| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495156 | A. BUILDING _____ B. WING _____ | R-C 09/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ACCORDIUS HEALTH AT ROANOKE | 324 KING GEORGE AVE SW ROANOKE, VA 24016 |

| (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 |
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| {E 000} | Initial Comments | {E 000} | | |
| {F 000} | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid revisit to the standard survey conducted 8/01/21 through 8/05/21, was conducted 9/22/21 through 9/23/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. No complaints were investigated during the survey.<br><br>The census in this 130 certified bed facility was 56 at the time of the survey. The survey sample consisted of 16 resident reviews. | {F 000} | | |
| {F 656} SS=D | Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). | {F 656} | **F656 Develop/Implement Comprehensive Care Plan**<br><br>1. **Care plan was updated for resident #101 on September 22, 2021.**<br>2. **Facility conducted an audit of care plans on September 29, 2021 for residents with dycem orders. Identified issues were addressed and care plans were updated.**<br>3. **Education of leadership team, nursing staff, and MDS on September 28, 2021 on care plan development.**<br>4. **DON or designee will conduct weekly audits of care plans for those residents using dycem x 4 weeks, then monthly x 2 months, with audits being presented to QAPI for accountability.**<br>5. **Date of compliance: October 15, 2021.** | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Joan Burnette | Administrator | 10/11/21 |

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

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| {F 656} | Continued From page 1<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to implement a comprehensive person-centered care plan for 1 of 16 residents in the survey sample, Resident #101.<br><br>For Resident #101, the facility staff failed to implement the person-centered care plan intervention for the use of Dycem (a non-slip material) in their wheelchair.<br><br>Resident #101's diagnosis list indicated diagnoses, which included, but not limited to Typical Atrial Flutter, Dementia in Other Diseases Classified Elsewhere without Behavioral Disturbance, Chronic Obstructive Pulmonary Disease Unspecified, History of Falling, and | {F 656} | | |

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| {F 656} | Continued From page 2<br>Anxiety Disorder Unspecified.<br><br>The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 9/15/21 coded the resident as being severely impaired in cognitive skills for daily decision making with short-term and long-term memory problems in section C, Cognitive Patterns. In section G, Functional Status, Resident #101 was coded as requiring extensive assistance with transfers, toilet use, and personal hygiene.<br><br>A review of Resident #101's comprehensive person-centered care plan revealed a focus area stating "(Resident #101) is a high risk for falls r/t (related to) impaired mobility and balance, safety awareness d/t (due to) dementia" with an intervention dated 3/18/14 stating "Dycem in W/C (wheelchair)".<br><br>On 9/22/21 at 2:08 pm, in the presence of the surveyor, CNA (certified nursing assistant) #1 and CNA #2 assisted Resident #101 to a standing position from their wheelchair and Dycem was not present on top or underneath the wheelchair cushion in the resident's wheelchair. CNA #1 and CNA #2 assisted Resident #101 to bed following the observation.<br><br>On 9/22/21 at 4:25 pm, surveyor met with the DON (director of nursing) and the MDS Coordinator and discussed the observation of Resident #101 sitting in their wheelchair without Dycem in place. The DON stated Dycem was now in place in Resident #101's wheelchair.<br><br>Surveyor requested and received the facility policy entitled, "Comprehensive Care Plans" which states in part, "Qualified staff responsible | {F 656} | | |

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| {F 656} | Continued From page 3<br>for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made".<br><br>No further information regarding this issue was presented to the survey team prior to the exit conference on 9/23/21. | {F 656} | | |
| {F 657} SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. | {F 657} | **F657 Care Plan Timing and Revision**<br>**1. Care plan was updated to for resident #102 on September 22, 2021.**<br>**2. Facility conducted an audit of care plans for residents with NPO orders on September 29, 2021 with identified issues addressed and care plans updated.**<br>**3. Education of leadership team, nursing staff, and MDS on September 28, 2021 on care plan development.**<br>**4. DON or designee will conduct weekly audits of care plans for those residents that are NPO x 4 weeks, then monthly x 2 months, with audits being presented to QAPI for accountability.**<br>**5. Date of compliance: October 15, 2021.** | |

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| {F 657} | Continued From page 4<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, clinical record review, and facility document review, the facility staff failed to review and revise the comprehensive person-centered care plan for 1 of 16 residents in the survey sample, Resident #102.<br><br>For Resident #102, the facility staff failed to revise the care plan for the resident's diet order.<br><br>Resident #102's diagnosis list indicated diagnoses, which included, but not limited to Hemiplegia and Hemiparesis following Cerebral Infarction affecting Right Dominant Side, Type 2 Diabetes Mellitus with Hyperglycemia, End Stage Renal Disease, Dysphagia Oropharyngeal Phase, and Adult Failure to Thrive.<br><br>The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 9/17/21 assigned the resident a BIMS (brief interview for mental status) score of 0 out of 15 in section C, Cognitive Patterns. Resident #102 was coded as requiring extensive assistance in eating in section G, Functional Status.<br><br>A review of Resident #102's current comprehensive person-centered care plan on 9/22/21 included a focus area stating "ADL (activities of daily living) self-care performance deficit r/t (related to) Stroke" with interventions stating in part "NPO (nothing by mouth)" and "Consumes a pureed diet".<br><br>Resident #102's current physician's orders included a diet order stating "AHR-Renal Diet, AHR-Puree texture, AHR-Nectar Thickened Fluids consistency, for nutrition needs" and an | {F 657} | | |

