STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	**208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277**

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 12/04/18 through 12/06/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. One complaint was investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 12/04/18 through 12/06/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 110 certified bed facility was 102 at the time of the survey. The survey sample consisted of 23 current Resident reviews and 3 closed record reviews.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).	F 578		1/18/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 12/20/2018

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

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F 578	Continued From page 1 (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure a complete and accurate DDNR (durable do not resuscitate) form for 2 of 26 Residents, Residents #14 and #73. The findings included: 1. For Resident #14 the facility staff failed to ensure a complete DDNR form. Resident #14 was admitted to the facility on	F 578	1.) Resident #14 and #73's DNR's were completed accurately and scanned into the electronic health record. 2.)Any resident has the potential to be affected if the DNR is not completed accurately. A 100% audit of DNR's was completed to ensure that all were completed accurately and scanned into the correct health record.	

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F 578

Continued From page 2

02/07/18 and readmitted on 04/07/18. Diagnoses included but not limited to hypertension, hyperlipidemia, dementia, depression, hypothyroidism, and atrial fibrillation.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 09/17/18 coded the Resident as 10 of 15 in section C, cognitive patterns. This a quarterly MDS.

Resident #14's clinical record was reviewed on 12/05/18. It contained a Virginia Department of Health DDNR form dated 04/18/18 which read as follows:

I further certify (must check 1 or 2):

[ ] 1. The Patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment. (Signature of patient is required).

[x] 2. The Patient is INCAPABLE of making an informed decision about provided, withholding, or withdrawing a specific medical treatment because he/she is unable to understand the nature, extent or probable consequences of the proposed medical decision , or to make a rational evaluation of the risks and benefits of alternatives to that decision.

If you checked 2 above, check A, B, or C below:

[ ] A. While capable of making an informed decision, the Patient has executed a written advanced directive which directs that life-prolonging procedures be withheld or withdrawn.

F 578

3.) Re-education initiated on 12/6/18 and provided to SSD and Medical Records regarding how to accurately complete the DNR and ensure that it is entered into he correct health record.

4.) Any new admissions will be audited weekly X4 weeks then monthly X2 months to ensure that if they are a DNR, there form is completed accurately and scanned into the health record.
Any and all findings to be reported to the QA committee for further review and recommendations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

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F 578 — F 578

Continued From page 3

[ ] B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf" with authority to direct that life-prolonging procedures be withheld or withdrawn. (Signature of "Person Authorized to Consent on the Patient's Behalf is required.)

[ ] C. The Patient has not executed a written advanced directive (living will or durable power of attorney for health care). (Signature of "Person Authorized to Consent on the Patient's Behalf is required).

Section 2 of the form had not been checked, nor had the Resident or the person authorized at consent on the Resident's behalf signed the form.

The concern of the incomplete DDNR form was discussed with the administrative team during a meeting on 12/05/18 at approximately 1630.

No further information was prior to exit.

2. For Resident #73, the facility staff failed to ensure the Residents DDNR (durable do not resuscitate) was complete. Section's 1 and 2 had been left blank.

The clinical record review revealed that Resident #73 had been admitted to the facility on 08/09/18. Diagnoses included, but were not limited to, hypertensive chronic kidney disease, diabetes, chronic obstructive pulmonary disease, and peripheral vascular disease.

Section C (cognitive patterns) of the Resident's

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	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

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F 578	Continued From page 4 most recent MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/03/18 included a BIMS (brief interview for mental status) summary score of 11 out of a possible 15 points. The Resident's clinical record included a DDNR order form from the Virginia Department of Health. This form was dated 08/13/18 and read in part. Under section 1 "I further certify [must check 1 or 2]: 1. The patient is CAPABLE of making an informed decision... 2. The patient is INCAPABLE of making an informed decision..." Neither box had been checked. Section 2 read, "If you checked 2 above, check A, B, or C below..." All three boxes had been left blank. This form had been signed by the Residents authorized representative. The administrative team were made aware of the above findings on 12/05/18 at 4:27 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 578		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to	F 622		1/18/19

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	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

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F 622	Continued From page 5 remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.	F 622		

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F 622	Continued From page 6 §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1)(A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary,	F 622		

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F 622	Continued From page 7 consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to provide the receiving provider with information that included the contact information of the practitioner responsible for the care of the resident, Resident representative information including contact information, Advance Directive information, all special instructions or precautions for ongoing care, as appropriate, comprehensive care plan goals, and all other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care for 6 of 26 residents (Resident #72, Resident #54, Resident #85, Resident #46, Resident #24 and Resident #1). The findings included: 1. The facility staff failed to provide the receiving provider the current comprehensive care plan goals and code status for Resident #72. The clinical record of Resident #72 was reviewed 12/4/18 through 12/6/18. Resident #72 was admitted to the facility 10/3/18 and readmitted 10/19/18 with diagnoses that included but not limited to muscle weakness, pneumonia, falls, hypertensive heart and chronic kidney disease with heart failure, chronic obstructive pulmonary disease, paroxysmal atrial fibrillation, gastroesophageal reflux disease, urinary tract infection, psychosis, hyperlipidemia, major	F 622	1.) Resident #'s 72, 54, 85, 46, 24, and 1 were already readmitted to the center prior to the end of the survey. Therefore, we were unable to supply the receiving provider with the comprehensive care plan goals. 2.) Any resident has the potential to be affected if the comprehensive care plan goals are not sent to the receiving provider upon transfer/discharge. As of 12/6/18, any resident that is transferred /discharged will have the comprehensive care plan goals sent with then to the receiving provider. 3.) Re-education initiated on 12/6/18 and provided to nursing regarding the requirement to send the comprehensive care plan goals to the receiving provider upon transfer/discharge. 4.)Any residents that are transferred/discharged will be audited weekly X4 weeks then monthly X2 months to ensure that the comprehensive care plan goals were sent to the receiving provider. Any and all findings to be reported to the QA committee for further review and recommendations.	

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	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

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F 622	Continued From page 8	F 622		

depressive disorder, anxiety, and dependence on supplemental oxygen.

Resident #72's significant change in status minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/31/18 assessed the resident with a BIMS (brief interview for mental status) as 13/15.

The 10/15/18 22:04 (10:04 p.m.) progress note read "Primary nurse reports to MD (medical doctor) called at 2130 (9:30 p.m.) with update on resident's condition and MD gave order to send resident to Hospital (name omitted) ER (emergency room) for eval (evaluation) due to little improvement after previous interventions/orders. C-Trans called and made aware of need to transport to ER for eval. Report called to Nurse Connect (name of nurse connect omitted). Resident aware. Called resident's sister and made aware as well."

The 10/15/18 22:30 (10:30 p.m.) progress note read "C-Trans here to transport resident to hospital (name omitted) ER at this time."
The 10/16/18 4:26 a.m. progress note read that the resident was being transferred to another hospital.

The 10/15/18 or 10/16/18 progress notes did not have documentation of information sent with the resident to the hospital.

The surveyor interviewed the director of nursing (DON) on 12/06/18 11:51a.m. on the process and paperwork when a resident is transferred to the hospital. The DON stated she notifies the MD (medical doctor)/RP (responsible party), sends a transfer form, MAR (medication administration

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	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

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F 622	Continued From page 9 record) and PN (progress notes). The DON stated, when asked, if she sends a copy of the comprehensive care plan goals, she stated she didn't. The surveyor met with the director of nursing (DON), assistant director of nursing (ADON), both corporate registered nurses and the interim administrator on 12/6/18 at 12:02 p.m. on the process for transferring a resident to the hospital. The DON stated notify MD/RP, call hospital and give report, after hours notified, call EMS (emergency medical services), send transfer treatment form, MAR, any special treatments, and pertinent laboratory tests. The DON stated comprehensive care plan goals were not sent. The facility provided the "Nursing Home to Hospital Transfer Form" for Resident #72 dated 10/16/18 and timed 5:27 a.m. The form did not include the code status or comprehensive care plan goals. The form did include primary goals of care at time of transfer and rehabilitation and/or medical therapy with intent of returning home marked but there were no comprehensive care plan goals documented. The surveyor informed the administrative staff of the above concern in the end of the day meeting on 12/6/18 at 4:14 p.m. No further information was provided prior to the exit on 12/6/18. 2. The facility staff failed to provide the receiving provider the comprehensive care plan goals for Resident #54. The clinical record of Resident #54 was reviewed	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

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F 622	Continued From page 10 12/4/18 through 12/6/18. Resident #54 was admitted to the facility 10/10/17 and readmitted 11/17/18 with diagnoses that included but not limited to unspecified dementia without behavioral disturbances, hypertensive heart and chronic kidney disease with heart failure, type 2 diabetes mellitus, chronic respiratory failure, hypothyroidism, atrial fibrillation, major depressive disorder, dysphagia, anemia, hyperlipidemia, gastro-esophageal reflux disease and dependence on supplemental oxygen. Resident #54's 14- day minimum data set assessment (MDS) with an assessment reference date (ARD) of 11/29/18 assessed the resident with a BIMS (brief interview for mental status) as 09/15. A progress note dated 11/14/18 at 10:30 read "Called to room per sitter, res (resident) noted to have SOB (shortness of breath). VS (vital signs) at this time BP (blood pressure) 181/77, P (pulse) 81, T (temperature) 99.1, R (respirations) 40, O2 (oxygen saturation level) 96% on 2 LPM (liters per minute) BS (blood sugar) 49. Daughter in room and aware of res condition. MD (medical doctor) in facility and notified. Verbal orders given for Rocephin 1 gm (gram) IM (intramuscular). Solu-Medrol 125 mg (milligrams), Lasix 40 mg IM all x1 dose now. Orders received to send res to ER (emergency room) for eval (evaluation)." Progress note dated 11/14/18 10:43 read "C Trans ambulance services notified of transport. Hospital (name omitted) given report. Daughter in room and aware." Progress note dated 11/14/18 at 15:08 (3:08 p.m.) read "Per hospital (name omitted) res being	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

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F 622	Continued From page 11	F 622		

admitted to ICU (intensive care unit) dx (diagnosis) resp (respiratory) failure."

The 11/14/18 progress notes did not have documentation of information sent with the resident to the hospital on 11/14/18.

The surveyor interviewed the director of nursing (DON) on 12/06/18 11:51a.m. on the process and paperwork when a resident is transferred to the hospital. The DON stated she notifies the MD (medical doctor)/RP (responsible party), sends a transfer form, MAR (medication administration record) and PN (progress notes). The DON stated, when asked, if a copy of the comprehensive care plan goals are sent, she stated she didn't.

The surveyor met with the director of nursing (DON), assistant director of nursing (ADON), both corporate registered nurses and the interim administrator on 12/6/18 at 12:02 p.m. on the process for transferring a resident to the hospital. The DON stated notify MD/RP, call hospital and give report, after hours notified, call EMS (emergency medical services), send transfer treatment form, MAR, any special treatments, and pertinent laboratory tests. The DON stated comprehensive care plan goals were not sent.

The facility provided the "Nursing Home to Hospital Transfer Form" for Resident #54 dated 11/14/18 and timed 11:13 a.m. The form did not include the comprehensive care plan goals. The form did include primary goals of care at time of transfer. Marked was chronic long-term goals. However, there were no specific comprehensive care plan goals.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

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F 622	Continued From page 12	F 622		

The surveyor informed the administrative staff of the above concern in the end of the day meeting on 12/6/18 at 4:14 p.m.

No further information was provided prior to the exit on 12/6/18.

3. The facility staff failed to provide the receiving provider with the comprehensive care plan goals for Resident #85.

The clinical record of Resident #85 was reviewed 12/4/18 through 12/6/18. Resident #85 was admitted to the facility 9/15/15 and readmitted 8/19/18 with diagnoses of but not limited to anoxic brain damage, gastrostomy tube, type 2 diabetes mellitus, hypertension, dysphagia, heart failure, cardiac pacemaker, atherosclerotic heart disease, pressure ulcer, allergic rhinitis, anemia, atrioventricular block, functional quadriplegia, hyperlipidemia, restless legs syndrome, major depressive disorder, cerebral infarction, contracture of right hip and right knee.

Resident #85's significant change in status minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/13/18 assessed the resident with short term memory problems, long term memory problems, and moderately impaired cognitive skills for daily decision making.

Resident #85's 8/18/18 progress note read in part that the resident had dark stools and was sent to the emergency room on 8/18/18. Guardian was notified. Resident #85 was admitted to the hospital with gastrointestinal bleeding (GI bleed).

The surveyor was unable to find evidence the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 622		F 622		

Continued From page 13
facility sent the comprehensive care plan goals to the receiving provider when the resident was transferred on 8/18/18.

The Nursing Home to Hospital Transfer Form dated 8/18/18 did not include comprehensive goals-only primary goals of care at time of transfer.

The surveyor interviewed the director of nursing (DON) on 12/06/18 11:51a.m. on the process and paperwork when a resident is transferred to the hospital. The DON stated she notifies the MD (medical doctor)/RP (responsible party), sends a transfer form, MAR (medication administration record) and PN (progress notes). The DON stated when asked if a copy of the comprehensive care plan goals are sent, she stated she didn't.

The surveyor met with the director of nursing (DON), assistant director of nursing (ADON), both corporate registered nurses and the interim administrator on 12/6/18 at 12:02 p.m. on the process for transferring a resident to the hospital. The DON stated notify MD/RP, call hospital and give report, after hours notified, call EMS (emergency medical services), send transfer treatment form, MAR, any special treatments, and pertinent laboratory tests. The DON stated comprehensive care plan goals were not sent.

The facility provided the "Nursing Home to Hospital Transfer Form" for Resident #85 dated 8/18/18 at 2:15 a.m. The form did not include the comprehensive care plan goals. The form did include primary goals of care at time of transfer for chronic long term care..

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 622

Continued From page 14

The surveyor informed the administrative staff of the above concern in the end of the day meeting on 12/6/18 at 4:14 p.m.

No further information was provided prior to the exit on 12/6/18.

4. For Resident #24, the facility staff failed to provide a copy of the comprehensive care plan goals to receiving facility when Resident #24 was transferred.

Resident #24 is a 44-year-old female who was originally admitted to the facility on 05/25/16, with a readmission date of 09/15/18. Diagnoses included, but were not limited to, hypertensive chronic kidney disease, major depressive disorder, scoliosis, and hemiplegia.

The clinical record for Resident #24 was reviewed on 12/5/18 at 1:14 pm. The most recent MDS (minimum data set) assessment for Resident #24 was a quarterly assessment with an ARD (assessment reference date) of 11/20/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident #24 had a BIMS (brief interview for mental status) score of 15 out of 15.

On 12/05/18 the surveyor reviewed Resident #24's progress notes. It contained a progress note in the clinical record documented on 09/11/18 at 7:30 pm which read in part, "Charge nurse telephoned ER (emergency room) to inquire on Resident's status. Resident admitted to (facility name withheld) with Dx (diagnosis): Sepsis, PNA (pneumonia), UTI (urinary tract infection). RP (responsible party) is at ER with Resident ...."

F 622

F 622 Continued From page 15 F 622

On 12/05/18 at 4:27 pm during the end of day meeting with the survey team and administrative team, the DON (director of nursing) was asked by the surveyor "what documents are provided to the receiving facility when a Resident is transferred?" The DON replied, "Transfer form, copy of MAR (medication administration record) and face sheet."

On 12/06/18 at 8:00 am, the DON provided the surveyor with a copy of a "Nursing Home to Hospital Transfer Form" that was sent with Resident #24 upon transfer to the emergency room on 09/11/18. The surveyor reviewed the transfer form and could not locate any documentation on the form that indicated the care plan goals were sent with Resident #24 upon transfer to the hospital.

On 12/06/18 at 11:47 am during a meeting with the administrative team, the DON agreed that the facility did not send comprehensive care plan goals with Resident #24 upon transfer to hospital on 09/11/18.

The administrative team was made aware of issue during end of day meeting on 12/06/18 at 11:53 am.
No further information regarding this issue was provided to the survey team prior to the exit conference on 12/06/18.

5. For Resident #46, the facility staff failed to provide a copy of the comprehensive care plan goals to receiving facility when Resident #46 was transferred.

Resident #46 is an 89-year-old female who was originally admitted to the facility on 08/11/16, with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 622	Continued From page 16	F 622		

a readmission date of 09/22/18. Diagnoses included, but were not limited to, vascular dementia, hypertension, major depressive disorder, and osteoporosis.

