STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 1/18/17 through 1/20/17. Corrections are required for complaince with 42CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey report will follow. The census in this 98 certified bed facility was 85 at the time of the survey. The survey consisted of 18 current Resident reviews (Resident #1 through #14 and includes #18). There were 3 closed record reviews conducted (Resident #15 through #17).	F 000		
F 167 SS=C	RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE CFR(s): 483.10(g)(10)(i)(11) (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and	F 167		3/1/17

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

Electronically Signed | 02/17/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 167	Continued From page 1 (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to post the results of the most recent life safety code survey and failed to post a notice of the availability of the last three preceding year's survey results and their corresponding plan of corrections. The findings included: During the initial tour of the facility on 1/18/17 at 12:40 p.m., the surveyor observed the survey result book located near the wing 1 nurse ' s station and activity area/dining room. The survey book was attached by a chain to the bulletin board. The surveyor reviewed the contents of the survey book. The survey book contained the most recent survey dated 3/3/16, a letter sent from the Virginia Department of Health Office of Licensure and Certification dated 3/10/16, and a second letter dated 5/13/16. The surveyor was unable to locate the most current life safety code survey report. There was no posting or notification indicating where the last three preceding year's survey results were available for review. The surveyor informed the administrator of the above concern on 1/18/17 at 4:30 p.m.	F 167	1. A memo about the results of our most recent survey and availability of previous surveys was created and posted at the front desk in a place readily accessible to residents, families, and legal representatives. A resident council meeting has been scheduled to communicate the location of posted survey results. 2. All residents have the potential to be affected from improper posting of survey results. 3. Upon completion of each annual and/or complaint survey including POC and LSC inspection, Administration will ensure results are posted per regulation. Posted notice of report availability will remain at the front desk. 4. Administration will periodically monitor for posting of latest inspections and continue to ensure that three years of results are available. 5. The memo was written and posted at the front desk on 2/9/17. Resident council meeting will take place on 3/1/17.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 167	Continued From page 2 A second surveyor conducted a group meeting with fifteen (15) residents of the facility on 1/19/17. During this meeting, only two of the fifteen residents verbalized to surveyor #2 that they were aware of where the current survey results were kept. The administrative staff were notified of the above concern during an end of the day meeting on 1/19/17 at 1:10 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference on 1/20/17.	F 167		
F 272 SS=D	COMPREHENSIVE ASSESSMENTS CFR(s): 483.20(b)(1) (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status.	F 272		1/31/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 272	Continued From page 3 (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure a complete and accurate Care Area Assessment (CAA) for 4 of 18 residents in the sample survey (Resident #1, Resident #8, Resident #5, and Resident #6). The findings included: 1. The facility staff failed to ensure Section V Care Area Assessment (CAA) Summary of the significant change in assessment MDS (minimum data set) with an assessment reference date (ARD) of 12/29/16 was accurate for Resident #1. The facility staff failed to document in the	F 272	1. 100% of comprehensive assessments, section V, CAA summaries were reviewed for compliance with identifying date/location of the CAA information. No residents were negatively affected by the deficient practice. 2. Any other resident with a comprehensive assessment has the potential to be affected by the deficient practice. 3. All Comprehensive Assessments,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 272	Continued From page 4 "Location and Date of CAA Documentation" where the supporting documentation could be located in the clinical record for communication, mood state, behavioral symptoms, and dental care. Resident #1's clinical record was reviewed 1/18/17 and 1/19/17. Resident #1 was admitted to the facility 8/19/15 and readmitted 11/14/16 with diagnoses that included but not limited to altered mental status, dementia with psychotic features, skin melanoma, hypertension, acute encephalopathy, anxiety, squamous cell carcinoma, depression, and calcified gallstone. Continued review of the clinical record revealed a significant change in assessment MDS with an assessment reference date (ARD) of 12/29/16. The facility staff coded Resident #1 with a Cognitive Summary Score of 5 out of 15. In Section V. Care Area Assessment (CAA) Resident #1 "triggered" for and the decision made to care plan the following: Cognitive Loss/Dementia, Communication, ADL (activities of daily living) Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Mood State, Behavioral Symptoms, Falls, Nutritional Status, Dental Care, Pressure Ulcer, Psychotropic Drug Use, and Physical Restraints. The facility staff failed to document in the "Location and Date of CAA documentation" where the supporting documentation could be located in the clinical record for these areas: communication, mood state, behavioral symptoms, and dental care. Each triggered area read "CAA WS (worksheet) dated 1/11/17." The surveyor interviewed registered nurse #1 (MDS) on 1/19/17 at 11:00 a.m. The surveyor asked RN #1 for the CAA worksheets. The surveyor reviewed the CAA worksheets but was unable to locate documentation that supported	F 272	Section V, are reviewed by MDS RN for compliance with the date/location of CAA information. 4. Comprehensive Assessments, Section V, CAA documentation will be monitored Q week for 12 weeks by the MDS RN. A weekly report will be forwarded to the Administrator/Designee for review. Report of the deficiency and POC will be communicated at the next quarterly QA meeting. 5. Corrective Action was complete the week of 1/31/17.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 272	Continued From page 5	F 272		

the triggered areas. The surveyor informed RN #1 that there was no documentation of dates/location for the triggered areas supporting information. R.N. #1 stated that information was missing from the CAA.
The surveyor informed the administrative staff of the above finding on 1/19/17 at 1:10 p.m.
No additional information was provided prior to exiting the facility on 1/20/17 as to why the facility staff failed to ensure a complete and accurate CAA Summary for Resident #1.
2. The facility staff failed to ensure the CAA (Care Area Assessment) Summary in Section V included the dates and location of supporting information for the triggered areas for Resident #8.
The clinical record of Resident #8 was reviewed 1/18/17 and 1/19/17. Resident #8 was admitted to the facility 5/27/15 and readmitted 9/29/15 with diagnoses that included but not limited to hypoglycemia, encephalopathy, diabetes mellitus, dementia in Alzheimer's disease, lumbar compression fracture (L1 and L5), hyperkalemia, peripheral vascular disease, Vitamin D deficiency, dermatitis of scalp and face, transient ischemic attacks, and urinary tract infections.
The annual minimum data set (MDS) with an assessment reference date (ARD) of 9/29/16 assessed the resident with short term memory problem, long term memory problem, and severely impaired skills for daily decision making. Resident #8 was without psychosis. Resident #8 was assessed to have physical behavioral symptoms directed at others and was assessed with inattention and disorganized thinking that was present continuously. Section V Care Area Assessment Summary identified the following triggered and care planned areas: Cognitive Loss/Dementia, Communication, Urinary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 272	Continued From page 6	F 272		

Incontinence and Indwelling Catheter, Psychosocial Well-Being, Behavioral Symptoms, Falls, Nutritional Status, Pressure Ulcer, Psychotropic Drug Use, and Physical Restraints. Under the "Location and Date of CAA Documentation", these triggered areas had no documentation of the location/dates of supporting information in the clinical record: communication, psychosocial well-being, behavioral symptoms, and physical restraints. Each of the triggered areas read "CAA WS (worksheet) dated 10/7/2016."
The surveyor interviewed registered nurse #1 (MDS) on 1/18/17 at 1:15 p.m. The surveyor asked RN #1 for the CAA worksheets. After reviewing the CAA worksheets, RN #1 stated there were no dates/location for the supporting information for triggered areas. R.N. #1 stated the information was missing.
The surveyor informed the administrative staff of the above finding on 1/19/17 at 1:10 p.m.
No additional information was provided prior to exiting the facility on 1/20/17 as to why the facility staff failed to ensure a complete and accurate CAA Summary for Resident #8.
3. For Resident #6, the facility staff failed to include the location of the CAA documentation in section V (care area assessment (CAA) summary) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 08/16/16.

Resident #6 was admitted to the facility on 12/15/15. Her diagnoses include but are not limited to: anxiety, anemia, psychosis, pacemaker, edema, major depressive disorder, and insomnia.

Resident #6's minimum data set (MDS)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 272	Continued From page 7	F 272		

assessment, with an assessment reference date (ARD) of 12/7/16 assessed her to usually understand and could usually be understood. Section C (cognitive patterns) of this assessment coded the resident to have short and long term memory problems with moderately impaired decision making. Section B coded the resident to understand and to be understood. In section N she was coded to have received antianxiety medication.
Her assessment revealed in section G, she needed assistance with daily activities of living.

The directions under section V of this assessment read in part: "3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found."

Under the column labeled "Location and Date of CAA documentation" for the area of visual function, dental, behavioral symptoms, and communication. "The actual date and location(s) regarding the documentation was not recorded in section V. The reader was referred to " see CAA work sheet. The surveyor looked at the CAA work sheet, but it did not reveal the required information.

On 1/19/17 at approximately 2:55 p.m., the surveyor and MDS nurse #1 reviewed the Section V and CAA worksheets. During this review, the MDS nurse #1 was asked if the information was in the CAA work sheet and she stated, " It won ' t be there. "

The administrative team was made aware of the MDS concerns on 1/19/17 during the end of the day meeting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 272	Continued From page 8	F 272		

No further information regarding this issue was provided to the survey team prior to the exit conference.
4. The facility staff failed to document the dates of when the documentation could be found in Resident #5's clinical record for Section V of the Care Area assessment (CAA) Summary of the Minimum Data Set (MDS).

Resident #5 was admitted to the facility on 9/16/16 with the following diagnoses of, but not limited to major depressive disorder, atrial fibrillation, high blood pressure, dementia, stroke, and dysphagia. The resident was coded on the significant change MDS with an ARD (Assessment Reference Date) of 11/11/16 as having a BIMS (Brief Interview for Mental Status, an assessment tool) score of 15 out of a possible score of 15. Resident #5 was also coded as requiring extensive assistance from 1 staff member for personal hygiene, bathing and dressing.

