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 12/14/2020

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

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E 000	Initial Comments An unannounced Emergency Preparedness (EP) COVID-19 Focused Survey was conducted onsite on 12/1/2020. Emergency Preparedness information was reviewed off site on 12/1 through 12/14/2020. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced abbreviated complaint and COVID-19 Focused Infection Control Survey was conducted onsite on 12/1/2020. Infection Control information was reviewed off site on 12/1 through 12/14/20. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirement. No corrections are required with F-880 of 42 CFR Part 483 Federal Long Term Care requirement(s). On 12/1/2020, the census in the 120 certified bed facility was 92. On 12/1/2020, 6 residents tested positive for COVID-19.	F 000		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on family interview, staff interview,	F 684	The statements made in the following	2/8/21

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

Electronically Signed | 01/17/2021

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 684	Continued From page 1 complainant interview, clinical record review and facility record review, and during a complaint investigation, facility staff failed to provide assessment and treatment as evidenced by failure to treat and assess a non-pressure skin wound as it progressed to a full thickness wound for 1 of 3 residents in the survey sample (Resident #1). Resident #1 was admitted to the facility with diagnoses including congestive heart failure, peripheral vascular disease (PVD), left lower limb cellulitis (dx. 8/11/2020), tinea pedis (dx. 8/11/2020), diabetes mellitus with diabetic chronic kidney disease and diabetic ophthalmic complication, presence of cardiac pacemaker, osteoarthritis, and atrial fibrillation. On the minimum data set assessment with assessment reference date 8/12/2020, the resident scored 9/15 on the brief interview for mental status and was assessed as vision and hearing impaired, and without signs of delirium, psychosis, or behaviors affecting care. The resident was assessed as having no venous or arterial ulcers and with an infection of the foot. The surveyor spoke with the resident's responsible party (RP) by phone on 12/2/2020. The RP repeated the complainant's allegations that the resident had been admitted to the hospital with septic wounds requiring amputation. The RP stated the nurse assigned to the resident on 11/21 told the RP that Resident #1's condition was not an emergency and the resident could not be sent to the hospital. The RP stated that the resident was allowed to go to the hospital after she insisted and called 911. Hospital admission records documented that the	F 684	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. 1. Resident #1 no longer resides in the facility. 2. Current Residents were reviewed to determine presence of skin impairments and to ensure assessment and treatment is accurate. Corrections were made at the time of identification. 3. Licensed nursing staff were educated regarding procedure for weekly skin evaluations to include assessment of skin impairments, evaluation of treatment, and notification of physician. Nursing leadership will review current Residents with skin impairment weekly X 8 weeks to validate assessment and current treatment. The physician will be notified as necessary. Corrections will be made at the time of identification. 4. Process will be reviewed in QA committee X 1 quarter.	

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F 684	Continued From page 2 resident arrived at the hospital with EMS on 10/21/2020 at 18:04. Notes indicated EMT had reported during transport a BP 70/0 at transport and had been told to administer 1 liter NS bolus. Hospital ED notes documented the resident's blood pressure on 10/21 at 18:13 was 119/56. The resident was documented to have toe wounds with odorous, purulent drainage and visible bone. The resident's left 2nd and 3rd toes were amputated on 10/22/2020 and the resident was treated for sepsis from the wounds. The surveyor noted a physician order dated 8/4/2020 for CLEANSE LEFT FOOT &LEFT TOES WITH NS, PAT DRY. WRAP IN KERLIX, WRAP IN ACE. weeping left foot and left toes related to CHRONIC DIASTOLIC (CONGESTIVE) HEART FAILURE. The treatment administration record recorded administration of the treatment twice per day from 8/5/2020 through 10/5/2020 with the exception of 9/9 day shift and 9/15 evening shift. No descriptions of the foot and toes or wounds were documented in progress notes, wound care notes or skin assessment notes in the clinical record. The surveyor noted a physician order dated 10/5/2020 for Cleanse Left 2nd and 3rd Toes with NS. Apply Santyl, NAD, and Wrap with Kerlix then ACE Wrap every day shift for wound care. Again, there was no description of the foot and toes or any wounds on the foot and toes. Clinical record review revealed multidisciplinary progress notes documented no foot lesions prior to 8/11/20, when left lower limb cellulitis and tinea pedis were diagnosed. There were no nursing notes between 8/3/20 and 8/11/20. The 8/11/20 Medical (MD, NP,PA)note	F 684	5. 2-8-20 6. Amy Taylor, DON	

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F 684	Continued From page 3 documented the resident was seen for nursing concern of warmth and drainage to left foot. The physical exam note by PA "yeasty rash along dorsal side of left toes, weeping and crusting over, between toes bilaterally is erythematous and moist with odor noted. There is erythema (dorsal side of left foot warm and tender to touch)...Tinea pedis of both feet, cellulitis of left foot, start lotrimin AF powder to bilateral toes and in between toes bid X 4 weeks, start keflex 500 mg q6 hours X 10 days. Nursing notes document treatment of cellulitis to RIGHT foot: on 8/11/20 at 14:45 and 12:43; on 8/12 at 01:58, 13:20, and 19:53, on 8/13 at 00:18 and 21:34; on 8/14 at 07:00 and 23:22: 8:15 and 21:50. Notes continued to indicate treatment for right foot cellulitis until a nursing note dated 8/20/20 at 21:10 indicated the LLE (left lower extremity) dressing was changed. No description of the condition of the wound or drainage characteristics were documented. No nursing notes were documented between 8/21 and 9/5. The next nursing note to mention foot or toes was a nursing "order note" dated 10/5/2020 "cleanse left 2nd and 3rd toes with NS (normal saline), apply Santyl, NAD, and wrap with Kerlix then ACE wrap every day shift for Wound Care. This note did not document the appearance of the foot, toes, or wound. No physician/nurse practitioner/physician assistant visit was associated with the order. The Medical Note (MD,NP, PA) dated 10/7/2020 documented "Edema (trace edema bilateral lower extremities) present. No tenderness." The note did not mention wounds, debridement, or dressing to lower extremities.	F 684		

