PRINTED: 03/29/2022 FORM APPROVED OMB NO 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495156	B. WING		02/11/20	022	
	PROVIDER OR SUPPLIER  HEALTHCARE AT RC	PANOKE					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		LD BE COM	(X5) IPLETION DATE	
E 000	Initial Comments		ΕO	000			
F 000	survey was conduc The facility was in s CFR Part 483.73, F Care Facilities.	Emergency Preparedness ted 2/8/22 through 2/11/22. ubstantial compliance with 42 Requirement for Long-Term	FO	000			
	Control Survey and conducted on 2/8/20 complaints were inv VA00054175, VA00 were all substantiate for compliance with Long Term Care recompliance.	COVID-19 Focused Infection complaint survey was 022 through 2/11/2022. Three restigated during the survey: 1054265, and VA00054266 ed. Corrections are required 42 CFR Part 483 Federal quirements.					
F 567 SS=E	facility was 57. The 15 current residents Of the 57 current re tested positive for the results were pendin Protection/Manager	survey sample consisted of and 1 closed record review. sidents, no residents had ne COVID-19 virus and no test g. ment of Personal Funds	F 5	67		18 18	
ABORATORY	manage his or her fithe right to know, in facility may impose a funds.  (i) The facility must deposit their person resident chooses to the facility, upon wri resident, the facility resident's funds and	resident has a right to nancial affairs. This includes advance, what charges a against a resident's personal not require residents to al funds with the facility. If a deposit personal funds with tten authorization of a must act as a fiduciary of the hold, safeguard, manage,	<b>ATURE</b>	TITLE	(X6) DA	VIE.	

-administrator 3-29-22 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.

03/21/2022

STATEMENT OF D		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	0 10		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
							С
		495156	B. WING	<u> </u>		02/	11/2022
CHOICE HEA	IDER OR SUPPLIER			33	TREET ADDRESS, CITY, STATE, ZIP CODE 24 KING GEORGE AVE SW ROANOKE, VA 24016		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
and dep sec (ii) (A) (D)( any an sep acc res acc for ma exc inte (B) The fun acc sep The not inte Thi: by: Ba rev cou stat their faci for the faci f	cosited with the fation.  Deposit of Funda In general: Excelli)(B) of this sector residents' personal facility must depend a count, and that counts, there must each resident's sintain a resident's each facility must depend a count (or account facility's operating account (or account facility must make the each resident's count. (In pooled facility must make the each second facility must make the ea	personal funds of the resident facility, as specified in this as.  Sept as set out in paragraph (f) (ion, the facility must deposit and funds in excess of \$100 in account (or accounts) that is of the facility's operating credits all interest earned on that account. (In pooled at be a separate accounting share.) The facility must as personal funds that do not con-interest bearing account, count, or petty cash fund. The care is funded by Medicaid: posit the residents' personal for in an interest bearing as) that is separate from any of the gaccounts, and that credits and resident's funds to that accounts, there must be a gror each resident's share.) A gror each resident's share.) A gror each resident's share. (It is not met as evidenced arview, facility document resentative review, and in the not investigation, the facility of 15 residents to manage, Resident #11, #3, #2, and #11, #3, #2, and #11, #3, #2, and #16 the disperse the requested funds e-arranged funeral expenses.	F	567	<ol> <li>Resident # 11, 3, 2, 16 funds released. RP notified.</li> <li>Facility audit of residents acc.</li> <li>Business office manager edu on polices regarding residen to manage his or her financia affairs to include the right to in advance, what charges a may impose against a reside personal funds</li> <li>Administrator/ or designee waudit 4 random resident accordered twice weekly for six and audit findings will reported to the facility QAPI Committee to review the need continued intervention or amendment of the plan.</li> <li>Allegation of compliance set 03.28.22</li> </ol>	counts.  ucated t rights al know, facility ent's  fill bunting weeks. be	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
,		495156	B. WING			C	
	PROVIDER OR SUPPLIER		D. WIING	STREET ADDRESS, CITY, STATE, ZIP CODE 324 KING GEORGE AVE SW	02	/11/2022	
CHOICE	HEALTHCARE AT RC	DANOKE	1 5	ROANOKE, VA 24016		:	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 567	Continued From pa	ge 2	F 5	567			
	which included but	ace sheet listed diagnoses not limited to epilepsy, Down ory failure, hypothyroidism, e, and pneumonia.					
	most recent compre MDS (minimum dat (assessment refere the resident as hav memory problems a cognitive skills for d Resident #11's clini	e patterns, of Resident #11's ehensive (significant change) a set) with an ARD nce date) of 12/07/21 coded ing both long and short term and severely impaired laily decision making. cal record also contained a DS, with an ARD of 12/13/21.					
	interviewed on 02/0 The RP stated they 2021 from the facilit manager) that the r in their account and The RP stated they arrangements to sp allowed amount. The Resident #11 passed went to funeral homarrangements, and had never received RP stated they spot December 21, and short-staffed, there	(responsible party) was 8/22 at 1:30 pm via telephone. had received a notice in July by BOM (business office esident had too much money it needed to be spent down, then went and made funeral end the money under the RP stated that when ed in December 2021, they he to finalize the was told the funeral home payment from the facility. The ke with the BOM in person on was told the facility was was no one to sign the check, who signs the checks was in					
	January 24, 2022 and had invoiced the factors	called the funeral home on nd was told the funeral home cility twice, but had still not The RP stated they called the					

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION ILDING		
		495156	B. WING				C / <b>11/2022</b>
6.00.000.00 - 5.00.000.00	PROVIDER OR SUPPLIER HEALTHCARE AT RO	DANOKE		STREET ADDRESS, CITY, STATE, 324 KING GEORGE AVE SW ROANOKE, VA 24016	ZIP CODE	1 02	711/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD THE APPROP	) BE	(X5) COMPLETION DATE
	2022, but BOM new stated they also cal 2022 to speak with told administrator was returned the call.  The funeral home of telephone on 02/08 director stated Resignally 2021 to make director stated they in July, but did not a Resident #11 passes arrangements and invoice to the facility.  The BOM was interpm. The BOM provide funeral home has from the facility.  The BOM stated, "I had the invoice came in worked about anoth When I was cleaning invoice. I knew Resso I laid it aside with asked if they had the that time and they so not had the ability shought and the research of not pre-planned funeral fune	the BOM on January 24, wer returned their call. The RP led the facility on January 31, the administrator, and was was in a meeting, and never director was interviewed via 1/22 at 4 pm. The funeral ident #11's RP initially came in arrangements. The funeral is sent an invoice to the facility receive payment. When ed, the RP came in to finalize again advised to send the y. At the time of the interview, and still not received payment of the invoice from ated 07/29/21, in the amount OM was asked why the end not been paid. The an assistant BOM at the time, and they got it. They only her week or so after that. If you was not deceased, in my files." The BOM was end ability to pay the invoice at stated that they did, but had ince "around the middle of int."	F.5	567			
	administrative team	(administrator, director of rector of nursing, regional					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495156	B. WING		00	C	
	PROVIDER OR SUPPLIER		D. WIII.O	STREET ADDRESS, CITY, STATE, ZIP CO 324 KING GEORGE AVE SW ROANOKE, VA 24016		/11/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		HOULD BE	(X5) COMPLETION DATE	
F 567	No further information This is a complaint 2. Resident #3's diadiagnoses, which in Chronic Obstructive Combined Congest Schizophrenia, End Essential Hyperten Dialysis, and Hypo-The most recent queset) with an ARD (a 2/05/22 assigned the interview for mental out of 15, indicating intact.  On 2/11/22, Reside provided by the fact manager) was revieresident's balance of the complete	n 02/11/22 at 11:55 am.	F 5	67			
		told the facility needs a ck before it can be sent to the					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495156	B. WING		02	C / <b>11/2022</b>	
	PROVIDER OR SUPPLIER HEALTHCARE AT RO			STREET ADDRESS, CITY, STATE, 3 324 KING GEORGE AVE SW ROANOKE, VA 24016			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 567	(business office masked if Resident # expenses had been account and the BO BOM further stated signers on the sign mid-November 202 paperwork to RFM Management System waiting for the okay. The BOM stated the new facility owner a last week and they. A copy of the bill previdenced the total	2 am, the facility BOM anager) was interviewed and f3's pre-arranged funeral in paid from their resident funds DM stated it had not. The I the facility has not had ature card since t2 and they have submitted S (Resident Funds em) yesterday and are now or that everything was updated, ey have been working with the land they received new billers were able to assist the BOM. Ovided by the funeral home funeral expenses were cument was signed by	F 5	567			
	On 2/11/22 at 11:55 the administrator, director of nursing, clinical services. The funds not being displayed funeral services as disucssed.  No further information presented prior to the services, which in Dementia, Type 2 Edisorder, Unsteadir Vascular Disease, M	of am, a meeting was held with irector of nursing, assistant and the regional director of the concern of Resident #3's persed to pay for pre-arranged requested by the resident was non regarding this concern was no exit conference on 2/11/22.  Agnosis list indicated accluded, but not limited to Diabetes Mellitus, Anxiety ness on Feet, Peripheral suscle Wasting and Atrophy, ydrocephalus, and Essential					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1007 Sharrowsan	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495156	B. WING		02	/11/2022	
	PROVIDER OR SUPPLIER HEALTHCARE AT RO			STREET ADDRESS, CITY, STATE, ZIP CO 324 KING GEORGE AVE SW ROANOKE, VA 24016	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 567	Continued From pa	age 6	F 5	67			
	set) with an ARD ( 1/13/22 assigned t interview for mental	uarterly MDS (minimum data assessment reference date) of the resident a BIMS (brief al status) summary score of 14 g Resident #2 was cognitively					
	statement provided office manager) wa	ent #2's resident funds d by the facility BOM (business as reviewed and documented nce on 2/03/22 was \$4,595.56.					
	interviewed and as that their resident of and the resident st #2's spouse was p notified of needing spent the money of #2's spouse stated home came to the made the arranger was asked if the fu and they stated the	25 am, Resident #2 was sked if they had been notified funds account was over \$2,000 rated "no ma'am". Resident resent and stated they were to do a "spend-down" and in funeral expenses. Resident I someone from the funeral facility "back in the fall" and ments. Resident #2's spouse neral expenses had been paid, a facility was supposed to have owe the cemetery additional					
	interviewed and as prearranged funerato the funeral home just received the st November or first oprovided by the fur total funeral expendocument was sign but not dated. At 1	7 am, the BOM was sked if Resident #2's al expenses had been paid out e. The BOM stated no, they tatement at the end of of December. A copy of the bill neral home documented the se was \$3317.00. This ned by Resident #2's spouse 1:06 am, the BOM stated the when the new facility signature					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		495156	B. WING	;			1	C <b>/11/2022</b>	
	PROVIDER OR SUPPLIER HEALTHCARE AT RO	DANOKE	STREET ADDRESS, CITY, STATE, ZIP CODE  324 KING GEORGE AVE SW  ROANOKE, VA 24016					711/2022	
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORF PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE AF DEFICIENCY)		HOULD	OULD BE COME		
F 567	okay was received Management Syste On 2/11/22 at 11:55	ning were updated and the from RFMS (Resident Funds em).  5 am, a meeting was held with	F	567			# A   F		
	director of nursing, clinical services. Th funds not being disp	lirector of nursing, assistant and the regional director of the concern of Resident #2's persed to pay for pre-arranged requested by the resident was							
	No further informati presented to the su conference on 2/11.	on regarding this concern was rvey team prior to the exit /22.							
	diagnoses, which in 2 Diabetes Mellitus Polyneuropathy, Ch Major Depressive D	iagnosis list indicated cluded, but not limited to Type with Diabetic Autonomic ronic Kidney Disease Stage 4, bisorder, Nontraumatic orrhage, and Chronic Pain.							
	set) with an ARD (a 1/14/22 assigned th interview for mental	arterly MDS (minimum data ssessment reference date) of e resident a BIMS (brief status) summary score of 14 the resident was cognitively							
	statement provided office manager) was	nt #16's resident funds by the facility BOM (business s reviewed and documented ce on 2/03/22 was \$4,904.15.						*	
	interviewed and ask that their resident fu	am, Resident #16 was ed if they had been notified nds account was over 6 stated they were notified of							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495156	B. WING	<u> </u>	0;	C 2/11/2022	
	PROVIDER OR SUPPLIER	DANOKE		STREET ADDRESS, CITY, STATE, ZIP COD 324 KING GEORGE AVE SW ROANOKE, VA 24016			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE	
F 567	money on funeral esomeone from the facility "back in the arrangements. Resfuneral expenses hithe facility was supstill owe the cemete. On 2/11/22 at 10:1 interviewed and as prearranged funerato the funeral home just received the st November or first oby the funeral home expense was \$331 signed by Resident am, the BOM state the new facility sign were updated and RFMS (Resident Fines). The facility policy established for the personal funds. Po Compliance Guidel chooses to deposit facility, upon writter the facility must acfund and hold, safe for the personal fur with the facility."	pend-down" and spent the expenses. Resident #16 stated funeral home came to the fall" and made the sident #16 was asked if the ad been paid and they stated posed to have paid it but they ery additional money.  7 am, the BOM was ked if Resident #16's all expenses had been paid out at Expenses had been paid out at Expenses had been paid out at Expenses. The bill provided at documented the total funeral 7.00. This document was at #16 but not dated. At 11:06 at the bill would be paid when nature cards for check signing the okay was received from unds Management System).  Intitled "Resident Personal at in part, "Policy: The resident and in part, "Policy: The resident and in part, "It is a pay impose against a resident's licy Explanation and ines: 2. If the resident their personal funds with the in authorization of a resident, it as fiduciary of the resident and of the resident deposited	F 5	667			
		5 am, a meeting was held with lirector of nursing, assistant					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495156	B. WING	C 02/11/2	0022	
	PROVIDER OR SUPPLIER HEALTHCARE AT RO	DANOKE		02/11/2	.022	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COM	(X5) MPLETION DATE
SS=E	director of nursing, clinical services. The funds not being dis funeral services as disucssed.  No further informat presented to the suconference on 2/11 Notice and Convey CFR(s): 483.10(f)(10)(iv) Conversion of the value of the resources, reaches person, the resident Medicaid or SSI.  §483.10(f)(10)(v) Conversion of the discharge resident with a person facility, the facility manner facility of the resident individual or probate resident's estate, in	and the regional director of the concern of Resident #16's opersed to pay for pre-arranged requested by the resident was arrow team prior to the exit 1/22.  ance of Personal Funds	F 569	<ol> <li>Resident # 11, 4, 7, 8 fun released. RP notified.</li> <li>Facility audit of residents Medicaid accounts.</li> </ol>	ds  with  educated cation of some count e SSI on and; If in the count	28.2022
	Based on staff inter review, resident rep	rview, facility document resentative interview, and in		03.28.22		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495156	B. WING		02	C 2/11/2022		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 324 KING GEORGE AVE SW ROANOKE, VA 24016				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 569	staff failed to provi residents personal Resident #11, Res Resident #8.  For Resident #11 to disperse the resided discharge/death. For the facility staff failleresident represent accounts were with (supplemental sec \$2000.00.  The findings included.	inplaint investigation, the facility de notice and conveyance of funds of 4 of 15 residents, ident #4, Resident #7, and the facility staff failed to ent's funds within 30 days of for Resident's #4, #7 and #8 ed to notify the resident and/or ative when the residents' nin \$200 of the SSI urity income) resource limit of	F 5	569				
	syndrome, respiral adult failure to thrival section C, cognitive most recent compression as a section of the resident as has memory problems cognitive skills for Resident #11's clir "death in facility" Mesident #11's Reterviewed on 02/08. The RP stated the 2021 from the facil manager) that Resident and their account account account account and their account account account and their account account account and their account	tory failure, hypothyroidism, ize, and pneumonia.  The patterns, of Resident #11's rehensive (significant change) at a set) with an ARD rence date) of 12/07/21 coded wing both long and short term and severely impaired daily decision making.  The patterns of Resident #11's rehensive (significant change) at a set) with an ARD rence date of 12/07/21 coded wing both long and short term and severely impaired daily decision making.  The patterns of 12/07/21 coded wing both long and short term and severely impaired daily decision making.  The patterns of Resident #11's rehensive of 12/07/21 coded wing both long and short term and record also contained a lDS, with an ARD of 12/13/21.  The patterns of Resident #13/07/21 coded wing both long and short term and record also contained a lDS, with an ARD of 12/13/21.  The patterns of Resident #11's rehensive (significant change) and short term and severely impaired with an ARD of 12/13/21.  The patterns of Resident #11's rehensive (significant change) and short term and severely impaired daily decision making.  The patterns of Resident #11's rehensive (significant change) and short term and severely impaired daily decision making.  The patterns of Resident #11's rehensive (significant change) and short term and severely impaired daily decision making.						