The clinical record for Resident #46 was reviewed on 12/5/18 at 8:29 am. The most recent MDS (minimum data set) assessment for Resident #46 was an annual assessment with an ARD (assessment reference date) of 10/10/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident #46 had a BIMS (brief interview for mental status) score of 06 out of 15.

On 12/05/18 the surveyor reviewed Resident #46's progress notes. It contained a progress note in the clinical record documented on 09/20/18 at 3:38 pm which read in part, "R/C (report called) from (facility name withheld) nurse stating this Resident is being admitted on the med surge floor with Dx (diagnosis) of respiratory failure with hypoxemia and pleural effusion to right lower lung."

On 12/05/18 at 4:27 pm during the end of day meeting with the survey team and administrative team, the DON (director of nursing) was asked by the surveyor "what documents are provided to the receiving facility when a Resident is transferred?" The DON replied, "Transfer form, copy of MAR (medication administration record) and face sheet."

On 12/06/18 at 8:00 am, the DON provided the surveyor with a copy of a "Nursing Home to Hospital Transfer Form" that was sent with Resident #46 upon transfer to the emergency room on 09/20/18. The surveyor reviewed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 622	Continued From page 17	F 622		

transfer form and could not locate any documentation on the form that indicated the care plan goals were sent with Resident #46 upon transfer to the hospital.

On 12/06/18 at 11:47 am during a meeting with the administrative team, the DON agreed that the facility did not send comprehensive care plan goals with Resident #46 upon transfer to hospital on 09/20/18.

The administrative team was made aware of issue during end of day meeting on 12/06/18 at 11:53 am.
No further information regarding this issue was provided to the survey team prior to the exit conference on 12/06/18.
6. For Resident #1 the facility staff failed to provide a copy of the comprehensive care plan goals to the receiving facility when the Resident was transferred to the hospital.

Resident #1 was admitted to the facility on 02/06/18 and readmitted on 11/09/18. Diagnoses included but not limited to anemia, hypertension, diabetes mellitus, hip fracture, dementia, depression, and gastroesophageal reflux disease.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 11/27/18 coded the Resident as 5 out of 15 in section C, cognitive patterns. This is a quarterly MDS.

Resident #1's clinical record was reviewed on 12/05/18. It contained a progress note dated 08/14/18 which read in part, "8/14/2018 18:19 Received call from sister, ...(name omitted), regarding Resident en route to .... (facility name omitted),....". The surveyor spoke with the DON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	**208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277**

(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 622	Continued From page 18 (director of nursing) on 12/06/18 at approximately 1155 regarding what type of paperwork is sent when a Resident is transferred to the hospital. DON stated the facility sends copies of the facility transfer form, MAR (medication administration record, any special treatments the Resident is receiving, and any diagnostic tests performed at the facility. DON stated that they do not send copies of the Resident's comprehensive care plan goals. The concern of not sending the Resident's comprehensive care plan goals when a Resident is transferred was discussed with the administrative team during a meeting on 12/06/18 at approximately 1615. No further information was provided prior to exit.	F 622		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F 623		1/18/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 623	Continued From page 19 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	**208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277**

(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 623	Continued From page 20 telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review	F 623	1.) Resident #'s 72, 54, 85, 46, 24, and 1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 623 Continued From page 21

and clinical record review, the facility staff failed to provide a written notice of transfer when 6 of 26 residents were transferred to other facilities. The residents effected were Resident #72, Resident #54, Resident #85, Resident #46, Resident #24, and Resident #1.

The findings included:

1. The facility staff failed to send written notice to the resident or resident representative of Resident #72's transfer to the acute care hospital on 10/15/18.

The clinical record of Resident #72 was reviewed 12/4/18 through 12/6/18. Resident #72 was admitted to the facility 10/3/18 and readmitted 10/19/18 with diagnoses that included but not limited to muscle weakness, pneumonia, falls, hypertensive heart and chronic kidney disease with heart failure, chronic obstructive pulmonary disease, paroxysmal atrial fibrillation, gastroesophageal reflux disease, urinary tract infection, psychosis, hyperlipidemia, major depressive disorder, anxiety, and dependence on supplemental oxygen.

Resident #72's significant change in status minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/31/18 assessed the resident with a BIMS (brief interview for mental status) as 13/15.

The 10/15/18 22:04 (10:04 p.m.) progress note read "Primary nurse reports to MD (medical doctor) called at 2130 (9:30 p.m.) with update on resident's condition and MD gave order to send resident to Hospital (name omitted) ER (emergency room) for eval (evaluation) due to

F 623

were already readmitted to the center prior to the end of the survey.

2.) Any resident has the potential to be affected if a written notice of transfer is not sent when a resident is transferred to another facility.
As of 12/6/18, and resident that is transferred will have a written notice of transfer sent to the appropriate individual.

3.) Re-education initiated on 12/6/18 and provided to nursing, admissions, and the BOM regarding the requirement that a written notice of transfer be sent to the appropriate individual upon a residents' transfer.

4.)Any residents that are transferred will be audited weekly X4 weeks then monthly X2 months to ensure that a written notice of transfer was sent to the appropriate individual.
Any and all findings to be reported to the QA committee for further review and recommendations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 623	Continued From page 22	F 623		

little improvement after previous interventions/orders. C-Trans called and made aware of need to transport to ER for eval. Report called to Nurse Connect (name of nurse connect omitted). Resident aware. Called resident's sister and made aware as well."

The 10/15/18 22:30 (10:30 p.m.) progress note read "C-Trans here to transport resident to hospital (name omitted) ER at this time."

The 10/16/18 4:26 a.m. progress note read that the resident was being transferred to another hospital.

The 10/15/18 or 10/16/18 progress notes did not have documentation of information sent with the resident to the hospital.

The surveyor interviewed the facility social worker on 12/06/18 at 1128. She stated she completes a transfer/discharge form when a resident is discharged home, to an ALF (assisted living facility) or to another nursing facility. The social worker stated she does not do a transfer form when residents are sent to the hospital and does not provide a written notice to the resident or resident representative.

The surveyor interviewed the director of nursing (DON) on 12/06/18 11:51a.m. on the process and paperwork when a resident is transferred to the hospital. The DON stated she notifies the MD (medical doctor)/RP (responsible party), sends a transfer form, MAR (medication administration record) and PN (progress notes). The DON stated, when asked, if a copy of the comprehensive care plan goals are sent, she stated she didn't.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 623	Continued From page 23	F 623		

The surveyor met with the director of nursing (DON), assistant director of nursing (ADON), both corporate registered nurses and the interim administrator on 12/6/18 at 12:02 p.m. on the process for transferring a resident to the hospital. The DON stated notify MD/RP, call hospital and give report, after hours notified, call EMS (emergency medical services), send transfer treatment form, MAR, any special treatments, and pertinent laboratory tests. The DON stated comprehensive care plan goals were not sent. The DON also stated no written documentation of transfers are sent to the family when the resident is transferred to hospital.

The surveyor informed the administrative staff of the above concern in the end of the day meeting on 12/6/18 at 4:14 p.m. and requested the facility policy on transfers.

No further information was provided prior to the exit on 12/6/18.

2. The facility staff failed to send written notice to the resident or resident representative of Resident #54's transfer to the acute care hospital on 11/14/18.

The clinical record of Resident #54 was reviewed 12/4/18 through 12/6/18. Resident #54 was admitted to the facility 10/10/17 and readmitted 11/17/18 with diagnoses that included but not limited to unspecified dementia without behavioral disturbances, hypertensive heart and chronic kidney disease with heart failure, type 2 diabetes mellitus, chronic respiratory failure, hypothyroidism, atrial fibrillation, major depressive disorder, dysphagia, anemia, hyperlipidemia,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 623	Continued From page 24 gastro-esophageal reflux disease and dependence on supplemental oxygen. Resident #54's 14- day minimum data set assessment (MDS) with an assessment reference date (ARD) of 11/29/18 assessed the resident with a BIMS (brief interview for mental status) as 09/15. A progress note dated 11/14/18 at 10:30 read "Called to room per sitter, res (resident) noted to have SOB (shortness of breath). VS (vital signs) at this time BP (blood pressure) 181/77, P (pulse) 81, T (temperature) 99.1, R (respirations) 40, O2 (oxygen saturation level) 96% on 2 LPM (liters per minute) BS (blood sugar) 49. Daughter in room and aware of res condition. MD (medical doctor) in facility and notified. Verbal orders given for Rocephin 1 gm (gram) IM (intramuscular). Solu-Medrol 125 mg (milligrams), Lasix 40 mg IM all x1 dose now. Orders received to send res to ER (emergency room) for eval (evaluation)." Progress note dated 11/14/18 10:43 read "C Trans ambulance services notified of transport. Hospital (name omitted) given report. Daughter in room and aware." Progress note dated 11/14/18 at 15:08 (3:08 p.m.) read "Per hospital (name omitted) res being admitted to ICU (intensive care unit) dx (diagnosis) resp (respiratory) failure." The 11/14/18 progress notes did not have documentation of information sent with the resident to the hospital on 11/14/18. The surveyor interviewed the facility social worker on 12/06/18 at 1128. She stated she completes a transfer/discharge form when a resident is	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 623	Continued From page 25	F 623		

discharged home, to an ALF (assisted living facility) or to another nursing facility. The social worker stated she does not do a transfer form when residents are sent to the hospital and does not provide a written notice to the resident or resident representative.

The surveyor interviewed the director of nursing (DON) on 12/06/18 11:51a.m. on the process and paperwork when a resident is transferred to the hospital. The DON stated she notifies the MD (medical doctor)/RP (responsible party), sends a transfer form, MAR (medication administration record) and PN (progress notes). The DON stated when asked if a copy of the comprehensive care plan goals are sent, she stated she didn't.

The surveyor met with the director of nursing (DON), assistant director of nursing (ADON), both corporate registered nurses and the interim administrator on 12/6/18 at 12:02 p.m. on the process for transferring a resident to the hospital. The DON stated notify MD/RP, call hospital and give report, after hours notified, call EMS (emergency medical services), send transfer treatment form, MAR, any special treatments, and pertinent laboratory tests. The DON stated comprehensive care plan goals were not sent. The DON also stated no written documentation of transfers are sent to the family when the resident is transferred to hospital.

The surveyor informed the administrative staff of the above concern in the end of the day meeting on 12/6/18 at 4:14 p.m. and requested the facility policy on transfers.

No further information was provided prior to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 623	Continued From page 26 exit on 12/6/18. 3. The facility staff failed to send written notice to the resident or resident representative of Resident #85's transfer to the acute care hospital on 8/18/18. The clinical record of Resident #85 was reviewed 12/4/18 through 12/6/18. Resident #85 was admitted to the facility 9/15/15 and readmitted 8/19/18 with diagnoses of but not limited to anoxic brain damage, gastrostomy tube, type 2 diabetes mellitus, hypertension, dysphagia, heart failure, cardiac pacemaker, atherosclerotic heart disease, pressure ulcer, allergic rhinitis, anemia, atrioventricular block, functional quadriplegia, hyperlipidemia, restless legs syndrome, major depressive disorder, cerebral infarction, contracture of right hip and right knee. Resident #85's significant change in status minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/13/18 assessed the resident with short term memory problems, long term memory problems, and moderately impaired cognitive skills for daily decision making. Resident #85's 8/18/18 progress note read in part that the resident had dark stools and was sent to the emergency room on 8/18/18. Guardian was notified. Resident #85 was admitted to the hospital with gastrointestinal bleeding (GI bleed). The surveyor interviewed the facility social worker on 12/06/18 at 1128. She stated she completes a transfer/discharge form when a resident is discharged home, to an ALF (assisted living facility) or to another nursing facility. The social	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 623		F 623		

Continued From page 27
worker stated she does not do a transfer form when residents are sent to the hospital and does not provide a written notice to the resident or resident representative.

The surveyor interviewed the director of nursing (DON) on 12/06/18 11:51a.m. on the process and paperwork when a resident is transferred to the hospital. The DON stated she notifies the MD (medical doctor)/RP (responsible party), sends a transfer form, MAR (medication administration record) and PN (progress notes). The DON stated when asked if a copy of the comprehensive care plan goals are sent, she stated she didn't.

The surveyor met with the director of nursing (DON), assistant director of nursing (ADON), both corporate registered nurses and the interim administrator on 12/6/18 at 12:02 p.m. on the process for transferring a resident to the hospital. The DON stated notify MD/RP, call hospital and give report, after hours notified, call EMS (emergency medical services), send transfer treatment form, MAR, any special treatments, and pertinent laboratory tests. The DON stated comprehensive care plan goals were not sent. The DON also stated no written documentation of transfers are sent to the family when the resident is transferred to hospital.

The surveyor informed the administrative staff of the above concern in the end of the day meeting on 12/6/18 at 4:14 p.m.

No further information was provided prior to the exit on 12/6/18.

4. For Resident #24, the facility staff failed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 623	Continued From page 28	F 623		

provide a written notice of transfer when Resident #24 was transferred to a local hospital.

Resident #24 is a 44-year-old female who was originally admitted to the facility on 05/25/16, with a readmission date of 09/15/18. Diagnoses included, but were not limited to, hypertensive chronic kidney disease, major depressive disorder, scoliosis, and hemiplegia.

The clinical record for Resident #24 was reviewed on 12/5/18 at 1:14 pm. The most recent MDS (minimum data set) assessment for Resident #24 was a quarterly assessment with an ARD (assessment reference date) of 11/20/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident #24 had a BIMS (brief interview for mental status) score of 15 out of 15.

On 12/05/18 the surveyor reviewed Resident #24's progress notes. It contained a progress note in the clinical record documented on 09/11/18 at 7:30 pm which read in part, "Charge nurse telephoned ER (emergency room) to inquire on Resident's status. Resident admitted to (facility name withheld) with Dx (diagnosis): Sepsis, PNA (pneumonia), UTI (urinary tract infection). RP (responsible party) is at ER with Resident ...."

The surveyor could not locate documentation in Resident #24's clinical record that indicated that Resident #24 and/or Resident #24's authorized representative was notified of Resident #24's transfer to the emergency room on 09/11/18 in writing.

On 12/06/18 at 2:45 pm the surveyor spoke with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 623	Continued From page 29	F 623		

DON (director of nursing) and it was clarified that the facility staff did not notify Resident #24 and/or Resident #24's authorized representative of transfer to hospital on 09/11/18 in writing.

The administrative team was made aware of issue during a meeting with survey team on 12/06/18 at 4:25 pm.

No further information regarding this issue was provided to the survey team prior to the exit conference on 12/06/18.

5. For Resident #46, the facility staff failed to provide written notice of transfer when Resident #46 was transferred to a local hospital.

Resident #46 is an 89-year-old female who was originally admitted to the facility on 08/11/16, with a readmission date of 09/22/18. Diagnoses included, but were not limited to, vascular dementia, hypertension, major depressive disorder, and osteoporosis.

The clinical record for Resident #46 was reviewed on 12/5/18 at 8:29 am. The most recent MDS (minimum data set) assessment for Resident #46 was an annual assessment with an ARD (assessment reference date) of 10/10/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident #46 had a BIMS (brief interview for mental status) score of 06 out of 15.

On 12/05/18 the surveyor reviewed Resident #46's progress notes. It contained a progress note in the clinical record documented on 09/20/18 at 3:38 pm which read in part, "R/C (report called) from (facility name withheld) nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 623		F 623		

Continued From page 30
stating this Resident is being admitted on the med surge floor with Dx (diagnosis) of respiratory failure with hypoxemia and pleural effusion to right lower lung."

The surveyor could not locate documentation in Resident #46's clinical record that indicated that Resident #46 and/or Resident #46's authorized representative was notified of Resident #46's transfer to the emergency room on 09/20/18 in writing.

On 12/06/18 at 2:45 pm the surveyor spoke with DON (director of nursing) and it was clarified that the facility staff did not notify Resident #46's authorized representative of transfer to hospital on 09/20/18 in writing.

The administrative team was made aware of issue during a meeting with survey team on 12/06/18 at 4:25 pm.

No further information regarding this issue was provided to the survey team prior to the exit conference on 12/06/18.
6. For Resident #1 the facility staff failed to provide a written notice of transfer to the Resident/representative when Resident was transferred to the hospital.