The surveyor reviewed the clinical record of Resident #5 on 1/18/17. The surveyor noted that on the MDS with an ARD of 11/11/16 in Section V of the CAA Summary the dates and locations of the documentation to support the triggered area for the following were not properly documented: Psychotropic Drug Use, ADL (Activities of Daily Living) Functional and Urinary Incontinence.

The MDS nurse #1 and director of nursing (DON) was interviewed on 1/19/17 at approximately 11am by the surveyor. The surveyor notified these staff members that on the CAA summary and CAA Worksheets for Resident #5 the following above documented areas were not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 272	Continued From page 9 properly documented with dates and locations of where the documentation could be found. The MDS nurse #1 stated "I didn't know we had to out the location and dates so the documentation could be referred back to. I have only been putting MDS with the ARD of whatever it was." The administrative team was notified of the above documented findings in the end of the day conference on 1/19/17 at approximately 2 pm by the surveyor. No further information was provided to the surveyor prior to the exit conference on 1/20/17.	F 272		
F 278 SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly-	F 278		1/31/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 278	Continued From page 10 (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview, and clinical record review, the facility staff failed to ensure an accurate Minimum Data Set (MDS) for 2 of 18 residents (Residents #2 and #9). The findings include: 1. The facility staff failed to ensure a diagnoses of psychosis was included in the MDS for Resident #2. Resident #2 was admitted to the facility on 9/4/12 with diagnoses of dementia, depression, hypertension, diabetes, anxiety, osteoporosis, chronic obstructive pulmonary disease, and renal insufficiency. The resident was given an additional diagnosis of psychosis on 10/24/16 when the physician gave a telephone order on 10/23/16 for the antipsychotic medication, Haldol 5 mg IM every 4 hours prn (as needed). The current significant change MDS with a reference date of 12/12/16 assessed the resident with short and long term memory deficit and	F 278	1. Modifications were completed during survey to include the Psychosis Diagnosis for the Haldol usage on most recent MDS's for residents #2 and #9. 2. Effective 1/23/17, the three additional residents with PRN Haldol usage, were reviewed to insure the psychosis diagnosis was included in Section I of the most recent MDS. 3. Random MDS's will have diagnosis reviewed and cross-referenced with the physicians orders to insure all proper current diagnosis are denoted in Section I. 4. The MDS RN will monitor randomly three residents weekly x 2 months for adherence to Section I diagnosis. Monitor will be forwarded to the Administrator/designee for review and onto QA committee. 5. The random monitor began on 1/31/17.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 278	Continued From page 11	F 278		

severely impaired for decision making. The resident required extensive assistance of 1 person for bed mobility, transfers, dressing,eating, toileting, bathing, and hygiene.

The clinical record was reviewed The physician had ordered the antipsychotic medication, Haldol, on 10/23/16 and gave the diagnosis of psychosis on 10/24/16 for the use of the Haldol.

Section "I" of the significant change MDS with a reference date of 12/12/16 for "Active Diagnoses" did not contain the diagnosis for psychosis.

The MDS coordinator (RN#3) was interviewed on 1/18/17 at 1:00 p.m. RN#3 stated the diagnosis should have been included and provided a correction to the MDS.

The administrator, director of nursing, and CEO were informed of the findings during a meeting with the survey team on 1/19/17 at 9:00 a.m.

2. The facility staff failed to ensure a diagnoses of psychosis was included in the MDS for Resident #9.

Resident #9 was admitted to the facility on 8/16/16 with diagnoses of psychosis, dementia with behavior, bipolar disease, seizure disorder, stroke, hypertension, osteoarthritis, and glaucoma.

The current significant change MDS with a reference date of 11/15/16 assessed the resident with a cognitive score of "9" of "15". The resident required supervision to extensive assistance of 1 person for bed mobility, transfers, dressing, eating, toileting, bathing, and hygiene.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 278	Continued From page 12 The clinical record was reviewed. The physician had ordered the antipsychotic medication, Haldol 5 mg IM every 4 hours prn (as needed), on 9/26/16 for frequent psychotic episodes in the evenings. Section "I" of the significant change MDS with a reference date of 11/15/16 for "Active Diagnoses" did not contain the diagnosis for psychosis. The MDS coordinator (RN#3) was interviewed on 1/18/17 at 3:30 p.m. RN#3 stated the diagnosis should have been included and provided a correction to the MDS. The administrator, director of nursing, and CEO were informed of the findings during a meeting with the survey team on 1/19/17 at 9:00 a.m.	F 278		
F 309 SS=E	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 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	F 309		3/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 309	Continued From page 13 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (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, facility document review, and clinical record review, the facility staff failed to provide services for the highest practicable well-being for 5 of 18 Residents, Residents #6, #1, #8, #11, and #5. The findings include: 1. The facility staff failed to provide non-pharmacological interventions for pain for Resident #6 prior to the administration of Ultram a pain medication. The clinical record of Resident #6 was reviewed on 1/18/17 through 1/19/16. Resident #6 was admitted to the facility on 12/15/15 with diagnoses that included, but were not limited to: anxiety, anemia, psychosis, pacemaker, edema, major depressive disorder, and insomnia.	F 309	1. There is no specific corrective action allowable for resident #1, #5, #6, #11. The TED hose for resident #8 were applied during survey. No ill-effects were caused to the residents identified in these deficient practices. 2. All residents with pain medications ordered have the potential to be affected by the deficient practice. There are no other residents with daily weight orders. All residents with TED hose ordered have the potential to be affected by this deficient practice. All residents with new or re-ordered medications have the potential to be affected by this deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 309	Continued From page 14 Resident #6 ' s most recent MDS (minimum data set) assessment completed on this resident was a quarterly assessment with an ARD (assessment reference date) of 12/7/16. Section C (cognitive patterns) of this assessment coded the resident to have short and long term memory problems with severely impaired decision making. In section B, the resident was coded to usually understand and to usually be understood. In section J, she was coded to have pain. The current comprehensive care plan initiated 6/28/16 included a focus area that read "Resident is on scheduled pain med ... received x1 prn during look back. " Goal: " the resident will not have an interruption in normal activities due to pain through the review date. " Interventions: "administer analgesia as per orders. Give ½ hour before treatments or care. Monitor/document for probable cause of each pain episode. Remove/limit causes where possible. Notify physician if interventions are unsuccessful or if current complaint is a significant change from resident ' s past experience of pain." There were no non-pharmacological interventions in the care plan with a date prior to 1/19/2017. Review of the Resident ' s current physician ' s summary of orders dated 1/1/17 revealed Resident #6 had an order for Ultram 50 mg one four times a day as needed for pain (PRN). Resident #6 ' s PRN medication documentation sheet revealed she received pain medication on 1/5/17 at 5:00pm for complaint of pain in her foot. There was no documentation of the results to indicate if the medication was effective. There was no documentation in the nurse ' s progress noted to indicate if non-pharmacological	F 309	3. In order to address the failure to provide non-pharmacological interventions and effectiveness of pain medications, the PRN medication sheet will be revised to include "action prior to med administration" and "Follow-up if needed". The daily weight tracking sheet has been eliminated to prevent multiple places of documentation and daily weight orders have been added to the MAR to include the weight. Re-education will be provided to the nurses and C.N.A.'s on utilizing the residents care plan to identify those residents with TED hose ordered. A copy of the available medications in the medication dispense system(facility on-hand emergency med supply) will be placed in the front of each MAR book and the medication tracking log of unavailable medications will be revised to include instructions if medication is not in the med cart. 4. Each on-coming charge/med nurse will monitor the previous shifts PRN sheets for appropriate documentation of non-pharmacological interventions and required follow-up if medication not effective daily X 2 months beginning 3/3/17. The monitoring tool will be put in the DON's designated box daily x 2 months. The Nursing Secretary/Dietary Manager will monitor documentation of daily weights 5X/wk x 4 wks, then weekly with report provided to sub QA-At risk team meeting or DON. The DON/designee will randomly check a sample of residents with TED hose ordered 3X/wk X 1 month, then wkly X 3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 309	Continued From page 15 interventions had been tried prior to the administration of the medication. The Resident ' s PRN medication documentation sheet revealed she received pain medication on 1/5/17 at 11:30pm for complaint of (C/O) pain " not saying where " . The documentation of the results indicated the medication was effective. There was no documentation in the nurse ' s progress notes to indicate if non-pharmacological interventions had been tried prior to the administration of the medication. On 1/8/17, the resident ' s PRN medication documentation sheet revealed she received pain medication at 12:15am for complaint of pain in her foot. There was no documentation of the results to indicate if the medication was effective. There was no documentation in the nurse ' s progress notes to indicate if non-pharmacological interventions had been tried prior to the administration of the medication. There was no documented non-pharmacological intervention prior to the administration of the pain medication for any of the above dates and times when Resident #6 complained of pain. The failure of the facility to provide non-pharmacological interventions for resident complaints of pain was discussed with the administrative staff on 1/19/17. No further information was provided prior to the exit conference on 1/20/17. 2. The facility staff failed to follow physician orders for Resident #1. The facility staff failed to obtain daily weights for Resident #1 as physician ordered on 11/14/16.	F 309	months. The DON/designee will review the medication tracking log for unavailable medications 2X/wk X 3months. Deficiency items and POC will be reviewed at next quarterly QA meeting. 5. The PRN medication sheet will be revised by 3/2/17 and the Medication tracking log will be revised by 2/21/17. Daily weights will be added to the MAR 2/1/17. Education to C.N.A.'s on utilizing the Care Plan for TED hose orders will occur 3/1&3/17 at monthly in-service and Charge/Med nurses on 3/2/17. Education to Charge/Med nurses on the form revisions and utilization of resident care plans will be complete by 3/2/17.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 309	Continued From page 16	F 309		

