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 01/09/2020

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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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 01/07/2020 through 01/09/2020. 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 VA00045481 (substantiated with no deficient practice).	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey and biennial State Licensure Inspection was conducted 01/07/2020 through 01/09/2020. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. Complaint #VA00045841 was investigated during the survey. This complaint was substantiated with no deficient practice. The census in this 110 certified bed facility was 99 at the time of the survey. The survey sample consisted of 20 current Resident reviews and 3 closed record reviews.	F 000		
F 684 SS=D	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	F 684		2/7/20

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

Electronically Signed | 02/06/2020

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F 684	Continued From page 1 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure that residents receive treatment and care by not following physician's orders for 1 of 20 residents (Resident #74) in the survey sample as evidenced by the staff not administrating the physician ordered medications on dialysis days. The findings included: The facility staff failed to administer medications as ordered by the physician on dialysis days. Resident #74 was a resident in the facility at the time of this survey. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/8/19, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15/15. Resident #74 was also coded as requiring limited assistance of 1 staff member for dressing, personal hygiene and bathing. The resident had the following diagnoses of, but not limited to high blood pressure, end stage renal disease, diabetes, congested heart failure and high cholesterol. The surveyor conducted a review on 1/8/2020 of Resident #74's clinical record and noted the following physician orders for medications: " Eliquis 2.5 mg (milligram) BID (twice a day) for blood clot prevention " Hydralazine 10 mg 1 tablet every 12 hours for high blood pressure " Metoprolol 50 mg BID for high blood pressure	F 684	1. Resident #74's chart was immediately updated to reflect a physician's order to omit medication when resident is out to dialysis. 2. Any resident has the potential to be affected if medication is not give per physician order. A 100% audit of dialysis patients was completed to ensure that medications were being given per physician order. 3. Re-education was initiated on 1/8/2020 and provided to nursing regarding ensuring that medications are being given per physician order. 4. 5 random charts will be audited weekly x4 weeks then monthly x2 months to ensure that medications have been given per physician order. Any and all findings to be reported to QA committee for further review and recommendations.	

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F 684	Continued From page 2	F 684		

The surveyor also reviewed the MAR (medication administration record) for Resident #74. During such review, the surveyor noted the documentation of "3" which by the chart code "3" meant "Absent from home". The code of "3" was noted on the December, 2019 and January, 2020 for the above documented physician ordered medications for the following dates and times:

" Metoprolol was not administered to the resident at 9 am on 12/4, 12/6, 12/9, 12/11, 12/13, 12/16, 12/18, 12/20, 1/6/2020 and 1/8/2020.
" Eliquis was not administrated to the resident at 9 am on 12/3, 12/6, 12/9, 12/11, 12/13, 12/16, 12/18, 12/20, 12/22, 12/24, 12/27, 1/6/2020 and 1/8/2020.
" Hydralazine was not administrated to the resident at 9 am on 12/4, 12/6, 12/9, 12/11, 12/13, 12/16, 12/18, 12/20, 1/6/2020 and 1/8/2020.
The surveyor notified the DON (director of nursing) on 1/8/2020 at 1 pm of the above documented findings. DON stated, "We will get this fixed."

The surveyor notified the administrator, DON, and regional nurse of the above documented findings at 4:30 pm.

On 1/8/2020 at approximately 11 am, the surveyor reviewed a physician order which read as follows:
" Omit AM (morning) medication when the resident is at dialysis every Monday, Wednesday and Friday.

No further information was provided to the

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F 684	Continued From page 3 surveyor prior to the exit conference on 1/8/2020 at 1:15 pm.	F 684		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not	F 756		2/7/20

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F 756	Continued From page 4 limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the physician failed to act upon a pharmacy recommendation for the month of June 2019 for 1 of 23 residents, Resident #41. Resulting in this same recommendation being made by the consultant pharmacist in October 2019. This recommendation was completed in October 2019. The findings included: The physician failed to act upon a pharmacy recommendation. The consultant pharmacist had recommended an AIMS (Abnormal Involuntary Movement Scale) test be completed on June 10, 2019. This test was not completed until a second pharmacy recommendation was made on October 8, 2019. A review of the clinical record was completed on January 9, 2020. The electronic health record included, but was not limited to the following diagnoses, vascular dementia without behavioral disturbance, major depressive disorder, unspecified psychosis, and generalized anxiety disorder. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of November 18, 2019 included a BIMS (brief	F 756	1. Resident #41 had an AIMS completed and entered into the medical record in October placing the resident in current compliance. 2. Any resident has the potential to be affected if pharmacy recommendations are not followed. A 100% audit of pharmacy recommendations was completed to ensure that all have been addressed by the physician and nursing and uploaded into the medical record. 3. Re-education initiated on 1/9/2020 and provided to physicians/nursing/Medical Records regarding ensuring that pharmacy recommendations are addressed timely and entered into the medical record. 4. 5 random charts will be audited weekly x4 weeks then monthly x2 months to ensure that pharmacy recommendations have been addresses and entered into the medical record. Any and all findings to be reported to QA committee for further review and recommendations.	

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F 756	Continued From page 5	F 756		

interview for mental status) summary score of 9 out of a possible 15 points.

The clinical record included the following pharmacy consultant notes.