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Fig. Same a		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495156	B. WING	;	77.5			C
NAME OF PROVIDER OR SUPPLIER  CHOICE HEALTHCARE AT ROANOKE			STF 324	REET ADDRESS, CITY, STATE, ZIP ( KING GEORGE AVE SW DANOKE, VA 24016	CODE	02/	11/2022	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ıx	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD APPROPE	BE	(X5) COMPLETION DATE
F 569	allowed amount. The Resident #11 passes went to funeral homeof arrangements, and had never received RP stated they spot December 2021, and short-staffed, there and that the person another state.  The facility BOM was 2:00 pm. The BOM done with resident for BOM stated they are days. The BOM was funds had not been have had a lot of turns.	end the money under the see RP stated that when sed in December 2021, they	F	569				
	2:30 pm. The BOM #11's quarterly "Res Service" statement, had an account bala 12/31/21. The BOM	viewed again on 02/09/22 at provided a copy of Resident ident Fund Management which indicated the resident ince of \$4576.55 as of stated they have not had the ds "since around the middle						
	Personal Funds" doc "Conveyance upon I 1. Upon the discharg resident with a perso facility, the facility wi resident's funds and	licy entitled "Resident cumented in part, Discharge, Eviction, or Death" ge, eviction, or death of a conal fund deposited with the II convey within 30 days the final account of those funds the case of death, the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1000 50	TIPLE CONSTRUCTION DING	(X3	(X3) DATE SURVEY COMPLETED		
		495156	B. WING			C <b>02/11/2022</b>		
	PROVIDER OR SUPPLIER	DANOKE		STREET ADDRESS, CITY, STATE, ZIP ( 324 KING GEORGE AVE SW ROANOKE, VA 24016	ODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	COMPLETION DATE		
F 569	resident's estate, in The concern of not the resident's funds passing was discusteam (administrator director of nursing, 02/11/22 at 11:55 a provided prior to ex This is a complaint  2. Resident #4's far which included but encephalopathy, defailure, cerebral infedisorders, convulsive respiratory failure. The primary payer at VA.  Section C, cognitive quarterly MDS (min (assessment reference the resident as have memory problems cognitive skills for complete the complete statement indicated that the rebalance of \$6694.4 (business office materials)	e jurisdiction administering the accordance with State law." dispersing the remainder of swithin 30 days of their seed with the administrative r, director of nursing, assistant regional nurse consultant) on im. No further information was sit.	F 5	569				
	account balance. T resident or their RF notified of the resident	The BOM was asked if the P (responsible party) had been lent's account exceeding the BOM stated, "There is no one						

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	C250 1470	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
a Mari		495156	B. WING		02	C /11/2022		
120340430740047760	PROVIDER OR SUPPLIER HEALTHCARE AT RO	DANOKE	12	STREET ADDRESS, CITY, STATE, ZIP CODE 324 KING GEORGE AVE SW ROANOKE, VA 24016				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG		LD BE	(X5) COMPLETION DATE		
	to notify, (Resident contact, and they d We need to apply f #4). The BOM was the resident's accorresource limit, and private pay until the go back to Medicaid. The concern of not when the resident's resource limit was administrative team nursing, assistant d nurse consultant) or further information of the total form the information of the total form the information of the total form the information of the inf	#4) only has an emergency on't want anything to do with it. or a guardian for (Resident asked what would happen if unt continued to be over the BOM stated, "They will go a money is gone, then they will d."  notifying the resident/RP account was over the discussed with the account was over the discussed with the account was over the discussed with the account was provided prior to exit.  deficiency agnosis list indicated account of limited to miparesis following account Disease Affecting Side, Dysphagia, Aphasia, itis C, Acute on Chronic Heart Failure, Essential ysmal Atrial Fibrillation, lar Disorder. Resident #7's sion record listed the ayer as Medicaid HMO accorganization).  arterly MDS (minimum data assessment reference date) of a resident a BIMS (brief status) summary score of 10 Resident #7 was moderately	F 5	69				
	The facility BMO (bu	siness office manager)				8.		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	101 501	TIPLE CONSTRUCTION		E SURVEY MPLETED
	9	495156	B. WING	=	- 1	C /11/2022
	PROVIDER OR SUPPLIER HEALTHCARE AT RO	DANOKE		STREET ADDRESS, CITY, STATE, ZIP COI 324 KING GEORGE AVE SW ROANOKE, VA 24016		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	1	HOULD BE	(X5) COMPLETION DATE
F 569	statement for the tii 2/03/22 entitled, "R Landscape". According the beginning of eas: 10/01/21 \$3,47: 12/01/21 \$2,040.14 2/01/22 \$2,120.18.  On 2/11/22 at 11:00 interviewed and as resident's represent resident's account of The BMO stated "I been." When asked made the BOM state director of nursing, and the regional director of nursing	#7's resident account me period of 7/01/21 through esident Statement ding to the resident at #7's account balances for other month were documented 3.08, 11/01/21 \$2,000.12, 1, 1/03/22 \$3,683.14, and 0 a.m., the BMO was ked if Resident #7 or the tative were notified of the being over the resource limit. don't think (his/her) family has don't think (his/her) family has don't think (his/her) family has don't didn't do it."  Cussed with the administrator, assistant director of nursing, rector of clinical services on m. during a meeting with the don't regarding this concern was arrey team prior to the exit 1/22.  If admitted to the facility with guadriplegia, tracheostomy, ioid schizophrenia, opulmonary disease, and type with foot ulcers. On the lata set assessment with noce date 12/16/2021, the sed with moderate long term t and moderate impairment of	F 5	569		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		JLTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495156	B. WING	3	C
	PROVIDER OR SUPPLIER HEALTHCARE AT RO			STREET ADDRESS, CITY, STATE, ZIP CODE 324 KING GEORGE AVE SW ROANOKE, VA 24016	02/11/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	FIX (EACH CORRECTIVE ACTION SHOU	D BE COMPLETION
	being notified that the balance exceeded that Residen care providers and hearing aid. The guresident had the fur. A copy of a facility propersonal Funds do Certain Balances 1. resident that receive the amount in the resident that receive the amount in the sincome) resource lift the amount in the action of the resident may los SSI."  The Business Office interviewed by on 2/2 unable to state why had not been notified account. The BOM of disburse funds for resone who worked for sign checks from resident may los SSI. The above concerns administrator, directed director of nursing, a clinical services on 2 meeting with the sur	the The guardian reported not the resident's personal fund the current limit. The guardian to the current limit. The guardian to the tresident #8 needed a ardian had been unaware the total for the copayment.  The facility must notify each the each desident's account reaches as Medicaid benefits: a. When the each desident's account reaches as I (supplemental security mit for one person and; b. If the each desident's account resources, ources limit for one person, are eligibility for Medicaid or the excess balance in the did report an inability to desident expenses because no the facility was authorized to sident accounts.  Was discussed with the for of nursing, assistant and the regional director of /11/22 at 11:55 a.m. during a	F	569	
	presented to the sur conference on 2/11/2	vey team prior to the exit			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	200 200		LE CONSTRUCTION		E SURVEY IPLETED
8.		495156	B. WING			1	C <b>11/2022</b>
	PROVIDER OR SUPPLIER  HEALTHCARE AT RC	ANOKE		3	STREET ADDRESS, CITY, STATE, ZIP CODE 324 KING GEORGE AVE SW ROANOKE, VA 24016	021	11/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580 SS=D	CFR(s): 483.10(g)( §483.10(g)(14) Noti (i) A facility must im consult with the res consistent with his or representative(s) w (A) An accident inversults in injury and physician interventi (B) A significant cha mental, or psychoso deterioration in hea status in either life-t clinical complication (C) A need to alter to a need to discontinut reatment due to ad commence a new fo (D) A decision to tra resident from the fa §483.15(c)(1)(ii). (ii) When making no (14)(i) of this section all pertinent informa is available and pro physician. (iii) The facility must resident and the res when there is- (A) A change in roon as specified in §483 (B) A change in resi State law or regulati (e)(10) of this section (iv) The facility must	fication of Changes. mediately inform the resident; ident's physician; and notify, or her authority, the resident hen there is- plying the resident which has the potential for requiring on; ange in the resident's physical, ocial status (that is, a lth, mental, or psychosocial hreatening conditions or is); reatment significantly (that is, ue an existing form of verse consequences, or to orm of treatment); or nsfer or discharge the cility as specified in otification under paragraph (g) n, the facility must ensure that tion specified in §483.15(c)(2) vided upon request to the et also promptly notify the ident representative, if any, or or roommate assignment 10(e)(6); or dent rights under Federal or ons as specified in paragraph n. record and periodically (mailing and email) and	F	580	<ol> <li>Resident #2 MD notified. No furth orders on received. RP notified.</li> <li>Full facility audit of all falls to end MD and RP notification.</li> <li>All licensed nursing staff reeduc regarding assessing falls and the causes and notification of chang policies by Director of Nursing.</li> <li>Director of Nursing/ or designee audit twice weekly for six weeks to ensure immediate MD and RF notification. Audits and audit finwill be reported to the facility QA Committee to review the need for continued intervention or amend of the plan.</li> <li>Allegation of compliance set for 03.28.2022</li> </ol>	ther sure ated eir ges will all falls dings	03.28.2022

NAME OF PROVIDER OR SUPPLIER  CHOICE HEALTHCARE AT ROANOKE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES RECEIPED BY FULL RECOVERY TAG  FREEIN TAG  FREEI		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	S 12 5000	LTIPLE CONSTRUCTION DING			E SURVEY MPLETED
CHOICE HEALTHCARE AT ROANOKE  CHOICE HEALTHCARE AT ROANOKE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION)  F 580 Continued From page 17  F 580 F 580 Continued From page 17  F 580 F 580 Continued From page 17  F 580 Continued From page 17  F 580 Continued From page 17  F 580 F 580 Continued From page 17  F 580 Continued Fro			495156					
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  F 580  Continued From page 17  \$483.10(g)(15)  Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under \$483.15(c)(9).  This REQUIREMENT is not met as evidenced by:  Based on staff interview, clinical record review, and facility document review, the facility staff failed to notify the resident's physician following an accident with injury for 1 of 16 residents in the survey sample, Resident #2. For Resident #2, the facility staff failed to notify the physician following a fall resulting in a cut over the resident's left eye.  The findings included:  Resident #2's diagnosis list indicated diagnoses, which included, but not limited to Dementia, Type 2 Diabetes Mellitus, Unsteadiness on Feet, Peripheral Vascular Disease, Muscle Wasting and Atrophy, Normal Pressure Hydrocephalus, Anxiety Disorder, and Essential Hypertension.  The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 1/13/22 assigned the resident a BIMS (brief interview for mental status) summary score of 14 out of 15 indicating Resident #2 was coded as requiring supervision only with transfers and walking.			ANOKE		324 KING GEORGE AVE SW	DDE	021	11/2022
§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.16(c)(9).  This REQUIREMENT is not met as evidenced by:  Based on staff interview, clinical record review, and facility document review, the facility staff failed to notify the resident's physician following an accident with injury for 1 of 16 residents in the survey sample, Resident #2. For Resident #2, the facility staff failed to notify the physician following a fall resulting in a cut over the resident's left eye.  The findings included:  Resident #2's diagnosis list indicated diagnoses, which included, but not limited to Dementia, Type 2 Diabetes Mellitus, Unsteadiness on Feet, Peripheral Vascular Disease, Muscle Wasting and Atrophy, Normal Pressure Hydrocephalus, Anxiety Disorder, and Essential Hypertension.  The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 1/1/3/22 assigned the resident a BIMS (brief interview for mental status) summary score of 14 out of 15 indicating Resident #2 was cognitively intact. Resident #2 was coded as requiring supervision only with transfers and walking.	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A	SHOULD	BE	COMPLETION
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).  This REQUIREMENT is not met as evidenced by:  Based on staff interview, clinical record review, and facility document review, the facility staff failed to notify the resident's physician following an accident with injury for 1 of 16 residents in the survey sample, Resident #2. For Resident #2, the facility staff failed to notify the physician following a fall resulting in a cut over the resident's left eye.  The findings included:  Resident #2's diagnosis list indicated diagnoses, which included, but not limited to Dementia, Type 2 Diabetes Mellitus, Unsteadiness on Feet, Peripheral Vascular Disease, Muscle Wasting and Atrophy, Normal Pressure Hydrocephalus, Anxiety Disorder, and Essential Hypertension.  The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 1/13/22 assigned the resident a BIMS (brief interview for mental status) summary score of 14 out of 15 indicating Resident #2 was coded as requiring supervision only with transfers and walking.	F 580			F 5	580		5.	
Resident #2's diagnosis list indicated diagnoses, which included, but not limited to Dementia, Type 2 Diabetes Mellitus, Unsteadiness on Feet, Peripheral Vascular Disease, Muscle Wasting and Atrophy, Normal Pressure Hydrocephalus, Anxiety Disorder, and Essential Hypertension.  The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 1/13/22 assigned the resident a BIMS (brief interview for mental status) summary score of 14 out of 15 indicating Resident #2 was cognitively intact. Resident #2 was coded as requiring supervision only with transfers and walking.		Admission to a com that is a composite §483.5) must disclo its physical configur locations that comp part, and must spectroom changes betwounder §483.15(c)(9). This REQUIREMENT by:  Based on staff interest and facility document failed to notify the rean accident with injusurvey sample, Rest the facility staff faile following a fall resul resident's left eye.	distinct part (as defined in se in its admission agreement ration, including the various rise the composite distinct cify the policies that apply to reen its different locations.)  IT is not met as evidenced review, clinical record review, not review, the facility staff resident's physician following arry for 1 of 16 residents in the rident #2. For Resident #2, d to notify the physician ting in a cut over the					
set) with an ARD (assessment reference date) of 1/13/22 assigned the resident a BIMS (brief interview for mental status) summary score of 14 out of 15 indicating Resident #2 was cognitively intact. Resident #2 was coded as requiring supervision only with transfers and walking.		Resident #2's diagn which included, but 2 Diabetes Mellitus, Peripheral Vascular and Atrophy, Norma	osis list indicated diagnoses, not limited to Dementia, Type Unsteadiness on Feet, Disease, Muscle Wasting I Pressure Hydrocephalus,					
A review of Resident #2's clinical record revealed		set) with an ARD (as 1/13/22 assigned the interview for mental out of 15 indicating I intact. Resident #2 v supervision only with	ssessment reference date) of e resident a BIMS (brief status) summary score of 14 Resident #2 was cognitively was coded as requiring of transfers and walking.					