Resident #1 was admitted to the facility on 02/06/18 and readmitted on 11/09/18. Diagnoses included but not limited to anemia, hypertension, diabetes mellitus, hip fracture, dementia, depression, and gastroesophageal reflux disease.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 11/27/18 coded the Resident as 5 out of 15 in section C,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 623	Continued From page 31 cognitive patterns. This is a quarterly MDS. Resident #1's clinical record was reviewed on 12/05/18. It contained a progress note dated 08/14/18 which read in part, "8/14/2018 18:19 Received call from sister, ...(name omitted), regarding Resident en route to .... (facility name omitted),....". The surveyor could not locate any documentation that indicated the a written notice of transfer was provided to the Resident or representative. Surveyor spoke with the social worker on 12/06/18 at approximately 1150. Social worker stated that she completes a transfer/discharge form when a Resident is discharged home, or to another facility. Social worker stated that she does not complete a transfer/discharge form when a Resident is sent to the hospital with the anticipation of return to the facility. The concern of not providing a written notice of transfer was discussed with the administrative team during a meeting on 12/06/18 at approximately 1615. No further information was provided prior to exit.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-	F 625		1/18/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 625	Continued From page 32 (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to offer a bed hold to 1 of 26 residents (Resident #85). The findings included: The facility staff failed to offer a bed hold to Resident #85 when the resident was transferred to the hospital on 8/18/18. The clinical record of Resident #85 was reviewed 12/4/18 through 12/6/18. Resident #85 was admitted to the facility 9/15/15 and readmitted 8/19/18 with diagnoses of but not limited to anoxic brain damage, gastrostomy tube, type 2 diabetes mellitus, hypertension, dysphagia, heart	F 625	1.) Resident #85 was already readmitted to the center prior to the end of the survey. 2.) Any resident has the potential to be affected if a bed hold is not offered to them upon transfer. As of 12/6/18, any resident that is transferred will have a bed hold offered to them upon transfer. 3.) Re-education initiated on 12/6/18 and provided to nursing, admissions, and the BOM regarding the requirement that a bed hold be offered to the resident upon transfer.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

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F 625	Continued From page 33 failure, cardiac pacemaker, atherosclerotic heart disease, pressure ulcer, allergic rhinitis, anemia, atrioventricular block, functional quadriplegia, hyperlipidemia, restless legs syndrome, major depressive disorder, cerebral infarction, contracture of right hip and right knee. Resident #85's significant change in status minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/13/18 assessed the resident with short term memory problems, long term memory problems, and moderately impaired cognitive skills for daily decision making. Resident #85's 8/18/18 progress note read in part that the resident had dark stools and was sent to the emergency room on 8/18/18. Guardian was notified. Resident #85 was admitted to the hospital with gastrointestinal bleeding (GI bleed). The clinical record did not reveal that a bed hold had been offered to the resident's guardian. The surveyor informed the administrative staff of the above concern on 12/5/18 at 3:07 p.m. The corporate registered nurse #2 stated the resident was sent out over the weekend and returned the next day. The corporate registered nurse #2 stated a bed hold was not offered to Resident #85. The facility provided the bed hold policy that read in part "1. I understand Virginia Medicaid will not hold beds during a hospital admission. If a resident chooses to hold a bed, these days will be considered private pay and all monies must be paid in advance. If a resident chooses not to hold a bed by paying privately, I understand that the	F 625	4.)Any resident that are transferred will be audited weekly X4 weeks then monthly X2 months to ensure that a bed hold was offered to them upon transfer. Any and all findings to be reported to the QA committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 625	Continued From page 34 resident will be discharged from the center." The surveyor informed the administrative staff of the above concern during the end of the day meeting on 12/6/18 at 4:14 p.m. No further information was provided prior to the exit conference on 12/6/18.	F 625		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656		1/18/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 656	Continued From page 35 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review the facility staff failed to develop a comprehensive care plan for 1 of 26 Resident, Resident #14. The findings included: For Resident #14 the facility staff failed to develop a care plan for skin picking behavior. Resident #14 was admitted to the facility on 02/07/18 and readmitted on 04/07/18. Diagnoses included but not limited to hypertension, hyperlipidemia, dementia, depression, hypothyroidism, and atrial fibrillation. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 09/17/18 coded the Resident as 10 of 15 in section C, cognitive patterns. Section E, behaviors, listed the Resident as having no behaviors. This a quarterly MDS. Surveyor observed Resident #14 on 12/04/18 at	F 656	1.) Resident #14's care plan was initiated on 12/5/18. 2.) All residents have the potential to be affected if behaviors are not captured and do not have a plan of care established. A 100% review of residents with behaviors was completed to confirm that a plan of care has been established and initiated. 3.) Re-education initiated on 12/6/18 and provided to nursing staff regarding reporting behaviors timely in order for a plan of care to be established and initiated. 4.) 5 random residents will be audited weekly X4 weeks then monthly X2 months to ensure that residents with behaviors have a plan of care established and initiated. Any and all findings to be reported to the QA committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 656	Continued From page 36 approximately 1430. Resident was resting in bed. Surveyor observed to have several scratches to the right side of her face. Surveyor asked Resident what had happened to her face and Resident stated, "I did that myself, I scratch at it sometimes, I don't know why". Surveyor observed Resident's fingernails to be long and ragged. Surveyor observed Resident #14 on 12/05/18 at approximately 0830. Resident was seated in wheelchair in hallway. Surveyor observed Resident picking at her arms, and observed several scratches on both arms. Resident stated to surveyor, "I've been picking at them, I get nervous sometimes." Resident's nails were observed to be long and ragged. Resident #14's clinical record was reviewed on 12/05/18. It contained a CCP (comprehensive care plan), however, the surveyor could not locate a care plan that addressed behavior of picking at skin. The surveyor spoke with unit manager on 12/06/18 at approximately 1345. Surveyor asked unit manager scratches on Resident #14's face and arms and unit manager stated, "She's a picker, as long as she's been here she's picked." The surveyor spoke with MDS coordinator on 12/0618 at approximately 1355. Surveyor asked the MDS coordinator why the Resident did not have a care plan that addressed her picking at herself and the MDS coordinator stated that she was not aware of the behavior. The concern of not developing a care plan for skin picking behavior was discussed during a meeting with the administrative staff on 12/0 /18	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 656	Continued From page 37 at approximately No further information was provided prior to exit.	F 656		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review the facility staff failed to follow professional standards of practice for 5 of 26 Residents, #70, #105, #154, #155, and #156. The findings included: 1. For Resident #70, the facility staff failed to follow the rights of medication administration. Which resulted in the Resident receiving the incorrect amount of the medication miralax and receiving a medication that had been discontinued in July of 2016. According to the national institute of health website https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4401721/ accessed 12/07/2018 there are 7 rights to medication administration. Right patient, right drug, right dose, right time, right route, right reason, and right documentation. The clinical record review revealed that Resident #70 had been admitted to the facility 07/31/2014.	F 658	1.) Resident #'s 70, 105, 154, 155, and 156 responsible parties were notified that the residents did not receive the medications as ordered. Each resident's physician was notified with no new orders and no negative outcomes noted. 2.) Any resident has the potential to be affected if medications are not administered per physician order. A 100% audit was performed on all residents to ensure that medications were available as per physician order. 3.) Re-education was initiated on 12/6/18 and provided to nursing regarding ensuring that medications are administered per physician order and on the proper procedures/processes regarding the use of the Omnicell and back-up pharmacy procedures. 4.) 5 random residents will be audited weekly X4 weeks then monthly X2 months to ensure that all medications are being	1/18/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 658	Continued From page 38	F 658		

Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertension, gastro esophageal reflux disease, osteoarthritis, and history of pulmonary embolism.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/31/2018 included a BIMS (brief interview for mental status) summary score of 14 out of a possible 15 points.

The Residents CCP (comprehensive care plan) included the focus areas has altered GI (gastro-intestinal) status-chooses not to take medication for constipation prevention at times despite education by nursing staff. Interventions included but were not limited to, give medications as ordered.

The facility used a "Paxit" system for administering medications. This system packaged the Residents tablets/capsules inside of a plastic bag that included the Residents name, room number, time of medication administration, date, name of facility, and the name of the Residents medications listed in alphabetical order. The bottom of the bag included the statement "Refer to MAR (medication administration record) for medication administration times and instructions..." Inside of the paxit, the medications were individually packaged in blister packs making each medication easily identifiable.

On 12/05/2018 at 9:34 AM the surveyor observed LPN (licensed practical nurse) #1 during a medication pass and pour observation. During this observation, LPN #1 prepared and

Provider's plan of correction (F 658):

administered per physician order.
Any and all findings to be reported to the QA committee for further review and recommendations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 658	Continued From page 39	F 658		

administered the Residents morning medications using the paxit system. When preparing the medications LPN #1 prepared 17 grams of miralax and mixed it with water. This was not included in the paxit medication bag. The paxit bag included 1 tablet of methylprednisolone 4 mg along with the Residents other morning medications. LPN #1 removed all the medications from the paxit bag, removed them from their blister packets, and placed them in a medication cup to administer to Resident #70. After preparing all of the Residents morning medications LPN #1 entered the Residents room and administered the medications.

After the medication observation, the surveyor reconciled the Residents medications using the Residents EHR (electronic health record). A review of the Residents EHR revealed that Resident #70 had a physicians order for polyethylene glycol (miralax) powder give 8.5 grams by mouth one time a day for constipation. Not 17 grams as administered by LPN #1. The surveyor was unable to locate an active order for the methylprednisolone. The EHR included a physician order that indicated this medication had been discontinued on 07/13/2016.

On 12/05/2018 at 10:45 AM, the surveyor and LPN #1 reviewed the Residents physician orders. After reviewing the orders LPN #1 verbalized to the surveyor that she had administered 17 grams of miralax and not 8.5. LPN #1 also verbalized that the methylprednisolone looked as if it had been discontinued.

On 12/05/2018 at 11:55 AM LPN #1 approached the surveyor, stated she had made 2 medication errors, that the physician was in the facility, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	**208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277**

(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 658	Continued From page 40 had been notified. On 12/06/2018 at 1:45 PM, the DON (director of nursing) provided the survey team with a copy of their policy/procedure titled "Physician Medication Orders." The DON stated we use this policy and it based on a standard of practice. This policy/procedure read in part, "...Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medication in this state..." The administrative staff were notified of the issues regarding the Residents miralax and methylprednisolone during a meeting with the survey team on 12/06/2018 at 4:14 PM. The facility provided the surveyor with a copy of an in-service attendance form titled "Obtain medications for new admissions." The date of this in-service was documented as 12/05/18. The 2nd page of this document read in part, "...Upon all new admissions', The Charge Nurse is responsible to call Pharmacy to have Patients profile uploaded into the Omnicel. You are to ensure that Pharmacy is using our back up Pharmacy to ensure all medication is available ASAP. NO EXCEPTIONS..." Prior to the exit conference the DON stated she had contacted the pharmacy and the issue with the methylprednisolone appeared to be a linking problem. No further information regarding these issues were provided to the survey team prior to the exit conference. 2. For Resident #105, the facility staff failed to	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 658 Continued From page 41 F 658

administer medications that were available at the facility and in the back up medication supply. The facility staff also failed to obtain medications that were not available in the back up medication supply at the facility at a backup pharmacy resulting in the Resident not receiving physician ordered medications.

The clinical record review revealed that Resident #105 had been admitted to the facility 11/28/2018. Diagnoses included, but were not limited to, pneumonia, difficulty in walking, hypertensive heart disease chronic atrial fibrillation, and chronic diastolic congestive heart failure.

There was no completed MDS (minimum data set) assessment on this Resident. However, the Resident was alert and orientated to person and place.

The Residents care plan included the following focus area has respiratory problem related to acute illness or chronic condition. Interventions included administer medications as ordered.

During initial tour of the facility on 12/04/2018, a family member of this Resident expressed a concern to the surveyor that the Resident had not received some of her medications when she had been admitted.

On 12/04/2018 at 3:14 PM, during an interview with Resident #105 the Resident stated they had been admitted late one evening and it took a couple of days to get my medicines straightened out.

12/04/18 at 4:33 PM, the surveyor asked RN (registered nurse) #1 if they had a backup

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 658	Continued From page 42	F 658		

pharmacy. RN #1 verbalized to the surveyor that they use-to-use one in town and now we use one in a neighboring city.

A review of the Residents EHR (electronic health record) revealed that the facility nursing staff had coded the following medications with a "9" on 11/28/18 colace, cozaar (hypertension), and lopressor (hypertension). For 11/29/18 nifediac (hypertension), osteo Bi-Flex, vitamin C, vitamin E, eliquis (atrial fibrillation-the facility had documented they had administered this on 11/28/18), lopressor, and floranex (probiotic). For 11/30/18 cefdinir (the facility had documented this had been administered on 11/28/18). Per the pre-printed code on the eMAR (electronic medication administration record) a" 9=Other/See Nurses Note."

On 11/29/2018 the nursing staff documented that they were awaiting pharmacy for the lopressor, floranex, cefdinir, eliquis, lopressor, nifediac, osteo Bi-flex, vitamin C, and vitamin E.

A review of the facility stat box and omnicell list revealed that the medications cozaar, lopressor, vitamin C, and cefdinir would have been available in the back up medication boxes for administration.

On 12/05/2018 at 4:27 PM, during a meeting with the administrative staff the DON (director of nursing) was asked the procedure to obtain medications for new admissions or if medications were not available. The DON verbalized to the survey team that if the medication is available in the omnicell, the nursing staff would have to call the pharmacy to access the Residents profile and they could use a backup pharmacy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 658	Continued From page 43	F 658		

On 12/06/18 at 9:14 AM, the surveyor interviewed pharmacist #1 via phone in regards to new admissions/unavailable medications. Pharmacist #1 verbalized to the surveyor that the procedure for the omnicell was as follows-orders are sent to the pharmacy and once they are verified, they are entered into the system. Pharmacist #1 also stated that they have a stat box at the facility and some medications can be pulled from that or they can utilize the backup system for more urgent medications such as blood pressure medications and antibiotics.

The facility policy/procedure titled "UNAVAILABLE MEDICATIONS" read in part, "...If the ordered medications are not available, the pharmacist is notified for delivery at next scheduled delivery time or if needed prior to the next scheduled med pass time, the pharmacy will contact the back-up pharmacy for the medication. A pharmacist is available 24 hours a day by phone...The attending physician is to be notified of medication that is not available from the pharmacy. The physician may order an alternative medication from EDK/STAT kits until the original medication is available."

Reference: Potter and Perry, Fundamentals of Nursing 6th edition, page 419. Professional standards dictate that care be administered according to physician direction: "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the resident..."

The facility provided the surveyor with a copy of an in-service attendance form titled "Obtain medications for new admissions." The date of this

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 658	Continued From page 44 in-service was documented as 12/05/18. The 2nd page of this document read in part, "...Upon all new admissions', The Charge Nurse is responsible to call Pharmacy to have Patients profile uploaded into the Omnicel. You are to ensure that Pharmacy is using our back up Pharmacy to ensure all medication is available ASAP. NO EXCEPTIONS..." The administrative staff were notified of the issue regarding the availability and administration of the Residents medications during a meeting with the survey team on 12/06/18 at 4:14 PM. No further information regarding this issue was provided to the survey team prior to the exit conference. 3. For Resident #154, the facility staff failed to administer medications that were available at the facility in the back up medication supply and failed to obtain medications that were not available in the back up medication supply at the facility from a backup pharmacy. This resulted in the Resident not receiving physician ordered medications. The clinical record review revealed that Resident #154 had been admitted to the facility on 12/03/18. Diagnoses included, but were not limited to, aftercare following surgery for neoplasm, muscle weakness, dysphagia, COPD (chronic obstructive pulmonary disease), and diabetes. There was no MDS (minimum data set) assessment completed on this Resident. However, the Resident was alert and orientated to person and place.	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 658	Continued From page 45	F 658		

During a medication pass and pour observation with LPN (licensed practical nurse) #2 on 12/05/18 at 10:03 AM LPN #2 verbalized to the surveyor that the Residents nystatin had not arrived from the pharmacy for administration.

The Residents physician order summary included the order "Nystatin Suspension...Give 10 cc orally three times a day for mouth care patient must spit out..." The order date was documented as 12/04/18.

When reviewing the Residents clinical record on 12/06/18 it was noted that LPN #2 had documented on the Residents eMAR (electronic medication administration record) that she had administered the nystatin at 9:00 AM and 1:00 PM on 12/05/18. When interviewing LPN #2 she stated she had marked that in error and she had not obtained the medication until around 3:30 PM from the backup pharmacy. Indicating the Resident had missed two doses.

Reference: Potter-Perry Fundamentals of Nursing, 6th Edition, page 477 "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice."

