STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495355		C 04/19/2018

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RADFORD HEALTH AND REHAB CENTER	700 RANDOLPH STREET RADFORD, VA 24141

(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 04/17/18 through 04/19/18. 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. The census in this 90 certified bed facility was 85 at the time of the survey. The final survey sample consisted of 18 current Resident reviews and 3 closed record reviews.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 4/17/18 through 4/19/18. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 90 certified bed facility was 85 at the time of the survey. The survey sample consisted of 24 current Resident reviews and 3 closed record reviews .	F 000		
F 578 SS=E	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	F 578		5/15/18

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

Electronically Signed — 05/15/2018

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 inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (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 accurately complete DDNR's (durable do not resuscitate orders) for four of 21 Residents, Residents #26, #71, #21, and #73. The findings included.	F 578	1. DNR□s for residents number 26, 21, and 73 were corrected immediately on 4/19/18. Resident number 71 had already discharged and was unable to be corrected. No negative outcome identified. 2. Any resident is at risk if their DNR is not	

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F 578	Continued From page 2 1. For Resident #26, Sections #1 and #2 of the Residents DDNR had been left blank. The record review revealed that Resident #26 had been admitted to the facility 03/27/18. Diagnoses included, but were not limited to, muscle weakness, charcot's joint, hypothyroidism, atherosclerotic heart disease, and chronic kidney disease. Section C (cognitive status) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 04/03/18 included a BIMS (brief interview for mental status) summary score of 13 out of a possible 15 points. The Residents EHR (electronic health record) included a DDNR order form from the Virginia Department of Health that had been signed and dated on 03/29/18. 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..." Both #1 and #2 were left unchecked. Section 2 read "If you checked 2 above, check A, B, or C below:" All three boxes had been left unchecked. The DON (director of nursing) was notified of the incomplete DDNR on 04/18/18 at approximately 1:15 p.m.	F 578	filled out properly. An audit of current patients was completed on 4/19/18 and any DNR forms found to be incomplete were corrected immediately. 3. Social Services staff, admissions staff, and licensed nursing staff will be educated on 5/16/18 to include proper completion of the DNR form. 4. Social Services Director or designee will audit 10% of DNR□s monthly x3 months to ensure they are properly filled out. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings. 5. May 31st, 2018	

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F 578	Continued From page 3 The administrative staff was notified of the incomplete DDNR during a meeting with the survey team on 04/18/18 at approximately 3:15 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #71, Sections #1 and #2 of the Residents DDNR had been left blank. The record review revealed that Resident #71 had been admitted to the facility 01/08/18. Diagnoses included, but were not limited to, traumatic hemorrhage or right cerebrum muscle weakness, paroxysmal atrial fibrillation, and hypertension. Section C (cognitive status) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 04/04/18 included a BIMS (brief interview for mental status) summary score of 12 out of a possible 15 points. The Residents EHR (electronic health record) included a DDNR order form from the Virginia Department of Health that had been signed and dated on 01/08/18. 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..." Both #1 and #2 had been left unchecked.	F 578		

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F 578	Continued From page 4 Section 2 read "If you checked 2 above, check A, B, or C below:" All three boxes had been left unchecked. The nurse consultant was notified of the incomplete DDNR on 04/18/18 at approximately 9:40 a.m. The administrative staff was notified of the incomplete DDNR during a meeting with the survey team on 04/18/18 at approximately 3:15 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference. 3. The facility failed to have a complete and accurate DDNR (Durable Do Not Resuscitate) for Resident #21. Resident #21 was admitted to the facility on 6/7/17 with the following diagnoses of, but not limited to anemia, atrial fibrillation, coronary artery disease, heart failure, high blood pressure and dementia. On the significant change MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 4/2/18; the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 10 out of a possible score of 15. Resident #21 was also coded as requiring limited assistance of 1 staff member for dressing, personal hygiene and being totally dependent on 1 staff member for bathing. The surveyor conducted a clinical record review of Resident #21 on 4/18/18. During this review, it was noted by the surveyor that the DDNR dated for 8/31/17 was not completely filled out. Section 1 of the DDNR read in part, "I further certify [must	F 578		