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495156	B. WING				C
	PROVIDER OR SUPPLIER HEALTHCARE AT RO		STREET ADDRESS, CITY, STATE, ZIP CO 324 KING GEORGE AVE SW ROANOKE, VA 24016			02/	11/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD HE APPROPR	BE	(X5) COMPLETION DATE
F 580	stating in part, "This residents room due stated (he/she) was (he/she) slipped on the door. Resident Resident stated (he hospital and that (he According to Reside also had a fall on the which (he/she) was abrasion to the fore There was no evide	note dated 1/18/22 6:53 a.m. s nurse was called into (sic) to resident fall. Resident s walking into the room when the plastic sheeting covering has a small cut over left eye.	F 5	580	8		
	DON (director of nu director of nursing), director of clinical st 2/09/22 at 4:21 p.m notification of the reoccurring on 1/18/22 On 2/10/22 at 3:29 the administrator, D the staff advised the additional informatic identified concern.  The facility policy er Their Causes" state in a significant injury staff will notify the p	cussed with the administrator, rrsing), ADON (assistant and the RDCS (regional ervices) during a meeting on and evidence of physician esident's fall with injury 2 was requested.  p.m., during a meeting with ON, ADON, and the RDCS, at the facility did not have any on to offer related to the entitled "Assessing Falls and d in part, "When a fall results or condition change, nursing ractitioner immediately by does not result in significant					
	injury or a condition	change, nursing staff will er routinely (e.g., by fax or by		9			

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DAT	TE SURVEY MPLETED
	495156	B. WING		1	1	C <b>/11/2022</b>
PROVIDER OR SUPPLIER HEALTHCARE AT RO	DANOKE		324 KII	NG GEORGE AVE SW		111/2022
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD	D BE	(X5) COMPLETION DATE
Continued From pa	ge 19	F 5	580			03.28.2022
No further informati presented to the su conference on 2/11. Safe/Clean/Comford CFR(s): 483.10(i)(1) §483.10(i) Safe Env. The resident has a comfortable and hot but not limited to resupports for daily liv. The facility must pro §483.10(i)(1) A safe homelike environme use his or her perso possible.  (i) This includes ensireceive care and se physical layout of thindependence and ci) The facility shall the protection of the or theft.  §483.10(i)(2) House services necessary and comfortable interesident room, as specific as a service of the conference of the services of the conference of the services necessary and comfortable interesident room, as specific as a service of the conference of the services of the conference of the services necessary and comfortable interesident room, as specific as a service of the services of	on regarding this concern was rivey team prior to the exit /22. table/Homelike Environment )-(7)  fronment. right to a safe, clean, melike environment, including ceiving treatment and ring safely.  ovide- e, clean, comfortable, and ent, allowing the resident to enal belongings to the extent suring that the resident can rivices safely and that the e facility maximizes resident does not pose a safety risk. exercise reasonable care for resident's property from loss excepting and maintenance to maintain a sanitary, orderly, erior;  bed and bath linens that are ecloset space in each pecified in §483.90 (e)(2)(iv);		F584 1884 2 3	1. Resident #6 and #7 tube fee pumps and poles cleaned, f mopped, debris removed from Resident #8 tube feeding pupple cleaned used inconting brief removed from room, deremoved from floor and wind Resident #9 plastic litter ren from floor, personal items plus bedside dresser and wardrof floor mopped.  2. Full facility audit to ensure a clean, comfortable, homelike environment for all residents.  3. All staff reeducated on Rou Cleaning and Disinfection prensure safe, clean, comfortation and homelike environment.  4. Administrator/ or designee wandit twice weekly for six were ensure no litter or debris is proutside of designated disposicontainers, tube feeding pole clean. Audits and audit finding be reported to the facility QAC Committee to review the need continued intervention or amendment of the plan.  Allegation of compliance set	door om floor. o	
levels in all areas;				55.25.2522		
	PROVIDER OR SUPPLIER  HEALTHCARE AT RO  SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE  Continued From pa  No further informati presented to the su conference on 2/11 Safe/Clean/Comford CFR(s): 483.10(i)(1) §483.10(i) Safe Env The resident has a comfortable and hot but not limited to resupports for daily liv The facility must pro §483.10(i)(1) A safe homelike environme use his or her perso possible. (i) This includes ens receive care and se physical layout of th independence and of (ii) The facility shall the protection of the or theft.  §483.10(i)(2) House services necessary and comfortable inte §483.10(i)(3) Clean in good condition; §483.10(i)(4) Private resident room, as sp	PROVIDER OR SUPPLIER  HEALTHCARE AT ROANOKE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 19  No further information regarding this concern was presented to the survey team prior to the exit conference on 2/11/22.  Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)  §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.  The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.  (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.  (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.  §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;  §483.10(i)(3) Clean bed and bath linens that are in good condition;  §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);  §483.10(i)(5) Adequate and comfortable lighting	PROVIDER OR SUPPLIER  HEALTHCARE AT ROANOKE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 19  No further information regarding this concern was presented to the survey team prior to the exit conference on 2/11/22.  Safe/Clean/Comfortable/Homelike Environment  CFR(s): 483.10(i)(1)-(7)  §483.10(i) Safe Environment.  The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.  The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.  (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.  (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.  §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;  §483.10(i)(3) Clean bed and bath linens that are in good condition;  §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);  §483.10(i)(5) Adequate and comfortable lighting	PROVIDER OR SUPPLIER  ### HEALTHCARE AT ROANOKE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 19  No further information regarding this concern was presented to the survey team prior to the exit conference on 2/11/22.  Safe/Clean/Comfortable/Homelike Environment  CFR(s): 483.10(i)(1)-(7)  §483.10(i) Safe Environment.  The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.  The facility must provide- \$483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.  (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.  (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.  \$483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;  \$483.10(i)(3) Clean bed and bath linens that are in good condition;  \$483.10(i)(4) Private closet space in each resident room, as specified in \$483.90 (e)(2)(iv);  \$483.10(i)(5) Adequate and comfortable lighting	CATE   PROVIDER SUPPLIER   A BUILDING	A SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  No further information regarding this concern was presented to the survey team prior to the exit conference on 2/11/22.  Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.  (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.  (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.  \$483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable inferior;  \$483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);  \$483.10(i)(5) Adequate and comfortable lighting    (3) ANTIFICE CONSTRUCTION   A BUILDING   DORDON   CREATED   CONTRUCTION   CEACH CORRECTIVE AS TATEMENT   CONTRUCTION   CREATE AS TATEMENT

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495156	B. WING		02/	11/2022
	PROVIDER OR SUPPLIER HEALTHCARE AT RO	DANOKE		STREET ADDRESS, CITY, STATE, ZIP CODE 324 KING GEORGE AVE SW ROANOKE, VA 24016		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 584	levels. Facilities init 1990 must maintain 81°F; and §483.10(i)(7) For th sound levels. This REQUIREMEN by: Based on observat complaint investigat maintain a clean, or environment for 4 or sample, Residents Findings include:  1. Resident #8 was diagnoses including gastrostomy, paran hypertension, cardio 2 diabetes mellitus annual minimum da assessment referen	ortable and safe temperature tially certified after October 1, in a temperature range of 71 to the maintenance of comfortable of the maintenance of comfortable of the maintenance of a tion, facility staff failed to comfortable homelike of 16 residents in the survey #6, 7, 8, and 9.	F 5	. 2		
	During initial tour or Resident #8's room on the room's windo head of the bed we style call bell, and fo brown dried matter On 2/9/2022, the room	t and moderate impairment of aily life.  n 2/8/2022, observed in was a used incontinence brief by sill. On the floor near the re plastic wrappers, a pad bam cups. There was light on the tube feeding pole.  om as observed. The brief but the rest remained.				о 2

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	S Same		CONSTRUCTION	90 S		E SURVEY
		495156	B. WING	i			1	C <b>11/2022</b>
	PROVIDER OR SUPPLIE		•	324	REET ADDRESS, CITY, STATE, ZIP COD KING GEORGE AVE SW ANOKE, VA 24016	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			(X5) COMPLETION DATE
F 584	director of nursing clinical services w	page 21 director of nursing, assistant g, and the regional director of vere notified of the concerns day meeting with the survey	F s	584				
	diagnoses including failure, sepsis, trae On the minimum of assessment references was assessed as	as admitted to the facility with ng cerebral infarct, respiratory cheostomy, and hypertension. data set assessment with ence date 11/24/21, the resident non-verbal and with highly earing, and cognition.						
	room was observed was a stuffed anim spoons, pieces of spots of a dried su	on 2/8/2022, Resident #9's ed. On the floor around the bed nal, a package of wipes, plastic clear plastic wrapping, and ubstance. On 2/9/2022, the bserved and the spots and remained.						
	director of nursing clinical services w during an end of d team.  3. Resident #6's fa which included bu failure, diabetes m respiratory failure,	director of nursing, assistant, and the regional director of ere notified of the concerns lay meeting with the survey are sheet listed diagnoses to not limited to respiratory nellitus type II, chronic anemia, pneumonia, us, dysphagia, and						
	an ARD (assessme assigned the resid mental status) sco	MDS (minimum data set) with ent reference date) of 01/15/22 ent a BIMS (brief interview for ore of 1 out 15 in section C, indicating severe cognitive						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(	(X3) DATE SURVEY COMPLETED	
	495156	B. WING		a [	C 02/11/2022	
NAME OF PROVIDER OR SUPPLIER  CHOICE HEALTHCARE AT RO			STREET ADDRESS, CITY, STATE, ZIP C 324 KING GEORGE AVE SW ROANOKE, VA 24016	ODE		
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
pm. Resident #6 warunning via pump. Tobserved on the top down the sides of the base of the feeding surrounding the fee Resident #6 was ob 8:30 am. Resident #6 feeding running via tan-colored debris of pump, pole, pole batagain observed.  The above concernadministrative team nursing, assistant dourse consultant) du 4:20 pm. On 02/11/2 the survey team that housekeeping depate evaluate the facility.  No further information This is a complaint of the facility.  No further information the facility of the survey team that housekeeping depate evaluate the facility.  This is a complaint of the facility of t	poserved on 02/08/22 at 12:10 as resting in bed, tube feeding fan-colored dried debris was and sides of feeding pump, he pump pole, around the pump pole, and on the floor ding pump.  Isserved again on 02/09/22 at #6 was resting in bed, tube feeding pump. Dried on and around the feeding see and surrounding floor was  was discussed with the (administrator, director of irector of nursing, regional uring a meeting on 02/09/22 at 22 the administrator informed at corporate members of the rtment were on site to  on was provided prior to exit.  deficiency.  agnosis list indicated cluded, but not limited to miparesis following ovascular Disease Affecting Side, Dysphagia, Aphasia, itis C, Acute on Chronic Heart Failure, Essential ysmal Atrial Fibrillation,	F 5	84			

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		16 (60)	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		495156	B. WING	3	C <b>02/11/2022</b>	
	PROVIDER OR SUPPLIER HEALTHCARE AT RO			STREET ADDRESS, CITY, STATE, ZIP CODE 324 KING GEORGE AVE SW ROANOKE, VA 24016		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		BE COMPLETIC	N
F 584	set) with an ARD (a 1/12/22 assigned th interview for mental	arterly MDS (minimum data assessment reference date) of the resident a BIMS (brief a status) summary score of 10 Resident #7 was moderately	F 5	584		
	observed in bed red formula via pump at 1.5 formula was liqu dried, light brown su tube feeding pump, at the base of the p	5 a.m., Resident #7 was seiving Jevity 1.5 tube feeding to 55 ml per hour. The Jevity uid and light brown in color. A substance was observed on the down the tube feeding pole, ole, on the cushioned fall mat side of the bed, and on the der the bed.				
	observed again. The	a.m, Resident #7 was e tube feeding pump, pole fall in the same condition as the				
	director of nursing, a clinical services wer observations on 2/0	lirector of nursing, assistant and the regional director of re notified of the above 9/22 at 4:21 p.m. during an with the survey team.				
F 607 SS=D	presented to the sur conference on 2/11/	Abuse/Neglect Policies	F 60	07		
		ity must develop and plicies and procedures that:				
	§483.12(b)(1) Prohil	oit and prevent abuse,		e		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495156	B. WING	i		5440 NO4	C 11/2022
	PROVIDER OR SUPPLIER HEALTHCARE AT RO	ANOKE		324	REET ADDRESS, CITY, STATE, ZIP CODE 4 KING GEORGE AVE SW DANOKE, VA 24016	02.	1112022
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 607	misappropriation of §483.12(b)(2) Estat to investigate any s §483.12(b)(3) Included paragraph §483.95. This REQUIREMENT by:  Based on staff interprise facility document real complaint investig implement abuse propring of unknown of the survey sample,  For Resident #1, the policies and proced an incident where Redown in the floor with the findings included Resident #1's diagn which included, but to MRSA (Methicillin Aureus), Chronic Off Acute Respiratory Fessential Hypertens Wasting and Atroph Dependence on Resident #1's diagn which included, but to MRSA (Methicillin Aureus), Chronic Off Acute Respiratory Fessential Hypertens Wasting and Atroph Dependence on Resident #1's diagn which included, but to MRSA (Methicillin Aureus), Chronic Off Acute Respiratory Fessential Hypertens Wasting and Atroph Dependence on Resident #1's diagn which included, but to MRSA (Methicillin Aureus), Chronic Off Acute Respiratory Fessential Hypertens Wasting and Atroph Dependence on Resident #1's diagn with an ARD (at 12/23/21 assigned to interview for mental out of 15 indicating the first part of the first paragraphs with an ARD (at 12/23/21 assigned to interview for mental out of 15 indicating the first paragraphs with an ARD (at 12/23/21 assigned to interview for mental out of 15 indicating the first paragraphs with t	ation of residents and resident property,  blish policies and procedures uch allegations, and  de training as required at  IT is not met as evidenced  rview, clinical record review, view, and during the course of ation, the facility staff failed to blicies and procedures for an rigin for 1 of 16 residents in Resident #1.  de facility staff failed to follow ures to investigate and report tesident #1 was found face the injuries.  de:  osis list indicated diagnoses, not limited to Pneumonia due Resistant Staphylococcus betructive Pulmonary Disease, ailure, Anxiety Disorder, sion, Dementia, Muscle y, Dysphagia, and	F	507	<ol> <li>In-service Administrator/Dire Nursing on Reporting abuse State Agencies and Other En Individuals policy and Abuse Investigation policy.</li> <li>Facility to perform 100% audiany reports of abuse.</li> <li>Corporate Clinical Consultant serviced Administrator/ Direct Nursing on Virginia Department Health Reporting of Incidenct facility policy on Abuse Prohiton.</li> <li>Administrator/ or designee with progress notes twice weekly weeks. Audits and audit find will be reported to the facility Committee monthly for three months to review the need for continued intervention or amendment of the plan.</li> <li>Allegation of compliance 3/28</li> </ol>	to ntities/ lit of  lit of  tin- ctor of ent of es and ibition.  ill audit for six ings QAPI or	03.28.2022

