeters) or more." The resident was also assessed as receiving insulin injections for the previous 7 days and as receiving diuretics (medication that induces excretion of fluid from the body) for the previous 6 days. The resident did trigger in the CAAS (care area assessment summary) section of this MDS for nutrition, feeding tube, and dehydration; all of these areas were marked to address in the resident's comprehensive care plan (CCP).

A complaint regarding Resident # 15, was investigated during the survey process on 08/09/16 through 08/11/16. The complaint alleged that Resident # 15 was transferred to the hospital on 03/14/16 where he was found to be severely dehydrated, with hypernatremia (high sodium level).

During clinical record review, Resident # 15's facility admission physician orders were reviewed. The orders included, but were not limited to: "...NPO (nothing by mouth)...Prostat SF (a sugar free ready to drink medical food providing 15 grams of protein) two times a day [no specific

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 505	Continued From page 56	F 505		

amount was indicated in the order]...Enteral Feed Order every evening and night shift...via pump-osmolite 1.5 at 95 of [sic] cc per hour for 14 of [sic] hours via pump per PEG tube...indicate start and stop times: Start infusion at 1800 [6:00 p.m.] and continue until 1000 [10:00 a.m.]...Enteral Feed Order every 6 hours...flush feeding tube with 100 cc of water...and with 10 cc of water before and after medication....hydrochlorothiazide [diuretic] 25 mg (milligrams) in the morning...BMP [Basic Metabolic Panel] one only for 1 day [start date 03/03/16]..." All of the above orders had a order date of 03/02/16.

The resident's CCP (comprehensive care plan) was then reviewed. The CCP dated 03/02/16 documented: "...PEG TF [tube feed], risk for aspiration/dehydration r/t CVA/ICH [cerebrovascular accident/intracranial hemorrhage], NPO [nothing by mouth] status, trach in place, dependence on staff for nourishment/hydration...Provide diet/fluid as ordered. Monitor intake and record..."

A BMP [Basic Metabolic Panel] laboratory test was drawn on 03/03/16 for Resident # 15. The BMP was reviewed and documented, the resident had a high glucose level of 427 (reference range: 65-99), BUN (blood urea nitrogen-used to determine kidney function) was high at 39 (reference range: 8-27), the resident's eGFR (if African Am) is a test to estimate glomerular filtration rate for African Americans and is used to detect early kidney damage, the resident's reading was 100 (reference range: greater than 59) a normal value, the resident's BUN/Creatinine Ration, which is used to assess kidney function was 49 (reference range: 10-22), well above

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 505	Continued From page 57	F 505		

normal, the resident's sodium level was slightly low at 133 (reference range: 134-144).

In the upper portion of the lab test it was documented, "Laboratory: 03/03/16 15:14 [3:14 p.m.] Basic Metabolic Panel Reviewed By [name of LPN # 4] on 03/13/16 13:42 [1:42 p.m.]..." This was documented as reviewed by LPN # 4 ten days after the lab test results.

No documentation could be located to indicate that the above lab values were reported to the physician.

A physician's progress note dated 03/08/16 (1 week after the resident's admission) was reviewed and documented: "...Nurses report patient had an episode of vomiting 03/5/16 and now with thick green sputum from trach tube. His vitals are otherwise normal...no edema...aphasic...positive recent aspiration, seizures secondary to CVA, Peg, DM I, HTN...plan cxr (chest xray) otherwise continue present care plan...signature of physician."

The physician's progress note did not address or acknowledge the resident's BMP (Basic Metabolic Panel) laboratory test results from 03/03/16.

A physician's order dated 03/02/16 (order date) for a "Swab trach for MRSA [methicillin-resistant Staphylococcus aureus] one time only for 1 day" was reviewed. The start date for this order was 03/04/16.

The swab for MRSA was completed on 03/04/16.

A nursing note dated 03/09/16 and timed 2:09 a.m. documented: "...100.4 [temp]...Noted trach

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 505	Continued From page 58	F 505		

culture results positive for MRSA. Lab results sent to MD...signature of LPN # 3."

The above lab result was not reported to the physician until 5 days after lab test was completed, Resident # 15 was started on antibiotics for the above infection on 03/11/16.

A physician's order dated 03/09/16 (no time) for "STAT" laboratory tests, including a CMP (complete metabolic panel), UA C/S (urinalysis culture and sensitivity), and a CBC (complete blood count) was found in the clinical record.