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F 578	Continued From page 5 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 beside #2 was checked. Section 2 read "If you checked 2 above, check A, B, or C below:" The three boxes below were blank. The surveyor notified the administrative team on 4/18/18 at 3:17 pm in the conference room. No further information was provided to the surveyor prior to the exit conference on 4/19/18. 4. The facility failed to have a complete and accurate DDNR (Durable Do Not Resuscitate) for Resident #73. Resident #73 was admitted to the facility on 1/22/18 with the following diagnoses of, but not limited to high blood pressure, end stage renal disease, arthritis and dementia. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/9/18; the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 12 out of a possible score of 15. Resident #73 was also coded as requiring extensive assistance of 1 staff member for personal hygiene and dressing and being totally dependent on 1 staff member for bathing. The surveyor conducted a clinical record review on Resident #73. During this review, it was noted by the surveyor that the DDNR dated for 1/22/18	F 578		

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F 578	Continued From page 6 was not filled out completely. Section 1 of 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 boxes beside #1 and #2 were blank. Section 2 read "If you checked 2 above, check A, B, or C below:" The three boxes below were blank. The surveyor notified the administrative team on 4/18/18 at 3:17 pm in the conference room. No further information was provided to the surveyor prior to the exit conference on 4/19/18.	F 578		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and employee file review, the facility staff failed to	F 607	1. Employees number 1, 2, 3, 4, 5, 24, 25, and 26 files were unable to be	5/15/18

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F 607	Continued From page 7 implement the written policies and procedures for 13 of 26 new employee files that were reviewed (Employee #1, #2, #3, #4, #5, #7, #15, #17, #22, #23, #24, #25 and #26). The findings included: The facility staff failed to implement the written policies and procedures for 13 newly hired employee files that were reviewed by the surveyor on 4/19/18 at 11 am. The surveyor had requested the following employee files on 4/19/18 at 9 am. The following documentation was noted to be missing from the following newly hired employees: " Employee #1 did not have the signature or date of the facility staff member that conducted the reference checks. " Employee #2 did not have the signature or date of the facility staff member that conducted the reference checks. " Employee #3 did not have the signature or date of the facility staff member that conducted the reference checks. " Employee #4 did not have the signature or date of the facility staff member that conducted the reference checks. " Employee #5 did not have the signature or date of the facility staff member that conducted the reference checks. " Employee #7 had a hire date of 5/16/17. The original license verification was performed on 5/16/17 with the expiration of the license noted to be 12/31/17. The next license verification was performed on 4/19/18 after the surveyor had requested this employee's file.	F 607	corrected as they are already hired and reference checks were not dated and/or signed. No negative outcome identified. Employees number 7, 15, 17, 22, and 23, have had current license verifications conducted and placed in their HR files. No negative outcomes identified. 2. Any resident is at risk if reference checks are not completed properly prior to the hire of an employee and if license verifications are not done when a license is renewed. Human Resource Generalist completed an audit of current employees on 5/10/18 to ensure current employees have reference checks signed and/or dated and employees have current license verifications. Any missing verifications were completed and placed in the employee's file. 3. Human Resource Generalist was educated on 5/10/18 to include the policy and proper procedure for completing reference checks and licensure verifications on all new hires and license verifications for current employees. 4. Administrator or designee will audit new hire files weekly x12 weeks to ensure reference checks are completed per policy prior to hire. Administrator or designee will audit 10% of HR files monthly to ensure license verifications completed per policy. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings.	

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F 607	Continued From page 8 " Employee #15 had a hire date of 9/5/16. The original license verification was performed on 8/13/17 with the expiration of the license noted to be 3/31/18. The next license verification was performed on 4/19/18 after the surveyor had requested this employee's file. " Employee #17 had a hire date of 8/8/16. The license verification was performed on 4/19/18 after the surveyor had requested this employee's file. " Employee #22 had a hire date of 8/8/17. The license verification was performed on 12/11/17. " Employee #23 had a hire date of 4/5/17. The original license verification was performed on 3/23/17 but the license was noted to have an expire date of 4/30/17. The next license verification was performed on 4/19/18 after the surveyor had requested this employee's file. " Employee #24 did not have the signature or date of the facility staff member that conducted the reference checks. " Employee #25 did not have the signature or date of the facility staff member that conducted the reference checks. " Employee #26 did not have any reference checks performed by the facility staff. The surveyor reviewed the missing information on each above employee as documented above with the administrator at 1:00 pm. The administrator stated, "I see where there is room for improvement based upon the information that we have discussed. The reference checks should had been performed then signed and dated to make them complete. The licenses were reviewed before giving the files to you. Some of them had to be verified this morning. The licenses that we reviewed that were expired, I went back and verified that these employees had	F 607	5. May 31st, 2018	