Resident #1's clinical record was reviewed 1/18/17 and 1/19/17. Resident #1 was admitted to the facility 8/19/15 and readmitted 11/14/16 with diagnoses that included but not limited to altered mental status, dementia with psychotic features, skin melanoma, hypertension, acute encephalopathy, anxiety, squamous cell carcinoma, depression, and calcified gallstone.
Continued review of the clinical record revealed a significant change in assessment MDS with an assessment reference date (ARD) of 12/29/16.
The facility staff coded Resident #1 with a Cognitive Summary Score of 5 out of 15.
The current comprehensive care plan revised 1/11/17 had the focus area of nutrition. The focus area read "Resident #1 has a nutritional problem r/t (related to) mechanically altered, therapeutic diet. Resident has lost weight, large amount of weight since initial admission; various interventions are in place to increase weight. Numerous interventions have been implemented in the past. Is on Marinol for the second month now. ST (speech therapy) has seen resident many times. RD (registered dietician) is involved. Interventions: Monitor/record/report weights-Inform MD of sign (significant) weight changes."
The readmission orders dated 11/14/16 and continued on the January 2017 physician order sheet read "Weigh daily. Review with RD weekly."
The surveyor reviewed the daily weight sheet for November 2016. There were no weights recorded for twelve days in November 2016 starting 11/14/16 on the daily weight record. Resident #1 refused to be weighed on 11/20/16. The monthly weight record had three recorded weights-11/14/16, 11/21/16 and 11/28/16). November weights not obtained were 11/15/16, 11/17/16, 11/18/16, 11/19/16, 11/21/16, 11/22/16,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 309	Continued From page 17	F 309		

11/23/16, 11/27/16, 11/29/16, and 11/30/16. Ten weights were not obtained.
The surveyor was unable to locate the daily weight record for December 2016. The December 2016 medication administration record (MAR) had initials that a weight was obtained from 12/1/16 through 12/13/16, on 12/16/16, and on 12/21/16; however, there were no recordings of the actual weights on the December 2016 MAR or in the December 2016 nurse ' s notes. The December 2016 MAR had no evidence weights were obtained on 12/14/16 and 12/15/16, 12/17/16 through 12/20/16, and 12/22/16 through 12/31/16. There were no initialed boxes on the MAR for these dates. Initials in a box indicated care had been provided. The only weights documented were on the monthly weights and vital signs charts and those dates were 12/12/16, 12/19/16, and 12/26/16. There was no evidence weights were obtained in December 2016 for 28 days.
The January 2017 daily weight record had no recorded weights for 1/1/17, 1/3/17, 1/5/17, 1/8/17, 1/11/17 through 1/13/17. The January 2017 medication administration record (MAR) indicated weights were obtained on 1/3/17, 1/6/17-1/8/17, 1/10/17, 1/11/17, and 1/13/17. January weights not obtained were 1/1/17 and 1/3/17.
The surveyor informed the director of nursing of the concern with the daily weights ordered on 11/14/16 and unable to locate all of the weights on 1/18/17 at 3:25 p.m. The DON stated the weights could be on the 24 hour report, on the daily weight record, in the nurse's notes or on the medication administration record. The DON was asked to locate the weights from 11/14/16 to present time.
The surveyor interviewed the registered dietician

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 309	Continued From page 18	F 309		

on 1/19/17 at 10:00 a.m. The RD stated Resident #1's weights were changed to weekly on 1/5/17 and the RD stated she would continue to monitor the resident for weight loss.
The surveyor informed the administrative staff of the above concern with daily weights not obtained in the end of the day meeting on 1/19/17 at 1:10 p.m.
No further information was provided about Resident #1's daily weights prior to the exit conference on 1/20/17.
3. The facility staff failed to follow Resident #8's physician ' s orders to apply TED (thromboembolic disease) hose in the morning and take off at bedtime.

The clinical record of Resident #8 was reviewed 1/18/17 and 1/19/17. Resident #8 was admitted to the facility 5/27/15 and readmitted 9/29/15 with diagnoses that included but not limited to hypoglycemia, encephalopathy, diabetes mellitus, dementia in Alzheimer's disease, lumbar compression fracture (L1 and L5), hyperkalemia, peripheral vascular disease, Vitamin D deficiency, dermatitis of scalp and face, transient ischemic attacks, and urinary tract infections.
The annual minimum data set (MDS) with an assessment reference date (ARD) of 9/29/16 assessed the resident with short term memory problem, long term memory problem, and severely impaired skills for daily decision making. Resident #8 was without psychosis. Resident #8 was assessed to have physical behavioral symptoms directed at others and was assessed with inattention and disorganized thinking that was present continuously.
A focus area on the current comprehensive care plan was ADL (activities of daily living) revised 10/7/16. Interventions included in part read

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 309	Continued From page 19	F 309		

"TEDS per MD (medical doctor)."
The signed January 2017 physician order sheet read "TED Hose Put stocking on in the morning and take off at bedtime. Order date 9/29/15."
The surveyor observed Resident #8 on 1/19/17 at 8:28 a.m. The resident was in bed and eating breakfast unassisted. No TED hose on during the observation. The surveyor observed Resident #8 again on 1/19/17 at 11:25 a.m. Resident #8 was observed sitting in a wheelchair. The surveyor requested the assistance of certified nursing assistant #3 to check Resident #8 legs for TED hose. Resident #8 had socks on both legs but no TED hose. C.N.A. #3 stated "I forgot to put them on this morning. My fault she doesn't have them on. I should have put them on this morning before she got out of bed." C.N.A. #3 retrieved the TED hose from the bathroom and applied the hose to Resident #8's legs.
L.P.N. #1 was asked about the TED hose. L.P.N. #1 stated "It is my responsibility to give the C.N.A. a report. I should have told C.N.A. #3 about the TED hose. C.N.A. #3 was from a local nursing agency." L.P.N. #1 also stated without the TED hose on, Resident #8 would have a lot of swelling in both legs. The surveyor interviewed C.N.A. #4 on 1/19/17 at 11:35 a.m. Certified nursing assistant #4 stated she tried to help the staff out and should have told C.N.A. #3 to check the ADL (activities of daily living) book when she arrived. C.N.A. #4 stated that's where the care plan information could be found.
The "Ongoing Care Plan" dated 12/7/16 included "TEDS."
The surveyor informed the administrative staff of the above concern on 1/19/17 at 1:10 p.m.
No further information was provided prior to the exit conference on 1/20/17.
4. The facility staff failed to obtain daily weights

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 309	Continued From page 20 on Resident #11. The clinical record of Resident #11 was reviewed 1/19/17. Resident #11 was admitted to the facility 3/9/16 and readmitted 12/7/16 with diagnoses that included but not limited to pulmonary hypertension, diabetes neuropathy, diabetes mellitus, type 2, uncontrolled, OSA (obstructive sleep apnea), hypothyroidism, paroxysmal atrial fibrillation, acute hypoxemic respiratory failure, sternal fracture, coronary artery disease, congestive heart failure, osteoporosis, and glaucoma. Resident #11's significant change in assessment minimum data set (MDS) assessment with an assessment reference date (ARD) of 12/9/16 assessed the resident with a cognitive summary score of 15 out of 15 and without any signs of delirium, psychosis or behaviors affecting others. The current comprehensive care plan reviewed 1/19/17 had the focus area titled "Resident has potential nutritional problem r/t (related to) facility placement. Interventions Monitor/record/report to MD PRN (whenever necessary) s/sx (signs/symptoms) of malnutrition: emaciation (cachexia), muscle wasting, significant weight loss: 3 lbs (pounds) in 1 week, > (greater than) 5 % in 1 month, > 7.5% in 3 months, > 10% in 6 months. RD to evaluate and make diet change recommendations PRN." The December 2016 and January 2017 physician orders read "Daily weights on 7-3. Contact MD (medical doctor) if 4 pounds ? (increase in 1 week.)" The December 2016 daily weight record was reviewed. There were no weights recorded for 12/14/16, 12/15/16, 12/27/16, and 12/29/16. The weight recorded on 12/13/16 was done on 3-11 shift-not 7-3 shift as ordered. There were no recorded weights in the December 2016 nurse's	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 309	Continued From page 21	F 309		

notes for 12/14/16, 12/15/16, 12/27/16 and 12/29/16.
The January 2017 daily weight record had omissions for 1/5/17, 1/13/17 and 1/18/17. The January 2017 medication administration records were reviewed. There were 2 different entries on the January 2017 MARs. One entry read "Weight Double check daily to make sure wt (weight) was done 3-11" and the second entry read "Weigh daily-contact MD if weight up 4 lbs (pounds) in 1 wk (week)." The January 2017 MAR with the entry for weights to be checked on 3-11 shift had no evidence weights were done; however, there were initials in each box. The entry for 7-3 weights had no evidence weights were done on the following days: 1/1/17-1/8/17, 1/11/17, 1/13/17, 1/14/17, and 1/18/17.
For the month of December 2016 and January 2017, the surveyor was unable to locate four weights in December 2016 (12/14/16, 12/15/16, 12/27/16 and 12/29/16) and three weights in January 2017 (1/5/17, 1/13/17 and 1/18/17).
The surveyor informed the administrative staff of the weights not obtained during the end of the day meeting on 1/19/17 at 1:10 p.m. The DON stated recordings weights could be several different locations (24 hour report, nurse's notes, MARs, and daily weight record/monthly weight record).
further weights were provNo ided prior to the exit conference on 1/20/17.
5. The facility staff failed to give a prescribed medication to Resident #5 as ordered by the physician.

Resident #5 was admitted to the facility on 9/16/16 with the following diagnoses of, but not limited to major depressive disorder, atrial fibrillation, high blood pressure, dementia, stroke,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 309	Continued From page 22	F 309		

and dysphagia. The resident was coded on the significant change MDS with an ARD (Assessment Reference Date) of 11/11/16 as having a BIMS (Brief Interview for Mental Status, an assessment tool) score of 15 out of a possible score of 15. Resident #5 was also coded as requiring extensive assistance from 1 staff member for personal hygiene, bathing and dressing.