A nursing note dated 03/09/16 and timed 11:04 a.m. documented, "...order received for ...CMP now...labs were sent routine as pick up was present..."

The CMP dated 03/09/16 for Resident # 15 was reviewed. The collection time was documented as 10:45 a.m., with results time of 5:35 p.m.

The CMP lab results documented that the resident had a critical BUN of 125 (reference range: 8-27), this was a significant increase from the BUN of 39 on 03/03/16; the resident's eGFR had significantly decreased from 100 (a normal value) on 03/03/16 to 54 a low, below normal value (reference range: greater than 59), the resident's BUN/Creatinine ratio was significantly higher at 87 (reference range: 10-22) compared to the result on 03/03/16, which was 49. The resident's sodium level was 150 on 03/09/16 in comparison to the 03/03/16 labs where the resident' sodium level was 133 (reference range: 134-144).

In the upper portion of the above lab test it was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 505	Continued From page 59	F 505		

documented, "Laboratory: 03/09/16 17:35 [5:35 p.m.] Comp. Metabolic Panel Reviewed By [name of LPN # 4] on 03/10/16 15:37 [3:37 p.m.]..." It was documented LPN # 4 reviewed the labs one day after the labs were drawn.

No evidence could be located throughout the clinical record to evidence that the physician was actually notified of the CMP results on 03/09/16.

A nursing note dated 03/10/16 and timed 2:46 p.m. documented, "...Resident is TAP [turned and positioned frequently], lethargic...CMP returned with alert BUN level of 125...Creatinine 1.44...MD made aware via nurse, awaiting new order...started on Levoquin yesterday...presumed UTI [urinary tract infection]...signature of LPN # 4"

No physician's orders were found to evidence that any type of action had been taken to address the critical CMP lab results for Resident # 15 and no physician correspondence of any kind could be located to evidence that the physician was informed/notified and/or received the CMP critical lab information for Resident # 15.

The CMP drawn on 03/14/16 at 1:00 a.m., with a result time of 2:10 p.m. were reviewed. The CMP was marked and flagged as critical. The resident's BUN was now 219 (range: 8-27) , the eGFR was now 21 (range: greater than 59), the Creatinine was now at 3.20 (range: 0.76-1.27), the BUN/Creatinine was now 68 (range: 10-22), and the Sodium was now 166 (range: 134-144).

In the upper portion of the above lab test it was documented, "Laboratory: 03/14/16 21:35 [9:35 p.m.] ...Comp. Metabolic Panel Reviewed By [name of LPN # 3] on 03/17/16 00:44 [12:44

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 505	Continued From page 60	F 505		

a.m.]..." It was documented LPN # 3 reviewed the labs three days after the labs were drawn and three days after the resident was discharged. Additional documentation on the labs under "Order Notes" documented, "Faxed and gave results to LPN # 5 at 3:23 p.m. 03/14/16, Faxed and gave critical results to and read back to LPN # 5 3:23 p.m."

A nursing note dated 03/14/16 and timed 5:04 p.m., documented, "...Change of Condition SBAR...This note is associated with a eInteract Change of Condition Evaluation...The signs/symptoms of the change of condition are...Abnormal lab results...this started on 03/07/16 during the afternoon...notified Physician # 2 [on] 03/13/16 6:00 p.m.. Orders obtained: Blood tests...signature of RN # 1."

The eInteract Change in Condition Evaluation was reviewed dated 03/14/16 and timed 5:04 p.m...other change in condition, started on 03/06/16...afternoon...diabetes...Are these the most recent vital signs after the change in condition occurred? No...Most recent Blood Glucose: 140 03/14/16 13:42 [1:42 p.m.]...Abnormal Results: complete blood count, chemistry...urinalysis, urine culture, x-ray...Reported to primary care clinician: Physician # 2 Date and time of clinician notification: 03/13/16 18:00 [6:00 p.m.] Orders obtained from the clinician: blood tests...03/14/16 17:42 [5:42 p.m.]...[completed by RN # 1]"

A nursing note dated 03/14/16 and timed 6:04 p.m. documented, "...MD notified of lab result: ...MD orders to send resident out 911 to ER [emergency room]...signature of RN # 1."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 505	Continued From page 61	F 505		

All of the above concerns were shared with the administrator, DON (director of nursing), and the corporate nurse in a meeting with the survey team on 08/09/16 at 3:00 p.m. The facility staff were informed of the complaint investigation and any and all assistance was requested for any additional information or documentation to evidence that the physician was actually notified, and/or notified in a timely manner regarding the critical labs results.

