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 09/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RALEIGH COURT HEALTH AND REHABILITATION CENTER	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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 09/16/2020 through 09/21/2020. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. One complaint (unsubstantiated) was investigated during the survey.	E 000		
F 000	INITIAL COMMENTS A unannounced COVID-19 Focused Infection Control Survey was conducted onsite on 09/16/2020 and offsite 09/16/2020 through 09/21/2020. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Corrections are not required for compliance with F-880 of 42 CFR Part 483 Federal Long Term Care requirement(s). One complaint (unsubstantiated) was investigated during the survey. The census in this 120 certified bed facility was 71 at the time of the onsite survey. Of the 71 residents 31 were positive for COVID-19 during the onsite portion of the survey. Eleven residents had expired and 10 staff were currently positive for COVID-19 with no reported deaths.	F 000		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information	F 842		10/5/20

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

Electronically Signed | 09/30/2020

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 09/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RALEIGH COURT HEALTH AND REHABILITATION CENTER	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 842	Continued From page 1 except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for-	F 842		

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 09/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RALEIGH COURT HEALTH AND REHABILITATION CENTER	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 842	Continued From page 2 (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interviews and the review of documents, it was determined the facility staff failed to ensure a complete and/or accurate clinical record for seven (7) of seven (7) sampled residents (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6 and Resident #7). The findings include: The facility staff failed to ensure the seven (7) sampled residents' clinical records included the documentation of respiratory surveillance assessments for residents who had not tested positive for COVID-19. Review of sample resident's clinical documentation failed to reveal evidence of screening/monitoring assessments prior to the	F 842	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F842 Residents #1, #2, #3, #4, #5, #6, and #7	

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 09/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RALEIGH COURT HEALTH AND REHABILITATION CENTER	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 842	Continued From page 3 residents' testing positive for the COVID-19 virus. The following information was found on the CDC (Centers for Disease Control and Prevention) website in a document titled "Preparing for COVID-19 in Nursing Homes": "Actively monitor all residents upon admission and at least daily for fever (T>100.0 F) and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry. If residents have fever or symptoms consistent with COVID-19, implement Transmission-Based Precautions as described below. Older adults with COVID-19 may not show common symptoms such as fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell. Additionally, more than two temperatures >99.0 F might also be a sign of fever in this population. Identification of these symptoms should prompt isolation and further evaluation for COVID-19. (https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html) The following information was found in a facility policy and procedure titled "Documentation Summary" (with an effective date of 11/1/19): "Licensed Nurses and CNAs will document all pertinent nursing assessments, care interventions, and follow up actions in the medical record." On 9/18/2020 at 9:55 a.m., during a survey team telephone interview with the facility's Administrator, Director of Nursing, Infection Preventionist, and Corporate Nurse the facility's process for assessment/surveillance of residents	F 842	have respiratory surveillance documented in the electronic clinical record. Current residents were reviewed to ensure respiratory surveillance is documented in the electronic clinical record. Corrections will be made as necessary. Current nurse managers were educated on the order entry process to enter respiratory surveillance prompts to appear on the MAR for documentation by the nurses. Current nurses were educated on the need to document these in the electronic medical record. Nursing administration will review 10 residents' electronic respiratory surveillance weekly x 2 weeks to ensure procedures are being followed. Any issues will be addressed immediately at the time of observation. Process will be reviewed in QA committee x 1 quarter 10-5-2020	

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 09/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RALEIGH COURT HEALTH AND REHABILITATION CENTER	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 842	Continued From page 4	F 842		

who had not tested positive for COVID-19 was discussed. The DON reported that residents who had not tested positive for COVID-19 were assessed every shift. The DON reported this information was documented on a form titled "Resident Respiratory Evaluation". This form was not maintained as part of residents' clinical documentation. This form had multiple resident names with their respective "Respiratory Evaluation" documented on the same sheet.

On 9/18/2020 at 9:05 a.m., a nurse practitioner (NP) who cared for Resident #6 was interviewed about the resident's symptoms and testing. The NP reported that he/she would not have reviewed the "Resident Respiratory Evaluation" forms that were not a part of the resident's clinical documentation; the NP clarified that he/she was not a part of the "primary care team".

Several days of the "Resident Respiratory Evaluation" forms were reviewed. It was noted that not all "Resident Respiratory Evaluation" forms had a nurse's signature to indicated who had completed the form. During a telephone interview on 9/18/2020 at 1:55 p.m., the DON was asked about the aforementioned absence of nurses' signatures. The DON stated, "We want them to put their name on it."

During a survey team meeting, on 9/18/2020 at 1:55 p.m. with the facility's Administrator, DON, and Corporate Nurse, the failure of the facility staff to ensure that residents' respiratory evaluations (for residents that had not tested positive for COVID-19) were documented in the residents' clinical records was discussed for a final time.