The surveyor performed a clinical review of Resident #5's record on 1/18/17. The surveyor was reviewing the nurses' notes for Resident #5 and the following documentation was noted as follows: "9/23/15 Fri (Friday) 9:30 am Contacted the pharmacy about the res (resident) scheduled dose of Peri-Colace 8.6/50 mg (milligram) ...med was not received with change over. Pharmacy scheduled to delivery tonight." The physician had ordered Peri-Colace 2 tablets to be given to the resident at bedtime for constipation.

The director of nursing (DON) was notified of the above documented findings by the surveyor at 5 pm. The DON stated, "That should have been given. That medication is in the STAT box in the medication room to be used in cases like these." The DON went to the medication room and returned to the surveyor with a copy of the contents of the STAT box medications. The DON pointed to the piece of paper and stated to the surveyor, "Look, there it is. It was here."

The administrative team was notified of the above findings on 1/19/17 at approximately 2 pm by the surveyor.

No further information was provided to the surveyor prior to the exit conference on 1/20/17.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 311 SS=D	TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS CFR(s): 483.24(a)(1) (a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to provide a bowel and bladder training program for 1 of 18 residents (Resident #1). The findings include: The facility staff failed to provide evidence that Resident #1's scheduled toileting was implemented. Resident #1's clinical record was reviewed 1/18/17 and 1/19/17. Resident #1 was admitted to the facility 8/19/15 and readmitted 11/14/16 with diagnoses that included but not limited to urinary tract infections, altered mental status, dementia with psychotic features, skin melanoma, hypertension, acute encephalopathy, anxiety, squamous cell carcinoma, depression, and calcified gallstone. Continued review of the clinical record revealed a significant change in assessment MDS with an assessment reference date (ARD) of 12/29/16. The facility staff coded Resident #1 with a Cognitive Summary Score of 5 out of 15. Section G Functional Status assessed Resident #1 to require extensive assistance of one person for toileting needs and Resident #1 was assessed to be frequently incontinent of bowel and bladder	F 311	1. Resident #1 was on a toileting schedule per resident CP of 1/17/17, not a bowel and bladder training program. Toileting schedule documentation was incomplete. 2. All residents with toileting schedule have the potential to be affected by the deficient practice. 3. Staff education will be provided to C.N.A.'s and nurses on the purpose and procedures to be followed using the toileting schedule form. 4. MDS RN/Nursing Secretary/DON will audit compliance with toileting schedule documentation twice weekly for 2 months. Results will be provided to DON/Administrator. 5. Staff education will be completed by 3/6/17.	3/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 311	Continued From page 24	F 311		

(Section H Bladder and Bowel).
Resident #1's current comprehensive care plan revised 1/11/17 had a focus area that read "Resident #1 has a history of urinary tract infections. Urology Consult recently with recommendations. Staff do toilet resident at scheduled times and at times she is successful. Interventions: Toilet resident as per her Toileting schedule."
The 11/14/16 Nursing Evaluation/Data Collection was reviewed. Bladder status and bowel status had both been left blank.
The November 2016, December 2016, and January 2017 toileting schedule for Resident #1 was reviewed on 1/18/17 and 1/19/17. All 3 months were incomplete-some days not marked at all with evidence that Resident #1 ' s toileting schedule was implemented; some days completed during the day shift only with no evidence toileting schedule was implemented on the evening shift. The toileting schedule had no evidence of implementation on the 11-7 shift.
The surveyor interviewed certified nursing assistant #2 on 1/19/17 at 9:10 a.m. C.N.A. #2 stated Resident #1 was to be toileted on 7-3 shift before breakfast, after breakfast, before lunch, and after lunch. C.N.A. #2 stated when Resident #1 was toileted, that's when her seatbelt was released.
The toileting schedule indicated Resident #1 was to be toileted on the 3-11 shift before dinner and after dinner and before bedtime. There was no evidence on the 3-11 toileting schedule for November 2016, December 2016, or January 2017 that this had been done.
The toileting schedule indicated that Resident #1 was to be toileted on the 11-7 shift between 11:00 p.m. and 3:00 a.m. and then again between 3:00 a.m. and 7:00 a.m.; however, there was no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 311	Continued From page 25 evidence Resident #1 had been toileted on the November 2016, December 2016, and January 2017 toileting sheets. Issues related to Resident #1's toileting schedule were discussed with the administrative staff on 1/19/17 at 1:10 p.m. No further information was provided prior to the exit conference on 1/20/17.	F 311		
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.	F 323		3/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 323	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to ensure a hazard free environment in 2 of 4 bathrooms. The findings included: The facility staff failed to ensure Clorox Healthcare® Bleach Germicidal Wipes were stored safely when not in use by staff in the shower rooms/bathrooms on wing 1. The surveyor checked the side 1 bathroom/shower room on 1/18/17 at 4:40 p.m. The shower room had an unlocked closet that contained various articles for activities of daily living (hair dryer, lotions, shampoos, etc.). In the closet, the surveyor observed 3 bottles of Clorox Healthcare ® Bleach Germicidal Wipes located on the top shelf. C.N.A. #1 stated the closet didn't lock and the wipes were always left in the closet. The door to the shower/bathroom did not lock. C.N.A #1 stated the wipes were used to clean the shower chairs between residents. Written on the bottle was "Keep Out of Reach of Children." The second shower room/bathroom located on wing 1 also had a closet that was unlocked as well as the door entering the shower room. Clorox Healthcare® Bleach Germicidal Wipes were also located in that closet. The surveyor interviewed and informed the director of nursing on 1/18/17 at 4:42 p.m. of the unlocked closet in both wing 1 bathroom/shower rooms and the Clorox wipes that were not secured. The DON stated the wipes were used	F 323	1. The two Wing 1 shower rooms had a latch lock installed during inspection at the top of the closet door to properly secure Clorox Bleach Wipes to keep out of resident reach. 2. After review, it was determined that the Wing 2 shower rooms as part of the resident environment had the potential to have similar occurrences of Clorox Bleach Wipes being accessible to residents. Review of all other areas by the housekeeping director found no other deficiencies. 3. Latch locks were placed on Wing 1 Shower room closet doors. Two locking cabinets were purchased for Wing 2 shower rooms for proper storage of Clorox Bleach wipes. Nursing and Housekeeping staff will be in-serviced for proper storage of chemicals in shower rooms on both units. 4. Housekeeping staff will check each shower room twice daily for proper storage of Clorox Bleach Wipes. The Housekeeping Director/designee will check each shower room for proper storage of Clorox Bleach Wipes at least once daily 5X/wk for 4 wks, then wkly X3 months, then randomly thereafter to monitor compliance. Results will be communicated to the Administrator. The deficiency and POC were communicated to the Sub-QA At Risk Team. In-servicing to C.N.A.'s regarding proper storage of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 323	Continued From page 27 to clean the shower chairs between residents. The surveyor requested the material safety data sheets (MSDS) and the facility policy on storage of chemicals at this time. The DON stated the Clorox wipes should be locked up. The surveyor also informed the administrator of the above concern with unsecured cleaning wipes on 1/18/17 at 4:45 p.m. The administrator stated locking the closets in the bathrooms would be an easy fix. The surveyor reviewed the Clorox Healthcare® Bleach Germicidal Wipes MSDS on 1/19/17. The MSDS read in part "4. First Aid Measures Eye Contact Hold eye open and rinse slowly and gently with water for 15-20 minutes. If present, remove contact lenses after the first 5 minutes of rinsing, then continue rinsing eye. Call a poison control center or doctor for further treatment advice. Skin Contact Rinse skin with plenty of water. If irritation persists, call a doctor. Inhalation Move to fresh air. If breathing problems develop, call a doctor. Ingestion Drink a glassful of water. Call a doctor or poison control center. Most important symptoms and effects, both acute and delayed Liquid may cause eye irritation. 7. Handling and Storage Handling Handle in accordance with good industrial hygiene and safety practice. Avoid contact with eyes, skin, and clothing. Do not eat, drink, or smoke when using this product. Storage Keep containers tightly closed in a dry, cool, and well-ventilated place. Incompatible products Ammonia, toilet bowl cleaners, rust removers, and acids. Toxicology Information Inhalation Exposure to vapor or mist may irritate respiratory tract. Eye Contact Liquid may cause irritation, may cause redness and tearing of the eyes. Skin	F 323	Clorox Bleach Wipes began on 1/19/17, has been ongoing, and will be in-serviced to all nursing staff at the mandatory meetings. 5. Wing 1 shower room latch locks were put in place on 1/19/17. Wing 2 shower room locking cabinets were installed 2/13/17. Education to nursing and Housekeeping staff will be completed by 3/3/17. Monitoring of proper storage of Clorox Bleach wipes by the Housekeeping Director/Designee will begin 2/20/17. Communication to Sub-QA meeting took place on 2/9/17.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 323	Continued From page 28 Contact Liquid may cause slight irritation. Ingestion Ingestion of liquid may cause slight irritation to mucous membranes and gastrointestinal tract. EPA (Environmental Protection Agency) This chemical is a pesticide product registered by the Environmental Protection Agency and is subject to certain labeling requirements under federal pesticide law. These requirements differ from the classification criteria and hazard information required for safety data sheets and for workplace labels of non-pesticide chemicals. Following is the hazard information as required on the pesticide label: CAUTION: Liquid causes moderate eye irritation. Do not get in eyes or on clothing. Avoid contact with clothing. Wear protective eyewear. Wash thoroughly with soap and water after handling and before eating, drinking, chewing gum, using tobacco or using the toilet. For sensitive skin or prolonged use, wear gloves." The facility policy titled "Storage Areas" was reviewed 1/19/17. The policy read "3. Cleaning supplies, etc., shall be stored in areas separate from food storage rooms and shall be stored as instructed on the labels of each product." The surveyor informed the administrative staff of the above concern on 1/19/17 at 1:10 p.m. No further information was provided prior to the exit conference on 1/20/17.	F 323		
F 329 SS=E	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2) 483.45(d) Unnecessary Drugs-General.	F 329		3/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 329	Continued From page 29 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document	F 329	1. All residents with orders for Haldol	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 329	Continued From page 30	F 329		

review, and clinical record review, the facility staff failed to assess, monitor, and ensure 7 of 18 residents (Residents # 2, #9, #6, #7, #11, #16, and #13) were free of unnecessary medications.