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F 607	Continued From page 9 been working." The surveyor requested the facility's policy on hiring of new employees. At 1:30 pm, the administrator provided a copy to the surveyor of the policy titled "Hiring Process, Evaluations, Employee Records, Resignations and Terminations". Under Section "B. References", it read in part, " ...Check all references before extending a job offer ...Sign (include job title) and date the reference." Under Section "C. License Verification", it read in part, "Obtain a copy of the license. Verify the license online through the Virginia Department of Health Professions ...before the hire date. Print copy of Primary Source Verification to maintain in file ..." No further information was provided to the surveyor prior to the exit conference on 4/19/18.	F 607		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders.	F 655		5/15/18

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F 655	Continued From page 10 (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to initiate and/or provide two of 21 Residents, with a copy or summary of their baseline care plan in a manner that the Resident and or representative could understand. Residents #280 and #180. The findings included. 1. For Resident #280, the facility staff failed to provide the Resident a copy/summary of their	F 655	1. Resident number 280 and 180 had their current care plan reviewed with them on 4/19/18 to ensure they understood their plan of care. No negative outcome identified. 2. All residents are at risk if a baseline care plan is not given in a language that the resident can understand. An audit of current admissions in the last 30 days was conducted on 5/11/18 to identify if baseline care plan was given and if	

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F 655	Continued From page 11 baseline care plan in a manner that the Resident could understand. The clinical record review revealed that Resident #280 had been admitted to the facility 04/16/18. Diagnoses included, but were not limited to, muscle weakness, diabetes, chronic kidney disease, benign prostatic hyperplasia, kidney transplant status, and end stage renal disease. There was no completed MDS (minimum data set) assessment on this Resident. However, the Resident was alert and orientated. The EHR (electronic health record) listed the Resident as his own responsible party. On 04/19/18 at 11:20 a.m., the surveyor interviewed Resident #280 regarding his baseline care plan. Resident #280 verbalized to the surveyor that he had received a copy of his care plan yesterday and stated a man had provided him with it. When asked if he understood it he stated "Well no" and he had given it to his mother so she could read it at her leisure. The MDS regional nurse consultant was notified of the problem regarding the Residents baseline care plan on 04/29/18. The regional nurse provided the survey team with a copy of the facility policy/procedure titled "Baseline Care plan Summary" at 1:30 p.m. on 04/29/18. This policy/procedure read in part, "...Any medical language in the above report should be clarified in language the patient/representative understands..." No further information regarding this issue was provided to the survey team prior to the exit	F 655	resident understood the document. Current care plan reviewed with Resident if he/she voiced not understanding the baseline care plan. 3. Administrator or designee will educate social services staff and nursing leadership on 5/16/18 to include the policy for distribution on baseline care plans to ensure that residents receive a baseline care plan in a language they can understand. 4. Administrator or designee will audit 10% of new admissions weekly x 12 weeks to ensure baseline care plan was given in a language in which the resident can understand. Any discrepancies will be addressed promptly and findings will be reported to the Quality Assurance committee for review and further analysis of findings. 5. May 31st, 2018	

