Raleigh Court
Health & Rehabilitation Center
A MEDICAL FACILITIES OF AMERICA HEALTH & REHABILITATION CENTER

1527 Grandin Road SW
Roanoke, VA 24015-2305
(540) 342-9525
FAX (540) 342-5682

October 18, 2016

Mr. Rodney Miller
Long Term Care Supervisor
Division of Long Term Care
9960 Mayland Drive
Suite 401
Henrico, Virginia 23233 – 1485

Dear Rodney:

Enclosed please find our Plan of Correction based on the results of the unannounced survey conducted by your staff ending September 22, 2016. Please contact me should you have any questions regarding our response.

Sincerely,

Mark Tubbs
Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495209	A. BUILDING _____ B. WING _____	C 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RALEIGH COURT HEALTH AND REHABILITAT	1527 GRANDIN ROAD SOUTHWEST ROANOKE, VA 24015

(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 9/20/16 through 9/22/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 113 at the time of the survey. The survey sample consisted of 20 current Resident reviews (Resident #1 through Resident #20) and 4 closed record reviews (Resident #21 through Resident #24).	F 000	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.	
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. This Requirement is not met as evidenced by:	F 155	F155 RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES 1. The DDNR form for resident #14 was completed while surveyors were on site.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mark Tuth — TITLE: Administrator — (X6) DATE: 10/18/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495209	A. BUILDING _____ B. WING _____	C 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RALEIGH COURT HEALTH AND REHABILITAT	1527 GRANDIN ROAD SOUTHWEST ROANOKE, VA 24015

(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 155	Continued From page 1 Based on staff interview, clinical record, and the Code of Virginia, it was determined that the facility staff failed to accurately complete the "Durable Do Not Resuscitate" (DDNR)/Golden Rod order sheet for 1 of 24 Residents in the sample survey, Resident #14. The Findings Included: For Resident #14, the facility staff failed to ensure that the "Durable Do Not Resuscitate" (DDNR/Golden Rod) order sheet was complete and accurate. Resident #14, a 105 year old female, was originally admitted on 1/29/03 and readmitted on 4/25/09. Admitting diagnoses included, but were not limited to: hypertension, hypothyroidism, dementia without behaviors, osteoporosis, macular degeneration and major depression. The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment, with an Assessment Reference Date (ARD) of 8/11/16. The facility staff coded that Resident #14 had short and long term memory impairment and was severely impaired with daily decision making regarding Activities of Daily Living (ADL's). The facility staff also coded that Resident #14 required total nursing care (4/3) with ADL's. On September 21, 2016 at 9:45 a.m. the surveyor reviewed Resident #14's clinical record. Review of the clinical record produced a "Durable Do Not Resuscitate" (DDNR)/Golden Rod sheet. The DDNR/Golden Rod was dated 12/15/14. Review of the DDNR/Golden Rod sheet revealed that the DDNR/Golden Rod sheet was not accurate. The DDNR/Golden Rod had not documented whether Resident #14 was Capable or Incapable of making an informed decision about providing, withholding or withdrawing specific medical treatment or course of medical treatment. Reference: Code of Virginia § 512.1-2987.1.	F 155	2. An audit of all current DDNR forms was completed by Unit Managers to ensure accuracy and completion. 3. The facility's physician assistant was in-serviced by the Assistant Director of Nursing related to accurate completion of DDNR forms. 4. All new DDNR forms will be reviewed to ensure accuracy and completion. This will be completed on a daily basis for four weeks. 5. Any discrepancies will be brought to QA committee and addressed as needed. Completion date: 11/9/16.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495209	A. BUILDING _____ B. WING _____	C 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RALEIGH COURT HEALTH AND REHABILITAT	1527 GRANDIN ROAD SOUTHWEST ROANOKE, VA 24015

(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 155	Continued From page 2	F 155		

Durable Do Not Resuscitate Orders. A. A Durable Do Not Resuscitate Order may be issued by a physician for his patient with whom he has a bona fide physician/patient relationship as defined in the guidelines of the Board of Medicine, and only with the consent of the patient or, if the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order, upon the request of and with the consent of the person authorized to consent on the patient's behalf.

On September 21, 2016 at 10:10 a.m. the surveyor notified the Assistant Director of Nursing (ADON) that Resident #14's DDNR/Golden Rod was not complete and accurate. The surveyor pointed out that the DDNR/Golden Rod was not coded as to whether Resident #14 was Capable or Incapable of making an informed decision about providing, withholding or withdrawing specific medical treatment or course of medical treatment. The ADON verified that the section of the DDNR/Golden Rod that certified whether or not Resident #14 was Capable or Incapable of making an informed decision was not complete and accurate. The surveyor notified the ADON that the DDNR/Golden Rod was part of the clinical record and was inaccurate and incomplete.