The findings include:

1. 1. The facility staff failed to monitor and assess the use of the antipsychotic medication, Haldol, for Resident #2.

Resident #2 was admitted to the facility on 9/4/12 with diagnoses of dementia, depression, hypertension, diabetes, anxiety, osteoporosis, chronic obstructive pulmonary disease, and renal insufficiency. The resident was given an additional diagnosis of psychosis on 10/24/16 when the physician gave a telephone order on 10/23/16 for the antipsychotic medication, Haldol 5 mg IM every 4 hours prn (as needed).

The current significant change MDS with a reference date of 12/12/16 assessed the resident with short and long term memory deficit and severely impaired for decision making. The resident required extensive assistance of 1 person for bed mobility, transfers, dressing,eating, toileting, bathing, and hygiene.

The clinical record was reviewed The physician had ordered the antipsychotic medication, Haldol, on 10/23/16 and gave the diagnosis of psychosis on 10/24/16 for the use of the Haldol.

The clinical record was reviewed. The nurses documented in the nursing note on 10/23/16 the resident was stating the staff wanted to kill her and was swinging arms and kicking feet and yelling in the hallway. The nurses notified the

have been reviewed and Haldol orders have been appropriately discontinued for residents #2,9,6,13. Resident #7 will have improved monitoring of non-pharmacological interventions prior to PRN anxiolytic medication administration and effectiveness after med administration. Resident #11 will have accucheck and insulin administration processes reviewed by DON, MD, and Pharmacy. Resident #16 has been discharged home.

2. The pharmacy will review all residents to identify who has the potential of being affected by the same deficient practice of unnecessary drugs.

3. There was an immediate review during survey and following of all residents with PRN Haldol orders. All PRN Haldol orders have been discontinued. Administrator met with Pharmacy administration on 2/13/17 discussing pharmacies role in facility QAPI project to review and eliminate unnecessary drugs and ensure adequate monitoring of insulin administration and blood pressure parameters. All current residents with medication orders that have parameters will be reviewed by the Medical Director for any needed clarifications. A policy and procedure for non-pharmacological interventions and behavior monitoring will be created and educated to all nursing staff. Re-education of Insulin administration policy and procedure will be provided to all nurses. The PRN medication sheet is being revised to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 329	Continued From page 31 physician and Haldol was ordered. The resident again became belligerent on 10/25/16 and hitting and cursing nurses. The nurses did not document any non pharmacological interventions prior to administering the Haldol. The nurses documented on the form "PRN Medications" the resident was given the Haldol for " increased agitation" and failed to document the results of the administration. The nurses also documented on the form the resident received Haldol on 10/26/16 for agitation with "no relief ". The nurses documented the resident took a wheelchair and was "raming it into the doors". Again there was no documentation of interventions prior to administration of the Haldol. There was no followup documentation when the Haldol was noted to be given without relief. The resident was diagnosed with a urinary tract infection on 10/26/16 and treated. The PRN Medication sheet contained documentation the resident received a dose of Haldol on 11/18/16 at 8:30 a.m. No results were documented. The nursing notes did not contain any documentation from 11/16/16 through 11/19/16. The clinical record also contained "Psychoactive Medication Monthly Flow Sheets" for the psychoactive medications administered. The one for the Haldol listed target behaviors as "increased anxiety, agitation, yelling, swinging arms". The October 2016 form was blank. The November 2016 form was blank for the date,11/18/16, when the Haldol was given. The comprehensive care plan was reviewed. The care plan contained a problem listed the resident	F 329	include non-pharmacological interventions and follow-up if needed and will be educated to all nurses. The facility will make systemic changes on non-pharmacological interventions by enhancing current psychiatric services for the residents to include psych medication review, staff education, and ongoing medication review. 4. The DON/Designee will monitor residents with medication parameters 2X/wk X 4wks then monthly X 3months. The DON/Designee will monitor Sliding Scale Insulin sheets on resident #11 and #8 2X/wk X 4wks then monthly X 3 months. The facility systemic changes will be monitored weekly at the sub-QA At Risk Team meeting and the quarterly QA meeting utilizing Quality Measure report, pharmacy reviews and summaries. 5. Pharmacy review will be completed by 3/6/17. Review of all residents on PRN Haldol was completed by 2/13/17. Creation and/or revision of policies and procedures for Non-pharmacological interventions, Behavior monitoring, and Insulin Administration will be completed by 3/1/17. Revision of PRN medication sheet will be completed by 3/1/17. Review and clarification if needed of medications with parameters by the Medical Director will be completed by 3/6/17. In-servicing to all nurses will be completed by 3/6/17 and to C.N.A.'s by 3/1&3/17.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 329	Continued From page 32	F 329		

refused medications, could be verbally and physically aggressive and had once removed her top. The interventions included to administer medications as needed and to attempt to redirect and if unsuccessful-leave and return later.

The director of nursing (DON) was asked about the monitoring and assessment of the resident for the use of the Haldol on 1/19/17 at 8:00 a.m. The DON stated she had reviewed the clinical record and agreed the staff failed to assess and monitor the resident.

The administrator, director of nursing, and CEO were informed of the findings during a meeting with the survey team on 1/19/17 at 9:00 a.m.

2. The facility staff failed to monitor and assess the use of the antipsychotic medication, Haldol, for Resident #9.

Resident #9 was admitted to the facility on 8/16/16 with diagnoses of psychosis, dementia with behavior, bipolar disease, seizure disorder, stroke, hypertension, osteoarthritis, and glaucoma.

The current significant change MDS with a reference date of 11/15/16 assessed the resident with a cognitive score of "9" of "15". The resident required supervision to extensive assistance of 1 person for bed mobility, transfers, dressing, eating, toileting, bathing, and hygiene.

The clinical record was reviewed. The physician had ordered the antipsychotic medication, Haldol 5 mg IM every 4 hours prn (as needed), on 9/26/16 for frequent psychotic episodes in the evenings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 329	Continued From page 33	F 329		

The clinical record was reviewed. The nurses documented in the nursing note on 9/26/16 the resident was at the front door demanding to leave at 2:00 a.m.. The nurses notified the physician and Haldol was ordered for agitation.

The nurses documented on 12/12/16 at 9:40 p.m. the resident became argumentative and agitated and began to fight and hit and yell at the nurses. The nurses did not document any non pharmacological interventions prior to administering the Haldol. The nurses documented on the form "PRN Medications" the resident was given the Haldol for " increased agitation" and documented the results as "very little effect". There was no follow up documentation.

The clinical record also contained "Psychoactive Medication Monthly Flow Sheets" for the psychoactive medications administered. The one for the Haldol listed target behaviors as "increased agitation, attempting to exit, and threatening staff ". The September 2016 form was blank. The October 2016 form was blank. The November 2016 form was blank. The December 2016 form was blank for the date, 12/12/16, when the Haldol was given.

The comprehensive care plan was reviewed. The care plan contained a problem listed the resident was at risk for experiencing psychotic episodes due to diagnosis. The interventions included to re-orient resident as necessary. The care plan also contained a problem listed the resident had cognitive deficits and to administer medications as ordered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 329	Continued From page 34	F 329		

The director of nursing (DON) was asked about the monitoring and assessment of the resident for the use of the Haldol on 1/19/17 at 8:00 a.m. The DON stated she had reviewed the clinical record and agreed the staff failed to assess, monitor, and document provision of non pharmacological interventions for the resident.

The administrator, director of nursing, and CEO were informed of the findings during a meeting with the survey team on 1/19/17 at 9:00 a.m.
3. For Resident #6, the facility failed to ensure she was monitored for behaviors and was free from an unnecessary medication.

The clinical record of Resident #6 was reviewed on 1/18/17 through 1/19/17. Resident #6 was admitted to the facility on 12/15/15 with diagnoses that included but were not limited to: anxiety, anemia, psychosis, pacemaker, edema, major depressive disorder, and insomnia.

Resident #6 ' s most recent MDS (minimum data set) assessment completed on this resident was a quarterly assessment with an ARD (assessment reference date) of 12/7/16. Section C (cognitive patterns) of this assessment coded the resident to have short and long term memory problems with severely impaired decision making. In section B, the resident was coded to usually understand and to usually be understood.
Review Resident #6 ' s physician summary of orders dated 1/2/17 revealed Haldol 5 mg 1 tablet by mouth every 4 hours as need for agitation/psychosis. While pyschosis is an approved diagnoses for the use of Haldol agitation or anxiety is not.
Review of the PRN medication administration record revealed Resident #6 had been given

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 329	Continued From page 35	F 329		

Haldol 5 mg for anxiety, agitation, and chanting and/or yelling out. The medication was given on 1/1/17 at 8:00 pm, 1/5/17 at 12:00 noon, 1/5/17 at 11:30 pm, 1/6/17 at 9:10 pm and on 1/11/17 at 7:00 pm.
There was no documentation in the January 2017 progress notes that identified the targeted behavior that Resident #6 exhibited prior to the administration of the Haldol. Resident #6 had behavior sheets that did not have any nursing documentation on them. There was no documentation in the progress notes that Resident #6 was offered non-pharmacological interventions prior to the administration of Haldol. There was no documentation located in the clinical record showing the resident had been monitored for, psychotic behavior or any other behavior warranting the administration of the Haldol.
On 1/18/17 and on 1/19/17, the administration staff was informed of the failure to monitor and document behaviors and the non-pharmacological interventions. No further information was provided to the surveyor prior to exit.