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|---|---|---|---|
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| {F 657} | Continued From page 5<br>enteral feeding order stating "continuous feeding Glucerna 1.5 at 65 hour".<br><br>On 9/22/21 at 4:24 pm, surveyor met with the DON (director of nursing) and MDS Coordinator and discussed the concern of Resident #102's care plan including the current interventions of "NPO" and "consumes a pureed diet". At approximately 4:45 pm, the MDS Coordinator stated they removed "NPO" from the resident's current care plan. On 9/23/21 at 1:49 pm, the MDS Coordinator stated at one point Resident #102 was NPO but it was not removed from the care plan.<br><br>No further information regarding this issue was presented to the survey team prior to the exit conference on 9/23/21. | {F 657} | **F677 ADL Care Provided for Dependent Residents**<br><br>**1. Resident # 109: Fingernails and toenails were trimmed and cleaned on September 26, 2021.**<br>**2. Facility audit of fingernails was conducted on September 27, 2021 with issues addressed.**<br>**3. Education of Licensed Nursing staff and Certified Nursing Assistants for ADL care and documentation on September 28, 2021.**<br>**4. DON or designee will conduct weekly audits of fingernails and toenails x 4 weeks, then monthly x 2 months, with audits being presented to QAPI for accountability.**<br>**5. Date of Compliance: October 15, 2021** | |
| {F 677} SS=D | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and clinical record review, the facility staff failed to ensure that residents who are unable to carry out ADLs (activities of daily living) receive the necessary care and services to maintain personal hygiene and grooming for 1 of 16 residents in the survey sample, Resident #109.<br><br>For Resident #109, the facility staff failed to provide nail care. Resident #109's fingernails were observed to be long with dark debris | {F 677} | | |

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| {F 677} | Continued From page 6<br>present under the nails.<br><br>Resident #109's diagnosis list indicated diagnoses, which included, but not limited to Quadriplegia C1-C4 Incomplete, Chronic Obstructive Pulmonary Disease Unspecified, Acute and Chronic Respiratory Failure with Hypercapnia, and Paranoid Schizophrenia.<br><br>The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 9/15/21 assigned the resident a BIMS score of 14 out of 15 in section C, Cognitive Patterns. In section G, Functional Status, Resident #109 was coded as being totally dependent on staff for personal hygiene and bathing.<br><br>Resident #109's current comprehensive person-center care plan included a focus area stating "(Resident #109) has an ADL self-care performance deficit r/t (related to) quadriparesis [sp], ventilator and tracheostomy dependent, PEG dependent" with an intervention dated 12/30/20 stating "check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse".<br><br>Surveyor reviewed Resident #109's bathing documentation and the resident received a bed bath on 9/21/21.<br><br>On 9/23/21 at 9:15 am, with the assistance of Respiratory Therapist #1, surveyor observed Resident #109 in bed, fingernails on both hands were long with dark debris present under the nails. Surveyor asked the resident if they liked the length of their nails, however, the resident did not respond to the surveyor. Surveyor notified the DON (director of nursing) and the MDS | {F 677} | | |

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| {F 677} | Continued From page 7<br>Coordinator of the concern of Resident #109's long fingernails with dark debris present.<br><br>No further information regarding this issue was presented to the survey team prior to the exit conference on 9/23/21. | {F 677} | | |
| {F 695} SS=D | Respiratory/Tracheostomy Care and Suctioning<br>CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to maintain respiratory equipment for 1 of 16 residents in the survey sample, Resident #105.<br><br>For Resident #105, the facility staff failed to store the resident's nebulizer mask in a manner to prevent contamination.<br><br>Resident #105's diagnosis list indicated diagnoses, which included, but not limited to Acute and Chronic Respiratory Failure with Hypoxia, Chronic Diastolic (Congestive) Heart Failure, Chronic Obstructive Pulmonary Disease Unspecified, and Chronic Kidney Disease Stage 3 Unspecified. | {F 695} | **F695**<br>**Respiratory/Tracheostomy Care and Suctioning**<br><br>1. **Resident #105: Nebulizer mask and tubing disposed of and new set provided with plastic bag for storage on September 23, 2021.**<br>2. **Audit of nebulizer residents, replacing sets with new sets and plastic bags for storage on September 27, 2021.**<br>3. **Education of Licensed Nursing staff on policy and procedure for storage of nebulizer equipment on September 28, 2021.**<br>4. **DON or designee will conduct weekly audits of nebulizer** residents x 4 weeks, then **monthly x 2 months, with audits being presented to QAPI for accountability.**<br>5. **Date of Compliance: October 15, 2021** | |