On September 21, 2016 at 4:50 p.m. the surveyor notified the Administrator (Adm), Director of Nursing (DON), Corporate Compliance Nurse (CCN) and ADON that Resident #14's DDNR/Golden Rod was incomplete/inaccurate. The surveyor notified the Administrative Team (AT) that Resident #14's DDNR/Golden Rod was not completed to certify whether or not Resident #14 was Capable or Incapable of making an informed decision regarding care and treatment. The surveyor specifically pointed out that the DDNR/Golden Rod was a part of Resident #14's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495209	A. BUILDING _____ B. WING _____	C 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RALEIGH COURT HEALTH AND REHABILITAT	1527 GRANDIN ROAD SOUTHWEST ROANOKE, VA 24015

(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 155	Continued From page 3 clinical record and was not complete or accurate. No further information was provided to the team prior to exiting the facility as to why the staff failed to ensure a complete and accurate DDNR/Golden Rod for Resident #14.	F 155		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: Based on observation, staff & family interview and clinical record review, it was determined the facility staff failed to follow care-planned interventions to prevent accidents (falls) for 1 of 24 residents (Resident #18.) Findings: Facility staff failed to follow care-planned interventions to prevent accidents (falls) for Resident #18. The resident's clinical record was reviewed on 9/21/16 at 5:00 PM. Resident #18 was admitted to the facility on 4/10/15. Her diagnoses included anemia, atrial fibrillation, hypertension, arthritis, fracture, Alzheimer's dementia, depression and COPD (chronic obstructive pulmonary disease.) Resident #18's latest MDS (minimum data set) assessment, dated 8/22/16 coded the resident with significant cognitive impairment due to	F 323	F323 FREE OF ACCIDENT HAZARDS/SUPERVISION/ DEVICES 1. Resident #18 bed was lowered by family while surveyors were on site. 2. A thorough round was completed to ensure residents identified as fall risks had their beds lowered to the floor. 3. All current nursing staff was in-serviced by the Staff Development Coordinator related to lowering residents' beds to lowest position after nursing care is provided. 4. Staff Development Coordinator or designee will complete rounds to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495209	A. BUILDING _____ B. WING _____	C 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RALEIGH COURT HEALTH AND REHABILITAT	1527 GRANDIN ROAD SOUTHWEST ROANOKE, VA 24015

(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 4 Alzheimer's disease. The resident was documented as rarely/never understands others. The MDS coded the resident as needing the support of staff members to accomplish all the ADLs (activities of daily living.) She was unable to ambulate, even with staff assistance. She was documented with two falls (without injury) since the most recent prior assessment and one fall with a major injury since the most recent prior assessment. The MDS care area assessment triggered for falls. Resident #18 was careplanned for falls as a result. Resident #18's CCP (comprehensive care plan) reviewed and revised on 9/2/16 included a focus on "Actual fall and at risk for fall r/t impaired mobility; dementia; psychotropic medication use." Interventions for staff included, "Assistive devices: assist bars, bed alarm, concave mattress, low bed with mat, broda chair, chair pad alarms.....Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs...." On 8/16/16 the physician signed and dated the following order to nursing staff, "Keep right arm cast clean and dry at all times, every shift." The nursing progress notes were reviewed: 1. 8/15/16 @ 2:20 AM - ".....Alarm was sounding went to check res(ident) on floor beside bed on fall mat....continue to monitor." 2. 8/15/16 @ 12:10 PM - ".....Resident's right arm observed swollen, and tender to touch. (Name of doctor) present and made aware...examined resident and ordered x-ray for right arm....."	F 323	residents that are identified as fall risks' beds are in lowest position. This will be done three times a week for four weeks. 5. Any discrepancies will be brought to QA committee and addressed as needed. Completion date: 11/9/16.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495209	A. BUILDING _____ B. WING _____	C 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RALEIGH COURT HEALTH AND REHABILITAT	1527 GRANDIN ROAD SOUTHWEST ROANOKE, VA 24015

(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 5	F 323		

On 8/15/16 the x-ray was documented as follows: ".....Acute non-displaced fracture of the distal humerus...."

Additional documentation indicated the resident was sent to the orthopedic doctor on 8/16/16 and returned with a cast to the right arm. The orthopedic specialist documented the following progress note for that visit, "Nondisplaced .... distal humerus fx (fracture)....Will put in arm cast...must keep dry..."

On 9/22/16 at 4:00 PM Resident #18 was observed in her bed. She had a cast on her right arm. The resident was fidgeting and trying to leave off the right side of the bed. A floor mat was on the right side of the bed. The bed was at a normal height at which care would be provided.