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F 655	Continued From page 12 conference. 2. The facility staff failed to provide the baseline care plan to Resident #180 within 48 hours after admission and in a language that the resident could understand. The clinical record of Resident #180 was reviewed 4/17/18 through 4/19/18. Resident #180 was initially admitted to the facility 2/8/18 and readmitted 4/12/18 with diagnoses that included but not limited to benign prostatic hypertrophy (BPH), chronic respiratory failure with hypoxia, hyperlipidemia, multiple fractures of ribs, urine retention, chronic obstructive pulmonary disease, emphysema, gastro-esophageal reflux disease, hypertensive chronic kidney disease stage 3, muscle weakness, paroxysmal atrial fibrillation, pneumonia, anemia, sciatica, and nicotine dependence. Resident #180's 30 day minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/21/18 assessed the resident with a BIMS score (brief interview for mental status) as 12 out of 15. The surveyor interviewed Resident #180 on 4/18/18 about the admission process and the care he was receiving. When the resident was asked if he received a copy of the baseline care plan, the resident stated "he guessed he got a copy." The surveyor spoke with the minimum data set (MDS) licensed practical nurse #1 on 4/18/18 at 10:42 a.m. L.P.N. #1 stated the social workers were responsible for the baseline care plans. The surveyor spoke with the social worker (other	F 655		

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F 655	Continued From page 13 #1) on 4/18/18 at 10:46 a.m. Other #1 stated she would follow-up and see what had been documented. The social worker provided the "Immediate Needs Plan of Care" to the surveyor on 4/18/18. The format included headings for pain, needs assistance with ADLs (activities of daily living), cardiovascular concerns, nutritional, concerns, IV (intravenous) therapy, safety concerns/fall risk, skin concerns, adjustment to new environment, diabetic management, anticoagulant therapy, fracture, renal disease/dialysis, respiratory concerns, infection, catheter care, potential for wandering/elopement/abuse, allergies, potential for fluid imbalance, need for coordination of care with other healthcare agencies, continence status, behavior monitoring, and other focus areas. Resident #180 had the following "Immediate Need Plan of Care" items checked: pain, ADL assistance, cardiovascular concerns, safety, skin, adjustment to new environment, anticoagulant therapy, fracture, respiratory concerns, catheter care, and allergies. Under each of these headings were a series of "Focuses, Goals, and Interventions" checked for each of the above needs. None of the focuses, goals, and interventions were person centered. The surveyor interviewed MDS/LPN #1, MDS/LPN #2, and the corporate registered nurse #1 on 4/19/18 at 11:15 a.m. MDS/LPN #1 stated the team based admission assessment (TBAA) was usually done within 48 hours after the resident had been admitted. Resident #180's TBAA took place 2/9/18 and the	F 655		

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F 655	Continued From page 14 boxes for team members participating were checked: social services case manager, patient, RP (responsible party)/POA (power of attorney)/Family/Interested Party, Nursing representative, Business Office representative, Dietary Representative, Activities Representative, and Rehab Representative. A progress note dated 2/12/18 at 9:07 a.m. by the social worker assistant read "Baseline care plan given." The baseline care plan was more than 48 hours after the resident was admitted, there was no evidence who received the baseline care plan, the baseline care plan was not in a language the resident could understand, the baseline care plan did not include person centered focuses, goals and interventions, and did not address Resident #180's nutrional needs or continence needs. The surveyor informed the corporate registered nurse, MDS/LPN #1 and MDS/LPN #2 of concerns with Resident #180's baseline care plan on 4/19/18 at 1:26 p.m. The corporate registered nurse stated the baseline care plan is developed within 48 hours but not completed. The corporate registered nurse provided the surveyor with a copy of the facility policy for baseline care plans titled "Baseline Care Plan Summary." Procedure 3.b.i. read in part "Any medical language in the above report should be clarified in language the patient/representative understands. 4. The provision of the Baseline Care Plan Summary will be documented in the Progress Note section of the patient's electronic Medical Record as a Progress note in a reasonable timeframe. (For clarity, the date the plan was provided should be entered into the body of the progress if not	F 655		

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F 655	Continued From page 15 provided the same day the note is written)." The surveyor informed the administrative staff of the above concern on 4/18/18 at 3:17 p.m. No further information was provided prior to the exit conference on 4/19/18.	F 655		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657		5/15/18

