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 06/28/2023

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 A COVID-19 Focused Emergency Preparedness Survey was conducted onsite from 06/27/23 through 06/28/23. The facility was in substantial compliance with 42 CFR Part 483.73(b)(6) emergency preparedness regulations, and has implemented The Centers for Medicare & Medicaid Services and Centers for disease Control recommended practices to prepare for COVID-19. The census in this 110 certified bed facility was 108 at the time of the survey.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control and Abbreviated Survey was conducted onsite 06/27/23 through 06/28/23. The facility was in substantial compliance with 42 CFR Part 483.80 infection control regulations, and has implemented The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirement for an unrelated deficiency cited. Complaint #VA00058786 - Unsubstantiated. Compliant with regulations, unrelated deficiency cited. The census in this 110 certified bed facility was 108 at the time of the survey. The survey sample consisted of six resident records reviewed.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		7/28/23

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

Electronically Signed | 07/13/2023

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F 684	Continued From page 1 § 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 interviews, clinical record review, and facility document review, the facility staff failed to provide medication in accordance with provider orders for 1 of 6 residents in the survey sample, Resident #3. The findings were: For Resident #3, the facility staff failed to administer the antibiotic as ordered by the provider. Resident #3's admission record listed diagnoses to include but not limited to, monoplegia of lower limb following cerebrovascular disease affecting right dominant side, type 2 diabetes mellitus with diabetic neuropathy, mood (affective) disorder, anxiety disorder, pneumonia, and urinary tract infection. An Admissions/Social Services Assistant's worksheet, provided by the administrator, assigned the resident a brief interview for mental status summary score of 15 out of 15. During a phone conversation with the facility ombudsman on 6/28/23 at 8:50 a.m., the ombudsman reported Resident #3 had not	F 684	1) Resident #3□s physician was notified, and the antibiotic therapy was extended to correct missed dose. 2) Any resident that has a new medication order has the potential to be affected by this deficient practice. A review of residents with new medication orders in the last week will be completed to ensure medications are available. 3) The DON or designee will re-educate all licensed nurses on procedure to obtain medications from the center□s onsite medication inventory cabinet when not available including the process for when to notify the physician and pharmacy. 4) The DON or designee will review order listing reports, Medication Administration Records, medication carts, and new admissions 5 X weekly X 12 weeks to ensure medications are available from onsite inventory or pharmacy and that the physician or pharmacy was notified as indicated. Findings will be reported to the QAA committee. 5) Date of compliance 7-28-23	

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F 684	Continued From page 2	F 684		

received antibiotics upon admission as ordered. Resident #3 was interviewed on 6/28/23 at 1:00 p.m. and said she had not received her antibiotic on the day she was admitted, nor had she received it for two more days.

The clinical record included a provider's order for Augmentin Oral Tablet 500-125 mg (Amoxicillin and Pot Clavulanate), give 1 tablet by mouth every 12 hours for infection for 7 days with a start date of 06/24/23 at 21:00. The first dose on 06/24/23 at 21:00 was not administered. A licensed practical nurse's (LPN) progress note regarding that dose read, "resident refused due to allergy to penicillin's [sic]". The next dose due, 06/25/23 at 09:00, was not administered with a different LPN's progress note which read, "Awaiting arrival from pharmacy".

The unit manager, a registered nurse (RN) documented a progress note on 06/25/23 at 16:40 that read, "Resident verbalized she could take the Augmentin with her penicillin allergy. This was reported to pharmacy so they could send medication ordered. Pharmacy advised the nurse could pull from stat box one Augmentin 250-125mg and on [sic] Amoxicillin 250mg to equal prescribed dose. MD notified and gave order to pull one Augmentin 250-125mg capsule and one amoxicillin 250mg capsule to equal the prescribed dose of Augmentin 500-125mg until correct dose arrives from pharmacy." According to the medication administration record (MAR), the following two doses were given as ordered.

The antibiotic order was updated to include the diagnosis of "acquired pneumonia" and extend the dates for administration to ensure the resident received all ordered doses.

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F 684	Continued From page 3	F 684		

The 06/26/23 21:00 dose was not administered. The LPN's progress note read, "medication not available from pharm or pull box". This LPN was not available for interview however the administrator, who was the facility's previous director of nursing, reported she had spoken to that LPN who was a new nurse and did not realize she could pull the two medications from the Cubex (medication dispenser machine) and combine them to equal the ordered medication. The administrator acknowledged this dose should have been given. The current DON had provided education to staff regarding pulling the medications from the Cubex. The administrator stated the first two doses Resident #3 did not receive was because the staff were awaiting clarification regarding the resident's penicillin allergy.

The facility's Cubex medication list was reviewed with the administrator and DON. The list included "AMOX TR-K CLV 250-125 MG TAB" and "AMOXICILLIN 250 MG CAPSULE". The administrator reported that these two medications given together would equal Resident #3's ordered antibiotic.

The off-site pharmacy manager was interviewed via phone on 06/28/23 at 2:59 p.m. He acknowledged Resident #3's antibiotic order was "going back and forth since 6/25/23" due to resident's allergies. The manager acknowledged the two medications available in the Cubex would be the same as the ordered antibiotic. The pharmacy manager and the facility's medical director had approved the medication and the extended time frame to ensure the resident received all ordered doses.

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F 684	Continued From page 4 This surveyor attempted to re-interview Resident #3 at approximately 3:30 p.m. however the administrator reported the resident had just been discharged home. The policy titled, "Medication Administration. Policy 5.3 GENERAL GUIDELINES FOR MEDICATION ADMINISTRATION" with an effective date of 06/21/2017 was reviewed and read in part, "Procedure... 9. If a medication is unavailable, contact the pharmacy and document accordingly." The administrator denied having a policy or procedure for how to pull medications from their Cubex. No further information was provided before the exit conference.	F 684		