Further review of the Residents EHR (electronic health record) revealed that the facility nursing staff had coded the following medications with a "9" on 12/03/18 depakote (seizures), olanzapine

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 658	Continued From page 46	F 658		

(antipsychotic), and atrovent nasal spray (COPD). For 12/04/18 ditropan (bladder spasms), atrovent nasal spray, and flomax. Per the pre-printed code on the eMAR (electronic medication administration record) a" 9=Other/See Nurses Note."

A review of the facility stat box and omnicell list revealed that the medications depakote, olanzapine, and flomax, would have been available in the back up medication boxes for administration.

On 12/05/2018 at 4:27 PM during a meeting with the administrative staff the DON (director of nursing) was asked the procedure for obtaining medications for new admissions or if medications were not available. The DON verbalized to the survey team that if the medication is available in the omnicell, the nursing staff would have to call the pharmacy to access the Residents profile and they could use a backup pharmacy.

During an interview with Resident #154 on 12/06/18 at 8:46 AM, Resident #154 stated they started his mouthwash. When asked how his mouth felt he stated before he used the mouthwash his mouth and throat hurt.

On 12/06/18 at 9:14 AM, the surveyor interviewed pharmacist #1 via phone in regards to new admissions/unavailable medications. Pharmacist #1 verbalized to the surveyor that the procedure for the omnicell was as follows-orders are sent to the pharmacy and once they are verified, they are entered into the system. Pharmacist #1 also stated that they have a stat box at the facility and some medications can be pulled from that or they can utilize the backup system for more urgent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 658	Continued From page 47	F 658		

medications such as blood pressure medications and antibiotics. When asked when the nystatin had been called into the back up pharmacy pharmacist stated yesterday (12/05/18) at 3:48 PM.

The facility policy/procedure titled "UNAVAILABLE MEDICATIONS" read in part, "...If the ordered medications are not available, the pharmacist is notified for delivery at next scheduled delivery time or if needed prior to the next scheduled med pass time, the pharmacy will contact the back-up pharmacy for the medication. A pharmacist is available 24 hours a day by phone...The attending physician is to be notified of medication that is not available from the pharmacy. The physician may order an alternative medication from EDK/STAT kits until the original medication is available."

Reference: Potter and Perry, Fundamentals of Nursing 6th edition, page 419. Professional standards dictate that care be administered according to physician direction: "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the resident..."

The facility provided the surveyor with a copy of an in-service attendance form titled "Obtain medications for new admissions." The date of this in-service was documented as 12/05/18. The 2nd page of this document read in part, "...Upon all new admissions', The Charge Nurse is responsible to call Pharmacy to have Patients profile uploaded into the Omnicel. You are to ensure that Pharmacy is using our back up Pharmacy to ensure all medication is available ASAP. NO EXCEPTIONS..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 658	Continued From page 48	F 658		

The administrative staff were notified of the issue regarding the availability and administration of the Residents medications during a meeting with the survey team on 12/06/18 at 4:14 PM.

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

4. For Resident #155, the facility staff failed to administer medications that were available at the facility in the back up medication supply and failed to obtain medications that were not available in the back up medication supply at the facility from a backup pharmacy. This resulted in the Resident not receiving physician ordered medications.

The clinical record review revealed that Resident #155 had been admitted to the facility on 12/03/18. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, diabetes, chronic diastolic congestive heart failure, depressive disorder, hypertensive heart disease, and peripheral vascular disease.

There was no MDS (minimum data set) assessment completed on this Resident. However, the Resident was alert and orientated to person and place.

A review of the Residents EHR (electronic health record) revealed that the facility nursing staff had coded the following medications with a "9" on 12/03/18 sennosides (stool softner), singulair, travatan (glaucoma), and budesonide suspension. For 12/04/18 atorvastatin (cholesterol), celexa (antidepressant), isosorbide

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 658	Continued From page 49	F 658		

ER (extended release), nifedipine ER (hypertension), protonix (stomach ulcers), carvedilol (hypertension) the facility nursing staff had documented that this medication had been administered on 12/03/18, and prazosin (high blood pressure). Per the pre-printed code on the eMAR (electronic medication administration record) a" 9=Other/See Nurses Note."

A review of the facility stat box and omnicell list revealed that the medications atorvastatin, celexa, isosorbide, protonix, sennosides, singulair, and carvedilol, would have been available in the back up medication boxes for administration.

On 12/05/2018 at 4:27 PM. during a meeting with the administrative staff the DON (director of nursing) was asked the procedure to obtain medications for new admissions or if medications were not available. The DON verbalized to the survey team that if the medication is available in the omnicell, the nursing staff would have to call the pharmacy to access the Residents profile and they could use a backup pharmacy.

The Residents care plan included the focus area to administer medications as ordered.

On 12/06/18 at 9:14 AM, the surveyor interviewed pharmacist #1 via phone in regards to new admissions/unavailable medications. Pharmacist #1 verbalized to the surveyor that the procedure for the omnicell was as follows-orders are sent to the pharmacy and once they are verified, they are entered into the system. Pharmacist #1 also stated that they have a stat box at the facility and some medications can be pulled from that or they can utilize the backup system for more urgent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 658		F 658		

Continued From page 50
medications such as blood pressure medications and antibiotics.

The facility policy/procedure titled "UNAVAILABLE MEDICATIONS" read in part, "...If the ordered medications are not available, the pharmacist is notified for delivery at next scheduled delivery time or if needed prior to the next scheduled med pass time, the pharmacy will contact the back-up pharmacy for the medication. A pharmacist is available 24 hours a day by phone...The attending physician is to be notified of medication that is not available from the pharmacy. The physician may order an alternative medication from EDK/STAT kits until the original medication is available."

Reference: Potter and Perry, Fundamentals of Nursing 6th edition, page 419. Professional standards dictate that care be administered according to physician direction: "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the resident..."

The administrative staff were notified of the issue regarding the availability and administration of the Residents medications during a meeting with the survey team on 12/06/18 at 4:14 PM.

The facility provided the surveyor with a copy of an in-service attendance form titled "Obtain medications for new admissions." The date of this in-service was documented as 12/05/18. The 2nd page of this document read in part, "...Upon all new admissions', The Charge Nurse is responsible to call Pharmacy to have Patients profile uploaded into the Omnicel. You are to ensure that Pharmacy is using our back up

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 658

Continued From page 51

Pharmacy to ensure all medication is available ASAP. NO EXCEPTIONS..."

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

5. For Resident #156, the facility staff failed to administer medications that were available at the facility in the back up medication supply and failed to obtain medications that were not available in the back up medication supply at the facility from a backup pharmacy. This resulted in the Resident not receiving physician ordered medications.

The clinical record review revealed that Resident #156 had been admitted to the facility on 11/28/18. Diagnoses included, but were not limited to, clostridium difficile, muscle weakness, atrial fibrillation, and pneumonia.

There was no MDS (minimum data set) assessment completed on this Resident. However, the Resident was alert and orientated to person and place.

A review of the Residents EHR (electronic health record) revealed that the facility nursing staff had coded the following medications with a "9" on 11/29/18 lopressor (hypertension) and nabumetone (pain). For 11/30/18, the facility had coded the antibiotic vancomycin with a "9". Per the pre-printed code on the eMAR (electronic medication administration record) a" 9=Other/See Nurses Note."

On 11/29/18, the facility staff had documented that they were waiting for the medications

F 658

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 658 Continued From page 52 F 658

nabumetone, vancomycin, and lopressor from the pharmacy.

A review of the facility stat box and omnicell list revealed that the medications lopressor and vancomycin would have been available in the back up medication boxes for administration.

On 12/05/2018 at 4:27 PM during a meeting with the administrative staff the DON (director of nursing) was asked the procedure to obtain medications for new admissions or if medications were not available. The DON verbalized to the survey team that if the medication is available in the omnicell, the nursing staff would have to call the pharmacy to access the Residents profile and they could use a backup pharmacy.

The Resident had been care planned for pain-administer pain medication as ordered and contact isolation due to clostridium difficile. Resident #156 had been prescribed the antibiotic vancomycin for the clostridium difficile.

On 12/06/18 at 9:14 AM, the surveyor interviewed pharmacist #1 via phone in regards to new admissions/unavailable medications. Pharmacist #1 verbalized to the surveyor that the procedure for the omnicell was as follows-orders are sent to the pharmacy and once they are verified, they are entered into the system. Pharmacist #1 also stated that they have a stat box at the facility and some medications can be pulled from that or they can utilize the backup system for more urgent medications such as blood pressure medications and antibiotics.

The facility policy/procedure titled "UNAVAILABLE MEDICATIONS" read in part, "...If the ordered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 658	Continued From page 53	F 658		

medications are not available, the pharmacist is notified for delivery at next scheduled delivery time or if needed prior to the next scheduled med pass time, the pharmacy will contact the back-up pharmacy for the medication. A pharmacist is available 24 hours a day by phone...The attending physician is to be notified of medication that is not available from the pharmacy. The physician may order an alternative medication from EDK/STAT kits until the original medication is available."

Reference: Potter and Perry, Fundamentals of Nursing 6th edition, page 419. Professional standards dictate that care be administered according to physician direction: "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the resident..."

The administrative staff were notified of the issue regarding the availability and administration of the Residents medications during a meeting with the survey team on 12/06/18 at 4:14 PM.

The facility provided the surveyor with a copy of an in-service attendance form titled "Obtain medications for new admissions." The date of this in-service was documented as 12/05/18. The 2nd page of this document read in part, "...Upon all new admissions', The Charge Nurse is responsible to call Pharmacy to have Patients profile uploaded into the Omnicel. You are to ensure that Pharmacy is using our back up Pharmacy to ensure all medication is available ASAP. NO EXCEPTIONS..."

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 658	Continued From page 54 conference.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review the facility staff failed to provide ADL care for 1 of 26 dependant Residents, Resident #14. The findings included: The facility staff failed to provide nail care for a dependent Resident. Resident #14 was admitted to the facility on 02/07/18 and readmitted on 04/07/18. Diagnoses included but not limited to hypertension, hyperlipidemia, dementia, depression, hypothyroidism, and atrial fibrillation. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 09/17/18 coded the Resident as 10 of 15 in section C, cognitive patterns. Section G, functional status, coded the Resident as 3/2 in the area of personal hygiene. This is equivalent to extensive assistance/one person physical assist. This a quarterly MDS. Surveyor observed Resident #14 on 12/04/18 at approximately 1430. Resident was resting in bed. Surveyor observed several scratches to the right	F 677	1.) Resident #14 was immediately provided with ADL care including appropriate nail care. 2.) Any resident has the potential to be affected if nail care is not provided. A 100% audit of all residents was performed to ensure that fingernails were appropriately cared for. 3.) Re-education was initiated on 12/4/18 and provided to nursing regarding all aspects of ADL care including nail care. 4.) 5 random residents will be audited weekly X4 weeks then monthly X2 months to ensure that nail care has been performed appropriately. Any and all findings to be reported to the QA committee for further review and recommendations.	1/18/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 677	Continued From page 55 side of Resident's face. Surveyor observed that Resident's fingernails were long and ragged. Surveyor observed Resident #14 again on 12/05/18 at approximately. Resident's fingernails were observed to be long and ragged. Resident #14's CCP (comprehensive care plan) was reviewed on 12/0518. It contained a care plan for "...requires assist wit ADL's (activities of daily living) r/t (related to) self care deficit...". Interventions listed for this care plan included "Provide assistance with bathing and hygiene as needed". The concern of not providing nail care was discussed with the administrative team during a meeting on 12/05/18 at approximately 1630. No further information was provided prior to exit.	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review the facility staff failed to follow physician's orders for 4 of 26 Residents, #105, #154, #155, and #156.	F 684	1.) Resident #'s 105, 154, 5, and 156 responsible parties were notified that the residents did not receive the medications as ordered. Each resident's physician	1/18/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 684	Continued From page 56 The findings included: 1. For Resident #105, the facility staff failed to administer physician ordered medications. The clinical record review revealed that Resident #105 had been admitted to the facility 11/28/2018. Diagnoses included, but were not limited to, pneumonia, difficulty in walking, hypertensive heart disease chronic atrial fibrillation, and chronic diastolic congestive heart failure. There was no completed MDS (minimum data set) assessment on this Resident. However, the Resident was alert and orientated to person and place. The Residents care plan included the following focus area has respiratory problem related to acute illness or chronic condition. Interventions included administer medications as ordered. During initial tour of the facility on 12/04/2018, a family member of this Resident expressed a concern to the surveyor that the Resident had not received some of her medications when she had been admitted. On 12/04/2018 at 3:14 PM, during an interview with Resident #105 the Resident stated the facility had a problem stated they had been admitted late one evening and it took a couple of days to get my medicines straightened out. 12/04/18 at 4:33 PM, the surveyor asked RN (registered nurse) #1 if they had a backup pharmacy. RN #1 verbalized to the surveyor that they use-to-use one in town and now we use one	F 684	was notified with no new orders and no negative outcomes noted. 2.) Any resident has the potential to be affected if medications are not administered per physician order. A 100% audit was performed on all residents to ensure that medications were available as per physician order. 3.) Re-education was initiated on 12/6/18 and provided to nursing regarding ensuring that medications are administered per physician order and on the proper procedures/processes regarding the use of the Omnicell and back-up pharmacy procedures. 4.) 5 random residents will be audited weekly X4 weeks then monthly X2 months to ensure that all medications are being administered per physician order. Any and all findings to be reported to the QA committee for further review and recommendations.	

F 684 Continued From page 57 F 684

in a neighboring city.

A review of the Residents EHR (electronic health record) revealed that the facility nursing staff had coded the following medications with a "9" on 11/28/18 colace, cozaar (hypertension), and lopressor (hypertension). For 11/29/18 nifediac (hypertension), osteo Bi-Flex, vitamin C, vitamin E, eliquis (atrial fibrillation-the facility had documented they had administered this on 11/28/18), lopressor, and floranex (probiotic). For 11/30/18 cefdinir (the facility had documented this had been administered on 11/28/18). Per the pre-printed code on the eMAR (electronic medication administration record) a" 9=Other/See Nurses Note."

On 11/29/2018 the nursing staff documented that they were awaiting pharmacy for the lopressor, floranex, cefdinir, eliquis, lopressor, nifediac, osteo Bi-flex, vitamin C, and vitamin E.

A review of the facility stat box and omnicell list revealed that the medications cozaar, lopressor, vitamin C, and cefdinir would have been available in the back up medication boxes for administration.

On 12/05/2018 at 4:27 PM, during a meeting with the administrative staff the DON (director of nursing) was asked the procedure for obtaining medications for new admissions or if medications were not available. The DON verbalized to the survey team that if the medication is available in the omnicell, the nursing staff would have to call the pharmacy to access the Residents profile and they could also use a backup pharmacy.

On 12/06/18 at 9:14 AM, the surveyor interviewed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 684	Continued From page 58	F 684		

pharmacist #1 via phone in regards to new admissions/unavailable medications. Pharmacist #1 verbalized to the surveyor that the procedure for the omnicell was as follows-orders are sent to the pharmacy and once they are verified, they are entered into the system. Pharmacist #1 also stated that they have a stat box at the facility and some medications can be pulled from that or they can utilize the backup system for more urgent medications such as blood pressure medications and antibiotics.

The facility policy/procedure titled "UNAVAILABLE MEDICATIONS" read in part, "...If the ordered medications are not available, the pharmacist is notified for delivery at next scheduled delivery time or if needed prior to the next scheduled med pass time, the pharmacy will contact the back-up pharmacy for the medication. A pharmacist is available 24 hours a day by phone...The attending physician is to be notified of medication that is not available from the pharmacy. The physician may order an alternative medication from EDK/STAT kits until the original medication is available."

The facility provided the surveyor with a copy of an in-service attendance form titled "Obtain medications for new admissions." The date of this in-service was documented as 12/05/18. The 2nd page of this document read in part, "...Upon all new admissions, The Charge Nurse is responsible to call Pharmacy to have Patients profile uploaded into the Omnicel. You are to ensure that Pharmacy is using our back up Pharmacy to ensure all medication is available ASAP. NO EXCEPTIONS..."