Resident #18's family member was in the room and told the surveyor the resident had a lot of falls since her admission. The family member told the surveyor the nursing staff was supposed to keep the bed in a low position because the resident was a fall risk--but they never lowered it back after providing care. She picked up the bed control and lowered the bed to it's lowest height--then called facility staff in to reposition the resident.

Facility staff came into the room (CNAs I and II) and raised the bed back up to reposition the resident and provide incontinence care. After CNA I and II left the room the surveyor reentered and found the bed left in a high position. The family member then got up and once again lowered it.

On 9/22/16 at 12:20 PM, the surveyor's findings

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495209	A. BUILDING _____ B. WING _____	C 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RALEIGH COURT HEALTH AND REHABILITAT	1527 GRANDIN ROAD SOUTHWEST ROANOKE, VA 24015

(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 6 were shared with the administrator and director of nursing. No additional information was provided.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic 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 and clinical record review, facility staff failed to ensure residents were free of medications administered without adequate indication for 2 of 24 residents in the survey sample (Residents #9 and 11). 1. For Resident #11, facility staff failed to ensure the antipsychotic medication Seroquel was	F 329	F329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 1. The psychotropic medication was justified for residents #11 and #9 by identifying adequate indications by licensed nursing staff and medical staff while surveyors were on site. 2. An audit of all current residents receiving psychotropic medication was done by Unit Manager and appropriate documentation for behaviors was added to the electronic medical record to ensure adequate indication for drug use. 3. Licensed nursing staff was in-serviced by the Staff Development Coordinator related to proper documentation on behaviors	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495209	A. BUILDING _____ B. WING _____	C 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RALEIGH COURT HEALTH AND REHABILITAT	1527 GRANDIN ROAD SOUTHWEST ROANOKE, VA 24015

(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 7 administered only with adequate indication. Resident #11 was admitted to the facility on 11/10/16 with diagnoses including Alzheimer's dementia, atrial fibrillation, and gastroesophageal reflux disease. On the minimum data set assessment with assessment reference date 8/29/16, the resident scored 15/15 on the brief interview for mental status and was assessed without delirium or psychosis. During clinical record review on 9/21/16, the surveyor noted a physician order dated 9/9/16 for Seroquel 50 mg daily for psychosis. A "Geriatric Psychiatry Consult Note" dated 9/9/16 listed reason for consult as " Nursing Report: Resident refused medication. Experienced increased behavior." Chief complaint was dementia; remains suspicious, has been refusing meds and worsening neuropsychiatric symptoms reported since Seroquel was tapered off. The surveyor was unable to locate nursing progress notes or other documentation of symptoms of psychosis or increased behaviors affecting others. The medication administration record for September 2016 did not document any behavior symptoms. The MAR documented evening medication refusals. Every medication refusal was documented by the same nurse. That nurse documented continued refusals after initiation of Seroquel on 9/9/16. The surveyor discussed the concern that dementia and medication refusal were not approved indications for antipsychotic medications with the administrator and director of nursing on 9/22/16.	F 329	for residents receiving psychotropic medication. 4. Unit Manager will audit six residents' medical records to ensure appropriate documentation of behaviors indicating psychotropic medication usage. This will be completed three times a week for four weeks. 5. Any discrepancies will be brought to QA committee and addressed as needed. Completion date: 11/9/16.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495209	A. BUILDING _____ B. WING _____	C 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RALEIGH COURT HEALTH AND REHABILITAT	1527 GRANDIN ROAD SOUTHWEST ROANOKE, VA 24015

(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 8 2. For Resident #11, facility staff failed to ensure the antipsychotic medication Seroquel was administered only with adequate indication. Resident #9 was admitted to the facility on 10/4/14 with diagnoses including gastrointestinal bleed, hypertension, atrial fibrillation, pain, and dementia with behavioral disturbance. On the minimum data set assessment with assessment reference date 6/29/16, the resident scored 3/15 on the brief interview for mental status and was assessed without symptoms of delirium, psychosis, or behavioral symptoms. During clinical record review on 9/21/16, the surveyor noted a physician order dated 8/29/16 for Seroquel 25 mg at bedtime related to unspecified dementia with behavioral disturbance. The surveyor was unable to locate nursing progress notes or other documentation of symptoms of increased behaviors affecting others. The medication administration record for September 2016 did not document any behavior symptoms. The surveyor discussed the concern that dementia and behavior symptoms were not approved indications for antipsychotic medications with the administrator and director of nursing on 9/22/16.	F 329		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441	F441 INFECTION CONTROL, PREVENT SPREAD, LINENS 1. Identified staff members LPN #1, LPN #2, and RN #1 were educated on infection	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495209	A. BUILDING _____ B. WING _____	C 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RALEIGH COURT HEALTH AND REHABILITAT	1527 GRANDIN ROAD SOUTHWEST ROANOKE, VA 24015

(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 441	Continued From page 9	F 441		

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident, and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

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 maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection during the medication pass on 2 of 2

control and medication administration policies while surveyors were on site.