Jun 10, 2019, "Medications and chart reviewed + Buspar 7.5mg TID (three times a day), Seroquel 25mg HS (bedtime/hour of sleep), Depakote 125mg Q (every) 12 (hours) Recommendation for nursing-AIMS."

October 8, 2019, "Medications and chart reviewed Recommendation for nursing-AIMS."

The surveyor was unable to find any pharmacy recommendations regarding these progress notes.

On January 9, 2020 at 10:43 a.m., the administrator and DON (director of nursing) were made aware of the missing pharmacy recommendations.

On January 9, 2020 at 11:26 a.m., the DON verbalized to the surveyor that the facility failed to complete the AIMS test for June and a second recommendation was made in October and an AIMS was completed on October 8, 2019. The DON also provided the surveyor with a copy of the recommendations made by the consulting pharmacist. For June 10, 2019 the pharmacist had wrote, "This resident is currently receiving antipsychotic therapy with Seroquel 25mg HS and therefore requires an Abnormal Involuntary Movement Test (AIMS) at baseline and every 6 months while on antipsychotic therapy. I was unable to locate a recent AIMS test in the chart. Please complete an AIMS test now, and every 6

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F 756	Continued From page 6 months while the resident remains on antipsychotic therapy." This same recommendation was made on October 8, 2019. Prior to the exit conference, the facility provided the surveyor with a copy of their policy/procedure titled "MEDICATION REGIMEN REVIEW POLICY." This policy read in part, "The pharmacist must report any irregularities to the Attending Physician, the facility's Medical Director and Director of Nursing, and these reports must be acted upon in a manner that meets the needs of the residents...If the Attending Physician declines or otherwise rejects the Consultant Pharmacist's recommendation, an explanation as to the rationale for the rejection shall be documented in the resident's medical record..." No further information regarding this issue was provided to the survey team prior to the exit conference on January 9, 2020.	F 756		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized	F 761		2/7/20

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F 761	Continued From page 7 personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility staff failed to ensure that the storage of all expired drugs and biologicals including expired laborary blood tubes in (one) of 3 (three) medication storage rooms (West Hall medication storage room) were disposed of from storage. The following findings were noted: 1. The facility staff failed to dispose of expired Aspirin suppositories and expired Promethazine suppositories. The facility's medication storage room on West Hall was observed by one surveyor along with facility staff on 01/07/2020 at 3:25 p.m. The medication refrigerator contained 10 (ten) 25mg Promethazine suppositories with an expiration date of 10/20/19 and 12 (twelve) 600mg Aspirin suppositories with an expiration date of 10/20/19. The facility's registered nurse (RN) working on West Hall acknowledged the suppositories were out of date and was unsure who was responsible for disposing of those expired medications. One of the facility's LPNs (licensed practical nurse) said the box the suppositories were kept in was	F 761	1. All identified expired medications and lab tubes were immediately discarded. 2. Any resident has the potential to be affected if expired supplies/medications are used and/or administered. A 100% audit of all medications in the Omnicell was completed on 1/7/2020 to identify expired medications. All medications remaining were found to be in date. A 100% audit of all lab tubes in the center was completed with any expired tubes found immediately discarded. 3. Re-education initiated on 1/7/2020 and provided to the pharmacy representative responsible for reviewing the contents of the Omnicell regarding ensuring that all medications are reviewed and expired medications discarded. Re-education initiated on 1/7/2020 and provided to nursing regarding ensuring that lab tubes are in date. 4. All lab tubes in the center will be audited weekly x4 weeks and then monthly x2 months to ensure they are within date.	

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F 761	Continued From page 8 referred to as the "omnicell box" (Omnicell is an automated medication supply system, omnicell box contained medications that required refrigeration) and therefore, the pharmacy staff was responsible for checking those medications. The LPN said the pharmacy staff was in the facility checking on the omnicell medications last week. The facility's director of nursing (DON) was informed of the above findings on 01/07/2020 at 4:14 p.m. The DON stated the suppositories were stock medications and were not for any specific resident and acknowledged that the pharmacy staff was supposed to check those medications, remove the expired medications and replace them. The DON was not sure why the pharmacy staff did not remove the expired suppositories. No further information was provided to the survey team prior to the exit conference. 2. The facility staff failed to remove expired laboratory blue top tubes (used for blood collection) from a supply cabinet. The facility's medication storage room on West Hall was observed by one surveyor along with facility staff on 01/07/2020 at 3:25 p.m. In an upper supply cabinet, an open pack of laboratory blue top tubes for blood collection were found with an expiration date of 12/31/19. One of the facility's RNs (registered nurses) acknowledged the blue top tubes were expired and removed them from the cabinet. The RN was not certain who was responsible for checking laboratory supplies for expiration dates.	F 761	The Omnicell representative will audit the Omnicell monthly x3 months to ensure that all medications are within date. Any and all findings to be reported to QA committee for further review and recommendations.	

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F 761	Continued From page 9 The facility's director of nursing (DON) was informed of the above findings on 01/07/2020 at 4:14 p.m. The DON stated there was no written policy that addressed who was responsible for checking expiration dates of laboratory tubes. The DON said it was everyone's responsibility to look for expired items but the facility's house supervisors were supposed to check for expired items/medications regularly. No further information was provided to the survey team prior to the exit conference.	F 761		