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		405450					С
NAMEOF	PROVIDER OR SUPPLIER	495156	B. WING	AU. 9		02	/11/2022
CHOICE	HEALTHCARE AT RO			3:	TREET ADDRESS, CITY, STATE, ZIP CODE 24 KING GEORGE AVE SW ROANOKE, VA 24016		n =
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 607	toileting, and person dependent on staff  A review of Residen a nursing progress am, "0400 (4:00 am down by the writer a ventilator making a assisted by CNA (ce RT (respiratory ther over. Resident was lacerations that were eye and left lateral stears to right should front of right knee a knee. After getting the around and back on and called 911, while room with the reside arrived and was given writer. Also, writer gwith the demograph 0430 (4:30 am) - The was receiving ventile.	e with bed mobility, dressing, hal hygiene and being totally for bathing.  It #1's clinical record revealed note dated 1/16/22 at 4:14  I) - Resident was found face after the writer heard the funny beeping sound. Writer rtified nursing assistant) and apist) to turn the rsd (resident) grunting and had several e bleeding from (his/her) left side of face, along with skin ler, right forearm, one on the end one on the right lateral he resident [sp] got turned a ventilator. The writer went e RT and CNA were in the ent. 0415 (4:15 am) - EMS en report from the RT and the gave them a transfer sheet ic information of the resident. e resident was stable and ations by ambu bag via trach (he/she) left the facility to go	F	307			
	On 2/09/22 at 10:56 nursing) was intervie and CNA working at were agency staff w facility since that day incident was request there was "no formathe weekend of a sn in the facility at the t found in the floor. D	am the DON (director of ewed and stated the nurse the time Resident #1 fell ho have not returned to the y. The investigation into the sted and the DON stated I work-up for that" and it was ow storm and they were not time of Resident #1 being ON further stated they "didn't the incident as they were		-		2	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495156	B. WING		C 02/11/2022
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02.11.2022
CHOICE	HEALTHCARE AT RO	ANOKE		324 KING GEORGE AVE SW ROANOKE, VA 24016	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 607	Continued From pa helping with resider	ge 26 It care during the snow storm.	F 6	07	
z *	of significant panic normally have the s	esident #1 has had episodes in the past and did not trength to move out of bed but d strength during panic			
	was submitted to th stated no. When as being completed, th	acility reported incident) report e State Agency and DON ked the reason for an FRI not e DON stated there was "no ley felt an FRI should have			
	The facility policy er Exploitation" docum	ntitled "Abuse, Neglect and ented in part:		*	
	not limited to:	Abuse, Neglect and ors of abuse include, but are a resident, of unknown			
100	Exploitation A. An immediate invalue of abuse, neglect or explored abused in a could be used in a	es for investigation include: esponsible for the on in handling evidence that riminal investigation (e.g., not			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X	(X3) DATE SURVEY COMPLETED  C 02/11/2022	
		495156	B. WING	i			
	PROVIDER OR SUPPLIER  HEALTHCARE AT RC	DANOKE	z	STREET ADDRESS, CITY, STATE, ZIP 324 KING GEORGE AVE SW ROANOKE, VA 24016	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
F 607	perpetrator, witness have knowledge of 5. Focusing the invalues, neglect, exphas occurred, the e 6. Providing complete documentation of the VII. Reporting/Reside. A. The facility will hinclude:  1. Reporting of all and Administrator, state services and to all collaw enforcement wis specified timeframe a. Immediately, but the allegation is matter allegation involved bodily injury, or b. Not later than 24 the allegation do not result in serious bods. The administrator government agencia confirm the initial rereport the results of final within 5 workin required by state agencial concerns of the facithoroughly investigation.	the alleged victim, alleged ses, and others who might the allegations; vestigation on determining if loitation, and/or mistreatment xtent, and cause; and ete and thorough he investigation.  Donse ave written procedures that alleged violations to the agency, adult protective other required agencies (e.g., hen applicable) within as: a not later than 2 hours after de, if the events that cause we abuse or result in serious thours if the event that cause it involve abuse and do not dily injury. In will follow up with es, during business hours, to port was received, and to the investigation when the g days of the incident, as	F	607			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		STRUCTION	(X3) DATE SURVEY COMPLETED	
		495156	B. WING_			02	C / <b>11/2022</b>
	PROVIDER OR SUPPLIER HEALTHCARE AT RO	PANOKE		324 KING	ADDRESS, CITY, STATE, ZIP CODE G GEORGE AVE SW DKE, VA 24016	02	71172022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD PROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 609	presented to the suconference on 2/11 Reporting of Alleged CFR(s): 483.12(c)(1) §483.12(c) In response lect, exploitation must: §483.12(c)(1) Ensuinvolving abuse, nemistreatment, include source and misapprare reported immed hours after the allegathat cause the allegaserious bodily injury the events that cause and do not rethe administrator of officials (including to adult protective service for jurisdiction in lonaccordance with Staprocedures. §483.12(c)(4) Repoinvestigations to the designated representaccordance with Staprocedures accordance with Stapropriate corrections REQUIREMENT by: Based on staff inter	on regarding this issue was rvey team prior to the exit /22. d Violations (1)(4) Inse to allegations of abuse, or mistreatment, the facility re that all alleged violations glect, exploitation or ding injuries of unknown ropriation of resident property, iately, but not later than 2 pation is made, if the events ation involve abuse or result in the control of the allegation do not involve esult in serious bodily injury, to the facility and to other the State Survey Agency and vices where state law provides ageterm care facilities) in ate law through established	F 60	1. 99 2. 3.	In-service Administrator/Dir. Nursing on Reporting abuse State Agencies and Other E Individuals policy and Abuse Investigation policy.  Facility to perform 100% au any reports of abuse.  Corporate Clinical Consulta serviced Administrator/ Dire Nursing on Virginia Departn Health Reporting of Incident facility policy on Abuse Prof  Administrator/ or designee w progress notes twice weekly weeks. Audits and audit fine will be reported to the facility Committee monthly for three months to review the need for continued intervention or amendment of the plan.  Allegation of compliance 3/2	e to Entities/ e  dit of  nt in- ctor of nent of ces and nibition.  vill audit / for six dings / QAPI e or	03.28.2022

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	18 45	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495156	B. WING	2		C <b>02/11/2022</b>	
	PROVIDER OR SUPPLIER  HEALTHCARE AT RO	DANOKE		STREET ADDRESS, CITY, STATE, ZIP O 324 KING GEORGE AVE SW ROANOKE, VA 24016			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE	
F 609	ensure an injury of for 1 of 16 residents. Resident #1.  For Resident #1, the an incident where the down in the floor with to the hospital.  The findings included Resident #1's diagnowhich included, but to MRSA (Methicillin Aureus), Chronic Ol Acute Respiratory Essential Hypertens Wasting and Atroph Dependence on Resident #1's with an ARD (at 12/23/21 assigned to interview for mental out of 15 indicating intact. Resident #1's extensive assistance to ileting, and persondependent on staff for the review of Resident #1's review of	gation, the facility staff failed to unknown source was reported in the survey sample,  e facility staff failed to report the resident was found face the injuries requiring transport and injuries requiring and injuries requiring and injuries requiring and injuries register and injuries requiring and injuries and	F 6	609			
	"Resident on vent re Evening meds by pe well by the rsd. Call	note dated 1/16/22 1:55 am, esting in bed with eyes closed. eg and tube feeding tolerated bell within reach. Will and follow POC (plan of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED			
		495156	B. WING		02	C <b>02/11/2022</b>	
	PROVIDER OR SUPPLIER HEALTHCARE AT RC	DANOKE		STREET ADDRESS, CITY, STATE, ZIP CO 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)  TAG  PROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHO  CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHO  CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHO  DEFICIENCY)		SHOULD BE	(X5) COMPLETION DATE			
F 609	am, "0400 (4:00 am down by the writer ventilator making a assisted by CNA (ce RT (respiratory ther over. Resident was lacerations that were eye and left lateral tears to right should front of right knee a knee. After getting around and back or and called 911, whill room with the reside arrived and was give writer. Also, writer with the demograph 0430 (4:30 am) - The was receiving ventil by paramedic when to the ER at (name).  On 2/09/22 at 10:50 nursing) was interviand CNA working at were agency staff we facility since that daincident was requested there was "no formathe weekend of a srin the facility at the since the stage of the sta	note dated 1/16/22 at 4:14 n) - Resident was found face after the writer heard the funny beeping sound. Writer entified nursing assistant) and rapist) to turn the rsd (resident) grunting and had several re bleeding from (his/her) left side of face, along with skin der, right forearm, one on the end one on the right lateral the resident [sp] got turned in ventilator. The writer went e RT and CNA were in the ent. 0415 (4:15 am) - EMS en report from the RT and the gave them a transfer sheet nic information of the resident. The resident was stable and lations by ambu bag via trach (he/she) left the facility to go	F6				
	helping with residen	t the incident as they were t care during the snow storm. sident #1 has had episodes					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		E SURVEY IPLETED
		495156	B. WING	3		C <b>11/2022</b>
	PROVIDER OR SUPPLIER HEALTHCARE AT RO	DANOKE		STREET ADDRESS, CITY, STATE, ZIP CODE 324 KING GEORGE AVE SW ROANOKE, VA 24016		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	anama	D BE	(X5) COMPLETION DATE
F 609	normally have the s may have increase attacks.	ge 31 in the past and did not trength to move out of bed but d strength during panic facility reported incident) report	F6	609		
15	was submitted to the stated no. When as being completed, the	e State Agency and DON ked the reason for an FRI not ne DON stated there was "no ney felt an FRI should have				
	RT #1 was present in the floor. RT #1 s room following roun and then heard the sounding for Reside	pm, RT #1 was interviewed. when Resident #1 was found stated they left Resident #1's ids and went up the hall way vent disconnection alarm ent #1. RT #1 stated they			,	
	face down on the flotheater bleeding "pre#1 stated they held maintained C-spine airway and the nurs	1's room and found (him/her) por between the bed and the etty bad" from the head. RT the resident's head still, precautions, secured the le checked the resident. RT ent had already started				
	swelling. RT #1 state to the side of the be and would squirm so that when they last incident, the resider side but not teeterin #1 stated the reside	ted Resident #1 liked to lean and when laying on their side ome in the bed. RT #1 stated saw Resident #1 prior to the not was laying "a little" on their g on the edge of the bed. RT and the saw apping over to do trach care.				3
	The facility policy en Exploitation" docum IV. Identification of Exploitation	titled "Abuse, Neglect and ented in part:			~	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The second secon	TIPLE CONSTRUCTION		E SURVEY PLETED
80		495156	B. WING			C 11/2022
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CHOICE	HEALTHCARE AT RO	ANOKE		324 KING GEORGE AVE SW ROANOKE, VA 24016		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE	(X5) COMPLETION DATE
F 609	not limited to: 3. Physical injury o source VII. Reporting/Res	f a resident, of unknown	F 6	09		
	include:  1. Reporting of all a Administrator, state services and to all a law enforcement where specified timeframes a. Immediately, but the allegation is matched allegation involved bodily injury, or b. Not later than 24 the allegation do not result in serious bods. The administrator government agencia confirm the initial rereport the results of	t not later than 2 hours after de, if the events that cause we abuse or result in serious hours if the event that cause of involve abuse and do not dily injury.  In will follow up with es, during business hours, to port was received, and to the investigation when the g days of the incident, as				
	administrator, DON the RDCS (regional concerns of the faci of Resident #1 bein injuries was discuss No further information presented to the su conference on 2/11.	on regarding this issue was rvey team prior to the exit /22. Correct Alleged Violation	F 6	10		

NAME OF PROVIDER OR SUPPLIER  CHOICE HEALTHCARE AT ROANOKE   STREET ADDRESS, CITY, STATE, ZIP CODE  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)  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  324 KING GEORGE AVE SW  ROANOKE, VA 24016  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  CMPLETION DATE		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				RUCTION		E SURVEY IPLETED
NAME OF PROVIDER OR SUPPLIER  CHOICE HEALTHCARE AT ROANOKE    SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGK   10 COMPRETIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY   10 COMPRETIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY   11 COMPRETIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY   11 COMPRETIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY   11 COMPRETIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY   12 COMPRETIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY   12 COMPRETIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY   12 COMPRETIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY   12 COMPRETIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY   12 COMPRETIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY   12 COMPRETIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY   12 COMPRETIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY   12 COMPRETIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY   12 COMPRETIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY   12 COMPRETIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY   12 COMPRETIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY   12 COMPRETIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY   12 COMPRETIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY   12 COMPRETIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY   12 COMPRETIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY   12 COMPRETIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY   12 COMPRETIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY   12 COMPRETIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY   12			495156		BUILDING			1	V-E-13
CHOICE HEALTHCARE AT ROANOKE  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 610 Continued From page 33 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:  \$483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.  \$483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.  \$483.12(c)(4) Report the results of all investigation to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:  Based on staff interview, clinical record review, facility document review, and during the course of a complaint investigation, the facility staff failed to ensure an injury of unknown source was investigated of 1 of 16 residents in the survey sample, Resident #1.  The findings included:  Resident #1's diagnosis list indicated diagnoses,	NAMEOF	DOWNER OF SUPPLIED	433130	D. WING				02/	11/2022
F610 Continued From page 33 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:  §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.  §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.  §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:  Based on staff interview, clinical record review, facility document review, and during the course of a complaint investigation, the facility staff failed to ensure an injury of unknown source was investigated for 1 of 16 residents in the survey sample, Resident #1.  The findings included:  Resident #1's diagnosis list indicated diagnoses,			DANOKE		324	KING	GEORGE AVE SW		
\$483.12(c) (n response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:  \$483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.  \$483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.  \$483.12(c)(4) Report the results of all investigation is in progress.  \$483.12(c)(4) Report the results of all investigation to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:  Based on staff interview, clinical record review, facility document review, and during the course of a complaint investigation, the facility staff failed to ensure an injury of unknown source was investigated for 1 of 16 residents in the survey sample, Resident #1.  The findings included:  Resident #1's diagnosis list indicated diagnoses,	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI			EACH CORRECTIVE ACTION SHOULD OSS-REFERENCED TO THE APPROPE	BE	COMPLETION
to MRSA (Methicillin Resistant Staphylococcus Aureus), Chronic Obstructive Pulmonary Disease, Acute Respiratory Failure, Anxiety Disorder, Essential Hypertension, Dementia, Muscle Wasting and Atrophy, Dysphagia, and Dependence on Respirator Status.  The most recent admission MDS (minimum data	F 610	§483.12(c) (1) Have violations are thorough with the second and th	evidence that all alleged ughly investigated.  ent further potential abuse, n, or mistreatment while the rogress.  ort the results of all eadministrator or his or her entative and to other officials in ate law, including to the State alleged violation is verified investion must be taken.  Note in the facility staff failed to unknown source was face residents in the survey in the facility staff failed to unknown source was face residents in the survey in the facility staff failed to unknown source was face residents in the survey in the facility staff failed to unknown source was face residents in the survey in the facility staff failed to unknown source was face residents in the survey in the facility staff failed to unknown source was face residents in the survey in the facility staff failed to unknown source was face residents in the survey in the facility staff failed to unknown source was face residents in the survey in the facility staff failed to unknown source was face residents in the survey in the facility staff failed to unknown source was face residents in the survey in the facility staff failed to unknown source was face residents in the survey in the facility staff failed to unknown source was face residents in the survey in the face of the face	Fé		<ol> <li>2.</li> <li>3.</li> </ol>	Nursing on Reporting abuse State Agencies and Other Elndividuals policy and Abuse Investigation policy.  Facility to perform 100% audi any reports of abuse.  Corporate Clinical Consultar serviced Administrator/ Direct Nursing on Virginia Departm Health Reporting of Incidence facility policy on Abuse Prohability policy on Abuse Prohability weeks. Audits and audit find will be reported to the facility Committee monthly for three months to review the need for continued intervention or amendment of the plan.	to ntities/ dit of  dit of  at in- ctor of ient of es and ibition.  dill audit for six dings QAPI eor	03.28.2022

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	82 (70)	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
1.5		495156	B. WING		C	
	PROVIDER OR SUPPLIER HEALTHCARE AT RO			STREET ADDRESS, CITY, STATE, ZIP CODE 324 KING GEORGE AVE SW	02/11/2022	
				ROANOKE, VA 24016		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		BE COMPLETION	
F 610	interview for mental out of 15 indicating intact. Resident #1 extensive assistance toileting, and person dependent on staff. A review of Resident a nursing progress am, "0400 (4:00 am down by the writer a ventilator making a assisted by CNA (ce RT (respiratory there over. Resident was lacerations that were eye and left lateral stears to right should front of right knee a knee. After getting the around and back on and called 911, while room with the reside arrived and was given writer. Also, writer with the demograph 0430 (4:30 am) - The was receiving ventility by paramedic when to the ER at (name).  On 2/09/22 at 10:56 nursing) was intervied and CNA working at were agency staff we facility since that day	assessment reference date) of the resident a BIMS (brief I status) summary score of 14 the resident was cognitively was coded as requiring we with bed mobility, dressing, and hygiene and being totally for bathing.  It #1's clinical record revealed note dated 1/16/22 at 4:14 a) - Resident was found face after the writer heard the funny beeping sound. Writer rtified nursing assistant) and apist) to turn the rsd (resident) grunting and had several e bleeding from (his/her) left side of face, along with skin ler, right forearm, one on the nd one on the right lateral he resident [sp] got turned a ventilator. The writer went e RT and CNA were in the part. 0415 (4:15 am) - EMS en report from the RT and the gave them a transfer sheet ic information of the resident. e resident was stable and ations by ambu bag via trach (he/she) left the facility to go	Fé	510		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	No.	LTIPLE CONSTRUCTION DING		OATE SURVEY
		495156	B. WING	24		C 02/11/2022
	PROVIDER OR SUPPLIER	)ANOKE		STREET ADDRESS, CITY, STATE, ZIP CO 324 KING GEORGE AVE SW ROANOKE, VA 24016		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE
F 610	the weekend of a sin the facility at the found in the floor. I directly know" about helping with resider. The DON stated Re of significant panic normally have the smay have increase attacks.  On 2/09/22 at 2:15 RT #1 was present in the floor. RT #1 sroom following rour and then heard the sounding for Reside entered Resident # face down on the fl heater bleeding "pr #1 stated they remember stood they remember stood they remember stood they remember stood the property of the property of the property of they remember stood	al work-up for that" and it was now storm and they were not time of Resident #1 being DON further stated they "didn't at the incident as they were not care during the snow storm.  Besident #1 has had episodes in the past and did not strength to move out of bed but distrength during panic  pm, RT #1 was interviewed. when Resident #1 was found stated they left Resident #1's and and went up the hall way vent disconnection alarm ent #1. RT #1 stated they etty bad" from the bed and the etty bad" from the head. RT the resident's head still, a precautions, secured the se checked the resident. RT ent had already started ted Resident #1 liked to lean ed when laying on their side some in the bed. RT #1 stated saw Resident #1 prior to the nt was laying "a little" on their ng on the edge of the bed. RT ent's bed was "pretty low" as oping over to do trach care.	F	610		
	Exploitation" docum	ntitled "Abuse, Neglect and nented in part: Abuse, Neglect and				