The DON, administrator and corporate nurse were again made aware of multiple concerns in an end of day meeting with the survey team on 08/10/16 at 5:00 p.m., again the facility staff were ask to provide any additional information or documentation to evidence Resident # 15's abnormal/critical lab results were reported, reported timely and acted upon by the physician.

On 08/11/16 at 8:50 a.m., RN (Registered Nurse) # 1 was interviewed in a meeting with the survey team. The RN was asked about the note written on 03/14/16 and timed 5:04 p.m. (the date of discharge for Resident # 15), the RN voiced that she could not remember what exactly happened on 03/14/16. The RN was asked about the change in condition note that was written, and asked specifically what was the change. RN # 1, voiced that she didn't remember and asked to see a copy of the note. The RN viewed a copy of the note and voiced the labs, that is why I notified the physician (physician # 2). It was pointed out to the RN that she notified the physician # 2 on 03/13/16 at 6:00 p.m. and was asked how she could notify physician # 2 of critical lab results that had not been drawn yet (referring to labs drawn on 03/14/16 1:00 a.m.), RN # 1 voiced that she notified the physician of the Resident's critical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 505	Continued From page 62	F 505		

lab work from 03/09/16 and further voiced that the results were abnormal. RN # 1 voiced that it is documented in her note (dated 03/14/16) that she notified physician # 2 on 03/13/16 at 6:00 p.m. and as a result of that notification, that physician ordered blood tests (for 03/14/16) to be drawn, those labs were drawn at 1:00 a.m. on 03/14/16. The RN voiced noticing everything going down starting on 03/07/16 (referring to resident and labs). The RN voiced the 03/14/16 lab results were documented to have been drawn at 10:45 a.m. and reported to the facility at 5:35 p.m. RN # 1 voiced that after the labs came back from 03/14/16 and the best she could remember was that she contacted the physician around 6:00 p.m. and the doctor gave an order to send out to hospital by 911. The RN was made aware that according to the lab results dated 03/14/16, that the results had been called back to LPN # 5 at 3:23 p.m. and was asked why it took 2 1/2 hours for physician # 2 to be notified of those results. RN # 1 voiced uncertainty and went on to say the resident was sent to the hospital via 911 at 6:20 p.m.

The facility's medical director, also known as physician # 1 was interviewed at 9:45 a.m. on 08/11/16, in a meeting with the survey team. Physician # 1 voiced that he is the medical director and has a partner, who is physician # 2. The physician was asked if he was familiar with Resident # 15 and the physician voiced, yes. The physician was made aware of the above concern regarding Resident # 15 and was asked if he was notified of the resident's lab work on 03/03/16 or 03/09/16. The physician voiced that he did not remember. The physician was given the labs results from both dates to review. The physician voiced, clearly there was a change in his labs and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 505	Continued From page 63	F 505		

voiced the resident's BUN and Creatinine were high. Physician # 1 voiced that the labs could have been reported to the physicians office, that facility staff send them via fax, physician # 1 voiced that he was not sure if he was notified directly, but voiced physician # 2 was probably the one notified, since his name was on the lab results. The physician was asked how the facility ensures that lab results are in fact reported by fax, phone or in person, and if the nurse documented that the physician was notified, how is it ensured that the labs are actually being validated to ensure that the physician has actually received results. Physician # 1 voiced that when he comes into the facility he will initial (the labs) as having checked them and I call back to address if they come to the office and then initial when he comes back to the facility. Physician # 1 asked this surveyor if the labs in question were initialed. The surveyor let physician # 1 look at the copies of the lab results, none of which had any initials. Physician # 1 voiced that he could not speak for physician # 2, and could not answer whether the labs were seen, but when the 03/14/16 labs were drawn and I was notified, it was obvious there was a significant change and immediately sent him to the hospital. The physician voiced that he would expect the nurses to contact and alert the physicians with all lab results.

No further information or documentation was presented by facility staff prior to the exit conference on 08/11/16 at 12:30 p.m., to evidence that Resident # 15's lab results were reported and/or reported in a timely manner so that prompt, appropriate action was taken for the resident's care.