The administrative staff were notified of the issue regarding the availability and administration of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 684	Continued From page 59 Residents medications during a meeting with the survey team on 12/06/18 at 4:14 PM. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #154, the facility staff failed to administer physician ordered medications. The clinical record review revealed that Resident #154 had been admitted to the facility on 12/03/2018. Diagnoses included, but were not limited to, aftercare following surgery for neoplasm, muscle weakness, dysphagia, COPD (chronic obstructive pulmonary disease), and diabetes. There was no MDS (minimum data set) assessment completed on this Resident. However, the Resident was alert and orientated to person and place. During a medication pass and pour observation with LPN (licensed practical nurse) #2 on 12/05/2018 at 10:03 AM LPN #2 verbalized to the surveyor that the Residents nystatin had not arrived from the pharmacy for administration. The Residents physician order summary included the order "Nystatin Suspension...Give 10 cc orally three times a day for mouth care patient must spit out..." The order date was documented as 12/04/18. When reviewing the Residents clinical record on 12/06/18 it was noted that LPN #2 had documented on the Residents eMAR (electronic medication administration record) that she had	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ____ B. WING ____	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 684	Continued From page 60	F 684		

administered the nystatin at 9:00 AM and 1:00 PM on 12/05/18. When interviewing LPN #2 she stated she had marked that in error and she had not obtained the medication until around 3:30 PM from the backup pharmacy. Indicating the Resident had missed 2 doses.

Further review of the Residents EHR (electronic health record) revealed that the facility nursing staff had coded the following medications with a "9" on 12/03/18 depakote (seizures), olanzapine (antipsychotic), and atrovent nasal spray (COPD). For 12/04/18 ditropan (bladder spasms), atrovent nasal spray, and flomax. Per the pre-printed code on the eMAR (electronic medication administration record) a" 9=Other/See Nurses Note."

A review of the facility stat box and omnicell list revealed that the medications depakote, olanzapine, and flomax, would have been available in the back up medication boxes for administration.

On 12/05/2018 at 4:27 PM, during a meeting with the administrative staff the DON (director of nursing) was asked the procedure for obtaining medications for new admissions or if medications were not available. The DON verbalized to the survey team that if the medication is available in the omnicell, the nursing staff would have to call the pharmacy to access the Residents profile and they could use a backup pharmacy.

During an interview with Resident #154 on 12/06/18 at 8:46 AM, Resident #154 stated they had started his mouthwash. When asked how his mouth felt he stated before he used the mouthwash his mouth and throat hurt.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 684	Continued From page 61 On 12/06/18 at 9:14 AM, the surveyor interviewed pharmacist #1 via phone in regards to new admissions/unavailable medications. Pharmacist #1 verbalized to the surveyor that the procedure for the omnicell was as follows-orders are sent to the pharmacy and once they are verified, they are entered into the system. Pharmacist #1 also stated that they have a stat box at the facility and some medications can be pulled from that or they can utilize the backup system for more urgent medications such as blood pressure medications and antibiotics. When asked when the nystatin had been called into the back up pharmacy pharmacist stated yesterday (12/05/18) at 3:48 PM. The facility policy/procedure titled "UNAVAILABLE MEDICATIONS" read in part, "...If the ordered medications are not available, the pharmacist is notified for delivery at next scheduled delivery time or if needed prior to the next scheduled med pass time, the pharmacy will contact the back-up pharmacy for the medication. A pharmacist is available 24 hours a day by phone...The attending physician is to be notified of medication that is not available from the pharmacy. The physician may order an alternative medication from EDK/STAT kits until the original medication is available." The facility provided the surveyor with a copy of an in-service attendance form titled "Obtain medications for new admissions." The date of this in-service was documented as 12/05/18. The 2nd page of this document read in part, "...Upon all new admissions, The Charge Nurse is responsible call Pharmacy to have Patients profile uploaded into the Omnicel. You are to ensure that Pharmacy is using our back up	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 684	Continued From page 62	F 684		

Pharmacy to ensure all medication is available ASAP. NO EXCEPTIONS..."

The administrative staff were notified of the issue regarding the availability and administration of the Residents medications during a meeting with the survey team on 12/06/18 at 4:14 PM.

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

3. For Resident #155, the facility staff failed to administer physician ordered medications.

The clinical record review revealed that Resident #155 had been admitted to the facility on 12/03/18. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, diabetes, chronic diastolic congestive heart failure, depressive disorder, hypertensive heart disease, and peripheral vascular disease.

There was no MDS (minimum data set) assessment completed on this Resident. However, the Resident was alert and orientated to person and place.

A review of the Residents EHR (electronic health record) revealed that the facility nursing staff had coded the following medications with a "9" on 12/03/18 sennosides (stool softner), singulair, travatan (glaucoma), and budesonide suspension. For 12/04/18 atorvastatin (cholesterol), celexa (antidepressant), isosorbide ER (extended release), nifedipine ER (hypertension), protonix (stomach ulcers), carvedilol (hypertension) the facility nursing staff had documented that this medication had been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 684	Continued From page 63	F 684		

administered on 12/03/18, and prazosin (high blood pressure). Per the pre-printed code on the eMAR (electronic medication administration record) a" 9=Other/See Nurses Note."

A review of the facility stat box and omnicell list revealed that the medications atorvastatin, celexa, isosorbide, protonix, sennosides, singulair, and carvedilol, would have been available in the back up medication boxes for administration.

On 12/05/2018 at 4:27 PM, during a meeting with the administrative staff the DON (director of nursing) was asked the procedure for obtaining medications for new admissions or if medications were not available. The DON verbalized to the survey team that if the medication is available in the omnicell, the nursing staff would have to call the pharmacy to access the Residents profile and they could use a backup pharmacy.

The Residents care plan included the focus area to administer medications as ordered.

On 12/06/18 at 9:14 AM, the surveyor interviewed pharmacist #1 via phone in regards to new admissions/unavailable medications. Pharmacist #1 verbalized to the surveyor that the procedure for the omnicell was as follows-orders are sent to the pharmacy and once they are verified, they are entered into the system. Pharmacist #1 also stated that they have a stat box at the facility and some medications can be pulled from that or they can utilize the backup system for more urgent medications such as blood pressure medications and antibiotics.

The facility policy/procedure titled "UNAVAILABLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 684	Continued From page 64	F 684		

MEDICATIONS" read in part, "...If the ordered medications are not available, the pharmacist is notified for delivery at next scheduled delivery time or if needed prior to the next scheduled med pass time, the pharmacy will contact the back-up pharmacy for the medication. A pharmacist is available 24 hours a day by phone...The attending physician is to be notified of medication that is not available from the pharmacy. The physician may order an alternative medication from EDK/STAT kits until the original medication is available."

The administrative staff were notified of the issue regarding the availability and administration of the Residents medications during a meeting with the survey team on 12/06/18 at 4:14 PM.

The facility provided the surveyor with a copy of an in-service attendance form titled "Obtain medications for new admissions." The date of this in-service was documented as 12/05/18. The 2nd page of this document read in part, "...Upon all new admissions', The Charge Nurse is responsible call Pharmacy to have Patients profile uploaded into the Omnicel. You are to ensure that Pharmacy is using our back up Pharmacy to ensure all medication is available ASAP. NO EXCEPTIONS..."

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

4. For Resident #156, the facility staff failed to administer physician ordered medications.

The clinical record review revealed that Resident #156 had been admitted to the facility on 11/28/18. Diagnoses included, but were not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 684	Continued From page 65	F 684		

limited to, clostridium difficile, muscle weakness, atrial fibrillation, and pneumonia.

There was no MDS (minimum data set) assessment completed on this Resident. However, the Resident was alert and orientated to person and place.

A review of the Residents EHR (electronic health record) revealed that the facility nursing staff had coded the following medications with a "9" on 11/29/18 lopressor (hypertension) and nabumetone (pain). For 11/30/18, the facility had coded the antibiotic vancomycin with a "9". Per the pre-printed code on the eMAR (electronic medication administration record) a" 9=Other/See Nurses Note."

A review of the facility stat box and omnicell list revealed that the medications lopressor and vancomycin would have been available in the back up medication boxes for administration.

On 11/29/18, the facility staff had documented that they were waiting for the medications nabumetone, vancomycin, and lopressor from the pharmacy.

On 12/05/2018 at 4:27 PM, during a meeting with the administrative staff the DON (director of nursing) was asked the procedure to obtain medications for new admissions or if medications were not available. The DON verbalized to the survey team that if the medication is available in the omnicell, the nursing staff would have to call the pharmacy to access the Residents profile and they could use a back up pharmacy.

The Resident had been care planned for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 684	Continued From page 66	F 684		

pain-administer pain medication as ordered and contact isolation due to clostridium difficile. Resident #156 had been prescribed the antibiotic vancomycin for the clostridium difficile.

On 12/06/18 at 9:14 AM, the surveyor interviewed pharmacist #1 via phone in regards to new admissions/unavailable medications. Pharmacist #1 verbalized to the surveyor that the procedure for the omnicell was as follows-orders are sent to the pharmacy and once they are verified, they are entered into the system. Pharmacist #1 also stated that they have a stat box at the facility and some medications can be pulled from that or they can utilize the backup system for more urgent medications such as blood pressure medications and antibiotics.

The facility policy/procedure titled "UNAVAILABLE MEDICATIONS" read in part, "...If the ordered medications are not available, the pharmacist is notified for delivery at next scheduled delivery time or if needed prior to the next scheduled med pass time, the pharmacy will contact the back-up pharmacy for the medication. A pharmacist is available 24 hours a day by phone...The attending physician is to be notified of medication that is not available from the pharmacy. The physician may order an alternative medication from EDK/STAT kits until the original medication is available."

The administrative staff were notified of the issue regarding the availability and administration of the Residents medications during a meeting with the survey team on 12/06/18 at 4:14 PM.

The facility provided the surveyor with a copy of an in-service attendance form titled "Obtain medications for new admissions." The date of this

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

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F 684	Continued From page 67 in-service was documented as 12/05/18. The 2nd page of this document read in part, "...Upon all new admissions, The Charge Nurse is responsible to call Pharmacy to have Patients profile uploaded into the Omnicel. You are to ensure that Pharmacy is using our back up Pharmacy to ensure all medication is available ASAP. NO EXCEPTIONS..." No further information regarding this issue was provided to the survey team prior to the exit conference.	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to ensure respiratory care and services were provided for 2 of 26 (Resident #54 and Resident #74) residents. The findings included: 1. The facility staff failed to ensure the oxygen filters on Resident #54's oxygen concentrator were clean.	F 695	1.) The O2 filters for resident #54 and #74 were immediately replaced with new filters. 2.) Any resident has the potential to be affected if respiratory care and services are not provided. A 100% audit of all residents on O2 was performed with filters cleaned/replaced as needed. 3.) Re-education was initiated on 12/6/18	1/18/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

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F 695	Continued From page 68 The clinical record of Resident #54 was reviewed 12/4/18 through 12/6/18. Resident #54 was admitted to the facility 10/10/17 and readmitted 11/17/18 with diagnoses that included but not limited to unspecified dementia without behavioral disturbances, hypertensive heart and chronic kidney disease with heart failure, type 2 diabetes mellitus, chronic respiratory failure, hypothyroidism, atrial fibrillation, major depressive disorder, dysphagia, anemia, hyperlipidemia, gastro-esophageal reflux disease and dependence on supplemental oxygen. Resident #54's 14- day minimum data set assessment (MDS) with an assessment reference date (ARD) of 11/29/18 assessed the resident with a BIMS (brief interview for mental status) as 09/15. Resident #54's current comprehensive care plan identified the focus area of respiratory problems r/t (related to) chronic respiratory failure. Date initiated 8/22/18 Revision on 9/03/18. Interventions read: Administer medications as ordered. Resident #54's December 2018 physician's orders read, "O2 @ (at) 3 L/M (liters per minute) via NC (nasal cannula) continuously every shift related to chronic respiratory failure, unspecified whether with hypoxia or hypercapnia." The surveyor observed Resident #54 during the initial tour of the facility on 12/4/18 beginning at 12:54 p.m. Resident #54 was positioned in bed, eyes closed with oxygen at 3 L/M via NC. Oxygen sign on door. Oxygen tubing was dated 12/2/18. The oxygen concentrator filters were observed to have a dust like grey color to both	F 695	and provided to nursing regarding respiratory care and services with a special focus on O2. 4.) 5 random residents will be audited weekly X4 weeks then monthly X2 months to ensure that O2 filters are clean. Any and all findings to be reported to the QA committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 695	Continued From page 69	F 695		

and a "fuzzy" white appearance on both.

The surveyor observed Resident #54 during breakfast on 12/5/18 at 8:54 a.m. Resident #54 was in bed with oxygen at 3 l/m per NC.
The oxygen concentrator filters were observed to have a fuzzy white and dusty grey appearance.

The surveyor informed the unit manager registered nurse #1 of the above concern on 12/5/18 at 10:32 a.m. R.N. #1 checked both filters and stated the filters need to be changed. The unit manager R.N. #1 was asked when were they changed or cleaned. The unit manager R.N. #1 stated the filters are changed weekly when the oxygen tubing was changed.

The surveyor informed the administrative staff of the above concern on 12/5/18 at 4:27 p.m. The surveyor requested the facility policy on the care of oxygen concentrators.

The surveyor reviewed the policy on oxygen titled "Oxygen Administration" on 12/5/18. The policy read in part "8. Change the cannula or mask every week. Date and initial. The cannula or mask must be placed in a plastic bag any time they are not in use."
The corporate registered nurse #1 stated the facility contracts with a company to oversee the oxygen equipment; however, the contents of what the contract covered was not provided.

No further information was provided prior to the exit conference on 12/6/18.

2. The facility staff failed to clean Resident #74's oxygen concentrator filters or place a sign on the door indicating that oxygen was in use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 695	Continued From page 70	F 695		

The clinical record of Resident #74 was reviewed 12/4/18 through 12/6/18. Resident #74 was admitted to the facility 10/6/18 with diagnoses that included but not limited to hypertensive heart disease with heart failure, ischemic cardiomyopathy, Alzheimer's disease, type 2 diabetes mellitus, benign prostatic hypertrophy, hypothyroidism, hyperlipidemia, dementia, major depressive disorder, atrial fibrillation, and gastroesophageal reflux disease.

Resident #74's 30-day minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/1/18 assessed the resident with a BIMS (brief interview for mental status) as 15/15.

Resident #74's December 2018 physician's orders read "O2 @ (oxygen at) 2 LPM (liters per minute) via NC (nasal cannula) every shift-order and start date 10/8/18."

The surveyor observed Resident #74 on 12/4/18 at 12:44 p.m. The resident was sitting on the side of the bed and eating lunch. Oxygen concentrator was on the left side of the bed and turned to 2 LPM. The oxygen tubing was dated 12/2/18. The surveyor observed both oxygen filters on the concentrator. Both had a layer of grey dust and "fuzzy white balls" on them. The surveyor did not observe a "No Smoking" sign at the entrance to the resident's rooms.

The surveyor interviewed licensed practical nurse #2 on 12/4/18 at 12:50 p.m. about oxygen signs. L.P.N. #2 stated signs are supposed to be put on the door if the resident uses oxygen.

The surveyor observed and interviewed Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 695	Continued From page 71 #74 on 12/5/18 at 10:18 a.m. Both oxygen filters were dirty with a layer of gray dirt/dust and those "fuzzy white balls". The surveyor asked licensed practical nurse #3 on 12/05/18 10:24 a.m. to check the oxygen concentrator filters. L.P.N. #3 stated, "They need to be cleaned." L.P.N. #3 stated she had only been here a month and didn't know if cleaning the filter comes with changing the tubing. The surveyor informed and showed the unit manager registered nurse #1 on 12/5/18 at 10:30 a.m. the oxygen concentrator filters. R.N. #1 stated the filters are changed out and will do that as soon as she gets them. The surveyor informed the administrative staff of the above concern on 12/5/18 at 4:27 p.m. The surveyor requested the facility policy on the care of oxygen concentrators. The surveyor reviewed the policy on oxygen titled "Oxygen Administration" on 12/5/18. The policy read in part "8. Change the cannula or mask every week. Date and initial. The cannula or mask must be placed in a plastic bag any time they are not in use." The corporate registered nurse #1 stated the facility contracts with a company to oversee the oxygen equipment; however, the contents of what the contract covered was not provided. No further information was provided prior to the exit conference on 12/6/18.	F 695		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		1/18/19

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 755	Continued From page 72 §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. 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. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review the facility staff failed to collaborate with the contracting pharmacy and identify that a medication was still being administered after being discontinued for 1 of 26 Residents, #70.	F 755	1.) Resident #70's responsible party was notified that the resident did not receive the medications as ordered. The physician was notified with no new orders and no negative outcomes noted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 755

Continued From page 73

The findings included:

The consulting pharmacy failed to identify that Resident #70 was receiving the medication methylprednisolone 4 mg. This medication had been discontinued by the physician in July 2016.