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	2004 2000000000000			(X3) DATE SURVEY COMPLETED	
	495156	B. WING	. WING		100	C 11/2022
NAME OF PROVIDER OR SUPPLIER  CHOICE HEALTHCARE AT ROANOKE			3:	24 KING GEORGE AVE SW	, J	2022
		BE	(X5) COMPLETION DATE			
B. Possible indicate not limited to:  3. Physical injury or source  V. Investigation of A Exploitation  A. An immediate in suspicion of abuse abuse, neglect or e. B. Written procedu  1. Identifying staff r investigation;  2. Exercising cautic could be used in a catampering or destro  3. Investigating difficional investigation;  4. Identifying and in persons, including the perpetrator, witness have knowledge of 5. Focusing the invabuse, neglect, explanas occurred, the explanation of the Concern of the fainvestigation into the resulting in Residen with injuries was disconsistent in the concern of the fainvestigation into the resulting in Residen with injuries was disconsistent in the concern of the fainvestigation into the resulting in Residen with injuries was disconsistent in the concern of the fainvestigation into the resulting in Residen with injuries was disconsistent in the concern of the fainvestigation into the resulting in Residen with injuries was disconsistent in the concern of the fainvestigation into the resulting in Residen with injuries was disconsistent in the concern of the fainvestigation into the resulting in Residen with injuries was disconsistent in the concern of the fainvestigation into the resulting in Residen with injuries was disconsistent in the concern of the fainvestigation into the resulting in Residen with injuries was disconsistent in the concern of the fainvestigation into the resulting in Residen with injuries was disconsistent in the concern of the fainvestigation into the resulting in Residen with injuries was disconsistent in the concern of the fainvestigation into the resulting in Residen with injuries was disconsistent in the concern of the fainvestigation into the concern of the fainvestigation into the concern of the fainvestigation into the concern of the fainvestigati	f a resident, of unknown Alleged Abuse, Neglect and vestigation is warranted when or exploitation, or reports of exploitation occur. res for investigation include: responsible for the on in handling evidence that criminal investigation (e.g., not ying evidence); erent types of alleged he alleged victim, alleged he alleged victim, alleged hes, and others who might the allegations; estigation on determining if loitation, and/or mistreatment extent, and cause; and ete and thorough e investigation.  om during a meeting with the ADON (assistant DON), and director of clinical services), acility not completing an e cause of the incident t #1 being found in the floor cussed.  on regarding this issue was	F	610			
					230	0
	PROVIDER OR SUPPLIER  HEALTHCARE AT RO  SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE  Continued From pa B. Possible indicate not limited to: 3. Physical injury o source V. Investigation of A Exploitation A. An immediate in suspicion of abuse abuse, neglect or e: B. Written procedu 1. Identifying staff r investigation; 2. Exercising cautic could be used in a c tampering or destro 3. Investigating diff violations; 4. Identifying and ir persons, including th perpetrator, witness have knowledge of 5. Focusing the inv abuse, neglect, expl has occurred, the e: 6. Providing comple documentation of th  On 2/09/22 at 4:21 p administrator, DON, the RDCS (regional the concern of the fa investigation into the resulting in Residen with injuries was dis  No further informatic presented to the sur	A95156  PROVIDER OR SUPPLIER  HEALTHCARE AT ROANOKE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 36  B. Possible indicators of abuse include, but are not limited to: 3. Physical injury of a resident, of unknown source  V. Investigation of Alleged Abuse, Neglect and Exploitation  A. An immediate investigation is warranted when suspicion of abuse or exploitation, or reports of abuse, neglect or exploitation occur.  B. Written procedures for investigation include: 1. Identifying staff responsible for the investigation; 2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence); 3. Investigating different types of alleged	PROVIDER OR SUPPLIER  HEALTHCARE AT ROANOKE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 36  B. Possible indicators of abuse include, but are not limited to:  3. Physical injury of a resident, of unknown source  V. Investigation of Alleged Abuse, Neglect and Exploitation  A. An immediate investigation is warranted when suspicion of abuse or exploitation, or reports of abuse, neglect or exploitation occur.  B. Written procedures for investigation include:  1. Identifying staff responsible for the investigation;  2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence);  3. Investigating different types of alleged violations;  4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations;  5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and  6. Providing complete and thorough documentation of the investigation.  On 2/09/22 at 4:21 pm during a meeting with the administrator, DON, ADON (assistant DON), and the RDCS (regional director of clinical services), the concern of the facility not completing an investigation into the cause of the incident resulting in Resident #1 being found in the floor with injuries was discussed.  No further information regarding this issue was presented to the survey team prior to the exit	A. BUILDING  495156  B. WING  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 36  B. Possible indicators of abuse include, but are not limited to: 3. Physical injury of a resident, of unknown source V. Investigation of Alleged Abuse, Neglect and Exploitation A. An immediate investigation is warranted when suspicion of abuse or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigation include: 1. 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No further information regarding this issue was presented to the survey team prior to the exit	A BUILDING  495156  ROVIDER OR SUPPLIER  HEALTHCARE AT ROANOKE  SUMMARY STATEMENT OF DEFICIENCIES [EACH DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 36  B. Possible indicators of abuse include, but are not limited to: 3. Physical injury of a resident, of unknown source  V. Investigation of Alleged Abuse, Neglect and Exploitation A. An immediate investigation is warranted when suspicion of abuse or exploitation, or reports of abuse, neglect or exploitation occur.  B. Written procedures for investigation include: 1. Identifying staff responsible for the investigation; 2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence); 3. Investigating different types of alleged vicitim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation.  On 2/09/22 at 4:21 pm during a meeting with the administrator, DON, ADON (assistant DON), and the RDCS (regional director of clinical services), the concern of the facility not completing an investigation into the cause of the incident resulting in Resident #1 being found in the floor with injuries was discussed.  No further information regarding this issue was presented to the survey team prior to the exit	A BUILDING  495156  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 324 KING GEORGE AVE SW ROANOKE, VA 24016  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 36  B. Possible indicators of abuse include, but are not limited to: 3. Physical injury of a resident, of unknown source V. Investigation of Alleged Abuse, Neglect and Exploitation A. An immediate investigation is warranted when suspicion of abuse or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigation include: 1. Identifying staff responsible for the investigation; 3. Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged violations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation.  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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY IPLETED
		495156	B. WING				C 11/2022
	PROVIDER OR SUPPLIER  HEALTHCARE AT RO	3		324 F	EET ADDRESS, CITY, STATE, ZIP CODE KING GEORGE AVE SW ANOKE, VA 24016		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE RIATE	(X5) COMPLETION DATE
F 684	applies to all treath facility residents. B assessment of a re that residents received accordance with propractice, the complicate plan, and the This REQUIREMED by:  Based on observarecord review, facility and the facility staff faile for 5 of 16 resident and #9.  The findings included but failure, chronic kidnanemia, dementia, dysphagia and other than the facility and the set) with an ARD (and short term medimpaired cognitive LPN (licensed pracadministering mediaccordance in the set) with an and short term medimpaired cognitive LPN (licensed pracadministering mediaccordance with pracadministeri	care fundamental principle that nent and care provided to ased on the comprehensive sident, the facility must ensure ive treatment and care in rofessional standards of rehensive person-centered residents' choices. NT is not met as evidenced tion, staff interview, clinical ity document review, and in pass and pour observation, ed to follow physician's orders s, Resident #13, #2, #3, #7,  ed: s face sheet listed diagnoses not limited to congestive heart ney disease, atrial fibrillation, glaucoma, polyneuropathy, er feeding difficulties.  uarterly MDS (minimum data assessment reference date) of e resident as having both long mory problems and moderately skills for daily decision making.  etical nurse) #2 was observed ications to Resident #13 during and pour on 02/09/22 at 8:15		584 584	<ol> <li>Resident medications/supple obtained for residents #13,re #2 order completed, resident medication obtained, resident longer in facility, MD notified further orders on received. Find notified.</li> <li>Full facility audit to ensure medication availability for all residents.</li> <li>All licensed nursing staff reeducated regarding medicadministration and unavailable medication policies by Direct Nursing.</li> <li>Director of Nursing/ or design audit twice weekly for six we availability of four randomly selected resident's medication documentation of resident medications. Audits and audindings will be reported to the facility QAPI Committee to rethe need for continued intervor amendment of the plan.</li> <li>Allegation of compliance set 03.28.2022</li> </ol>	ation ole tor of nee will eks the ons to n and dit ne eview vention	

	MENT OF DEFICIENCIES LAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	B. Brenner	LTIPLE CONSTRUCTION DING	(XS	3) DATE SURVEY COMPLETED	
		495156	B. WING	3		C <b>02/11/2022</b>	
oer-seneral	OF PROVIDER OR SUPPLIER	DANOKE		STREET ADDRESS, CITY, STATE, ZIP O 324 KING GEORGE AVE SW ROANOKE, VA 24016	ODE	OZI I II ZOZZ	
(X4) PRE TA	FIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE		
F6	was unavailable. LI member if they cou LPN #2 then pourer into a cup, took it a medications and ac Resident #13's med 02/09/22 at 9:30 and was not listed on thorders.  On 02/09/22 at 9:45 the Med Pass, and they're all the same b. Resident #13's pithe month of February in the same i	tated that resident's Ensure PN #2 asked another staff Id get the Ensure for them. Id the supplement Med Pass and the resident's prepared Iministered to the resident. Idications were reconciled on In. The supplement Med Pass Is e resident's physician's Is am LPN #2 was asked about LPN #2 stated, "You know In just the name's different." In president's order summary for In any 2022 contained an order, In gabapentin capsule 300 mg.	F6	584			
	record) was reviewed entry which read in mg. Give 1 capsule neuropathy." This et 02/09/22 and 02/10/defined as "other/se Resident #13's nurs were reviewed and other sections.	e's notes for these dates contained notes, "02/09/2022					
	mouth at bedtime fo available," and "02/1 300 mg. Give 1 caps neuropathy. awaiting	le 300 mg. Give 1 capsule by r neuropathy. med not 0/2022gabapentin capsule sule by mouth at bedtime for g pharmacy."				200	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			No. 1 Management Committee	TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		495156	B. WING		C 02/11/2022	
AND AND THE STATE OF	PROVIDER OR SUPPLIER HEALTHCARE AT RO	DANOKE		STREET ADDRESS, CITY, STATE, ZIP CODE 324 KING GEORGE AVE SW ROANOKE, VA 24016	32/11/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	[20]	D BE COMPLETION	
F 684	Resident #13's comreviewed and conta for alteration in com (osteoarthritis) and for this care plan in The comprehensive care plan for " is a dementia, and dysp care plan included ordered".  The facility policy et Medications" docum supply of commonly	was reviewed and Gabapentin as being available.  Inprehensive care plan was ained a care plan for "At risk infort r/t (related to) OA polyneuropathy". Interventions cluded "medicate as ordered". In the care plan also contained a lat nutritional risk r/t (related to) ohagia". Interventions for this 'Provide supplements as	F6	584		
	Pass for Ensure and resident's gabapent was discussed with (administrator, direct director of nursing, 102/11/22 at 11:55 at an acceptable subsorder.  No further information 2. Resident #2's diadiagnoses, which in Dementia, Type 2 Disorder, Unsteadin Vascular Disease, M	stituting the supplement Med d not administering the tin per the physician's order the administrative team etor of nursing, assistant regional nurse consultant) on m. The DON stated this is not titution without a physician's on was provided prior to exit. In a signosis list indicated cluded, but not limited to biabetes Mellitus, Anxiety ness on Feet, Peripheral uscle Wasting and Atrophy, ydrocephalus, and Essential				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	S. Olay War In	495156	B. WING	1	C <b>02/11/2022</b>	
	PROVIDER OR SUPPLIER	ANOKE		STREET ADDRESS, CITY, STATE, ZIP CODE 324 KING GEORGE AVE SW ROANOKE, VA 24016	OLI III LOLL	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		LD BE COMPLETION	
F 684	set) with an ARD (a 1/13/22 assigned the interview for mental out of 15 indicating intact.  Resident #2's clinic physician's order for every eight (8) hour start on 1/09/22.  A review of the resid (medication administ Resident #2 received Clonazepam on 1/1  According to the nut Clonazepam was not 1/09/22 at 10:00 p.m of "awaiting arrival fat 6:00 a.m. for the order".  On 2/08/22 at 4:52 nursing) stated Clonazepam 0.5 mg hand supply of one supply of zero (0).  On 2/09/22 at 1:39 Clonazepam was not 1/09/22 and 1/10/22 and 1/10/22 and 1/10/22 and 1/10/22	arterly MDS (minimum data assessment reference date) of the resident a BIMS (brief a status) summary score of 14 Resident #2 was cognitively all record included a racionazepam 1 mg by mouth soft anxiety for one week, to ent's January 2022 MAR stration record) revealed and the first administration of 0/22 at 2:00 pm.  Tring progress notes, on administered as ordered on the documented reason from pharmacy" and 1/10/22 documented reason of "on p.m. the DON (director of the documented reason of "on p.m. the DON (director of the documented reason of "on p.m. the DON (director of the documented reason of "on p.m. the DON (director of the documented reason of "on p.m. the DON (director of the documented reason of "on p.m. the DON (director of the documented reason of "on p.m. the DON (director of the documented reason of "on p.m. the DON verified of the documented of the	F 6	84		

	FEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X DENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495156	B. WING		C 02/11/2	022
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/11/2	.022
CHOICE	HEALTHCARE AT RO	DANOKE	8	324 KING GEORGE AVE SW ROANOKE, VA 24016		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		BE COM	(X5) MPLETION DATE
F 684	Continued From pa	ge 41	F6	584		Istil ex
	DON, and the regio	Iministrator, DON, assistant nal director of clinical services of the concern of Resident #2 zepam as ordered.				
		on regarding this concern was rvey team prior to the exit /22.				
	diagnoses, which in Chronic Obstructive Combined Congest Schizophrenia, End Essential Hypertens	agnosis list indicated noluded, but not limited to e Pulmonary Disease, Acute ive Heart Failure, Paranoid I Stage Renal Disease, sion, Dependence on Renal osmolality and Hyponatremia.				
	set) with an ARD (a 2/05/22 assigned the interview for mental	arterly MDS (minimum data assessment reference date) of the resident a BIMS (brief a status) score of 15 out of 15, and was cognitively intact.				
	an order dated 5/19 ER Extended Release one time a day, and a previous order da HCL 25 mg two (2)	e physician's orders included /21 for Isosorbide Mononitrate ase 24 hour 30 mg by mouth an order dated 2/08/22 (with te of 5/19/21) for Hydralazine tablets by mouth three (3) Monday, Wednesday, Friday,				a u
	(medication adminis 2022 MAR, and nur Isosorbide Mononiti	t #3's January 2022 MAR stration record), February sing progress notes, revealed rate was not administered on for the documented reason ion from pharmacy.				