4. The facility staff failed to monitor/document Resident #7's behavior prior to the administration of an anxiolytic medication Ativan.

Resident #7 was administered Ativan PRN (as needed) without any indication of the attempt to use non-pharmacological interventions prior to the administration. The facility staff failed to identify the targeted behavior for the use of the prn Ativan and failed to provide evidence of monitoring when the anxiolytic was administered. The clinical record of Resident #6 was reviewed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 329	Continued From page 36	F 329		

1/18/17 through 1/19/17. Resident #7 was admitted to the facility on 1/21/15, with diagnoses that included, but were not limited to: anxiety, depressive disorder, high blood pressure, right fractured femur, and dementia.
Resident #7's significant change in assessment MDS with an assessment reference date (ARD) of 12/9/16, coded the resident with a cognitive summary score of 04 out of 15 in Section C0500. Resident #6 was assessed to rarely be understood, and to rarely understand.

Resident #7's current comprehensive care plan initiated 10/18/16 with revisions on 1/17/17 identified cognitive behavior as a focus due to diagnosis of dementia, depression, anxiety, and pyschosis. Interventions: " Administer medications as ordered. Monitor/document for side effects and effectiveness. " The comprehensive care had no documented non-pharmacological interventions for anxiety.

The January 2017 physician order sheet read: "Ativan tablet 0.5 mg (Lorazepam) take 1 tablet by mouth twice daily as needed for anxiety."

The PRN (as needed) medication administration record identified Resident #6 received Ativan for anxiety on 1/4/17 at 8:00pm, and on 1/7/17 at 8:00pm, with effective results, on 1/8/17 at 3:30pm given for anxiety with negative results. On 1/8/17 at 8:00 pm, and 1/9/17 at 6:00 pm, Ativan was again given for her anxiety with positive results. On 1/11/17 at 7:00 pm, under results the word helpful was documented. Ativan was given again for anxiety on 1/12/17 at 7:00 pm and on 1/16/17 at 8:00pm for anxiety with positive results.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 329	Continued From page 37	F 329		

There was no documentation in the January 2017 progress notes that identified the targeted behavior that Resident #7 exhibited prior to the administration of the Ativan. Resident #7 had behavior sheets that did not have any nursing documentation on them. There was no documentation in the progress notes that Resident #7 was offered non-pharmacological interventions prior to the administration of Ativan.

RN #1 was asked why she had not documented the Resident ' s behavior on the behavior sheets or in the nurse ' s progress notes. She said, " I didn ' t due to time. "

On 1/18/17 and on 1/19/17, the administration staff was informed of the failure to monitor and document behaviors and the non-pharmacological interventions for anxiety. No further information was provided to the surveyor prior to exit.

5. The facility staff failed to obtain blood sugars and follow the physician ordered blood sugar parameters for the administration of sliding scale insulin for Resident #11. The facility staff failed to ensure the blood sugars were obtained and sliding scale insulin administered as ordered.

The clinical record of Resident #11 was reviewed 1/19/17. Resident #11 was admitted to the facility 3/9/16 and readmitted 12/7/16 with diagnoses that included but not limited to pulmonary hypertension, diabetes neuropathy, diabetes mellitus, type 2, uncontrolled, OSA (obstructive sleep apnea), hypothyroidism, paroxysmal atrial fibrillation, acute hypoxemic respiratory failure, sternal fracture, coronary artery disease, congestive heart failure, osteoporosis, and glaucoma.

Resident #11's significant change in assessment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 329	Continued From page 38	F 329		

minimum data set (MDS) assessment with an assessment reference date (ARD) of 12/9/16 assessed the resident with a cognitive summary score of 15 out of 15 and without any signs of delirium, psychosis or behaviors affecting others. The current comprehensive care plan with a revised date of 12/14/16 included the focus that read "Resident #11 has Diabetes Mellitus and her blood sugars can fluctuate rapidly she will also eat food items that can affect blood sugar and is aware she does this as well staff attempt to encourage her to avoid foods that will affect blood sugar but she frequently chooses to eat inappropriate foods for her currently she has low concentrated diet order. Resident goes to snack machine and gets what she wants out and md (medical doctor), family aware. Interventions Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Glucometer readings per MD order."

The January 2017 physician order sheet (POS) read:
**SS (sliding scale) before breakfast, lunch and dinner:
0-200=0 units
201-250=2 units
251-300=3 units
301-350=4 units
351-400=5 units
401-450=6 units
451-500=8 units
Over 500 Call MD (name omitted)

**Continued SS insulin orders for bedtime read:
No SS until 300
300-349= 2 units
350-399=3 units

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 329	Continued From page 39 Over 400 4 units Over 500 must call MD or MD on call **SS at 2AM No SS until 300 300-349= 2units 350-399=3 units Over 400 4 units Over 500 must call MD or MD on call. The surveyor reviewed the blood sugar check log for December 2016 and January 2017. The 12/21/16 bedtime blood sugar was not obtained. There were no recorded results on the blood sugar log. The 12/25/16 11:30 a.m. blood sugar was not obtained. There were no recorded results on the blood sugar log. The 1/13/17 11:30 a.m. had no results of a blood sugar. There were no recorded results on the blood sugar log. The surveyor informed the director of nursing of the failure of the facility to monitor Resident #11's blood sugar on 1/19/17 at 5:30 p.m. The director of nursing stated Resident #11's family provided her glucometer and strips and kept up with the blood sugar results. The surveyor requested the facility policy on Diabetic Management from the director of nursing. The director of nursing informed the surveyor that she had contacted Resident #11's family and obtained the blood sugar results on 1/19/17 at 5:35 p.m. The 12/21/16 blood sugar at bedtime was 243. Resident #11 did not require sliding scale coverage for the blood sugar. The 12/25/16 11:30 a.m. blood sugar was 382. Resident #11	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 329	Continued From page 40	F 329		

should have received 5 units of insulin. The 1/13/17 11:30 a.m. blood sugar was 133. No insulin was required.

The surveyor reviewed the facility policy titled "Insulin Administration" on 1/20/17. The policy was reviewed and read in part "9. For residents with sliding scale (S/S) insulin:
· Sliding scale insulin is given per resident's individual physician's order. It is specifically ordered to coincide with the blood sugars. Nurses will document the blood sugar, time of administration, location and amount of insulin administered, and nurse's initial after giving S/S insulin on the Blood Sugar MAR."

The surveyor informed the administrative staff of the above concern with the diabetic management of Resident #11 on 1/20/17 at 8:55 a.m.

No further information was provided prior to the exit conference on 1/20/17.

6. The facility staff failed to follow the physician ordered blood pressure parameters for the administration of an antihypertensive medication (Lopressor) for Resident #16.

The clinical record of Resident #16 was reviewed 1/19/17. Resident #16 was admitted to the faciltiy11/4/16 with diagnoses that included but not limited to hypertension, atrial fibrillation, IDDM (insulin dependent diabetes mellitus), coronary artery disease, cerebral infarction, depression, breast cancer, hyperlipidemia, and peripheral vascular disease with a non-healing foot ulcer.

Resident #16's admission minimum data set (MDS) assessment with an assessment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 329	Continued From page 41	F 329		

reference date (ARD) of 11/11/16 assessed the resident with a cognitive summary score of 11 out of 15 and without signs of delirium, psychosis, or behaviors that affected others.

Resident #16's admission physician orders read in part "Lopressor 25 mg (milligrams) tablet Take half tab to = 12.5 mg by mouth two times a day. Hold for SBP (systolic blood pressure) < (less than) 110 (HTN) (hypertension)."

The surveyor reviewed the November 2016 medication administration record and the daily/weekly blood pressure log.

The blood pressure obtained on 11/12/16 at 10:00a (am) read 105/50. The blood pressure obtained on 11/13/16 at 10 a (am) read 101/55. The boxes for 11/12/16 and 11/13/16 at 9:00 a.m. were both initialed. Initialed boxes indicated a treatment had been provided/physician's orders completed.

Based on the physician orders to hold the medication Lopressor when the top number (systolic) of the blood pressure was less than 110, the medication should have been held on 11/12/16 and 11/13/16. The medication Lopressor was administered on both 11/12/16 and 11/13/16 at 9:00 a.m.

The surveyor discussed the physician order with the director of nursing on 1/19/17 at 5:20 p.m. The director of nursing reviewed the physician order, the blood pressure results and stated the Lopressor should have been held.

The surveyor informed the administrative staff of the above finding on 1/20/17 at 8:55 a.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 329	Continued From page 42	F 329		

No further information was provided prior to the exit conference on 1/20/17.

7. The facility staff failed to assess and monitor the use of an antipsychotic medication, Haldol to Resident #13.

Resident #13 was admitted to the facility on 11/17/16 with the following diagnoses of, but not limited to anemia, high blood pressure, gastro-esophageal reflux disease, atrial fibrillation and muscle weakness. The resident was coded on the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/28/16 as having a BIMS (Brief Interview for Mental Status) score of 7 out of a possible score of 15. Under Section E for Behavior, the resident was coded as none of the above. Under Behavior Symptoms, the resident was coded as having physical behavioral symptoms directed toward others. Resident #13 was also coded as being totally dependent on 2 or more staff members for personal hygiene and bathing.

On the resident's comprehensive care plan there were no non-pharmalogical interventions to be used prior to the administration of Haldol. There was also no documentation of these interventions in the nurses' notes that were reviewed for Resident #13.

