DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 **06/02/2022**

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 05/31/2022 through 06/07/2022. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid survey was conducted 05/31/2022 through 06/07/2022. Three complaints (VA00055275 - Unsubstantiated, VA00054777 - Substantiated without deficiency, VA00054657 - Unsubstantiated) were investigated during the survey. Corrections were required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 110 certified bed facility was 101 at the time of the survey. The survey sample consisted of 21 current resident reviews and 3 closed record reviews. The Life Safety Code survey/report will follow.	F 000		
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	F 842		6/20/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 06/27/2022

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 842	Continued From page 1 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- (i) The period of time required by State law; or	F 842		

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F 842	Continued From page 2 (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 and clinical record review the facility staff failed to maintain a complete and accurate clinical record for 2 of 21 residents, Residents #104 and #255. 1. For Resident #104, the facility staff failed to obtain a physician order for a foley catheter. 2. For Resident #255, the facility staff failed to accurately complete a Durable Do Not Resuscitate (DDNR) order form. The findings included: 1. Section C (cognitive patterns) of Resident #104's significant change minimum data set (MDS) assessment with an assessment reference date (ARD) of 05/19/22 included a brief interview for mental status summary score (BIMS) of 9 out of a possible 15 points. Section H (bladder and bowel) was coded to indicate the	F 842	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. 1. Resident #104 foley catheter order was obtained 6/1/2022. Resident #255 DDNR form was accurately completed 6/2/2022.	

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F 842 Continued From page 3

resident had a foley catheter in place.

The clinical record included the diagnoses diabetes and chronic kidney disease.

The residents comprehensive care plan included the focus area has an indwelling foley catheter in place.

06/01/22 1:10 p.m., the surveyor observed a foley catheter on the right side of the residents bed draining dark colored urine.

During a review of the clinical record, the surveyor was unable to locate an order for the foley catheter. On 05/19/22 the nursing staff documented "...foley cath intact and patent. Yellow urine noted..."

06/01/22 1:11 p.m., Licensed Practical Nurse (LPN) #2 reviewed the clinical record and stated they were unable to locate order for the foley catheter. LPN #2 then stated the order was probably not put in when the resident had been readmitted (05/12/22).

06/01/22 1:15 p.m., the Director of Nursing (DON) was made aware that Resident #104 did not have an order for the foley catheter.

06/01/22, the facility staff transcribed an order for an indwelling catheter. The medical reason was documented as obstructive uropathy.

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

2. There was no completed minimum data set

F 842

2. Any resident has the potential to be affected if accurate medical records are not maintained, including foley catheter orders as needed and accurately completed DDNR forms.
A 100% audit was completed for all current residents with foley catheters for physician order on 6/8/2022.
A 100% audit of all current residents with DNR order was completed for accurately completed DDNR forms on 6/8/2022.
3. Re-education was provided on 6/2/2022 to licensed nurses to ensure all residents upon admission or readmission are assessed for foley catheters and appropriate physician orders are obtained.
Re-education was provided on 6/2/2022 to licensed nurses and social services to ensure that all residents with a DNR order have an accurately completed DDNR form.
4. The DON/ADON or designee will audit compliance of residents with foley catheter orders 5 times a week for 4 weeks then 2 times a week for 4 weeks then monthly times 2 to ensure compliance.
The DON/ADON/social services or designee will audit compliance with DNR order for accurate completion of DDNR form weekly times 4 weeks then monthly time 2 to ensure compliance.
Findings of audits will be reported to QAPI committee for further review.
5. Date of compliance 6/20/2022

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(MDS) assessment on this resident.

The clinical record included the diagnoses cerebrovascular disease and vascular dementia.

The clinical record included an original DDNR order form from the Virginia Department of Health dated 05/13/22. Section 2 of this form had been left blank.

Under section 1, the DDNR read in part, "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..."
The box bedside of #2 had been marked.

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

The residents clinical record included an order for comfort measures (06/01/22) and a do not resuscitate (DNR) order dated 05/18/22.

06/01/22 11:37 a.m., the Director of Nursing (DON) was made aware of the incomplete DNR.

06/01/22 4:35 p.m., the Administrator and DON were notified of the incomplete DNR.

Prior to the exit conference, the DON provided the surveyor with an updated DNR form.

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