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F 657	Continued From page 16 by: Based on Resident interview, staff interview, and clinical record review, the facility staff failed to review and revise the Residents comprehensive care plan for one of 21 Residents, Resident #1. The findings included. For Resident #1, the facility staff failed to review and revise the Residents CCP (comprehensive care plan) in regards to use of the Residents right arm for lab work and blood pressures. The clinical record review revealed that Resident #1 had been re-admitted to the facility 02/17/17. Diagnoses included, but were not limited to, end stage renal disease, aphasia, hemiplegia, chronic obstructive pulmonary disease, hypertension, peripheral vascular disease, and anemia. Section C (cognitive patterns) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 02/12/18 included a BIMS (brief interview for mental status) summary score of three out of a possible 15 points. Section O (special treatments/procedures/programs) had been checked to indicate the Resident was receiving dialysis. The Residents current order summary report included "No BP (blood pressure) or lab sticks in Left Arm..." The CCP included the focus area "...has a diagnosis of...CVA (cerebral vascular disease)...ASA (aspirin) and Plavix use with risk for bleeding, excessive bruising." Interventions included "No BP or VP (venipuncture) in either	F 657	1. Resident number 1 care plan updated on 4/19/18 to reflect correct arm to obtain a blood pressure from per physicians orders related to shunt placement. 2. Any resident is at risk if his or her care plan does not reflect the proper arm for obtaining a blood pressure per physician□s orders related to shunt placement. DON or designee completed an audit on 5/10/18 of current patients with shunts or ports implanted to ensure care plans reflect the physician□s current and accurate instructional interventions. 3. Licensed nursing staff will be educated on 5/16/18 to include the proper policy and procedure for updating care plans to reflect current physician instructional interventions or orders. 4. DON or designee will audit patients with shunts or ports weekly x12 weeks to ensure care plans reflect proper arm to obtain vitals in per physician orders. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings. 5. May 31st, 2018	

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F 657	Continued From page 17 arm." The MDS/care plan nurse was asked about the conflicting information regarding the use of the right and left arm for lab draws and blood pressures on 04/19/18 at approximately 10:15 a.m. On 04/19/18 at 10:20 a.m., the surveyor spoke with Resident #1. When asked if they still had a dialysis access in their right arm the Resident shook their head no. On 04/19/18 at 11:20 a.m., the MDS nurse verbalized to the surveyor that they had obtained clarification on the Residents use of their right arm for blood draws and stated that we can now use the right arm. When asked if the care plan should have been updated to reflect that previously she stated it should have been. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 657		
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, family interview, staff interview and clinical record review, the facility staff failed to provide ADL care to 1 of 18 dependent residents (Resident #63).	F 677	1. Resident number 63 face was cleaned and fingernails were cleaned and trimmed immediately on 4/18/18. On 4/19/18 the resident had his beard trimmed by facility beautician as per the resident and	5/15/18

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F 677	Continued From page 18 The findings included: The facility staff failed to provide ADL care to Resident #63. Resident #63 had crumbs of food in his beard and dirty fingernails on his left hand. Resident #63's clinical record was reviewed 4/17/18 through 4/19/18. Resident #63 was admitted to the facility 12/1/17 with diagnoses that included but not limited to cerebral amyloid angiopathy, epilepsy, abdominal aortic aneurysm without rupture, hypertension, long term use of aspirin, dementia with behavioral disturbances, anemia, anxiety/depression, benign prostatic hypertrophy (BPH), urinary frequency, insomnia, edema, congestive heart failure (CHF), constipation, pneumonia, and acute encephalopathy, s/p (status post) brain biopsy. Resident #63's significant change in minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/16/18 assessed the resident with a brief interview for mental status (BIMS) as 3 out of 15. Resident #63 was assessed to require extensive assistance of 2 persons for bed mobility, transfers, dressing, toileting, and personal hygiene. Resident #63 required extensive assistance of one person for eating and was totally dependent on one person for bathing. Current comprehensive care plan identified that Resident #63 needed assistance with bathing and hygiene. The surveyor observed Resident #63 on 4/18/18 during breakfast at 8:20 a.m. in the dining room. A certified nursing assistant (C.N.A.) was feeding the resident a croissant, sausage, and the resident had a coke.	F 677	responsible party request. 2. Any resident is at risk if they have food debris in their facial hair or if their facial hair is longer than desired. DON or designee audited current residents on 5/9/18 with facial hair to ensure they are free of food debris and facial hair is at a length at which the resident prefers. Any resident is at risk if their fingernails are not clean and maintained at an acceptable length. DON or designee audited current patients on 5/9/18 to ensure fingernails were trimmed and clean. 3. Licensed and certified nursing staff will be educated on 5/16/18 to ensure patients faces are free of debris after meal time and that patient□s facial hair is kept at a length that is acceptable to the patient and that patient□s fingernails are clean and trimmed. 4. DON or designee will observe 10% of patients weekly x12 weeks to ensure their faces are clean of food debris and that facial hair is at an acceptable length for the patient and that fingernails are clean and trimmed. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings. 5. May 31st 2018	

