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 09/15/2020

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

(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 COVID-19 Focused Survey was conducted onsite on 9/1/2020. Emergency Preparedness information was reviewed off-site on 9/4/2020, 9/9/2020, 9/10/2020, 9/11/2020 and 9/15/2020. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. On 9/1/2020, the census in this 110 certified bed facility was 94. Facility staff reported having had four (4) positive COVID-19 cases with three (3) of the four (4) resolved.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid complaint survey and COVID-19 Focused Infection Control Survey was conducted onsite on 9/1/2020. Infection control and complaint information was reviewed off site on 9/4/2020, 9/8/2020, 9/9/2020, 9/10/20, 9/11/20, 9/14/2020, and 9/15/2020. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Corrections are not required for compliance with F-880 of 42 CFR Part 483 Federal Long Term Care requirement(s). Two (2) complaints were investigated during the survey. On 9/1/2020, the census in this 110 certified bed facility was 94. Facility staff reported having had four (4) positive COVID-19 cases with three (3) of the four (4) resolved.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)	F 609		10/9/20

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

Electronically Signed | 09/29/2020

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F 609	Continued From page 1 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews and the review of documents, it was determined the facility staff failed to report to the state agency of injuries of unknown source for one (1) of three (3) sampled residents (Resident #2). The findings include: The facility staff failed to notify the state agency of	F 609	1. Resident #2 discharged from the center on 7/19/2020. Further notification cannot be made due to this. The nurse that made the initial note was re-educated on notification procedures and accurate medical records. 2. Any resident has the potential to be affected if notification procedures are not adhered to. A 100% audit of residents in	

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F 609	Continued From page 2 Resident #2's injuries of unknown source. Resident #2's diagnoses included, but were not limited to: high blood pressure, heart failure, kidney disease, diabetes, and dementia. Resident #2's minimum data set (MDS) assessment with an assessment reference date of 4/1/2020 had the resident assessed as having short-term and long-term memory problems. The resident was also assessed as requiring the assistance of two (2) or more individuals with bed mobility, transfers, toilet use, and personal hygiene. Resident #2's clinical documentation included: - A provider "PROGRESS NOTE" dated 1/14/2020. This note included the following information: "Today, patient is being seen for a toenail issue second nail left foot ... This was noted (recently) (1-13-20) by (nursing staff) ... I had previously noted the other foot with ? [sic] Fungal nail ... The patient has advanced dementia and does not speak ... (Patient's) second toenail on left foot appears as (possible) fungal nail and (reddened) around the toenail ... I think the patient has onychomycosis on the second toe of the left foot and I believe that the podiatrist may want to take the toenail off ..." - A "skin note" dated 1/14/2020 at 11:59 a.m. This note included the following information: " ... (Right) foot dorsum aspect noted to have approximately 4cm x 4cm faded yellow/green/blue discoloration. (Left) foot (second) digit toenail noted to be lifting from nail bed with mild erythema surrounding it. No exudate, inflammation, or calor noted ... (Right) dorsum of hand has small approximately 1cm faded yellow discoloration ... (Left) hand has fading yellow discoloration to webspace between	F 609	the center in the last 30 days was completed to ensure that any injury of unknown source was investigated and reported on as necessary. 3. Re-education initiated on 9/29/2020 and provided to nursing regarding ensuring that all injuries of unknown source are investigated and reported on as necessary, and that the 24 hour report is reviewed daily to identify evidence of injuries of unknown source. 4. The 24 hour report will be reviewed daily Monday through Friday X3 months to ensure that injuries of unknown source have been investigated and reported on as necessary. Findings will be reported to QA committee for further review and recommendations.	

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F 609	Continued From page 3	F 609		

thumb and First [sic] digit ..."
- A podiatry note dated 1/15/2020. This note included the following information: "Left (second) toenail has blood under it. Toenail is lifted loose. No abscess. No drainage. Mild erythema. Looks like trauma ... Plan: Applied triple antibiotic ointment and dry sterile dressing to left (second) toe after removing toenail and removing the dried blood. Small amount of bleeding. Orders written for daily application of triple antibiotic ointment and bandaid [sic] until healed."

Resident #2's clinical documentation also included the following note which had been 'struck out' as evidenced by a single line being placed through the text of the note and the addition of the phrase "Data entry error" just prior to the 'struck out' text: "Note Text: Called to resident's room per staff. Resident's (second) toe of the (left) foot noted to be reddened around the top of (pronoun omitted) toe and nail. Warm and tender to touch. Toenail appears dark in color and bent in shape and appears broken across the center of the nail. No distress or discomfort noted or voiced. (Adult child) (name omitted) at bedside. MD notified and will assess upon rounds tomorrow 1/13/20." This 'struck out' note had been dated as documented on 1/12/2020 at 2:35 p.m.