According to a communication sheet to the physician dated for 11/21/16, the following documentation was noted as follows: "Resident has history of combative and abusive behavior ..." It was not until on 12/1/16 that a diagnosis of Psychosis was given to the resident by the physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 329	Continued From page 43 The following date and times were documented on the PRN Medications sheet of the Haldol being administered to the resident with the reason of "prior to ADL (Activities of Daily Living) care: 11/23/16 9 am, 11/25/16 9:30 am, 11/26/16 10:10 am, 11/27/16 10:15 am, 11/28/16 9:30 am, 11/29/16 9 am, 11/30/16 8:40 am, 12/2/16 9 am, 12/3/16 9 am, 12/6/16 10:30 am, 12/7/16 9:40 am, 12/8/16 8:45 am, 12/9/16 8:15 am, 12/10/16 9:15 am, 12/12/16 9:45 am, 12/13/16 9:30 am, 12/14/16 8:40 am, 12/15/16 10:20 am, 12/16/16 9 am, 12/17/16 9:30 am, 12/18/16 9:40 am, 12/19/16 9:10 am, 12/20/16 10:25 am, 12/21/16 9:30 am, 12/22/16 9:10 am, 12/25/16 10:15 am, 12/26/16 10:15 am, 12/27/16 9 am, 12/28/16 8:30 am and 12/29/16 8:30 am. The administrative team was notified of the above documented findings by the surveyor on 1/19/17 at approximately 4 pm. The director of nursing reviewed the above findings with the surveyor after the above conference. The director of nursing agreed that the staff did not assess, monitor or document non pharma logical interventions prior to the use of Haldol for Resident #13. No further information was provided to the surveyor prior to the exit conference on 1/20/17.	F 329		
F 333 SS=D	RESIDENTS FREE OF SIGNIFICANT MED ERRORS CFR(s): 483.45(f)(2) 483.45(f) Medication Errors. The facility must ensure that its-	F 333		3/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 333	Continued From page 44 (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure 2 of 18 residents (Resident #8 and Resident #11) were free of a significant medication error. The findings included: 1. The facility staff failed to administer insulin per the physician order for Resident #8. The clinical record of Resident #8 was reviewed 1/18/17 and 1/19/17. Resident #8 was admitted to the facility 5/27/15 and readmitted 9/29/15 with diagnoses that included but not limited to hypoglycemia, encephalopathy, diabetes mellitus, dementia in Alzheimer's disease, lumbar compression fracture (L1 and L5), hyperkalemia, peripheral vascular disease, Vitamin D deficiency, dermatitis of scalp and face, transient ischemic attacks, and urinary tract infections. The annual minimum data set (MDS) with an assessment reference date (ARD) of 9/29/16 assessed the resident with short term memory problem, long term memory problem, and severely impaired skills for daily decision making. Resident #8 was without psychosis. Resident #8 was assessed to have physical behavioral symptoms directed at others and was assessed with inattention and disorganized thinking that was present continuously. Resident #8's current comprehensive careplan revised 12/11/16 had the focus area that read "The resident has Diabetes Mellitus-Insulin dep	F 333	1. Education/counseling to the appropriate nurses for the medication errors for residents #8 and #11 will be done. Review of medication administration policy and procedure will be done by the DON and Administrator. 2. All other residents with Sliding Scale Insulin orders have the potential to be affected by this deficient practice. 3. Nursing will be re-educated the policy and procedure for medication administration to include the specific process of following and documenting sliding scale insulin orders. Administrative review of medication pass procedures is being done. 4. Beginning 3/3/17 during each medication cart key exchange, both nurses will check Sliding Scale Insulin sheets for accuracy and proper documentation and document on a monitoring sheet for 2months. These monitoring sheets will be reviewed by DON/designee weekly X 2 months. 5. Re-education of Medication administration policy and procedure to all nurses will be done on 3/6/17. Review of all other residents with sliding scale insulin orders will be reviewed by the DON/Designee by 3/1/17.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 333	Continued From page 45	F 333		

(dependent)--Receives a therapeutic diet. Weight is stable. Interventions: Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Fastin serum blood sugar as ordered by doctor."
The clinical record was reviewed 1/18/17 and 1/19/17. The January 2017 physician orders read "accucheck (blood sugar monitoring) check blood sugar before meals and at bedtime with sliding scale prn (whenever necessary). Sliding scale insulin schedule of Novolog for blood sugar results read " Below 200 none, 200-249 2 units, 250-299 4 units, and for blood sugar above 300 6 units."

The January 2017 blood sugar checks log was reviewed. The blood sugar obtained 1/3/17 at 11:30 a.m. was 210. In the box for insulin administered there was a zero with a diagonal line through it. Resident #8 should have received 2 units of Novolog insulin. Resident #8 didn't receive insulin. The blood sugar result for 1/3/17 at 8:30 p.m. was 250. The box for the amount of insulin administered also had a zero with a diagonal line. Resident #8 should have received 4 units of Novolog insulin. Resident #8 did not. The blood sugar obtained 1/12/17 at 8:00 p.m. was 219. Resident #8 should have received 2 units. There was no indication in the box for the insulin administered that the medication was administered. The box was blank. The blood sugar obtained 1/17/17 at 11:20 a.m. was 212. Resident #8 should have received 2 units. The box for the amount of insulin administered had a zero with a diagonal line through it. Resident #8 did not receive insulin.

The director of nursing and the surveyor reviewed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 333	Continued From page 46	F 333		

the concern with the diabetic management of Resident #8 on 1/18/17 at 4:00 p.m. The DON reviewed the dates and times insulin was administered and stated one nurse was a facility employee and one was an agency nurse.

The director of nursing (DON) provided the surveyor with a copy of the facility policy on "Insulin Administration" on 1/19/17.

The surveyor reviewed the facility policy titled "Insulin Administration" was reviewed on 1/19/17. The policy was reviewed and read in part "9. For residents with sliding scale (S/S) insulin:
? Sliding scale insulin is given per resident's individual physician's order. It is specifically ordered to coincide with the blood sugars. Nurses will document the blood sugar, time of administration, location and amount of insulin administered, and nurse's initial after giving S/S insulin on the Blood Sugar MAR."

The surveyor informed the administrative staff of the concern with Resident #8's diabetic management on 1/20/17 at 8:55 a.m.

No further information was provided prior to the exit conference on 1/20/17.

2. The facility staff failed to administer Resident #11 ' s insulin as ordered by the physician.

The clinical record of Resident #11 was reviewed 1/19/17. Resident #11 was admitted to the facility 3/9/16 and readmitted 12/7/16 with diagnoses that included but not limited to pulmonary hypertension, diabetes neuropathy, diabetes mellitus, type 2, uncontrolled, OSA (obstructive sleep apnea), hypothyroidism, paroxysmal atrial

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 333	Continued From page 47	F 333		

fibrillation, acute hypoxemic respiratory failure, sternal fracture, coronary artery disease, congestive heart failure, osteoporosis, and glaucoma.
Resident #11's significant change in assessment minimum data set (MDS) assessment with an assessment reference date (ARD) of 12/9/16 assessed the resident with a cognitive summary score of 15 out of 15 and without any signs of delirium, psychosis or behaviors affecting others.
The current comprehensive care plan with a revised date of 12/14/16 included the focus that read "Resident #11 has Diabetes Mellitus and her blood sugars can fluctuate rapidly she will also eat food items that can affect blood sugar and is aware she does this as well staff attempt to encourage her to avoid foods that will affect blood sugar but she frequently chooses to eat inappropriate foods for her currently she has low concentrated diet order. Resident goes to snack machine and gets what she wants out and md (medical doctor), family aware. Interventions Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Glucometer readings per MD order. " "

The January 2017 physician order sheet (POS) read:
**SS (sliding scale) before breakfast, lunch and dinner:
0-200=0 units
201-250=2 units
251-300=3 units
301-350=4 units
351-400=5 units
401-450=6 units
451-500=8 units
Over 500 Call MD (name omitted)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 333	Continued From page 48	F 333		

**Continued SS insulin orders for bedtime read:
No SS until 300
300-349= 2 units
350-399=3 units
Over 400 4 units
Over 500 must call MD or MD on call

**SS at 2AM
No SS until 300
300-349= 2units
350-399=3 units
Over 400 4 units
Over 500 must call MD or MD on call.

The surveyor reviewed the blood sugar check log for December 2016 and January 2017.

The 12/21/16 bedtime blood sugar was not obtained. There were no recorded results on the blood sugar log.
The 12/25/16 11:30 a.m. blood sugar was not obtained. There were no recorded results on the blood sugar log.
The 1/13/17 11:30 a.m. had no results of a blood sugar. There were no recorded results on the blood sugar log.

The surveyor informed the director of nursing of the failure of the facility to monitor Resident #11's blood sugar on 1/19/17 at 5:30 p.m. The director of nursing stated Resident #11 ' s family provided her glucometer and strips and kept up with the blood sugar results. The surveyor requested the facility policy on Diabetic Management from the director of nursing.

The director of nursing informed the surveyor that she had contacted Resident #11's family and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 333	Continued From page 49 obtained the blood sugar results on 1/19/17 at 5:35 p.m. The 12/21/16 blood sugar at bedtime was 243. Resident #11 did not require sliding scale coverage for the blood sugar. The 12/25/16 11:30 a.m. blood sugar was 382. Resident #11 should have received 5 units of insulin. There was no evidence Resident #11 received the physician ordered insulin. The 1/13/17 11:30 a.m. blood sugar was 133. No insulin was required. The surveyor reviewed the facility policy titled "Insulin Administration" on 1/20/17. The policy was reviewed and read in part "9. For residents with sliding scale (S/S) insulin: · Sliding scale insulin is given per resident ' s individual physician ' s order. It is specifically ordered to coincide with the blood sugars. Nurses will document the blood sugar, time of administration, location and amount of insulin administered, and nurse ' s initial after giving S/S insulin on the Blood Sugar MAR." The surveyor informed the administrative staff of the above concern with the diabetic management of Resident #11 on 1/20/17 at 8:55 a.m. No further information was provided prior to the exit conference on 1/20/17.	F 333		
F 431 SS=D	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h) The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general	F 431		3/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 431	Continued From page 50	F 431		

supervision of a licensed nurse.