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| {F 695} | Continued From page 8<br>The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 8/31/21 assigned the resident a BIMS (brief interview for mental status) score of 14 out of 15 in section C, Cognitive Patterns.<br><br>Resident #105's current physician's orders included an order dated 5/13/21 stating "Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML 1 application inhale orally every 4 hours as needed for sob (shortness of breath)/wheezing".<br><br>On 9/22/21 at 12:15 pm, surveyor observed Resident #105 resting in bed with the overbed table directly beside the bed. Surveyor observed the resident's nebulizer machine, tubing, and uncovered nebulizer mask on the overbed table. Surveyor again observed the resident's nebulizer mask uncovered on the overbed table at 2:10 pm. On each observation, surveyor did not observe a bag available for use near the nebulizer mask.<br><br>Surveyor entered Resident #105's room on 9/23/21 at 8:16 am and the nebulizer mask was covered with a clear plastic bag. Surveyor returned to Resident #105's room again at 10:49 am and the resident's nebulizer mask on lying directly on the overbed table beside the clear plastic bag.<br><br>A review of Resident #105's September 2021 MAR (medication administration record) revealed Ipratropium-Albuterol was last administered on 9/13/21.<br><br>Surveyor requested and received the facility policy entitled, "Nebulizer Therapy" which stated in part, "Once completely dry, store the nebulizer | {F 695} | | |

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|---|---|---|---|---|
| {F 695} | Continued From page 9<br>cup and mouthpiece in a zip lock bag".<br><br>On 9/23/21 at 12:03 pm, surveyor met with the MDS Coordinator and discussed the concern of Resident #105's nebulizer mask observed to be uncovered on three out of four observations. The MDS Coordinator stated Resident #105 removes their nebulizer mask from the bag and they will check the care plan to see if this has been documented on the care plan. MDS Coordinator returned with a copy of Resident #105's care plan for a focus area dated 9/08/21 and revised on 9/23/21 stating "(Resident #105) has a dx (diagnosis) COPD (chronic obstructive pulmonary disease), hx (history) of respiratory failure, hx of O2 (oxygen) use, cdCHF [sp] (congestive heart failure)" and "9/23/21 (Resident #105) becomes upset when face mask nebulizer is placed in a bag". An intervention dated 9/23/21 states "Encourage (Resident #105) to allow staff to place nebulizer set in O2 bag".<br><br>No further information regarding this issue was presented to the survey team prior to the exit conference on 9/23/21. | {F 695} | | |
| {F 919} SS=E | Resident Call System<br>CFR(s): 483.90(g)(2)<br><br>§483.90(g) Resident Call System<br>The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area.<br><br>§483.90(g)(2) Toilet and bathing facilities.<br>This REQUIREMENT is not met as evidenced by: | {F 919} | | |

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| (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 |
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| {F 919} | Continued From page 10<br>Based on observation and staff interview, facility staff failed to maintain a call system that allowed all residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area as evidenced by failure of call systems in resident rooms and bathrooms failing to sound or light when activated.<br><br>On 9/23/2021 at 10 AM, surveyors checked call systems in each resident room and restroom. Surveyors found call buttons for beds 20A, 21A, 63A, 63B, and 58B did not sound and/or light in the hall when activated. Call buttons for bathrooms between room 10/12, 19/21, and 57/58 did not light in the hallway when activated.<br><br>The maintenance director stated that all room and bathroom call bells worked when checked a month prior. The maintenance director was able to fix each issue as it was reported. Facility staff were unable to verbalize the procedure ensuring the call system remained fully functional.<br><br>The director of nursing and minimum data set assessment coordinator were notified of the concern with assessing and maintaining call system function during plan of correction review on 9/23/21. | {F 919} | **F919 Resident Call System**<br><br>1. **Room 20A, 21A, 63A, 63B, 58B call light system repaired on September 22, 2021. Room 10/12, 19/21, and 57/58 shared bathroom call light system repaired, September 22, 2021.**<br>2. **Audit of call bell system by Maintenance Director with noted issues corrected. September 24, 2021.**<br>3. **Education of Maintenance Director on Policy and Procedure for Call Light System on September 27, 2021.**<br>4. **Maintenance Director or designee will conduct a weekly audit of Call Light System weekly x 4 weeks then monthly x 6 months, with audits being presented to QAPI** for accountability.<br>5. **Date of Compliance: October 15, 2021** | |