2. An audit of all medication carts was performed by Staff Development Coordinator to ensure proper infection control measures were being followed.

3. All licensed nursing staff was in-serviced by the Staff Development Coordinator related to infection control and medication administration policies, specifically cleaning the glucometer before and after use, as well as appropriate measures to be taken when medication is dropped.

4. Staff Development Coordinator or designee will complete rounds and medication pass observations to ensure infection control policies and medication administration policies are

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495209	A. BUILDING _____ B. WING _____	C 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RALEIGH COURT HEALTH AND REHABILITAT	1527 GRANDIN ROAD SOUTHWEST ROANOKE, VA 24015

(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 441	Continued From page 10 units. The findings included: During a medication pass observation on 9/20/16 at 3:40pm the surveyor observed LPN #1 take a glucometer from the medication cart drawer along with a lancet an alcohol pad and gauze pad. He then locked his cart and taking the glucometer and other items with him he entered a resident ' s room. LPN # 2 told the resident that he was going to check her blood sugar. He then laid the glucometer on the bed and opened the alcohol pad and cleaned the resident ' s finger and then obtained the blood completing the procedure. He went to the sink and washed his hands laying the glucometer on the sink. After washing his hands he went back to the medication cart and opened the cart and drawer and placed the glucometer in the drawer. He told the surveyor he was going to the next resident. LPN #1 did not clean the glucometer before use nor was it cleaned after it was used. On 9/21/16 at 7:35 am, the surveyor asked RN #1 to observe her medication pass. During the medication pour for the second resident the first pill landed on the top of the medication cart and RN #1 quickly scooped it up with the medication cup. After pouring several more medications a second pill hit the top of the medication cart. This pill was picked up and placed in the trash. RN #1 then administered the medication to Resident #21. On 9/21/16 at approximately 3:55 pm the surveyor observed LPN #2 during medication pass. LPN #2 removed a basket containing a glucometer and supplies from her cart drawer. She then cleaned the machine with alcohol pads	F 441	being followed appropriately. This will be done three times a week for four weeks. 5. Any discrepancies will be brought to QA committee and addressed as needed. Completion date: 11/9/16.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495209	A. BUILDING _____ B. WING _____	C 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RALEIGH COURT HEALTH AND REHABILITAT	1527 GRANDIN ROAD SOUTHWEST ROANOKE, VA 24015

(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 441	Continued From page 11	F 441		

and placed the machine back into the basket. Picking up the basket she entered a residents room and set the basket down on the over bed table. After completing the blood sugar check she washed her hands and took the basket back to the medication cart. LPN #2 then cleaned the glucometer with an alcohol pad and placed it back into the basket and put the basket into the cart. The basket was not cleaned prior to or after use.

On 9/22/16 at 10.15 am the administration staff was informed of the above medication pass infection control concerns. The director of nurses said these are all new staff.

The facility infection control policy titled Cleaning and Disinfecting Guidelines revealed the following: to clean the outside of the blood glucose meter, use a lent-free cloth dampened with soapy water or isopropyl alcohol. The medication policy titled 6.0 General Dose Preparation and Medication Administration read under 6.4 Clean any reusable equipment or supplies.

Prior to exit on 9/22/16 the requested infection control and medication policy and procedures were provided to the surveyor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495209	A. BUILDING _____ B. WING _____	09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RALEIGH COURT HEALTH AND REHABILITATION C	1527 GRANDIN ROAD SOUTHWEST ROANOKE, VA 24015

(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) COMPLETE DATE
F 000	Initial Comments An unannounced Medicare/Medicaid standard survey and a Biennial State Licensure Inspection was conducted 9/20/16 through 9/22/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 113 at the time of the survey. The survey sample consisted of 20 current Resident reviews (Resident #1 through Resident #20) and 4 closed record reviews (Resident #21 through Resident #24).	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities. Physician Services 12 VAC 5-371-240 (D)-Cross reference to F tag 155 Nursing Services 12 VAC 5-371-220 (B)-Cross reference to F tag 323 and F tag 329 Infection Control 12 VAC 5-371-180 (C)-Cross reference to F tag 441	F 001		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mark Tuba — TITLE: Administrator — (X6) DATE: 10/18/2016