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	11000 100000000000000000000000000000000	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
3.0		495156	B. WING				C <b>11/2022</b>
	PROVIDER OR SUPPLIER	MANOKE		STREET ADDRESS, CITY, STATE, ZIP ( 324 KING GEORGE AVE SW	CODE	UZI	11/2022
CHOICE	TIEAETHOAKE AT KO	MIONE		ROANOKE, VA 24016			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD E	BE	(X5) COMPLETION DATE
F 684		ot administered on 1/31/22 at	F 6	84			
	documented reason was not administered	2/22 at 6:00 a.m. for the n of being on order, and also ed on 2/02/22 at 2:00 p.m. for				75 3	o.
	The list of medication	ason of pending pharmacy.  ons available in the facility					
	Isosorbide Mononiti maximum supply of supply of four (4), a	cation supply included rate ER 30 mg tablets with a ten (10) and a minimum and hydralazine 25 mg tablets pply of ten (10) and a four (4).				ä	
	(director of nursing) regional director of of the concern of Re Isosorbide Mononiti	p.m., the administrator, DON , assistant DON, and the clinical services were notified esident #3 not receiving rate and Hydralazine as each medication was available supply.	g.				
		p.m., the management team additional information related				v 2	
		on regarding this concern was rvey team prior to the exit (22.					20 DEC
	Hemiplegia and Her Unspecified Cerebro Left Non-Dominant Chronic Viral Hepat Systolic Congestive Hypertension, Paroxy	cluded, but not limited to				-	,

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		495156	B. WING		C 02/11/2022	
	PROVIDER OR SUPPLIER HEALTHCARE AT RO	ANOKE		STREET ADDRESS, CITY, STATE, ZIP CODE 324 KING GEORGE AVE SW ROANOKE, VA 24016		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	^^~~	D BE COMPLÉTION	
F 684	set) with an ARD (a 1/12/22 assigned the interview for mental out of 15 indicating cognitively impaired. Resident #7's active an order dated 9/10 give 0.5 tablet via Prelated to Anxiety D. A review of Resident February 2022 MAF records) revealed Ladministered on the reason documented follows: 1/03/22 5:00 p.m 1/04/22 9:00 a.m 1/04/22 9:00 a.m 1/05/22 9:00 a.m 1/06/22 9:00 a.m 1/06/22 5:00 p.m 1/06/22 5:00	arterly MDS (minimum data assessment reference date) of the resident a BIMS (brief status) summary score of 10 Resident #7 was moderately l.  The physician's orders included 1/21, "Lorazepam Tablet 1 mg PEG-Tube two times a day isorder".  The third is the two times and the third isorder and the third isorde	F 6			
	accident), becomes are not met, agitatio not easily redirected	anxious if immediate needs n, screaming, grabbing and is d." Interventions included in ti-anxiety medications as				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100 1007 10000	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495156	B. WING			C <b>/11/2022</b>	
	PROVIDER OR SUPPLIER HEALTHCARE AT RC	DANOKE		STREET ADDRESS, CITY, STATE, ZIP 324 KING GEORGE AVE SW ROANOKE, VA 24016			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 684	Cubex onsite medic Lorazepam 0.5 mg supply of two (2) and (1) to be available.  On 2/08/22 at 4:52 nursing) stated Lora Cubex in the dose of Cubex in the do	ons available in the facility cation supply included tablets with a maximum and a minimum supply of one  p.m. the DON (director of azepam was available in the of 0.5 mg.  p.m. the DON verified the awas not administered on the des/times.  p.m., the administrator, DON, at the regional director of ere notified of the concern of eiving Lorazepam as ordered occasions despite being lity onsite supply.  on regarding this issue was rvey team prior to the exit	F	584			
	Those medications Amlodipine besylate	were: e tablet 5 mg Give 1 tablet via		7 6 8		1.1	

	F CORRECTION IDENTIFICATION NUMBER: A. BUILDING COM		E SURVEY PLETED				
		495156	B. WING				C 11/2022
	PROVIDER OR SUPPLIER HEALTHCARE AT RO	DANOKE	36.	STREET ADDRESS, CITY, STATE, ZIP 324 KING GEORGE AVE SW ROANOKE, VA 24016	CODE		p p
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD E APPROPE	BE	(X5) COMPLETION DATE
F 684	dbp<60 Tube three Enoxaparin Sodium 0.4 ml subcutaneou clots Famotidine Tablet 4 Tube one time a da Ferrous Sulfate liquitime a day for iron Glycopyrrolate Tab Tube 3 times a day An order for Check	e a day hold for sbp<100 or times a day for secretions a Solution 40 mg/.4 ml inject usly one time a day for blood 40 mg Give 1 tablet via PEG by for GERD uid Give 5 ml via Peg-tube one let 2 mg Give 1 tablet via PEG for secretions vital signs (temp and O2 sat)	F 6	84			
	2/5/2022 at 4:00 All No nursing note ad the medications on On 2/11/2022, the discussed with the acknowledged ther medications had be The facility policy en Medications" docur 2. A STAT supply is maintained in-ho	dressed failure to administer that date.  planks on the MAR were director of nursing, who e was no evidence the een administered.					
	for ensuring reside medications.  4. Medications ma of reason. Staff sha when it is known th unavailable: a. Determine reason	follow established procedures into have a sufficient supply of any be unavailable for a number all take immediate action at the medication is on for unavailability, length of unavailable, and what efforts					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	S Same		LE CONSTRUCTION		E SURVEY
		495156	B. WING		- 4 A	1	C <b>11/2022</b>
	PROVIDER OR SUPPLIER HEALTHCARE AT RO	PANOKE		3	STREET ADDRESS, CITY, STATE, ZIP CODE 324 KING GEORGE AVE SW ROANOKE, VA 24016	021	11/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 690	obtain the medication b. Notify physician medication upon not medication is not attreatment orders and monitoring resident.  No further information presented to the succonference on 2/11. Bowel/Bladder Inco CFR(s): 483.25(e) (1) The fresident who is conference on admission receives maintain continence condition is or beconot possible to main §483.25(e)(2) For a incontinence, based comprehensive asseensure that— (i) A resident who enindwelling catheter is resident's clinical concatheterization was (ii) A resident who enindwelling catheter of its assessed for remain as possible unless the demonstrates that condition is or second that the condition is or beconot possible unless the demonstrates that condition is or beconot possible unles	cility or pharmacy provider to con.  of inability to obtain alternate vallable. Obtain alternate od/or specific orders for while medication is on hold.  on regarding this issue was rvey team prior to the exit /22.  Intinence, Catheter, UTI (1)-(3)  ence.  acility must ensure that inent of bladder and bowel on services and assistance to exprice and assistance to exprise such that continence is stain.  resident with urinary on the resident's essment, the facility must an expression of the catheterized unless the notition demonstrates that	F6	84	<ol> <li>Resident #4 catheter bag waremoved from the floor, place privacy bag, and then secure immovable part of the reside bed frame immediately. No a effect noted.</li> <li>Full facility audit to ensure all catheters secured and not on floor.</li> <li>All nursing staff will be educathe foley catheter care policy.</li> <li>Director of Nursing/ or design audit twice weekly for six weeresidents with a foley cathete ensure foleys are secure and on the floor. Audits and audit findings will be reported to the facility QAPI Committee month three months to review the necontinued intervention or amendment of the plan.</li> <li>Allegation of compliance set for 03.28.2022.</li> </ol>	ed in a ed to an int's adverse I foley in the ed to an interest in the ed to a	03.28.2022

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		San Stanson	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495156	B. WING	j	0:	C 2/11/2022
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 324 KING GEORGE AVE SW ROANOKE, VA 24016		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 690	\$483.25(e)(3) For a incontinence, base comprehensive assensure that a reside receives appropriate restore as much not possible.  This REQUIREMED by:  Based on observation document review, to Foley catheter care infections for 1 of 1 Resident #4's Foley.	extent possible.  a resident with fecal d on the resident's sessment, the facility must ent who is incontinent of bowel te treatment and services to ormal bowel function as  NT is not met as evidenced  tion, staff interview, and facility he facility staff failed to provide to prevent urinary tract for residents, Resident #4.  y catheter bag was observed two (2) separate occasions	F	690		
	included but not limencephalopathy, oburinary tract infection failure, cerebral infection disorders, convulsion respiratory failure.  Section C, cognitive quarterly MDS (min (assessment refere the resident as have memory problems a cognitive skills for description of the cognitive skil	estructive and reflux uropathy, on, dementia, congestive heart arction, developmental ons, hypertension, and e patterns, of Resident #4's imum data set) with an ARD nce date) of 12/28/22 coded ing both long and short term and severely impaired aily decision making.				
7	Resident #4's compreviewed and conta	orehensive care plan was ined a care plan for " has a				

	FATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495156	B. WING	18		C 02/11/2022	
	PROVIDER OR SUPPLIER  HEALTHCARE AT RO	)ANOKE		STREET ADDRESS, CITY, STATE, ZIP CO 324 KING GEORGE AVE SW ROANOKE, VA 24016			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD BE	COMPLETION DATE	
F 690	issues, including ki requiring Foley cath	age 48 bladder and kidney related dney stones, infections neter to be replaced. Recent to scrotal abscess. Has	F 6	90			
	Resident #4 was ol am. Resident #4 wa	bserved on 02/08/22 at 11:45 as resting in bed. A Foley bag was observed lying on the ent #4's bed.					
	3:30 pm. Resident a catheter drainage b	bserved again on 02/08/22 at #4 was resting in bed. A Foley bag was observed lying in floor #4's bed, in same area as d.					
	documented in part this procedure is to urinary tract infection	ntitled "Catheter Care, Urinary" t, "Purpose: The purpose of prevent catheter-associated ons. Infection Control: 2. b. Be ubing and drainage bag are					
	team (administrator director of nursing, during a meeting or	cussed with the administrative r, director of nursing, assistant regional nurse consultant) n 02/11/22 at 11:55 am. The stated this was a breach of					
	No further informati Nutrition/Hydration CFR(s): 483.25(g)(		F 6	92			
	(Includes naso-gas	d nutrition and hydration. tric and gastrostomy tubes, endoscopic gastrostomy and					

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495156	B. WING					C
NAME OF	200/4050 00 01 1001 150	493130	D. WING_				02/	11/2022
NAME OF	PROVIDER OR SUPPLIER					DDRESS, CITY, STATE, ZIP CODE		
CHOICE	HEALTHCARE AT RO	ANOKE				GEORGE AVE SW (E, VA 24016		Ť
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		BE	(X5) COMPLETION DATE
		150-61		F69	92			03.28.2022
F 692	Continued From pa	<b>→</b> // / / / / / / / / / / / / / / / / /	F 69	92				
	percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-				1.	Resident #1 No longer at factoresident #6 rate corrected, motified, no further orders,		
	§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition					Full facility audit to ensure actube feeding orders.		
	demonstrates that this is not possible or resident preferences indicate otherwise;					All licensed nursing staff regare-educated by Director of N on .		
	§483.25(g)(2) Is offer maintain proper hyd	ered sufficient fluid intake to Iration and health;				Director of Nursing/ or design audit tube feeding orders and	d pump	
	there is a nutritional provider orders a th This REQUIREMEN by: Based on observat	IT is not met as evidenced ion, staff interview, clinical facility document review,				for accuracy twice weekly for weeks. Audits and audit find will be reported to the facility Committee monthly for three months to review the need for continued intervention or amendment of the plan.	ings QAPI	
	parameters of nutrit	on and hydration for 2 of 16 rey sample, Residents #1 and				Allegation of compliance set 03.28.2022	for	
	tube feeding formula	flushes via enteral tube						
		facility staff failed to follow rs for tube feeding and water						
	The findings include	d:						8
	1. Resident #1's dia	ignosis list indicated						