During an interview on 9/14/2020 at 1:02 p.m., the DON stated that a Facility Reported Incident (FRI) was not submitted to the stated agency due to the provider's determination that the left second toe findings was a fungal infection. Documentation of the investigation of this skin issue failed to include information related to the podiatrist's assessment that indicated trauma could have been a contributing factor to Resident

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F 609	Continued From page 4 #2's left second toe condition. The facility investigation, of an identified "Injury of unknown source" for Resident #2, dated as occurring on 1/15/2020 and concluding on 1/16/2020, was reviewed. This investigation's "Detailed description of incident" was documented as "Bruise to top of right hand". Interviews documented as part of this investigation stated that Resident #2 was observed to hit his/her hand on the side rail during care. The investigation also documented the resident was taking multiple medications which put the resident at risk for skin issues. The outcome of this investigation was documented as "Bruise deemed occurred during ADL care provided on 1/15/2020 per staff interviews. No further follow up needed." This investigation did not address the skin and/or nail areas documented to the left hand, right foot, or left second toe. During a telephone meeting with the facility's Director of Nursing and Clinical Services Consultant on 9/15/2020 at 1:09 p.m., the failure of the facility staff to notify the state agency of Resident #2's injuries of unknown source was discussed for a final time.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.	F 610		10/9/20

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F 610	Continued From page 5 §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews, the review of documents, and in the course of a complaint investigation, it was determined the facility staff failed to ensure injuries of unknown source were thoroughly investigated for one (1) of three (3) sampled residents (Resident #2). The findings include: The facility staff failed to include all documented findings related to Resident #2 skin assessments into the investigation of Resident #2's skin condition. This investigation concluded on 1/16/2020. Resident #2's diagnoses included, but were not limited to: high blood pressure, heart failure, kidney disease, diabetes, and dementia. Resident #2's minimum data set (MDS) assessment with an assessment reference date of 4/1/2020 had the resident assessed as having short-term and long-term memory problems. The resident was also assessed as requiring the assistance of two (2) or more individuals with bed mobility, transfers, toilet use, and personal hygiene.	F 610	1. Resident #2 discharged from the center on 7/19/2020. Further correction/assessment cannot be made due to this. 2. Any resident has the potential to be affected if injuries are not correctly investigated. A 100% audit of residents in the center in the last 30 days was completed to ensure that any injury was investigated and reported on as necessary. 3. Re-education initiated on 9/29/2020 and provided to nursing regarding ensuring that all injuries are investigated and reported on as necessary. 4. The 24 hour report will be reviewed daily Monday through Friday X3 months to ensure that injuries have been investigated and reported on as necessary. Findings will be reported to QA committee for further review and recommendations.	

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F 610	Continued From page 6	F 610		

Resident #2's clinical documentation included:
- A provider "PROGRESS NOTE" dated 1/14/2020. This note included the following information: "Today, patient is being seen for a toenail issue second nail left foot ... This was noted (recently) (1-13-20) by (nursing staff) ... I had previously noted the other foot with ? [sic] Fungal nail ... The patient has advanced dementia and does not speak ... (Patient's) second toenail on left foot appears as (possible) fungal nail and (reddened) around the toenail ... I think the patient has onychomycosis on the second toe of the left foot and I believe that the podiatrist may want to take the toenail off ..."
- A "skin note" dated 1/14/2020 at 11:59 a.m. This note included the following information: " ... (Right) foot dorsum aspect noted to have approximately 4cm x 4cm faded yellow/green/blue discoloration. (Left) foot (second) digit toenail noted to be lifting from nail bed with mild erythema surrounding it. No exudate, inflammation, or calor noted ... (Right) dorsum of hand has small approximately 1cm faded yellow discoloration ... (Left) hand has fading yellow discoloration to webspace between thumb and First [sic] digit ..."
- A podiatry note dated 1/15/2020. This note included the following information: "Left (second) toenail has blood under it. Toenail is lifted loose. No abscess. No drainage. Mild erythema. Looks like trauma ... Plan: Applied triple antibiotic ointment and dry sterile dressing to left (second) toe after removing toenail and removing the dried blood. Small amount of bleeding. Orders written for daily application of triple antibiotic ointment and bandaid [sic] until healed."

The facility investigation, of an identified "Injury of

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F 610	Continued From page 7	F 610		

unknown source" for Resident #2, dated as occurring on 1/15/2020 and concluding on 1/16/2020, was reviewed. This investigation's "Detailed description of incident" was documented as "Bruise to top of right hand". Interviews documented as part of this investigation stated that Resident #2 was observed to hit his/her hand on the side rail during care. The investigation also documented the resident was taking multiple medications which put the resident at risk for skin issues. The outcome of this investigation was documented as "Bruise deemed occurred during ADL care provided on 1/15/2020 per staff interviews. No further follow up needed." This investigation did not address the skin and/or nail areas documented to the left hand, right foot, or left second toe.

The facility's incidents log had an entry for Resident #2 related to a skin condition documented on 1/12/2020 but this entry had been 'struck out' as evidenced by a single line being placed through the text of the entry. During an interview with the facility's Administrator and Director of Nursing (DON) on 9/11/2020 at 12:40 p.m., the Administrator acknowledged the entry had been 'struck out' after the provider determined the toenail condition to be related to a fungal infection. Although the aforementioned entry on the incident log had been 'struck out', the facility staff had completed an investigation of the left toenail findings; this investigation failed to include information from the podiatry note dated 1/15/2020 which indicated the left toenail issue could be trauma related.