The clinical record review revealed that Resident #70 had been admitted to the facility 07/31/2014. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertension, gastro esophageal reflux disease, osteoarthritis, and history of pulmonary embolism.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/31/2018 included a BIMS (brief interview for mental status) summary score of 14 out of a possible 15 points.

The Residents CCP (comprehensive care plan) included the intervention give medications as ordered.

The facility used a "Paxit" system for administering medications. This system packaged the Residents tablets/capsules inside of a plastic bag that included the Residents name, room number, time of medication administration, date, name of facility, and the name of the Residents medications listed in alphabetical order. The bottom of the bag included the statement "Refer to MAR (medication administration record) for medication administration times and instructions..." Inside of the paxit, the medications were individually packaged in blister packs making each

F 755

The contracting pharmacy was notified with a resolution reached on 12/6/18.

2.) Any resident has the potential to be affected if medications are not administered per physician order.
A 100% audit was performed on all residents to ensure that medications were available as per physician order.

3.) Re-education was initiated on 12/6/18 and provided to nursing regarding ensuring that medications are administered per physician order and on communicating with the pharmacy if a medication discrepancy is found.

4.) 5 random residents will be audited weekly X4 weeks then monthly X2 months to ensure that all medications are being administered per physician order.
Any and all findings to be reported to the QA committee for further review and recommendations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 755	Continued From page 74 medication easily identifiable. On 12/05/2018 at 9:34 AM, the surveyor observed LPN (licensed practical nurse) #1 prepare and administer Resident #70's morning medications. During this observation, LPN #1 prepared and administered the Residents morning medications using the paxit system. The paxit bag included 1 tablet of methylprednisolone 4 mg along with the Residents other morning medications. LPN #1 removed all the medications from the paxit bag, removed them from the blister packs, and placed them in a medication cup to administer to Resident #70. After preparing all of the Residents morning medications LPN #1 entered the Residents room and administered the medications to Resident #70. After the medication observations the surveyor reconciled the Residents medications using the Residents EHR (electronic health record). The surveyor was unable to locate an active order for the methylprednisolone. The EHR included a physician order that indicated this medication had been discontinued on 07/13/2016. On 12/05/2018 at 10:45 AM, the surveyor and LPN #1 reviewed the Residents physician orders. After reviewing the orders, LPN #1 verbalized to the surveyor that the methylprednisolone looked as if it had been discontinued. The monthly medication regimen reviews completed by the pharmacist did not include any information to indicate the pharmacy had identified that the medication methylprednisolone was continuing to be packaged, sent, and administered to the Resident.	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 755	Continued From page 75 On 12/06/18 at 3:03 PM, LPN #1 stated she had called the pharmacy on 12/05/18 to ensure the medication would be discontinued. After this interview the surveyor and LPN #1 checked the paxit medication pack that had delivered to the facility after LPN #1 had contacted the pharmacy. This paxit still contained the medication methylprednisolone. The administrative staff were notified of the issues regarding the methylprednisolone during a meeting with the survey team on 12/06/2018 at 4:14 PM. Prior to the exit conference the DON (director of nursing) stated she had contacted the pharmacy and the issue with the methylprednisolone appeared to be a linking problem. No further information regarding these issues were provided to the survey team prior to the exit conference.	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its	F 757		1/18/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

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F 757	Continued From page 76 use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review the facility staff failed to ensure 1 of 26 Residents were free of an unnecessary medication, Resident #70. The findings included: The facility nursing staff continued to administer the medication methylprednisolone 4 mg for an excessive duration and without adequate indications for use. The physician had discontinued this medication in July of 2016. The clinical record review revealed that Resident #70 had been admitted to the facility 07/31/2014. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertension, gastro-esophageal reflux disease, osteoarthritis, and history of pulmonary embolism. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/31/2018 included a BIMS (brief interview for mental status) summary score of 14 out of a possible 15 points. The Residents CCP (comprehensive care plan)	F 757	1.) Resident #70's responsible party was notified that the resident did not receive the medications as ordered. The physician was notified with no new orders and no negative outcomes noted. 2.) Any resident has the potential to be affected if medications are not administered per physician order. A 100% audit was performed on all residents to ensure that medications were available as per physician order. 3.) Re-education was initiated on 12/6/18 and provided to nursing regarding ensuring that medications are administered per physician order. 4.) 5 random residents will be audited weekly X4 weeks then monthly X2 months to ensure that all medications are being administered per physician order. Any and all findings to be reported to the QA committee for further review and recommendations.	

F 757 Continued From page 77 F 757

included the intervention give medications as ordered.

The facility used a "Paxit" system for administering medications. This system packaged the Residents tablets/capsules inside of a plastic bag that included the Residents name, room number, time of medication administration, date, name of facility, and the name of the Residents medications listed in alphabetical order. The bottom of the bag included the statement "Refer to MAR (medication administration record) for medication administration times and instructions..." Inside of the paxit, the medications were individually packaged in blister packs making each medication easily identifiable.

On 12/05/2018 at 9:34 AM, the surveyor observed LPN (licensed practical nurse) #1 prepare and administer Resident #70's morning medications. During this observation, LPN #1 prepared and administered the Residents morning medications using the paxit system. The paxit bag included 1 tablet of methylprednisolone 4 mg along with the Residents other morning medications. LPN #1 removed all the medications from the paxit bag, removed them from the blister packs, and placed them in a medication cup to administer to Resident #70. After preparing all of the Residents morning medications LPN #1 entered the Residents room and administered the medications to Resident #70.

After the medication observations, the surveyor reconciled the Residents medications using the Residents EHR (electronic health record). The surveyor was unable to locate an active order for the methylprednisolone. The EHR included a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 757	Continued From page 78	F 757		

physician order that indicated this medication had been discontinued on 07/13/2016.

On 12/05/2018 at 10:45 AM, the surveyor and LPN #1 reviewed the Residents physician orders. After reviewing the orders, LPN #1 verbalized to the surveyor that the methylprednisolone looked as if it had been discontinued.

The monthly medication regimen reviews completed by the pharmacist did not include any information to indicate the pharmacy had identified that the medication methylprednisolone was continuing to be packaged, sent, and administered to the Resident.

On 12/06/18 at 3:03 PM, LPN #1 stated she had called the pharmacy on 12/05/18 to ensure the medication would be discontinued. After this interview, the surveyor and LPN #1 checked the paxit medication pack that had delivered to the facility after LPN #1 had contacted the pharmacy. This paxit still contained the medication methylprednisolone.

The administrative staff were notified of the issues regarding the methylprednisolone during a meeting with the survey team on 12/06/2018 at 4:14 PM.

Prior to the exit conference the DON (director of nursing) stated she had contacted the pharmacy and the issue with the methylprednisolone appeared to be a linking problem.

No further information regarding these issues were provided to the survey team prior to the exit conference.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

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F 759	Continued From page 79	F 759		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and during a medication pass and pour observation the facility staff failed to ensure a medication error rate of less than 5%. There were 6 errors in 34 opportunities for a medication error rate of 17.65%. These errors effected Residents #39, #70, and #154. The findings included: 1. For Resident #39, the facility staff crushed the medication potassium ER (extended release) prior to administering. The clinical record review revealed that Resident #39 had been admitted to the facility on 02/08/15. Diagnosis included, but were not limited to, Alzheimer's, chronic obstructive pulmonary disease, hypertension, dementia, depressive disorder, osteoporosis, and anxiety disorder. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/05/18 had been coded 1/1/2 to indicate the Resident had problems with long and short term memory and was moderately impaired in cognitive skills for daily decision making.	F 759	1.) Resident #'s 39, 70, and 154 responsible parties were notified that the residents did not receive the medications as ordered. Each resident's physician was notified with no new orders and no negative outcomes noted. 2.) Any resident has the potential to be affected if medications are not administered per physician order. A 100% audit was performed on all residents to ensure that medications were available as per physician order. A 100% audit was performed on all residents receiving potassium to ensure that it was being administered accurately. A 100% audit was performed on all residents that were receiving medications via a PICC line to ensure that the proper flushing protocol was being adhered to. 3.) Re-education was initiated on 12/6/18 and provided to nursing regarding ensuring that medications are administered per physician order. 4.) 5 random residents will be audited weekly X4 weeks then monthly X2 months to ensure that all medications are being	1/18/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

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F 759	Continued From page 80 On 12/05/18 at 8:08 AM, the surveyor observed LPN (licensed practical nurse) #3 prepare and administer Resident #39's morning medications. During this observation, LPN #3 was observed to remove 10 meq of potassium ER from a blister pack and place it into a medication cup with all of the Residents other am medications. LPN #3 then crushed all of the Residents medications and then proceeded into the Residents room and administered the medications to Resident #39. On 12/05/18 at 10:37 AM, the surveyor spoke with pharmacist #1 via phone regarding the potassium. Pharmacist #1 verbalized to the surveyor that the potassium could be crushed. However, it would no longer be an extended release product. On 12/05/18 at 2:52 PM, the surveyor interviewed LPN #3 when asked if she had crushed the Residents potassium she stated she had. When asked if she usually crushed this medication, she stated she did and then stated we need to get that changed. Prior to the exit conference, the facility provided the surveyor with a copy of the Residents new potassium order "Potassium Chloride Solution 20 MEQ/15ML...Give 10 mEq orally one time a day for supplement." Indicating the facility had the medication changed to a liquid after the medication pass. The facility provided the surveyor with a copy of document titled "Potassium Chloride" this document read in part, "...Extended-release tablets: Swallow whole; do NOT crush or chew..." The facility also provided the surveyor with a copy of an in-service attendance form dated 12/05/18	F 759	administered per physician order. Any and all findings to be reported to the QA committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	**208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277**

(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 759	Continued From page 81	F 759		

the instructions included, "Do not crush extended release medication. Please pay close attention to ensure they are not crushed."

The administrative staff were notified of the issues regarding Resident #39's potassium being crushed on 12/06/18 at 4:14 PM.

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

2. For Resident #70, the facility staff administered the incorrect amount of the medication miralax and administered a medication that had been discontinued in July of 2016.

The clinical record review revealed that Resident #70 had been admitted to the facility 07/31/2014. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertension, gastro-esophageal reflux disease, osteoarthritis, and history of pulmonary embolism.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/31/2018 included a BIMS (brief interview for mental status) summary score of 14 out of a possible 15 points.

The facility used a "Paxit" system for administering medications. This system packaged the Residents tablets/capsules inside of a plastic bag that included the Residents name, room number, time of medication administration, date, name of facility, and the name of the Residents medications listed in alphabetical order. The bottom of the bag

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 759		F 759		

Continued From page 82
included the statement "Refer to MAR (medication administration record) for medication administration times and instructions..." Inside of the paxit, the medications were individually packaged in blister packs making each medication easily identifiable.

On 12/05/2018 at 9:34 AM, the surveyor observed LPN (licensed practical nurse) #1 during a medication pass and pour observation. During this observation, LPN #1 prepared and administered the Residents morning medications using the paxit system. When preparing the medications LPN #1 prepared 17 grams of miralax and mixed it with water. This was not included in the paxit medication bag. The paxit bag included 1 tablet of methylprednisolone 4 mg along with the Residents other morning medications. LPN #1 removed all the medications from the paxit bag, removed them from their individual blister packets, and then placed them in a medication cup to administer to Resident #70. After preparing all of Resident #70's morning medications LPN #1 entered the Residents room and administered the medications.

After the medication observation, the surveyor reconciled the Residents medications using the Residents EHR (electronic health record). A review of the Residents EHR revealed that Resident #70 had a physicians order for polyethylene glycol (miralax) powder give 8.5 grams by mouth one time a day for constipation. Not 17 grams as administered by LPN #1. The surveyor was unable to locate an active order for the methylprednisolone. The EHR included a physician order that indicated this medication had been discontinued on 07/13/2016.

F 759

Continued From page 83

F 759

On 12/05/2018 at 10:45 AM, the surveyor and LPN #1 reviewed the Residents physician orders. After reviewing the orders LPN #1 verbalized to the surveyor that she had administered 17 grams of miralax and not 8.5. LPN #1 also verbalized that the methylprednisolone looked as if it had been discontinued.

On 12/05/2018 at 11:55 AM, LPN #1 approached the surveyor and stated she had made 2 medication errors, LPN #1 also stated that the physician was in the facility and had been notified.

The administrative staff were notified of the issues regarding the Residents miralax and methylprednisolone during a meeting with the survey team on 12/06/2018 at 4:14 PM.

Prior to the exit conference the DON (director of nursing) stated she had contacted the pharmacy and the issue with the methylprednisolone appeared to be a linking problem.

No further information regarding these issues were provided to the survey team prior to the exit conference.

3. For Resident #154, the facility failed to obtain and administer the physician ordered medication nystatin and failed to flush a PICC (peripherally inserted central catheter) line with heparin and saline after accessing.

A PICC line is a thin, soft, flexible tube-an intravenous (IV) line. Treatments, such as IV medications, can be given though a PICC.

The clinical record review revealed that Resident #154 had been admitted to the facility on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 759

Continued From page 84

12/03/2018. Diagnoses included, but were not limited to, aftercare following surgery for neoplasm, muscle weakness, dysphagia, COPD (chronic obstructive pulmonary disease), and diabetes.

There was no MDS (minimum data set) assessment completed on this Resident. However, the Resident was alert and orientated to person and place.

During a medication pass and pour observation with LPN (licensed practical nurse) #2 on 12/05/2018 at 10:03 AM LPN #2 verbalized to the surveyor that the Residents nystatin had not arrived from the pharmacy for administration. LPN #2 then proceeded to prepare the Residents medication octreotide (sandostatin) 50 mcg for administration. LPN #2 pulled up 1 ml of this medication into a syringe and entered the Residents room. LPN #2 attempted to insert this medication into one line of the Residents PICC. However, she was unable to do so. LPN #2 then returned to the medication cart and retrieved a 10 ml flush of saline. LPN #2 reentered the Residents room and flushed the Residents PICC with 9 mls of this saline. LPN #2 then placed the medication into the PICC line. LPN #2 did not flush this line after administering the medication.

The Residents physician order summary included the orders "SandoSTATIN Solution 50 MCG/ML...Use 1 milliliter intravenously three times a day for Supplement...Nystatin Suspension...Give 10 cc orally three times a day for mouth care patient must spit out..." The order date for the nystatin was documented as 12/04/18.

F 759

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

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F 759 Continued From page 85 F 759

When reviewing the Residents clinical record on 12/06/18 it was noted that LPN #2 had documented on the Residents eMAR (electronic medication administration record) that she had administered the nystatin at 9:00 AM and 1:00 PM on 12/05/18. When interviewing LPN #2 she stated she had marked that in error and she had not obtained the medication until around 3:30 PM from the backup pharmacy. Indicating the Resident had missed 2 doses.

The DON (director of nursing) and LPN #2 were interviewed on 12/05/18 at 11:04 AM regarding the flushing of the Residents PICC line. LPN #2 verbalized to the surveyor that she had not flushed the PICC line after administering the medication.

On 12/05/18 at 12:26 PM, the DON verbalized to the surveyor that the nurse should have used the SASH (saline, administer medication, saline, heparin) method when flushing the PICC line. The DON provided the surveyor with a copy of their policy/procedure titled "Flushing Midline and Central Line IV Catheters" under the heading "Flushing Solutions" the policy/procedure read in part, "Use the SASH method (saline, administer medication, saline, heparin) for intermittent treatments. These catheters will have a clamp on the outside lumen." This PICC line was equipped with a clamp.

On 12/05/2018 at 4:27 PM, during a meeting with the administrative staff the DON was asked the procedure to obtain medications for new admissions or if medications were not available. The DON verbalized to the survey team that if the medication is available in the omnicell, the nursing staff would have to call the pharmacy to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 759	Continued From page 86	F 759		

access the Residents profile and they could use a backup pharmacy.

During an interview with Resident #154 on 12/06/18 at 8:46 AM, Resident #154 stated they started his mouthwash. When asked how his mouth felt he stated before he used the mouthwash his mouth and throat hurt.

On 12/06/18 at 9:14 AM, the surveyor interviewed pharmacist #1 via phone in regards to new admissions/unavailable medications. Pharmacist #1 verbalized to the surveyor that the procedure for the omnicell was as follows-orders are sent to the pharmacy and once they are verified, they are entered into the system. Pharmacist #1 also stated that they have a stat box at the facility and some medications can be pulled from that or they can utilize the backup system for more urgent medications such as blood pressure medications and antibiotics. When asked when the nystatin had been called into the back up pharmacy pharmacist stated yesterday (12/05/18) at 3:48 PM.