NAME OF PROVIDER OR SUPPLIER  CHOICE HEALTHCARE AT ROANOKE  SUMMARY STATEMENT OF DEFICIENCIES (AS) ID PREFIX (EACH DEFICIENCY OR LSC IDENTIFYMS INFORMATION)  FREETY (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYMS INFORMATION)  F 692 Continued From page 50 diagnoses, which included, but not limited to Pneumonia due to MRSA (Methicillin Resistant Staphylococcus Aureus), Chronic Obstructive Pulmonary Disease, Acute Respiratory Failure, Arixiety Disorder, Essential Hypertension, Dementia, Muscle Wasting and Atrophy, Dysphagia, and Dependence on Respirator Status.  The most recent admission MDS (minimum data set) with an ARD (assessment reference date) of 12/23/21 assigned the resident as BIMS (brief interview for mental status) summary score of 14 out of 15 indicating the resident was cognitively intact. Resident #1 was coded for the presence of a feeding tube in which they were receiving 51% or more of total calories and 501 co/day or more of average fluid intake per tube feeding.  Resident #1's current physician's orders included an order dated 2/07/22, "Enteral Feed Order every shift for nutrition Osmolite 1.5 continuous 50 ml (milliliters) limit for water flushes.  Since Resident #1's readmission to the facility on 2/7/22, there was no nutrition assessment for hydration needs. Prior to Resident #1 ging out to the hospital, the resident had a physician's order for 125 ml of water every four hours.		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Market Schoolses Color	MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
CHOICE HEALTHCARE AT ROANOKE  STREET ADDRESS, CITY, STATE, ZIP CODE 324 KING GEORGE AVE SW ROANOKE, VA 24016  (X4) ID PREFIX  GEACH DEPTICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 692  Continued From page 50 diagnoses, which included, but not limited to Pneumonia due to MRSA (Methicillin Resistant Staphylococcus Aureus), Chronic Obstructive Pulmonary Disease, Acute Respiratory Failure, Anxiety Disorder, Essential Hypertension, Dementia, Muscle Wasting and Atrophy, Dysphagia, and Dependence on Respirator Status.  The most recent admission MDS (minimum data set) with an ARD (assessment reference date) of 12/23/21 assigned the resident at BIMS (brief interview for mental status) summary score of 14 out of 15 indicating the resident was cognitively intact. Resident #1 was coded for the presence of a feeding tube in which they were receiving 51% or more of total calories and 501 cc/day or more of average fluid intake per tube feeding.  Resident #1's current physician's orders included an order dated 2/07/22, "Enteral Feed Order every shift for nutrition Osmolite 1.5 continuous 50 ml (milliliters)/hr (hour)." There was no current physician's order for water flushes.  Since Resident #1's readmission to the facility on 2/7/22, there was no nutrition assessment for hydration needs. Prior to Resident #1 going out to the hospital, the resident had a physician's order		=	495156	B. WING	·				
PREFIX TAG    (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG			PANOKE		3	324 KING GEORGE AVE SW			
diagnoses, which included, but not limited to Pneumonia due to MRSA (Methicillin Resistant Staphylococcus Aureus), Chronic Obstructive Pulmonary Disease, Acute Respiratory Failure, Anxiety Disorder, Essential Hypertension, Dementia, Muscle Wasting and Atrophy, Dysphagia, and Dependence on Respirator Status.  The most recent admission MDS (minimum data set) with an ARD (assessment reference date) of 12/23/21 assigned the resident a BIMS (brief interview for mental status) summary score of 14 out of 15 indicating the resident was cognitively intact. Resident #1 was coded for the presence of a feeding tube in which they were receiving 51% or more of total calories and 501 cc/day or more of average fluid intake per tube feeding.  Resident #1's current physician's orders included an order dated 2/07/22, "Enteral Feed Order every shift for nutrition Osmolite 1.5 continuous 50 ml (milliliters)/hr (hour)." There was no current physician's order for water flushes.  Since Resident #1's readmission to the facility on 2/7/22, there was no nutrition assessment for hydration needs. Prior to Resident #1 going out to the hospital, the resident had a physician's order	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION	
On 2/08/22 at 2:00 pm, Resident #1 was observed in bed receiving Jevity 1.5 TF (tube feeding) formula via pump at 50 ml/hour. A fillable TF bag with approximately 1,000 ml of water was also attached to the TF pump with the pump set to deliver 100 ml water flushes every	F 692	diagnoses, which in Pneumonia due to Staphylococcus Aur Pulmonary Disease Anxiety Disorder, E Dementia, Muscle V Dysphagia, and De Status.  The most recent ad set) with an ARD (a 12/23/21 assigned interview for mental out of 15 indicating intact. Resident #1 of a feeding tube in 51% or more of total more of average flux Resident #1's currer an order dated 2/07 every shift for nutriti 50 ml (milliliters)/hr physician's order for Since Resident #1's 2/7/22, there was no hydration needs. Prothe hospital, the resident properties for 125 ml of water of the hospital of the resident properties for 125 ml of water of the hospital of the resident properties for 125 ml of water of the hospital of the resident properties for 125 ml of water of the hospital of the resident properties for 125 ml of water of the hospital of the resident properties for 125 ml of water of the hospital of the resident properties for 125 ml of water of the hospital of the resident properties for 125 ml of water of the hospital of the resident properties for 125 ml of water of the hospital	included, but not limited to MRSA (Methicillin Resistant reus), Chronic Obstructive, Acute Respiratory Failure, ssential Hypertension, Wasting and Atrophy, pendence on Respirator  Imission MDS (minimum data issessment reference date) of the resident a BIMS (brief I status) summary score of 14 the resident was cognitively was coded for the presence which they were receiving al calories and 501 cc/day or id intake per tube feeding.  Int physician's orders included 1/22, "Enteral Feed Order ion Osmolite 1.5 continuous (hour)." There was no current r water flushes.  Is readmission to the facility on on nutrition assessment for ior to Resident #1 going out to ident had a physician's order every four hours.  In pm, Resident #1 was beiving Jevity 1.5 TF (tube in pump at 50 ml/hour. A papproximately 1,000 ml of ched to the TF pump with the	F	692				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495156	B. WING			0.000	C / <b>11/2022</b>
NAME OF PROVIDER OR SUF CHOICE HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CO 324 KING GEORGE AVE SW ROANOKE, VA 24016			
PREFIX (EACH DEFI	CIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	33.22	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
(medication a Osmolite 1.5 administered On 2/09/22 at observed in beformula via puralso receiving deliver 100 m. On 2/09/22 at nursing) was water flushes physician's or On 2/09/22 at assistant DOI clinical service Resident #1 r without a currely without a currely without a currely conference or 2. Resident #6 which include failure, diabet respiratory fait tracheostomy hypertension. The most receivan ARD (asses assigned the mental status	8:05 8:05 8:05 8:05 8:05 8:05 8:05 8:05	nt #1's February MAR istration record) revealed signed on the MAR as being 08/22 for day and night shift.  am, Resident #1 was reciving Osmolite 1.5 TF at 50 ml/hr. Resident #1 was er flushes via pump set to ry four (4) hours.  4 am, the DON (director of red of Resident #1 receiving reding tube without a  pm, the administrator, DON, deter regional director of rere advised of the concern of ring water flushes via tube rhysician's order.  ion regarding this issue was survey team prior to the exit 1/22.  re sheet listed diagnoses rot limited to respiratory relitius type II, chronic reanemia, pneumonia, ris, dysphagia, and  DS (minimum data set) with reference date) of 01/15/22 ret a BIMS (brief interview for re of 1 out 15 in section C, indicating the resident was	F	592			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY MPLETED
		495156	B. WING			C 02/11/2022	
	PROVIDER OR SUPPLIER HEALTHCARE AT RO	PANOKE		3:	TREET ADDRESS, CITY, STATE, ZIP CODE 24 KING GEORGE AVE SW ROANOKE, VA 24016	02/	11/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	C00000	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 692	02/09/22 and conta summary for the maincluded, "Enteral Funtrition. Enteral 1-RTH (ready to hang via pump. Rate: 50 Free H20 75 ml ever Resident #6's eMAI administration reconsus reviewed and contain part, "Enteral Fee nutrition. Enteral 1-RTH per JT via pum hours/day; Free H2 entry was initialed a shift.  Resident #6 was ob pm. Resident #6 was feeding of Promote free water flushes on the state of the sta	al record was reviewed on ined a physician's order onth of February 2022, which feed Order every shift for Feeding: Administer Promote g) per JT (jejunostomy tube) ml/hour, for 24 hours/day; ery 2 hours."  R (electronic medication red) for the month of February contained an entry which read ed Order every shift for Feeding: Administer Promote np. Rate: 50 ml/hour, for 24 0 75 ml every 2 hours." This as being completed for each eserved on 02/08/22 at 12:10 as lying in bed with tube running at 70 ml/hour, with f 60 ml every 2 hours.  served again on 02/09/22 at 46 was in bed with tube running at 70 ml/hour, with f 60 ml every 2 hours.  served again on 02/09/22 at erunning at 70 ml/hour, with f 60 ml every 2 hours.  The ensive care plan was ined a care plan for " is at reation risk aeb (as evidenced 2DM (type 2 diabetes ertension), anemia, alcohol eight per BMI (body mass g by mouth)/requires enteral	F	592			
		taneous endoscopic					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1,000	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
1		495156	B. WING		C 02/11/2022
	PROVIDER OR SUPPLIER HEALTHCARE AT RO	PANOKE	*	STREET ADDRESS, CITY, STATE, ZIP CODE 324 KING GEORGE AVE SW ROANOKE, VA 24016	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	. [ - [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]	LD BE COMPLETION
F 692	"Provide, serve die Resident #6 was ol on 02/09/22 at 3:25 resident's tube feed rate. The DON stat	or this care plan included as ordered"  Deserved with the DON present of pm. The DON stated that the ling was not running at correct ed, "The nurse did not verify of set it up and signed off on	F6	592	
	The facility policy e documented in part	ntitled "Enteral Nutrition" , "Policy Statement: Adequate hrough enteral feeding will be			
	feeding order was of administrative team nursing, assistant of	following the resident's tube discussed with the (administrator, director of irector of nursing, regional uring a meeting on 02/11/21 at			
	No further informati Pain Management CFR(s): 483.25(k)	on was provided prior to exit.	F6	97	
	provided to residen consistent with profithe comprehensive and the residents' g This REQUIREMEN by: Based on staff inte clinical record review and during a medical	nagement. sure that pain management is to who require such services, essional standards of practice, person-centered care plan, oals and preferences.  IT is not met as evidenced rview, resident interview, w, facility document review, ation pass and pour illity staff failed to provide			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
	495156	B. WING	<u> </u>	02	C <b>/11/2022</b>	
NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT RO			STREET ADDRESS, CITY, STATE, ZIP CODE  324 KING GEORGE AVE SW  ROANOKE, VA 24016			
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		OULD BE	(X5) COMPLETION DATE	
Resident #12, resupain medications of gabapentin 300 mg administration.  The findings included Resident #12's fact included but not ling pneumonia, chronist motor and sensory scoliosis and preceded resident #12's moderated (minimum data set) reference date) of a BIMS (brief intervals out of 15 in section and including the resident #12's particular medications. While medications, LPN #1 medications, LPN #1 medications, LPN #1 medications, LPN #1 sesident #12's pair supply due to the pscript prior to giving medications. Upon LPN #1 asked and resident had return	nagement for 1 of 16 residents, alting in harm. Resident #12's exycodone 10 mg and g were not available for ed:  e sheet listed diagnoses which nited to ventilator associated c respiratory failure, anxiety, neuropathy, dysphagia, ordial pain.  st recent quarterly MDS with an ARD (assessment 12/31/21 assigned the resident view for mental status) score of tion C, cognitive patterns, ent was cognitively intact.  stical nurse) #1 was observed in pass and pour on 02/09/22 at vas preparing Resident #12's preparing the resident's #1 stated that they did not have odone or gabapentin available to the resident having been in ad only returned "early this stated they could not pull in medications from the stat charmacy needing a new hard g an authorization code to pull exiting Resident #12's room, ther staff member when the ed from the hospital, and this " came back early Monday"	F 6	1. Resident # 12 no longe 2. As all residents could paffected by this deficient practice, a full facility at performed to ensure or medication availability for residents. 3. All licensed nursing star reeducated regarding paredication administration unavailable medication Director of Nursing. 4. Director of Nursing/ or caudit new admissions for analgesics to ensure meavailable, twice weekly weeks. Audits and audit will be reported to the factor continued intervention camendment of the plan. 5. Allegation of compliance 03.28.2022	otentially be by in dit was lered pain or all fain policy, on, and policies by esignee will or ordered edication is or six t findings cility QAPI hree ed for		

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 2 2	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495156	B. WING			C /11/2022	
	PROVIDER OR SUPPLIER  HEALTHCARE AT RC	DANOKE	STREET ADDRESS, CITY, STATE, ZIP CO 324 KING GEORGE AVE SW ROANOKE, VA 24016				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 697	o2/09/21. Resident summary for the more following, "Gabape capsule by mouth the leg" and "oxyCODO tablet by mouth two pain."  Resident #12's eM/ administration reconsule 300 mg. Gotimes a day for rest HCI Tablet 10 mg. Gotimes a day for r/t (Indate for these medical for the summary for	dications were reconciled on #12's physician's order onth of February contained the ntin Capsule 300 mg. Give 2 hree times a day for restless DNE HCI Tablet 10 mg. Give 1 or times a day for r/t (related to)  AR (electronic medication rd) for the month of February documented, "Gabapentin ive 2 capsule by mouth three less leg" and "oxyCODONE Give 1 tablet by mouth two related to) pain." The start cations was listed as	F 6	997			
	administered on 02. pm. On 02/08/22 at "9". The entry for ga administered on 02. pm. On 02/08/22 at "9". The chart code "Other/See Nurse N Resident #12's nurse no documentation of Resident #12's compressed and contain comfort related to musculoskeletal r/t MD (muscular dystrower contractures	e's notes were reviewed and was located regarding					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		8 (8)	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
		495156	B. WING			C <b>02/11/2022</b>	
	PROVIDER OR SUPPLIER	DANOKE	STREET ADDRESS, CITY, STATE, ZIP COD 324 KING GEORGE AVE SW ROANOKE, VA 24016			02/11/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE	(X5) COMPLETION DATE	
F 697	Dystrophy, Chronic dependency has with noted deformit Interventions for the medications per MI analgesics as order physician if pain coobserve for nonveronable. The DON (director 02/09/22 at 10:55 at medications. The Don Don the pain medications from the Don was asked were signed as adrand the Don state falsification of a reception of the polymer medications, day revious meds when hospital so there were the Don provided the medications, day provided a copy of record for each medications had been been medications and provided the medications and the Don and Adon nursing).  Resident #12 was in 1:15 pm. Resident pain medications and got back from the hopain meds straighted asked if they were signed as a straighted asked if they are signed as a straighted asked if they were signed as a straighted asked if they are signed as a straighted asked if they were signed as a straighted asked if they are signed as a straighted asked if they are signed as a straighted asked if they are signed asked if they are	liagnosis): of Muscular cresp. failure with vent intermittent pain due to MD ties to joints, especially back". ese care plans included D (medical doctor) orders, give red by the physician, notify the introl is ineffective, and bal indications of pain.  of nursing) was interviewed on am regarding Resident #12's DON stated they had faxed the harmacy and confirmed that and the interest of the inter	F	597			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495156	B. WING		C 02/11/2022	
NAME OF	PROVIDER OR SUPPLIER	<b>!</b>		STREET ADDRESS, CITY, STATE, ZIP CODE	02.1.1.2022	
CHOICE	HEALTHCARE AT RO	ANOKE		324 KING GEORGE AVE SW ROANOKE, VA 24016		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		D BE COMPLETION	N
F 697	feet." Resident #12 on a scale of 1-10 a nerve pain in my le 10, probably 5-6 in have scoliosis in m asked if they had re and the resident sta doesn't help much."  Resident #12's phy contained an order (Acetaminophen) Ghours as needed for	night was bad in my legs and was asked to rate their pain and the resident stated, "I have gs and feet and it was over a my back, it comes and goes. I y back." Resident #12 was eceived anything else for pain ated, "Only Tylenol, but it "  sician's order summary for, "Tylenol Tablet 325 mg tive 650 mg by mouth every 8 r pain or fever."	F6	97		
	Tylenol 325 mg tab every 8 hours as no entry listed a pain le am. This administratineffective.  The facility documer Management Strate medication regimer documenting the re  The concern of not	AR included an entry for let, give 650 mg by mouth eeded for pain or fever. This evel of "7" on 02/08/22 at 8:20 ation was documented as at "Pain Assessment and ded, "Implementing Pain egies: 6. Implement the as ordered, carefully sults of the interventions."				
	administrative team regional nurse cons am.  No further informati	#12 was discussed with the (administrator, DON, ADON, sultant) on 02/11/22 at 11:55 on was provided prior to exit. occdures/Pharmacist/Records (b)(1)-(3)	F 75	55		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	LTIP	LE CONSTRUCTION	(X3) DAT	E SURVEY
/	on connection	IDENTIFICATION NOWBER.	A. BUIL	DING	S		IPLETED C
		495156	B. WING	·		1	11/2022
2.5500000000000000000000000000000000000	PROVIDER OR SUPPLIER HEALTHCARE AT RC	ANOKE		STREET ADDRESS, CITY, STATE, ZIP CODE 324 KING GEORGE AVE SW ROANOKE, VA 24016		12 2	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 755	drugs and biological them under an agre §483.70(g). The fact personnel to admin permits, but only una licensed nurse.  §483.45(a) Procedupharmaceutical sent that assure the accidispensing, and adbiologicals) to meet §483.45(b) Service must employ or obtapharmacist who-  §483.45(b)(1) Provi aspects of the provi the facility.  §483.45(b)(2) Establication; and §483.45(b)(3) Deter order and disposit sufficient detail to expect the expect of the province of the p	Services ovide routine and emergency alls to its residents, or obtain rement described in sement described	F	755	<ol> <li>Resident medications/supple obtained for residents #12, r longer at facility, resident #1 medication obtained resident medication obtained, resident MD notified. No further orde received. RP notified.</li> <li>Full facility audit to ensure medication availability for all residents.</li> <li>All licensed nursing staff reeducated regarding medicadministration and unavailable medication policies by Direct Nursing.</li> <li>Director of Nursing/ or design audit twice weekly for six we availability of four randomly selected resident's medication documentation of resident medications. Audits and audit findings will be reported to the facility QAPI Committee more three months to review the nucontinued intervention or amendment of the plan.</li> <li>Allegation of compliance set 03.28.2022</li> </ol>	ation ole tor of nee will eks the ons to and dit need for eed for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495156	B. WING				C 0 <b>2/11/2022</b>
	PROVIDER OR SUPPLIER HEALTHCARE AT RO	DANOKE		324	EET ADDRESS, CITY, STATE, ZIP COD KING GEORGE AVE SW ANOKE, VA 24016		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION		HOULD BE	(X5) COMPLETION DATE	
F 755	Continued From pa	ge 59	F7	755			
	oxycodone (pain m	he facility staff failed to ensure edication) and gabapentin tion) were available.					
	For Resident #13, t Cosopt PF (used to Glaucoma) eye dro	he facility staff failed to ensure lower eye pressure and treat ps were available.					
	Diltiazem (calcium high blood pressure	e facility staff failed to ensure channel blocker used to treat e and control angina), acitracin ointment were stration.					,
		ne facility staff failed to ensure intment was available for					
	The findings include	ed:					
	which included but associated pneumo anxiety, motor and	ace sheet listed diagnoses not limited to ventilator nia, chronic respiratory failure, sensory neuropathy, s and precordial pain.					
	(minimum data set) v reference date) of 1 a BIMS (brief interv 15 out of 15 in secti	with an ARD (assessment 2/31/21 assigned the resident ew for mental status) score of on C, cognitive patterns, ent was cognitively intact.					
	during a medication 7:50 am. LPN #1 warmedications. While	pass and pour on 02/09/22 at as preparing Resident #12's preparing the resident's 1 stated that they did not have					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
3.30		495156	B. WING	j			C <b>11/2022</b>
	PROVIDER OR SUPPLIER HEALTHCARE AT RC	DANOKE		STREET ADDRESS, CITY, STATE, ZIP CO 324 KING GEORGE AVE SW ROANOKE, VA 24016	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD	BE	(X5) COMPLETION DATE
F 755	to administer due to the hospital, and harmorning". LPN #1 s Resident #12's pair supply due to the p script prior to giving medications. Upon LPN #1 asked anot resident had returns staff person stated morning (02/07/22).  Resident #12's eM/administration record was reviewed and c Capsule 300 mg. G times a day for rest HCI Tablet 10 mg. G times a day for r/t (r date for these medio 02/07/22.  The entry for oxyco administered on 02/07/22.  The entry for oxyco administered on 02/07/22 at "9". The entry for ga administered on 02/07/8/22 at "9". The chart code "Other/See Nurse Nesident #12's nurse no documentation we Resident #12's mediant #12	odone or gabapentin available to the resident having been in ad only returned "early this stated they could not pull in medications from the stat harmacy needing a new hard an authorization code to pull exiting Resident #12's room, her staff member when the ed from the hospital, and this " came back early Monday."  AR (electronic medication and) for the month of February documented, "Gabapentin ive 2 capsule by mouth three less leg" and "oxyCODONE Give 1 tablet by mouth two related to) pain." The start cations was listed as  done was initialed as	F 7	755			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 3 Barrier	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
		495156	B. WING	4	C 02/11/2022
	PROVIDER OR SUPPLIER HEALTHCARE AT RO	PANOKE	*	STREET ADDRESS, CITY, STATE, ZIP CODE 324 KING GEORGE AVE SW ROANOKE, VA 24016	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 755	they were received obtained an authori	ge 61 narmacy and confirmed that The DON stated they had zation code to pull the ne stat supply this morning.	F 7	55	
	The concern of med administration for R with administrative	dication not being available for desident #12 was discussed team (administrator, DON, rse consultant) on 02/11/22 at			
	2. Resident #13's fa which included but i failure, chronic kidn anemia, dementia,	on was provided prior to exit.  ace sheet listed diagnoses not limited to congestive heart ey disease, atrial fibrillation, glaucoma, polyneuropathy, or feeding difficulties.			
	set) with an ARD (a 11/07/21 coded the and short term men	arterly MDS (minimum data ssessment reference date) of resident as having both long nory problems and moderately skills for daily decision making.			
	administering medical a medication pass a am. LPN #2 prepare	cical nurse) #2 was observed cations to Resident #13 during and pour on 02/09/22 at 8:15 ed Resident #13's tated that resident's eye drops			
	02/09/22 at 9:30 am summary for the mo- contained an order to 2-0.5% (Dorzolamid	ications were reconciled on n. The physician's order onth of February 2022 for, "Cosopt PF Solution le HCI-Timolol Mal PF) Instill 1 to times a day for Glaucoma."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	20, 0000	ILTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495156	B. WING		02	C 2/11/2022	
	PROVIDER OR SUPPLIER	DANOKE		STREET ADDRESS, CITY, STATE, ZIP COD 324 KING GEORGE AVE SW ROANOKE, VA 24016			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		OULD BE	(X5) COMPLETION DATE	
F 755	medication supply drops was not liste supply.  The concern of the	age 62 s available in the facility stat was reviewed. Cosopt eye d as available in the stat resident's eye drops not being istration was discussed with	F	755			
	the administrative s nursing, assistant of nurse consultant) of No further informati 3. Resident #3's dia diagnoses, which in Chronic Obstructive Combined Congest Schizophrenia, End Essential Hypertens	staff (administrator, director of director of nursing, regional in 02/11/22 at 11:55 am.  ion was provided prior to exit. agnosis list indicated included, but not limited to be Pulmonary Disease, Acute tive Heart Failure, Paranoid in Stage Renal Disease, sion, Dependence on Renal osmolality and Hyponatremia.					
	set) with an ARD (a 2/05/22 assigned the interview for mental	parterly MDS (minimum data assessment reference date) of the resident a BIMS (brief a status) score of 15 out of 15, the rent was cognitively intact.					
	active orders dated HCL ER) Extended one capsule by more (hypertension); and give 1 tablet by more Failure/Dialysis. Re order dated 2/07/22	nt physician's orders included 5/18/21 for Dilt-XR (Diltiazem Release 24 Hour 180 mg give ath one time a day for HTN Nephro-Vite Tablet 0.8 mg ath one time a day for Renal sident #3 also had an active for Bacitracin Ointment 500 ateral lower extremity topically wound care.					
		t #3's January 2022 MAR stration record) revealed		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			