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F 677	Continued From page 19 The surveyor interviewed the wife by telephone on 4/18/18 at 10:04 a.m. The resident's wife stated she had concerns about the resident's beard and the beard not being maintained (cut). The facial hair was long and in need of a trim. The surveyor informed the administrator of the interview with the wife on 4/18/18 and the concerns she had voiced. The surveyor observed the resident on 04/18/18 10:07 AM in the small activity/dining room sitting in a reclining wheelchair. The surveyor observed breadcrumbs in his beard. The resident's left pinkie and middle finger had a brown type substance on them. The surveyor spoke with Resident #63's wife on 4/18/18 at 3:10 p.m. Resident #63's wife here to visit and concerned with multiple issues. The surveyor and the wife observed food debris (breadcrumbs) present in resident's beard. The wife stated "This is unacceptable" when she observed Resident #63's beard, hands and clothes. Wife concerned hands are dirty and clothes are dirty. The surveyor informed the director of nursing and the assistant director of nursing of these concerns with food in the resident's beard, brown debris on fingers and the left cuff of resident's shirt with a brown substance on it. The wife stated, "I wonder if his hands are ever washed." Two C.N.A.s came promptly to attend to the resident's beard and hands. The surveyor informed the administrative staff of the concerns with Resident #63's ADL care during the end of the day meeting on 4/18/18 at 3:17 p.m. No further information was provided prior to the	F 677		

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F 677	Continued From page 20 exit conference on 4/19/18.	F 677		
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 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview, clinical record review, and facility document review, the facility failed to ensure the Residents highest practicable well-being for one of 21 Residents, Resident #34. The findings included: For Resident #34, the facility staff failed to follow their bowel protocol. The record review revealed that Resident #34 had been admitted to the facility 02/13/18. Diagnosis included, but were not limited to, hypertension, gastro-esophageal reflux disease, osteoarthritis, depressive disorder, insomnia, and psoriasis. Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 02/20/18 included a BIMS (brief interview for mental status) summary score of 15 out of a	F 684	1. Resident number 34 had a bowel movement on 4/12/18 and since the timeframe identified that she had not had one. No negative outcome identified. 2. Any resident is at risk if he or she has not had a bowel movement for more than 3 days. DON or designee audited current residents on 5/8/18 to ensure that current residents have not gone greater than 3 days without a bowel movement and that a proper medical intervention has been implemented as per Physician review as required. 3. Licensed nursing staff will be educated on 5/16/18 to include following appropriate physician orders which are to be implemented on residents who have not had a bowel movement in greater than 3 days. 4. DON or designee will audit clinical PCC	5/15/18

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F 684	Continued From page 21 possible 15 points. Section G (functional status) was coded to indicate the Resident required extensive assistance of one person for toileting and personal hygiene. A review of the Residents bowel movement sheets for the last 30 days revealed that Resident #34 had a BM (bowel movement) on 04/12/18 but did not have another BM until 04/18/18. During an interview with Resident #34 on 04/17/18 at 03:23 p.m., the Resident stated she had not had a BM since Friday. When asked if she had reported this to anyone she stated she had not. The current order summary report indicated that the Resident was receiving colace 100 mg 2 capsules by mouth at bedtime for constipation. During an interview with the DON (director of nursing) on 04/19/18 at approximately 10:35 a.m., the DON verbalized to the surveyor that the facility staff should be reviewing the Residents BM's. A review of the facility procedure in regards to constipation read "Constipation (no BM X 3 days) a. Give Miralax daily X 1 day b. If not (sic) results use Dulcolax suppository X 1 c. Check for presence of stool in rectum d. If no results give fleets enema X 1 e. If no results, notify provider for further instructions" A review of the Residents eMARs (electronic medication administration records) revealed that	F 684	dashboard no less than 5 days a week x4 weeks then weekly x8 weeks to ensure residents who are identified as no bowel movement for greater than 3 days have had proper medical intervention. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings. 5. May 31st 2018	