During a telephone interview/meeting with the facility's DON and Clinical Services Consultant on

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F 610	Continued From page 8 9/15/2020 at 1:09 p.m., the facility staff's investigation of Resident #2's abnormal skin assessments was discussed for a final time. The failure of facility staff to ensure Resident #2's abnormal skin findings investigations included evidence that all abnormal skin areas were investigated was discussed. In addition, the failure of facility staff to include information from the podiatrist's assessment as part of the investigation was discussed. This is a complaint deficiency.	F 610		
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 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	F 842		10/9/20

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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-
(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

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F 842	Continued From page 10 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interviews and the review of documents, it was determined the facility staff failed to maintain a complete and accurate clinical record for one (1) of three (3) sampled residents (Resident #2). The findings include: Resident #2's clinical documentation was incomplete and/or inaccurate as evidenced by the facility's computer system automatically 'striking out' a nurse's note and marking the 'struck out' note as a "data entry error". No evidence was provided to indicate this note was an actual "data entry error". Resident #2's diagnoses included, but were not limited to: high blood pressure, heart failure, kidney disease, diabetes, and dementia. Resident #2's minimum data set (MDS) assessment with an assessment reference date of 4/1/2020 had the resident assessed as having short-term and long-term memory problems. The resident was also assessed as requiring the assistance of two (2) or more individuals with bed mobility, transfers, toilet use, and personal hygiene. Review of Resident #2's clinical documentation revealed a note documented by a nurse on 1/12/2020 at 14:35. This note, although still able to be read, had been 'struck out' with a single line placed through the text and the phrase "Data entry error" added prior to the 'struck out' text. The 'struck out' note read as follows: "Note Text:	F 842	1. Resident #2 discharged from the center on 7/19/2020. Further correction/assessment cannot be made due to this. 2. Any resident has the potential to be affected if the clinical record is not complete and accurate. A 100% audit of resident charts for the prior 30 days was completed to ensure that any struck-out note was done for appropriate reasons and if needed, re-entered. 3. Re-education initiated on 9/29/2020 and provided to nursing regarding ensuring that all clinical records are complete and accurate with emphasis on the appropriate process for striking-out notes. 4. A "Progress Notes Report" will be audited weekly X3 months to ensure that any struck-out note was done for appropriate reasons and if needed re-entered. Findings will be reported to QA committee for further review and recommendations.	

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Called to resident's room per staff. Resident's (second) toe of (left) foot noted to be reddened around the top of (his/her) toe and nail. Warm and tender to touch. Toenail appears dark in color and bent in shape and appears broken across the center of the nail. No distress or discomfort noted or voiced. (Adult child's name omitted) at bedside, MD notified and will assess upon rounds tomorrow 1/13/20."

During an interview on 9/11/2020 at 12:40 p.m. with the facility's Administrator and Director of Nursing (DON), the aforementioned 'struck out' note was discussed. The Administrator explained the note was automatically 'struck out' by the facility's computer system when the left toe incident/investigation entry was struck out due to a provider indicating it was a result of a fungal infection.

Resident #2's clinical record included the following provider "PROGRESS NOTE" dated 1/14/2020: "Today, patient is being seen for a toenail issue second nail left foot ... This was noted (recently) (1-13-20) by (nursing staff) ... I had previously noted the other foot with ? [sic] Fungal nail ... The patient has advanced dementia and does not speak ... (Patients) second toenail on left foot appears as (possible) fungal nail and (reddened) around the toenail ... I think the patient has onychomycosis on the second toe of the left foot and I believe that the podiatrist may want to take the toenail off ..."

The following information was found in a facility policy and procedure titled "Designated Record Set" (with an initiated date of 8-14):
- "Designated Record Set (DRS): A group of records maintained by or for a facility that is: (i)

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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

(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
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the medical records and billing records about individuals maintained by or for a covered health care provider; (ii) the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or (iii) used, in whole or in part, by or for the facility to make decisions about individuals."
- "Record: Any item, collection, or grouping of information that includes protected health information (PHI) and is maintained, collected, used, or disseminated by or for a facility."
- "Each facility must identify which forms and reports, when present in a patient's paper or electronic file, will be included in the DRS based on the HIPAA DRS definition. At a minimum, the following forms and reports must be included in the facility's DRS: ... Progress Notes ... Nursing documentation, including items such as vital sign graphics, intake and output records, neurocheck [sic], medication sheets, intravenous fluid flow sheets, shift assessments, nursing notes, telemetry, admission history, care plan, discharge instructions, and release of body form, etc. ..."

The failure of facility staff to ensure Resident #2's clinical record was complete and accurate was discussed for a final time with the facility's DON and Clinical Services Consultant during a telephone meeting on 9/15/2020 at 1:09 p.m.