On 12/06/18 at 10:11 AM, the surveyor confirmed with pharmacist #1 that sandostatin was a medication.

The facility policy/procedure titled "UNAVAILABLE MEDICATIONS" read in part, "...If the ordered medications are not available, the pharmacist is notified for delivery at next scheduled delivery time or if needed prior to the next scheduled med pass time, the pharmacy will contact the back-up pharmacy for the medication. A pharmacist is available 24 hours a day by phone...The attending physician is to be notified of medication that is not available from the pharmacy. The physician may

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 759	Continued From page 87 order an alternative medication from EDK/STAT kits until the original medication is available." The administrative staff were notified of the issue regarding the Residents nystatin and flushing of the PICC line during a meeting with the survey team on 12/06/18 at 4:14 PM. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 759		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and during a medication pass and pour observation, the facility staff failed to ensure 4 of 26 Residents were free of significant medication errors. These errors effected Residents #39, #70, #154, and #156. The findings included: 1. For Resident #39, the facility staff crushed the medication potassium ER (extended release) prior to administering. The clinical record review revealed that Resident #39 had been admitted to the facility on 02/08/15. Diagnosis included, but were not limited to, Alzheimer's, chronic obstructive pulmonary disease, hypertension, dementia, depressive disorder, osteoporosis, and anxiety disorder.	F 760	1.) Resident #'s 39, 70, 154, and 156 responsible parties were notified that the residents did not receive the medications as ordered. Each resident's physician was notified with no new orders and no negative outcomes noted. 2.) Any resident has the potential to be affected if medications are not administered per physician order. A 100% audit was performed on all residents to ensure that medications were available as per physician order. A 100% audit was performed on all residents receiving potassium to ensure that it was being administered accurately. A 100% audit was performed on all residents that were receiving medications via a PICC line to ensure that the proper	1/18/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 760

Continued From page 88

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/05/18 had been coded 1/1/2 to indicate the Resident had problems with long and short term memory and was moderately impaired in cognitive skills for daily decision making.

On 12/05/18 at 8:08 AM the surveyor observed LPN (licensed practical nurse) #3 prepare and administer Resident #39's morning medications. During this observation LPN #3 was observed to open a blister packet that contained 10 meq of potassium ER and place it into a medication cup with all of the Residents other am medications. LPN #3 crushed all of the Residents medications, then proceeded into the Residents room, and administered the medications to Resident #39.

On 12/05/18 at 10:37 AM, the surveyor spoke with pharmacist #1 via phone regarding the potassium. Pharmacist #1 verbalized to the surveyor that the potassium could be crushed. However, it would no longer be an extended release product.

On 12/05/18 at 2:52 PM, the surveyor interviewed LPN #3 when asked if she had crushed the Residents potassium she stated she had. When asked if she usually crushed these medications, she stated she did and then stated we need to get that changed.

Prior to the exit conference, the facility provided the surveyor with a copy of the Residents new potassium order "Potassium Chloride Solution 20 MEQ/15ML...Give 10 mEq orally one time a day for supplement." Indicating the facility had the

F 760

flushing protocol was being adhered to.

3.) Re-education was initiated on 12/6/18 and provided to nursing regarding ensuring that medications are administered per physician order.

4.) 5 random residents will be audited weekly X4 weeks then monthly X2 months to ensure that all medications are being administered per physician order.
Any and all findings to be reported to the QA committee for further review and recommendations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 760		F 760		

Continued From page 89
medication changed to a liquid after the medication pass.

The facility provided the surveyor with a copy of document titled "Potassium Chloride" this document read in part, "...Extended-release tablets: Swallow whole; do NOT crush or chew..." The facility also provided the surveyor with a copy of an in-service attendance form dated 12/05/18 the instructions included, "Do not crush extended release medication. Please pay close attention to ensure they are not crushed."

The administrative staff were notified of the issues regarding Resident #39's potassium being crushed on 12/06/18 at 4:14 PM.

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

2. For Resident #70, the facility staff administered the medication methylprednisolone. This medication had been discontinued in July of 2016.

Methylprednisolone provides relief for inflamed areas of the body. It is used to treat a number of different conditions, such as inflammation (swelling), severe allergies, adrenal problems, arthritis, asthma, blood or bone marrow problems, eye or vision problems, lupus, skin conditions, kidney problems, ulcerative colitis, and flare-ups of multiple sclerosis. This medicine is available only with your doctor's prescription. https://www.mayoclinic.org/drugs-supplements/methylprednisolone-oral-route/description/drg-20075237 accessed 12/10/18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 760	Continued From page 90	F 760		

The clinical record review revealed that Resident #70 had been admitted to the facility 07/31/2014. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertension, gastro-esophageal reflux disease, osteoarthritis, and history of pulmonary embolism.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/31/2018 included a BIMS (brief interview for mental status) summary score of 14 out of a possible 15 points.

The Residents CCP (comprehensive care plan) included the intervention give medications as ordered.

The facility used a "Paxit" system for administering medications. This system packaged the Residents tablets/capsules inside of a plastic bag that included the Residents name, room number, time of medication administration, date, name of facility, and the name of the Residents medications listed in alphabetical order. The bottom of the bag included the statement "Refer to MAR (medication administration record) for medication administration times and instructions..." Inside of the paxit, the medications were individually packaged in blister packs making each medication easily identifiable.

On 12/05/2018 at 9:34 AM, the surveyor observed LPN (licensed practical nurse) #1 prepare and administer Resident #70's morning medications. During this observation, LPN #1 prepared and administered the Residents morning medications using the paxit system. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 760	Continued From page 91	F 760		

paxit bag included 1 tablet of methylprednisolone 4 mg along with the Residents other morning medications. LPN #1 removed all the medications from the paxit bag, removed them from the blister packs and placed them in a medication cup to administer to Resident #70. After preparing all of the Residents morning medications LPN #1 entered the Residents room and administered the medications to Resident #70.

After the medication observations, the surveyor reconciled the Residents medications using the Residents EHR (electronic health record). The surveyor was unable to locate an active order for the methylprednisolone. The EHR included a physician order that indicated this medication had been discontinued on 07/13/2016.

On 12/05/2018 at 10:45 AM, the surveyor and LPN #1 reviewed the Residents physician orders. After reviewing the orders, LPN #1 verbalized to the surveyor that the methylprednisolone looked as if it had been discontinued.

The monthly medication regimen reviews completed by the pharmacist did not include any information to indicate the pharmacy had identified that the medication methylprednisolone was continuing to be packaged, sent, and administered to the Resident.

On 12/06/18 at 3:03 PM, LPN #1 stated she had called the pharmacy on 12/05/18 to ensure the medication would be discontinued. After this interview, the surveyor and LPN #1 checked the paxit medication pack that had delivered to the facility after LPN #1 had contacted the pharmacy. This paxit still contained the medication methylprednisolone.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 760	Continued From page 92	F 760		

The administrative staff were notified of the issues regarding the methylprednisolone during a meeting with the survey team on 12/06/2018 at 4:14 PM.

Prior to the exit conference the DON (director of nursing) stated she had contacted the pharmacy and the issue with the methylprednisolone appeared to be a linking problem.

No further information regarding these issues were provided to the survey team prior to the exit conference.

3. For Resident #154, the facility failed to flush a PICC (peripherally inserted central catheter) line with heparin and saline after accessing.

A PICC line is a thin, soft, flexible tube-an intravenous (IV) line. Treatments, such as IV medications, can be given though a PICC.

The clinical record review revealed that Resident #154 had been admitted to the facility on 12/03/2018. Diagnoses included, but were not limited to, aftercare following surgery for neoplasm, muscle weakness, dysphagia, COPD (chronic obstructive pulmonary disease), and diabetes.

There was no MDS (minimum data set) assessment completed on this Resident. However, the Resident was alert and orientated to person and place.

During a medication pass and pour observation with LPN (licensed practical nurse) #2 on 12/05/2018 at 10:03 AM the surveyor observed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 760	Continued From page 93	F 760		

LPN #2 prepare and administer the Residents medication octreotide (sandostatin) 50 mcg. LPN #2 pulled up 1 ml of this medication into a syringe and entered the Residents room. LPN #2 attempted to insert this medication into one line of the Residents PICC. However, she was unable to do so. LPN #2 then returned to the medication cart and retrieved a 10 ml flush of saline. LPN #2 reentered the Residents room and flushed the Residents PICC with 9 ml's of saline. LPN #2 then placed the medication into the PICC line. LPN #2 did not flush this line after administering the medication.

The Residents physician order summary included the orders "SandoSTATIN Solution 50 MCG/ML...Use 1 milliliter intravenously three times a day for Supplement..."

The DON (director of nursing) and LPN #2 were interviewed on 12/05/18 at 11:04 AM regarding the flushing of the Residents PICC line. LPN #2 verbalized to the surveyor that she had not flushed the PICC line after administering the medication.

On 12/05/18 at 12:26 PM, the DON verbalized to the surveyor that the nurse should have used the SASH (saline, administer medication, saline, heparin) method when flushing the PICC line and provided the surveyor with a copy of their policy/procedure titled "Flushing Midline and Central Line IV Catheters" under the heading "Flushing Solutions" the policy/procedure read in part, "Use the SASH method (saline, administer medication, saline, heparin) for intermittent treatments. These catheters will have a clamp on the outside lumen." This PICC line was equipped with a clamp.

F 760 Continued From page 94 F 760

On 12/06/18 at 10:11 AM, the surveyor confirmed with pharmacist #1 that sandostatin was a medication.

The administrative staff were notified of the issue regarding the flushing of the Residents PICC line during a meeting with the survey team on 12/06/18 at 4:14 PM.

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

4. For Resident #156, the facility staff failed to obtain and administer the Residents antibiotic vancomycin. This medication was in the back-up medication box at the facility. This resulted in the Resident missing 2 doses. The Resident was on contact isolation for clostridium difficile.

The clinical record review revealed that Resident #156 had been admitted to the facility on 11/28/18. Diagnoses included, but were not limited to, clostridium difficile, muscle weakness, atrial fibrillation, and pneumonia.

There was no MDS (minimum data set) assessment completed on this Resident. However, the Resident was alert and orientated to person and place.

A review of the Residents EHR (electronic health record) revealed that the facility nursing staff had coded the antibiotic medication vancomycin with a "9" on 11/29/18 at midnight and 6:00 AM. Per the pre-printed code on the eMAR (electronic medication administration record) a" 9=Other/See Nurses Note."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 760	Continued From page 95	F 760		

A review of the nursing progress notes for 11/29/18 revealed that the nursing staff had documented at 1:19 AM and 5:28 AM for the vancomycin "...awaiting pharmacy."

A review of the facility stat box and omnicell list revealed that the medication vancomycin would have been available in the back up medication boxes for administration.

On 12/05/2018 at 4:27 PM, during a meeting with the administrative staff the DON (director of nursing) was asked the procedure to obtain medications for new admissions or if medications were not available. The DON verbalized to the survey team that if the medication is available in the omnicell, the nursing staff would have to call the pharmacy to access the Residents profile and they could use a backup pharmacy.

The Resident had been care planned for contact isolation due to clostridium difficile.

On 12/06/18 at 9:14 AM, the surveyor interviewed pharmacist #1 via phone in regards to new admissions/unavailable medications. Pharmacist #1 verbalized to the surveyor that the procedure for the omnicell was as follows-orders are sent to the pharmacy and once they are verified, they are entered into the system. Pharmacist #1 also stated that they have a stat box at the facility and some medications can be pulled from that or they can utilize the backup system for more urgent medications such as blood pressure medications and antibiotics.

The facility policy/procedure titled "UNAVAILABLE MEDICATIONS" read in part, "...If the ordered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 760	Continued From page 96 medications are not available, the pharmacist is notified for delivery at next scheduled delivery time or if needed prior to the next scheduled med pass time, the pharmacy will contact the back-up pharmacy for the medication. A pharmacist is available 24 hours a day by phone...The attending physician is to be notified of medication that is not available from the pharmacy. The physician may order an alternative medication from EDK/STAT kits until the original medication is available." The administrative staff were notified of the issue regarding the availability and administration of the Residents medications during a meeting with the survey team on 12/06/18 at 4:14 PM. The facility provided the surveyor with a copy of an in-service attendance form titled "Obtain medications for new admissions." The date of this in-service was documented as 12/05/18. The 2nd page of this document read in part, "...Upon all new admissions, The Charge Nurse is responsible to call Pharmacy to have Patients profile uploaded into the Omnicel. You are to ensure that Pharmacy is using our back up Pharmacy to ensure all medication is available ASAP. NO EXCEPTIONS..." No further information regarding this issue was provided to the survey team prior to the exit conference.	F 760		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812		1/18/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 812	Continued From page 97 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, facility document review and staff interview, the facility staff failed to store, label and date food items in the kitchen and the resident pantries. The findings included: The facility staff failed to label and date food items in the kitchen and pantry. The surveyor toured the kitchen with the dietary manager on 12/4/18 at 11:45 a.m. In the reach in refrigerator, two (2) bowls of cole slaw were not labeled or dated. The dietary manager removed both of these and she stated both needed a label and a date. A large container of Italian seasoning was observed opened but not dated. The dietary manager stated she did expect staff to date items when opened. The dietary manager stated all condiments and spices were dated when they come in and are discarded after a year.	F 812	1.) The spice bottle was immediately dated and the cole slaw was disposed of. 2.) Any resident has the potential to be affected if food items are not dated properly. A 100% audit was performed on all food items to ensure that all were properly dated. 3.) Re-education was initiated on 12/6/18 and provided to dietary staff regarding the process of accurately and properly dating all food items. 4.) Random audits of 10 food items will be performed weekly X4 weeks then monthly X2 months to ensure that all items are accurately and properly dated. Any and all findings to be reported to the QA committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 812	Continued From page 98 The surveyor checked the pantry on the dementia unit on 12/04/18 at 2:19 p.m. with licensed practical nurse #1. There was a large container of yogurt (24 ounces) that did not have a date when opened and a carton of Resource 2.0 that was opened but no date. L.P.N. #1 stated the Resource 2.0 was just opened that morning. R.N. #2 was asked if the Resource and yogurt should be dated when opened. L.P.N. #1 stated yes. The surveyor requested the facility policy on labeling and dating from the dietary manager on 12/4/18. The surveyor reviewed the facility policy titled "Food and Supply Storage" on 12/4/18. Refrigerated Foods 2. All commercially packaged foods which require refrigeration after opening must be dated when received and dated again when opened with an opened and use by date. The surveyor informed the administrative staff of the above concern during the end of the day meeting on 12/5/18 at 4:27 p.m. No further information was provided prior to the exit conference on 12/6/18.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information	F 842		1/18/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 842	Continued From page 99	F 842		

Continued From page 99
except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 842	Continued From page 100 (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review the facility staff failed to ensure a complete and accurate clinical record for 3 of 26 Residents #73, #54, and #74 Findings included: 1. For Resident #73, the facility staff failed to ensure the Residents DDNR (durable do not resuscitate) was corrected accurately per facility policy. The clinical record review revealed that Resident #73 had been admitted to the facility on 08/09/18. Diagnoses included, but were not limited to, hypertensive chronic kidney disease, diabetes, chronic obstructive pulmonary disease, and peripheral vascular disease.	F 842	1.) Resident #73's DNR was completed accurately and scanned into the electronic health record. The incorrect DNR was removed from Resident #54's chart and the weight was entered into her medical record. All weights were entered into the clinical record for Resident #74. 2.) Any resident has the potential to be affected if inaccurate information is placed in the clinical record. Any resident has the potential to be affected if weights are not recorded in the clinical record. A 100% audit of DNR's was completed to ensure that all were scanned into the correct health record. As of 12/6/18, all residents' weights have been entered into the clinical record.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	**208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277**

(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 842

Continued From page 101

Section C (cognitive patterns) of the Resident's most recent MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/03/18 included a BIMS (brief interview for mental status) summary score of 11 out of a possible 15 points.

The Resident's clinical record included a DDNR order form from the Virginia Department of Health. This form was dated 08/13/18 and read in part.

Under section 1 "I further certify [must check 1 or 2]:
1. The patient is CAPABLE of making an informed decision...
2. The patient is INCAPABLE of making an informed decision..."
Neither box had been checked.

Section 2 read, "If you checked 2 above, check A, B, or C below..." All three boxes had been left blank.

This form had been signed by the Residents authorized representative.