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F 684	Continued From page 22 the bowel protocol had not been followed. The Residents CCP (comprehensive care plan) included the focus area "...is receiving medication to help prevent constipation with risk for related dehydration." Interventions included, but were not limited to, administer medication as ordered, encourage resident to sit on toilet to evacuate bowels if possible, follow facility bowel procedures for bowel management, observe for medication side effect of constipation, and observe/document/report to MD PRN (as needed) s/sx (sign/symptoms) of complications related to constipation. The administrative staff were notified of the problems regarding the Residents BM's on 04/18/18 at approximately 3:15 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 684		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review the facility staff failed to coordinate care with the dialysis center for one of 21 Residents (Resident #1) in regards to pre and post dialysis weights.	F 698	1. Resident number 1 weights were obtained from dialysis and placed in the clinical record on 4/19/18. 2. Any dialysis resident is at risk if weights	5/15/18

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F 698	Continued From page 23 The findings included. For Resident #1, the facility staff failed to obtain the Residents pre (before) and post (after) dialysis weights from the dialysis unit. The clinical record review revealed that Resident #1 had been admitted to the facility 02/17/17. Diagnoses included, but were not limited to, end stage renal disease, aphasia, hemiplegia, chronic obstructive pulmonary disease, hypertension, peripheral vascular disease, and anemia. Section C (cognitive patterns) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 02/12/18 included a BIMS (brief interview for mental status) summary score of three out of a possible 15 points. Section O (special treatments/procedures/programs) had been checked to indicate the Resident was receiving dialysis. The Residents current order summary report included orders to "Obtain post Dialysis Weight every M-W-F..." A review of the dialysis communication sheets revealed that the facility had failed to obtain weights from the dialysis center on 11/22 (pre/post), 11/24 (pre), 11/27 (pre/post), 11/29 (pre), 12/01 (pre), 12/04 (pre/post), 12/06 (pre/post), 12/18 (pre), 12/20 (pre/post), 12/27 (pre/post), 12/29 (pre/post), 01/05/18 (pre/post), 01/08 (pre/post), 01/12 (post), 01/15 (pre/post), 01/19 (pre/post), 01/22 (pre/post), 01/26 (pre/post), 01/29 (pre/post), 02/16 (pre/post), 03/11 (pre/post), 03/28 (pre/post), 03/30	F 698	are not maintained in the residents clinical record. DON or designee completed an audit on 5/10/18 of current patients on dialysis to ensure weights were available in the applicable resident□s clinical record. 3. Licensed nursing staff will be educated 5/16/18 to ensure dialysis weights are properly entered in the applicable resident□s clinical record. 4. DON or designee will audit patients on dialysis weekly x12 weeks to ensure dialysis weights are in the clinical record. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings. 5. May 31st, 2018	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RADFORD HEALTH AND REHAB CENTER	700 RANDOLPH STREET RADFORD, VA 24141

(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 698	Continued From page 24 (pre/post), and 04/09 (pre/post). The dialysis services agreement read in part, "...Obligations of the ESRD (end stage renal disease) dialysis unit...To provide to the Nursing Facility information on all aspects of the management of the ESRD Resident's care related to the provision of Services..." The DON (director of nursing) was notified of the missing weights on 04/17/18 at approximately 02:05 p.m. On 04/17/18 at approximately 2:35 p.m., the DON stated she was attempting to get additional weights from dialysis. On 04/17/18 at approximately 3:00 p.m., the DON provided the surveyor with pre and post weights from the dialysis center. The DON stated she had called the dialysis center and asked them to send them to the facility. Per the pre populated time and date stamp on this form they were received at the facility on 04/17/18 at 2:52 p.m. The administrative staff was notified of this issue during a meeting with the survey team on 04/18/18 at approximately 3:15 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 698		