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F 684	Continued From page 4 The next mention of the resident's foot in notes was a nursing note dated 10/17/2020 at 12:53 'this nurse changed dressing to rsd left foot, vascular wounds to top of foot noted to have increased drainage, green discharge, slough present, strong odor noted. this nurse cleaned wound, applied santyl as ordered and wrapped with kerlix, notified [sic] NP who placed a N. O. for Keflex 500 mg Q 8 hours x 10 days. RP made aware." Nursing notes documented the resident on antibiotics for wound infection without mention of wound appearance on 10/17 at 18:19, 10/18 at 06:26, 10/18 at 21:17, and 10:19 at 06:33. The next progress note after the 10:19 note was 10/21/2020 at 13:09 concerning ear wax treatment. A nursing note dated 10/21/20 at 14:22 documented the facility wound physician ordered a vascular surgery consultation and new wound treatment and that medical director and RP were aware. The 10/21/2020 visit was the only time the wound care physician saw the resident. A note dated 10/21/2020 at 18:26 titled Infection Note documented "Rsd still on ABX for wound infection on her left 2nd and 3rd toes. She tolerated the pill without any complications. No s/s of adverse reaction noted. No c/o of pain noted or voiced. VS 131/71, 97.3, 17, 60, 92%." [* See reference below] A note dated 10/21/2020 at 19:05 titled Health Status Note "[responsible party name] wants pt sent to Lewis Gale Salem for wound/vascular surgery evaluation. Order from [medical director name] to send pt out per family request. [* See reference below] A note dated 10/21/2020 at 22:47 titled Health Status Note "Resident admitted to LGH hospital. A late entry for discharge planning was made on 10/21/2020 at 11:18 (PM) Discharge Planning Progress notes Late entry: Resident D/C to hospital on 10/21/20. RP made aware of transport. "	F 684		

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F 684	Continued From page 5 The surveyor reviewed weekly skin assessments from 7/31/21 through discharge on 10/21/20. A McGeer assessment dated 8/11/2020 at 13:14 did not name a wound site, but the following items were checked A: pus present at wound, skin, or soft tissue and B: 2. Redness at the affected site, 3. Swelling at the affected site and C: a. Resident meets criteria for cellulitis, SSTI, wound infection. The 9/11/2020 Weekly Skin Evaluation documented the skin was intact without impairment and there were no wounds present. Under 5. Notes, the nurse documented "weeping left foot and toes. area wrap with 10/1/2020 documented and described a right lower leg skin tear and a left upper arm skin tear. Both skin tears were described under the Wound section of the form. Observations 5. Notes documented "weeping left foot and toes. area wrap with kerlix and ACE wrap." The surveyor requested the policies concerning skin assessments. Facility staff provided Policy #2401 titled Skin Assessments. The policy stated that skin assessments will be completed for all patients. Procedure: 1- licensed nurse to conduct skin risk assessments on admission and quarterly, 2-skin risk assessment on readmission, 3- weekly skin assessment, 4- care plan based on skin risk assessment and individual needs. The surveyor discussed the findings by phone with the facility administration team (Administrator and Director of Clinical Services) on 12/10/2020. The surveyor described the failure to document the condition of the resident's foot prior to initiation of treatment on 8/4/20 and failure to document condition of the foot either in nursing progress notes or in weekly skin assessment	F 684		

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F 684	Continued From page 6 notes. When asked, the director of clinical services (DCS) did say descriptions of wounds at treatment were expected. The only physician note addressing the wounds was the one dated 8/11/20. The one subsequent physician note did not address the wounds to the feet. ** Per clinical documentation, facility staff were unable to report when the resident left the facility or what her condition was when she left. Nursing staff were documenting the resident's status as if the resident was still in the building after the resident had been admitted to the hospital ED. The surveyor reported that the EMS low blood pressure was a concern, particularly when the facility clinical record did not document the resident's status at discharge. The surveyor expressed concern that the resident's foot was not assessed by a physician between 8/11/2020 and 10/21/2020. The administrator stated that the EMT low blood pressure was likely an error in light of the blood pressure obtained at admission to the ED. A wound physician assessment note that was not in the clinical record at the time of the review was forwarded to the surveyor. That note was dated 10/21/2020. The time of assessment was not documented, but the assessment described both toes in question and ordered a vascular surgery consultation. The surveyor concluded that the time gap between the first physician assessment documenting the foot wounds on 8/11/20 and the next physician assessment on 10/21/20 (exacerbated by the failure of the physician to assess the wounds on 10/7/20) contributed to the resident being transferred to a higher level of care and a delay in treatment. In addition, facility	F 684		

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F 684	Continued From page 7 staff's failure to regularly document the condition of the resident's foot wounds, either in nursing progress notes or in periodic skin assessment notes made it impossible to determine when the wounds formed and the resident's condition deteriorated. The surveyor was unable to determine who ordered the wound physician consultation, when it was ordered, or what the resident's condition was at the time. The surveyor concluded that these failures constituted neglect of the resident that resulted in harm to the resident. The facility administrative team were notified of the surveyor's conclusions during a phone conference call on 12/14/2020. This is a complaint deficiency.	F 684		