On 12/05/18 at 11:40 am the DON (director of nursing) was asked by surveyor to obtain a copy of Resident #73's DDNR order form, MDS assessment, face sheet, and physician's orders. At 11:58 am the DON provided the surveyor with the requested documents. The copy of the DDNR order form obtained had section 1 and 2 checked the DDNR was dated 8/13/18 and there was no initials or date on the form indicating it was corrected.

On 12/05/18, the surveyor reviewed the

F 842

3.) Re-education was initiated on 12/6/18 and provided to Medical Records/SSD regarding the proper and accurate completion of advanced medical directives and the scanning into the clinical record.
Re-education initiated on 12/6/18 and provided to nursing regarding entering weights into the clinical record.

4.) 5 random chart will be audited weekly X4 weeks then monthly X2 months to ensure that the correct information has been scanned into the clinical record and that all weights have been entered..
Any and all findings to be reported to the QA committee for further review and recommendations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 842	Continued From page 102	F 842		

Residents clinical record and the DDNR order form originally viewed had been removed. The clinical record now included a DDNR order form with an upload date of 12/05/18. Sections 1 and 2 had now been completed.

On 12/05/18 at 12:00 pm the DON was asked by the surveyor, "Should the document have been initialed and dated if corrected?" The DON stated "yes".

On 12/05/18 at 12:06 pm, the surveyor spoke to RN (registered nurse) #1 that oversees the code status of Residents upon admission. RN #1 voiced that she did view the DDNR order form for Resident #73 the morning of 12/05/18 due to it being on another unit and had the document placed on the unit that Resident #73 was currently residing. RN #1 could not remember if sections 1 and 2 were checked on the DDNR order form at that time.

On 12/05/18 at 12:20 pm the DON provided the surveyor with a facility document titled "charting errors and/or admissions". The document read in part under section 5, "All corrections, changes, or addenda must be signed and dated by the person making such entries". The DON voiced she could not determine when sections 1 and 2 of the DDNR order form was checked. The surveyor asked the DON, "Would you expect the staff to have dated, placed time, and initialed the document with corrections?" The DON stated "yes". The DON voiced a new DDNR order form would be obtained today to clarify and correct the issues of inaccurate record and documentation.

The administrative team were made aware of the above findings on 12/05/18 at 4:27 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 842	Continued From page 103	F 842		

No further information regarding this issue was provided to the survey team prior to the exit conference.
2. The facility staff scanned another resident's DNR into Resident #54's electronic clinical record and facility staff failed to record a daily weight in the clinical record.

The clinical record of Resident #54 was reviewed 12/4/18 through 12/6/18. Resident #54 was admitted to the facility 10/10/17 and readmitted 11/17/18 with diagnoses that included but not limited to unspecified dementia without behavioral disturbances, hypertensive heart and chronic kidney disease with heart failure, type 2 diabetes mellitus, chronic respiratory failure, hypothyroidism, atrial fibrillation, major depressive disorder, dysphagia, anemia, hyperlipidemia, gastro-esophageal reflux disease and dependence on supplemental oxygen.

Resident #54's 14- day minimum data set assessment (MDS) with an assessment reference date (ARD) of 11/29/18 assessed the resident with a BIMS (brief interview for mental status) as 09/15.

(a) Resident #54's December 2018 physician's orders read "DNR (do not resuscitate)/DNI (do not intubate)" order dated 11/17/18.
The surveyor reviewed the electronic clinical record for Resident #54's DNR. When the electronic clinical record was accessed, another resident's DNR had been scanned in to Resident #54's record.

The surveyor informed the director of nursing and both corporate registered nurses on 12/5/18 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 842	Continued From page 104 1:26 p.m. Corporate registered nurse #1 stated the DNR was scanned in wrong and she would check with medical records and find Resident #54's DNR. The DNR was uploaded 11/28/18 into the electronic clinical record per corporate RN #1. The corporate registered nurse #1 stated the facility has hard copies on the unit as a second check. The surveyor requested the facility policy on uploading and scanning documents from the corporate R.N. #1 on 12/5/18 at 1:33 p.m. The facility policy titled "Medical Records Scanning" was reviewed 12/5/18. The instruction guide read in part "Scan the documents into the network folder provided. Second Check. A person other than the uploader verifies the accuracy of the upload (within 48 hours of upload) then puts the documents in the shred bin." (b). Resident #54's November 2018 physician's orders had orders for daily weights for CHF (congestive heart failure): Order Date 11/17/18 Start Date 11/25/18. The surveyor was unable to locate a weight for 11/25/18. The surveyor informed the assistant director of nursing on 12/6/18 at 2:11 p.m. The ADON provided the surveyor with the 11/25/18 weight for Resident #54. The ADON stated the weight had been recorded on the certified nursing assistant assignment sheets. The ADON was asked if this was part of the clinical record and the ADON stated no.	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 842	Continued From page 105	F 842		

The surveyor informed the administrative staff of the above concern during the end of the day meeting on 12/6/18 at 4:14 p.m. and requested the facility policy on documentation.

No further information was provided prior to the exit conference on 12/6/18.

3. The facility staff failed to document daily weights in the clinical record for Resident #74.

The clinical record of Resident #74 was reviewed 12/4/18 through 12/6/18. Resident #74 was admitted to the facility 10/6/18 with diagnoses that included but not limited to hypertensive heart disease with heart failure, ischemic cardiomyopathy, Alzheimer's disease, type 2 diabetes mellitus, benign prostatic hypertrophy, hypothyroidism, hyperlipidemia, dementia, major depressive disorder, atrial fibrillation, and gastroesophageal reflux disease.

Resident #74's 30-day minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/1/18 assessed the resident with a BIMS (brief interview for mental status) as 15/15.

Resident #74's October 2018 through December 2018 physician's orders had orders for daily weight in the morning related to hypertensive heart disease with heart failure-Order date 10/14/18 Start Date 10/14/18.

The surveyor reviewed the electronic weights/vitals summary sheet and the medication and treatment administration records but was unable to locate the following weights: 10/26/18, 11/3/18, 11/8/18, 11/11/18, 11/24/18, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 842	Continued From page 106 11/25/18. The surveyor informed the corporate registered nurse #2 on 12/06/18 08:35 a.m. of the missing weights. The surveyor was provided all of the weights that were not located in the clinical record from the corporate registered nurse #2. The corporate registered nurse #2 stated the weights had been recorded on the certified nursing assistant's assignment sheets. The surveyor informed the administrative staff of the failure to record daily weights in the clinical record on 12/6/18 at 4:14 p.m. The surveyor requested the facility policy on documentation during the end of the day meeting on 12/6/18 at 4:14 p.m. No further information was provided prior to the exit conference on 12/6/18.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		1/18/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 880	Continued From page 107	F 880		

Continued From page 107

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 880	Continued From page 108 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review the facility staff failed to follow established infection control procedures for 5 of 26 Residents, #155, #156, #27 and #79. The findings included: 1. For Resident's #155 and #156, the facility cohorted Resident #155 and #156 in the same room. Resident #155 was on contact isolation for clostridium difficile. Both Residents were continent and used the same bathroom. The clinical record review revealed that Resident #155 had been admitted to the facility on 12/03/18. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, diabetes, chronic diastolic congestive heart failure, depressive disorder, hypertensive heart disease, and peripheral vascular disease. There was no MDS (minimum data set) assessment completed on this Resident. However, the Resident was alert and orientated	F 880	1.) Resident #155 was immediately placed in another room on 12/4/18. All isolation carts were audited to ensure hand sanitizer was available and present on each. The CNA identified that was providing care for Resident #27 was re-educated on hand washing and isolation precautions. Resident #79's catheter tubing was anchored appropriately to ensure that it was not touching the floor. 2.) Any resident has the potential to be affected if infection prevention guidelines are not complied with. A 100% audit was performed on all isolation patients to ensure that they were cohorted appropriately. All isolation carts were audited to ensure that hand sanitizer was available and present on each. A 100% audit was performed on all residents with catheters to ensure that the tubing was anchored appropriately.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ____ B. WING ____	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 880 Continued From page 109
to person and place.

The clinical record review revealed that Resident #156 had been admitted to the facility on 11/28/18. Diagnoses included, but were not limited to, clostridium difficile, muscle weakness, atrial fibrillation, and pneumonia.

There was no MDS (minimum data set) assessment completed on this Resident. However, the Resident was alert and orientated to person and place.

Resident #156 had been care planned for contact isolation.

During initial tour of the facility on 12/04/18 at 12:10 PM the surveyor observed an isolation cart that contained PPE (personal protective equipment) outside the room that both of these Residents resided in. The unit manager was asked which Resident was on isolation and why. The unit manager stated Resident #156 was on isolation and Resident #155 had been admitted last night. Resident #156 was identified as having clostridium difficile. The unit manager stated both Residents were continent and were using the same commode.

After this interview CNA (certified nursing assistant) #1 was observed taking a bedside commode into the Residents room. CNA #1 was asked if both of the Residents were continent, to which she replied yes. When asked if they had both been using the same commode she stated they had been.

On 12/04/18 at 12:35 PM, the surveyor observed a visitor in the Residents room sitting beside of

F 880

3.) Re-education was initiated on 12/6/18 and provided to nursing regarding infection prevention guidelines..

4.) 5 random residents will be audited weekly X4 weeks then monthly X2 months to ensure that all infection prevention measures have been complied with.
Any and all findings to be reported to the QA committee for further review and recommendations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 880	Continued From page 110	F 880		

Resident #156's bed. This visitor did not have any PPE in place. The surveyor spoke to this visitor and the visitor stated that no one had explained anything to her regarding the need to wear PPE. Both Residents were interviewed and both stated they have been using the commode in the bathroom. The visitor then added that they just brought in the bedside commode. The surveyor observed the bin that was being used to place the dirty PPE was placed next to the bed of the Resident without the infection (#155). Resident #155's respiratory equipment was also observed to be uncovered.

On 12/04/18 at 1:11 PM, the ADON (assistant director of nursing) who had been identified as the infection control nurse was interviewed regarding the cohorting of these two Residents. The ADON stated Resident #155 came late last night and he did not know why they were put in a room together. The ADON then stated they tried to put Residents with clostridium difficile in separate rooms.

The director of admissions was identified as the person who would assign the rooms and was interviewed on 12/04/18 at 1:24 PM. During this interview, the director of admission stated she did not realize that Resident #156 was on isolation and she did not check the room. The director of admissions stated they would be moving Resident #155 to another room and everyone had been notified.

On 12/04/18 at 3:01 PM, the surveyor observed that Resident #155 had been moved to another room.

Prior to the exit offence the facility provided the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 880	Continued From page 111	F 880		

surveyor with a copy of an in-service form titled "PPE/Isolation Accommodations" this form read in part, "Please ensure that when a pt/res (patient/Resident) require isolation that all appropriate PPE that is required for the specific type of isolation is in place with particular attention to toileting requirements that may be impacted by the type of isolation...Please also ensure that any family/visitors are educated appropriately regarding PPE requirements of isolation."

The facility policy on "Transmission Based Precautions" read in part, "...Contact-direct contact with skin, or indirect contact with contaminated surfaces, and physical transfer of organisms (usually on the hands of healthcare workers) from an infected or colonized person to a susceptible host..."

The administrative staff were notified of the problems regarding the infection control issues and Resident #155 and #156 during a meeting with the survey team on 12/05/18 at 4:27 PM.

No further information regarding this issue was provided to the survey team prior to the exit conference.
2. The facility staff failed to follow contact precautions posted on the door to Resident #27's room.

The clinical record of Resident #27 was reviewed 12/4/18 through 12/6/18. Resident #27 was admitted to the facility 4/26/18 and readmitted 9/15/18 with diagnoses of but not limited to hemiplegia and hemiparesis, malignant neoplasm of rectum, anus, and anal canal, indwelling urethral catheter, urinary tract infection, ulcerative

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 880 Continued From page 112 F 880

colitis, major depressive disorder, neuromuscular dysfunction of the bladder, anxiety, and hyperlipidemia.

Resident #27's significant change in status minimum data set (MDS) assessment with an assessment reference date (ARD) of 9/28/18 assessed the resident with a BIMS (brief interview for mental status) as 00/15.

The surveyor observed the resident during the initial tour on 12/4/18 at 12:33 p.m. At the entrance to the door was a sign that read "Contact Precautions." A three-drawer cart was observed at the entrance to the door. The surveyor checked each drawer. There were gloves, shoe covers, gowns, masks, and blood pressure equipment but no hand sanitizer on top of the cart or in the cart.

The surveyor observed Resident #27 again on 12/4/18 at 3:18 p.m. Resident #27 was observed in bed and observed to have a Foley drainage bag attached to the bed frame. The surveyor asked certified nursing assistant #1 to check the anchorage of Resident #27's indwelling Foley catheter. C.N.A. #1 donned gloves, gowns, and shoe covers and entered the resident's room. No hand washing or hand hygiene was performed before donning gloves. C.N.A. #1 checked the Foley for anchorage and then removed the gloves, gown, shoe covers and exited the room. No handwashing or hand hygiene was observed. C.N.A. #1 walked to the nurse's station after leaving the resident's room. The surveyor did not observe any hand hygiene while C.N.A. #1 was at the nurse's station. C.N.A. #1 picked up something at the nurses station and proceeded to walk down the first hall adjacent to the nurse's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 880	Continued From page 113	F 880		

station.

The surveyor requested the infection control policy and the posted sign at the entrance to Resident #27's room from the director of nursing on 12/4/18 at 4:24 p.m.

The sign on Resident #27's room entrance read "Contact Precautions" In addition to Standard Precautions 1. Wash hands. 2. Gowns are indicated if soiling is likely. 3. Gloves are indicated, when touching infective material. Change frequently after contact. 4. Bag linen to prevent contamination of self, environment, or outside of bag. 5. Discard infectious trash to prevent contamination of self, environment, or outside of bag. 6. Wash hands."

The surveyor reviewed the facility policy titled "Infection Prevention and Control Program" on 12/6/18. The policy read in part "4. Hand Hygiene Protocol: a. All staff shall wash their hands when coming on duty, between resident contacts, after handling contaminated objects, after PPE (personal protective equipment) removal, before and after eating, before and after toileting, and before going off duty."

The director of nursing showed the surveyor the isolation carts currently in use on 12/6/18 at 1:46 p.m. The unit manager registered nurse #1 stated to the DON that the isolation cart used for Resident #27's roommate was the old set-up isolation cart-not the new ones.

The surveyor informed the administrative staff of the above concern on 12/5/18 at 4:14 p.m.

No further information was provided prior to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	**208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277**

(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 880

Continued From page 114

exit conference on 12/6/18.
3. For Resident #79 the facility staff failed to follow establish infection control procedures related to catheter use.

Resident #79 was admitted to the facility on 10/19/15 and readmitted on 03/22/16. Diagnoses included but not limited to anemia, atrial fibrillation, heart failure, hypertension, renal failure, neurogenic bladder, diabetes mellitus, hyperlipidemia, hypothyroidism, osteoporosis, dementia, anxiety, and depression.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 11/11/18 coded the Resident as 0 of 15 in section C, cognitive patterns. This is an annual MDS.

Surveyor observed Resident #79 on 12/0418 at approximately 1215. Resident was resting in low bed. Resident's catheter bag was observed hanging from side of bed. Catheter tubing was observed to be resting on the floor.

Surveyor observed Resident #79 on 12/05/18 at approximately 0920. Resident was seated in geri-chair in the dining area. Resident's catheter bag was attached to the chair, with catheter tubing hanging in the floor under the chair. Surveyor observed CNA #1 wheel Resident #79 from the dining area to her room in the geri-chair. Catheter tubing was observed dragging along the floor under the geri-chair.

Surveyor observed Resident #79 again on 12/05/18 at approximately 1300. Resident was resting in bed, with catheter bag attached to side of bed. Catheter tubing was resting on the floor. Surveyor spoke with unit manager on 12/05/18 at

F 880

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE HEALTH AND REHAB CENTER	208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277

(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 880	Continued From page 115	F 880		

approximately 1305 regarding catheter tubing being in floor. Surveyor asked unit manager if tubing should be touching the floor and unit manager stated that it should not.

Surveyor spoke with the infection control nurse on 12/06/18 at approximately 0900 regarding Resident #79's catheter tubing. Surveyor asked the infection control nurse if the catheter tubing should be touching the floor and the infection control nurse stated that it should not.

Surveyor was provided with a copy of a facility policy entitled "Catheter Care" which read in part, "H. Position catheter tubing and collection container so that: 3. Tubing is not touching the floor".

The concern of the Resident's catheter tubing touching the floor was discussed with the administrative team during a meeting on 12/05/18 at approximately 1630.

No further information was provide prior to exit.