(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(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.

(h) Storage of Drugs and Biologicals.
(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 personnel to have access to the keys.

(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 431	Continued From page 51 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 observation, staff interview, facility document review, and clinical record review, the facility staff failed to ensure the narcotic box on 1 of 2 units (unit 2) was permanently affixed and failed to date bottles/tubes of medications when opened for 3 of 18 residents (Resident #7, Resident #10, and Resident #11). The findings included: (1). The narcotic box in the refrigerator on unit 2 was not permanently affixed. This narcotic box contained Ativan 2mg (milligram)/ml (milliliter) injectable medication, Humulin R 10 ml, Promethazine 25 mg, and Humulin 70-30 insulin. The medication room on unit 2 was checked 1/18/17 at 11:25 a.m. with licensed practical nurse #2. The refrigerator contained a green/clear box that was easily removed from the refrigerator by the surveyor. L.P.N. #2 identified this box as the emergency box. The surveyor was able to remove this box from the refrigerator and hand it to the nursing staff. The nursing staff unlocked the box and the surveyor was able to observe the contents. The box contained Ativan 2mg (milligram)/ml (milliliter) injectable medication, Humulin R 10 ml, Promethazine 25 mg, and Humulin 70-30 insulin. The surveyor informed the director of nursing of	F 431	1. New refrigerators were purchased for each med room that will allow for the narcotic box to be permanently affixed. Nursing in-servicing will be done to educate the proper storage and labeling of medications. 2. Upon review of the medication fridges and labeling of appropriate medications, no other deficiencies were noted. 3. The facility purchased new medication refrigerators with capability to have affixed storage boxes for schedule 2 medications. A policy has been written and will be educated to all nursing staff by 3/2/17 and put in place by 3/3/17. Re-education of current facility policy of "opening/dating inhalers etc" will be completed by 3/2/17. Each nurse will be educated that anytime they take assignment of a med cart, they will check all appropriate meds for proper dates per the policy. 4. The refrigerators for the med rooms were purchased on 2/14/17. They will be in place by 3/1/17. Beginning 3/3/17, the DON will check the medication refrigerators weekly x 4wks, then monthly for proper affixation of narcotic boxes and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 431	Continued From page 52 the above concern on 1/18/17 at 1:30 p.m. The director of nursing stated the surveyor was correct that the narcotic box could be easily removed from the refrigerator. (2). The facility staff failed to date bottles of medications when opened for Resident #7. The surveyor checked the medication cart located on unit 2 with licensed practical nurse #2 on 1/18/17 at 11:30 a.m. In Resident #7's medication compartment was an opened bottle of Travatan Z 0.004% eye drops. The bottle did not include a date when the eye drops were opened. L.P.N. #2 stated medications were to be dated when opened. Resident #7 was admitted 1/21/15 with diagnosis that included but not limited to closed fracture of humerus, hypertension, hyperlipidemia, weakness, depression, macular degeneration, glaucoma, senile dementia, cerebrovascular accident, psychosis, anxiety, insomnia, and blindness d/t (due to) macular degeneration. Resident #7's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/16/17 assessed the resident with short term memory problems, long term memory problems, and moderately impaired cognitive skills-decisions poor, cues/supervision required. Resident #7's January 2017 physician ordered medications included current orders for Travatan Z 0.004% eye drops 1 drop in each eye once daily. (3). The facility staff failed to date bottles of eye drops when opened for Resident #10.	F 431	to ensure only schedule 2 medications are stored in the narcotic box. Charge/Med nurse will check all required labeling and dating of medications daily x 1month, then wkly x 2 months to ensure no medications are being left improperly marked. These scheduled checks by the nurses will be checked by the DON weekly x 3months for compliance. The deficiency and POC will be communicated at the next scheduled quarterly QA meeting. 5. New medication refrigerators were ordered 2/14/17 and will be in place by 3/6/17. The new policy will be written by 3/1/17 and put in place on 3/3/17. Nursing education will be completed by 3/6/17.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 431	Continued From page 53	F 431		

The surveyor checked the medication cart located on unit 2 on 1/18/17 at 11:30 a.m. with licensed practical nurse. Resident #10 ' s medication compartment included two eye drops-Tamolol 0.5% and Naphcon A. Neither bottle of eye drops had a date when opened. L.P.N. #2 stated medications were to be dated when opened.

Resident #10 was admitted to the facility 12/30/15 with diagnoses that included but not limited to hypertension, coronary artery disease, atrial fibrillation, pulmonary hypertension, compression fractures of lumbar vertebrae, cataract, and glaucoma.

Resident #10's significant change in assessment minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/7/16 assessed the resident with a cognitive summary score of 15.

Resident #10's current physician ' s orders (January 2017) included orders for Timoptic 0.5% (Timolol) 0.5% O/S 5 ml (milliliter) 1 drop into left eye once daily for glaucoma and Naphcon A prn (as needed).

4. The facility staff failed to date eye medication when opened for Resident #11.

The surveyor checked the medication cart on unit 2 on 1/18/17 at 11:30 a.m. with licensed practical nurse. In Resident #11's medication compartment was a tube of Systane night time ophthalmic ointment 3.5 grams. The tube of medication was opened but the surveyor and L.P.N. #2 observed that the tube did not have a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 431	Continued From page 54	F 431		

date when opened. L.P.N. #2 stated medications were to be dated when opened.

The clinical record of Resident #11 was reviewed 1/19/17. Resident #11 was admitted to the facility 3/9/16 and readmitted 12/7/16 with diagnoses that included but not limited to pulmonary hypertension, diabetes neuropathy, diabetes mellitus, type 2, uncontrolled, OSA (obstructive sleep apnea), hypothyroidism, paroxysmal atrial fibrillation, acute hypoxemic respiratory failure, sternal fracture, coronary artery disease, congestive heart failure, osteoporosis, and glaucoma.
Resident #11's significant change in assessment minimum data set (MDS) assessment with an assessment reference date (ARD) of 12/9/16 assessed the resident with a cognitive summary score of 15 out of 15 and without any signs of delirium, psychosis or behaviors affecting others.
Resident #11's January 2017 physician order sheet was reviewed and included a current order for Systane Night Time Ophthalmic apply 0.5 inches to affected eye as directed at bedtime.

The administrative staff were notified of the above in an end of the day meeting with the survey team on 1/19/17 at 1:10 p.m. The surveyor requested the facility policy on labeling, dating, and storage of medications. The director of nursing stated she expected nurses to date bottles of medication when opened.

The surveyor reviewed the facility policy titled "Opening/dating inhalers, insulins, injectables, inhalants, and patches." The policy read in part "The nurses will date inhalers, insulins, injectables, inhalants, and patches when opened."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 431	Continued From page 55 No further information was provided prior to the exit conference on 1/20/17.	F 431		
F 502 SS=D	ADMINISTRATION CFR(s): 483.50(a)(1) (a) Laboratory Services (1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain a physician ordered lab on 1 of 18 residents in the survey sample. (Resident #4) The findings included: Resident #4 was readmitted to the facility on 2/11/15 with the following diagnoses of, but not limited to anemia, high blood pressure, dementia, Alzheimer's disease, anxiety disorder and depression. The resident was coded on the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 11/11/15 with a BIMS (Brief Interview for Mental Status, an assessment tool used) with a score of 0 out of a possible score of 15. Resident #4 was also coded as requiring extensive assistance of 1 staff member for dressing, personal hygiene and bathing. The surveyor conducted a clinical record review of Resident #4's chart on 1/19/17. In performing this review, the surveyor noted that on a "Note to Attending Physician/Prescriber" from the	F 502	1. Education/counseling to the nurse receiving the lab order was done by the DON. 2. All residents with labs ordered in the last 6 months will be audited for proper scheduling per the physician order in order to identify residents that could potentially be affected by the deficient practice. 3. The facility current lab tracking process that was put in place a few years ago has proven to be very successful in not missing ordered labs. Re-education to all nurses receiving orders for labs will be done to ensure proper notation and adherence to lab tracking. 4. The charge nurse for 11-7 on each unit will audit all daily orders for their respective unit to ensure there is adequate processing and steps taken to prevent ordered labs from not being	3/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 502	Continued From page 56 consulting pharmacist, it was recommended that the resident have a decrease in Vitamin B12 to 1000mcg (micrograms) daily for supplement. The physician marked the box that he was in agreement with this suggestion and wrote the following in the comment section as follows: "r with a check mark (meaning to recheck) B12 3 mos (months) p with a line over it (after) above triangle (which means change)." This order was signed by the physician on 5/25/16. The surveyor could not locate the results of the Vitamin B12 level that was to be drawn in the month of August, 2016. On 1/19/17 at approximately 11 am, the director of nursing (DON) was notified of the above documented findings. The DON stated, "This lab was not obtained in August but let me keep checking on it." The administrative team was notified of the above documented findings on 1/19/17 at approximately 2 pm by the surveyor. The DON returned to the surveyor at approximately 4:45 pm and stated, "This lab was not done. I have already notified the physician of this." No further information was provided to the surveyor prior to the exit conference on 1/20/17.	F 502	obtained timely. The DON will review the 11-7 audit weekly x 3 months, then randomly thereafter to monitor compliance. 5. Current procedures for lab ordering will be educated to all nurses by 3/6/17. The daily lab audit for 11-7 charge nurse will begin 3/2/17. Education/counseling to RN noting the order for the lab will be done by 2/17/17.	