	OF CORRECTION   (X1) PROVIDER/SUPPLIER/CLIA   (X2) MULTIPLE CONSTRUCTION   A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495156	B. WING_		1	C /11/2022
NAME OF F	PROVIDER OR SUPPLIER	2 (5-5-7)		STREET ADDRESS, CITY, STATE, ZIP CODE		
CHOICE	HEALTHCARE AT RO	ANOKE		324 KING GEORGE AVE SW ROANOKE, VA 24016		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 755	Continued From pa	ge 63	F 75	55		
	8:00 am. According progress notes, Dilt due to awaiting med The January MAR a	administered on 1/04/22 at to the resident's nursing clazem was not administered dication from the pharmacy. Also indicated Nephro-Vite was a 1/11/22 at 8:00 am due to				9
ū	revealed Bacitracin administered on 2/0 at 8:00 am. Accordi progress notes, Bac	t #3's February 2022 MAR ointment was not 08/22 at 8:00 am and 2/09/22 ng to the resident's nursing citracin was not administered ue to awaiting pharmacy				
	(director of nursing) regional director of aware of the concer	p.m., the administrator, DON , assistant DON, and the clinical services were made n of Resident #3 not receiving /ite, and Bacitracin ointment				
		on regarding this concern was rvey team prior to the exit /22.				
	diagnoses, which in Paranoid Schizophr Generalized Anxiety	iagnosis list indicated cluded, but not limited to renia, Alzheimer's Disease, Disorder, Bilateral Vitreous Essential Hypertension.				=
	set) with an ARD (a 1/04/22 coded the r	arterly MDS (minimum data ssessment reference date) of esident as being severely with short-term and problems.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
	500.00	495156	B. WING		1	C / <b>11/2022</b>
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		11/2022
CHOICE	HEALTHCARE AT RO	ANOKE		324 KING GEORGE AVE SW ROANOKE, VA 24016		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		JLD BE	(X5) COMPLETION DATE
F 755	revealed a scanned titled "Nursing Com documented, "milky Also included at the	ge 64 t #15's clinical record l document dated (sic) 2/02/21 munication Form" which drainage from both eyes." bottom of this document was stelephone order dated	F 7	755		
	2/03/22 for, "Ciprofl into both eyes Q (e bacterial conjunctive	oxacin 0.3% apply 1 gtt (drop) very) 4 (hours) x (for) 14 days itis."				
	documented, "new of	note dated 2/03/22 9:46 am order to start Ciprofloxacin 0.3 s r/t (related to) bacterial				
	administration recor	ruary MAR (medication of the control				
	medication was not documented reason	NT 1			1937	
	2/04/22 12:00 pm - '2/04/22 4:00 pm - '2/04/22 8:00 pm - '2/05/22 8:00 am - '2/05/22 12:00 pm - '2/05/22 1	pending pharmacy" awaiting delivery"				
	pharmacy" 2/05/22 4:00 pm - "p pharmacy" 2/07/22 12:00 pm - '	pending arrival from				
	2/08/22 8:00 am - "v pharmacy"	vaiting to be received from				
	On 2/10/22 at 1:52 p	om, the pharmacy tech #1				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
10		495156	B. WING			C <b>/11/2022</b>
	PROVIDER OR SUPPLIER HEALTHCARE AT RO	DANOKE		STREET ADDRESS, CITY, STATE, ZIP ( 324 KING GEORGE AVE SW ROANOKE, VA 24016		1179
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 755	Ciprofloxacin eye of Pharmacy tech #1 delivered to the fact to provide the exact tech #1 stated ther of the facility contact delivery of the medication is Ciloxan Oin 0.3% Cointment) with a disnext available refill  The DON also prove "Pharmacy Memo" Resident #15's "Cildocumenting, "Medical Sent (sic) on ASAP	intment unavailability. stated the medication was stated the medication was lility on 2/07/22 but was unable to time of delivery. Pharmacy we were no notes in the systemeting the pharmacy concerning ication.  pm, the DON provided a copy abel from Resident #15's DP (Ciprofloxacin eyespense date of 2/03/22 and date of 2/09/22.  ided a copy of a form entitled, dated 2/03/22 regarding oxan oin 0.3% OP" licine is on order and will be (as soon as possible)."	F7	55		
	Medications" docur 3. The facility shall for ensuring resider medications. 4. Medications may of reason. Staff sha when it is known th unavailable: a. Determine reaso time medication is thave been	ntitled, "Unavailable nented in part: follow established procedures nts have a sufficient supply of y be unavailable for a number all take immediate action at the medication is on for unavailability, length of unavailable, and what efforts cility or pharmacy provider to on.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED	
		495156	B. WING _	<u> </u>		C <b>11/2022</b>
	PROVIDER OR SUPPLIER  HEALTHCARE AT RO	ANOKE		STREET ADDRESS, CITY, STATE, ZIP CODE 324 KING GEORGE AVE SW		San S
		,		ROANOKE, VA 24016	В	202
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 755	medication is not av	ge 66  tification or awareness that  vailable. Obtain alternate  d/or specific orders for	F 75	5		
	monitoring resident On 2/10/22 at 3:29 ADON, and the reg services, were advis #15 not receiving C ordered.	while medication is on hold.  pm, the administrator, DON, ional director of clinical sed of the concern of Resident iprofloxacin eye ointment as			2	
	presented to the su conference on 2/11	Error Rts 5 Pront or More )	F 759	9		
	percent or greater; This REQUIREMEN by:	ation error rates are not 5  IT is not met as evidenced  view, clinical record review,				1 9
	and during a medical observation, the fact medication error rate	ation pass and pour ility staff failed to ensure a e of less than 5 %. There opportunities for a medication				\$
	Resident #12's fa which included but r associated pneumor anxiety, motor and s	ce sheet listed diagnoses not limited to ventilator nia, chronic respiratory failure, sensory neuropathy, and precordial pain.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		495156	B. WING			C 02/11/2022	
CHOICE HEALTHCARE AT ROANOKE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES		ATEMENT OF DEFICIENCIES	ID	324	REET ADDRESS, CITY, STATE, ZIP CODE 4 KING GEORGE AVE SW DANOKE, VA 24016  PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	(EACH DEFICIENCY REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	COMPLETION DATE
F 759	(minimum data set) reference date) of 1 a BIMS (brief interv 15 out of 15 in sect indicating the reside LPN (licensed praction of 150 am. LPN #1 w medications. While medications, LPN # the resident's oxycoto administer due to the hospital, and hamorning". LPN #1 s Resident #12's pair supply due to the place of the post of the place of the pl	st recent quarterly MDS with an ARD (assessment 2/31/21 assigned the resident iew for mental status) score of ion C, cognitive patterns, ent was cognitively intact.  tical nurse) #1 was observed a pass and pour on 02/09/22 at as preparing Resident #12's preparing the resident's at stated that they did not have be of the resident having been in ad only returned "early this stated they could not pull a medications from the stat harmacy needing a new hard an authorization code to pull exiting Resident #12's room, her staff member when the ed from the hospital, and this	F 7		<ol> <li>Resident medications/supple obtained for residents #12, r longer at facility, resident #1 medication obtained resider medication obtained, resider orders reconciled, MD notififurther orders on received. Finotified.</li> <li>Full facility audit to ensure availability of supplements for residents.</li> <li>All licensed nursing staff reeducated regarding medication and unavailable medication policies by Direct Nursing.</li> </ol>	no 3 nt #3 nt #14 ed. No RP or all	03.28.2022
	morning (02/07/22).  Resident #12's med 02/09/21. Resident summary for the mofollowing, "Gabaper capsule by mouth the g" and "oxyCODC tablet by mouth two pain."  The facility staff was regarding Resident.	dications were reconciled on #12's physician's order onth of February contained the ntin Capsule 300 mg. Give 2 pree times a day for restless ONE HCI Tablet 10 mg. Give 1 times a day for r/t (related to) is notified of the issues #12's medications during an on 02/09/22 at 4:20 pm.			4. Director of Nursing/ or design audit twice weekly for six we availability of four randomly selected resident's supplementation of resident supplements. Audits and audindings will be reported to the facility QAPI Committee to rethe need for continued intervor amendment of the plan.  5. Allegation of compliance set	eks the ents to a and dit dit eeview rention	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
5.04860	495156	B. WING		_		C <b>11/2022</b>
NAME OF PROVIDER OR SUPPLIER  CHOICE HEALTHCARE AT RO	DANOKE		STREET ADDRESS, CITY, STA 324 KING GEORGE AVE SI ROANOKE, VA 24016		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCED		BE	(X5) COMPLETION DATE
which included but failure, chronic kidn anemia, dementia, dysphagia and other the most recent queset) with an ARD (a 11/07/21 coded the and short term mentimpaired cognitive states a medication pass a am. LPN (licensed practical administering medical a medication pass a am. LPN #2 preparamedications, then states drops were unavailated. Resident #13's medications, then states are unavailated to the modical process of the modical process of the modical process. The facility staff was regarding Resident end of day meeting.  3. Resident #14's fawhich included but resident #14's fawhich included but resident #14's most (minimum data set) were ference date) of 0.	ace sheet listed diagnoses not limited to congestive heart ney disease, atrial fibrillation, glaucoma, polyneuropathy, er feeding difficulties.  Parterly MDS (minimum data assessment reference date) of a resident as having both long mory problems and moderately skills for daily decision making.  Itical nurse) #2 was observed cations to Resident #13 during and pour on 02/09/22 at 8:15 ed Resident #13's stated that the resident's eye able.  Idications were reconciled on n. The physician's order onth of February 2022		759			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495156	B. WING		0:	C 2/11/2022	
	PROVIDER OR SUPPLIER HEALTHCARE AT RO	DANOKE		STREET ADDRESS, CITY, STATE, ZIP COD 324 KING GEORGE AVE SW ROANOKE, VA 24016		11112022	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE	
F 759	indicating the reside impaired.  LPN (licensed praction 02/09/22 at 8:30 and pour. LPN #3 president #14's med Magnesium 500 mg Resident #14 was it consumed breakfastable. LPN #3 preparent for the resident #14's med 02/09/22 at 9:40 am summary contained "Magnesium oxide mouth one time a discensional mouth one time a discensional mouth two times are summary contained "Insulin Aspart Solutinject 10 unit subcurrelated to TYPE 2 ENYPERGLYCEMIA (LPN #3 was intervier regarding Resident was asked to confirm magnesium and columnistered the wind summary contained to medications and columnistered the wind columnister was asked to confirm agnesium and columnistered the wind columnister was asked to confirm agnesium and columnister was asked to confirm agnesium	tical nurse) #3 was observed am during a medication pass orepared and administered dications, which included g, Colace 100 mg ii capsules. In the room, with a partially st tray sitting on the overbed ared and administered 10 units PN #3 did not prepare or lent's insulin aspart.  dications were reconciled on a. Resident #14's physician's lorders which included: 400 mg. Give 1 tablet by any for supplement" sodium Tablet 8.6-50 mg state Sodium). Give 2 tablet by day for bowel movement tion Pen-Injector 100 unit/ml. taneously before meals DIABETES MELLITUS WITH E11.65) hold if <150."	F 7	759			
	and LPN #3 stated, off."  A facility policy entitl	"I gave it after you walked ed "Administering					

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495156	B. WING			C 02/11/2022	
200220000	PROVIDER OR SUPPLIER  HEALTHCARE AT RC	DANOKE		STREET ADDRESS, CITY, STATE, ZIP COD 324 KING GEORGE AVE SW ROANOKE, VA 24016			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			IX (EACH CORRECTIVE ACTION SE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 759	Statement: Medica a safe and timely m Medications must b with the orders, incl frame. 4. Medicatio within one (1) hour unless otherwise sp and after meal orde administering the m label THREE (3) tin right medication, rig	ge 70 mented in part, "Policy stions shall be administered in nanner, and as prescribed. 3. be administered in accordance luding any required time ns must be administered of their prescribed time, becified (for example, before ers). 7. The individual medication must check the mes to verify the right resident, what dosage, right time and right dministration before giving	F	759			
	regarding Resident end of day meeting  The concern of the error rate of greater the administrative s nursing, assistant d nurse consultant) on  No further information Residents are Free CFR(s): 483.45(f)(2)  The facility must ensemble statement of the second review, facility record review record	sure that its- ents are free of any significant IT is not met as evidenced ion, staff interview, and clinical ty staff failed to ensure of significant errors as	F 7	760			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		(X3) DATE SURVEY COMPLETED		
		495156	B. WING	<b>.</b>			C
	PROVIDER OR SUPPLIER		j s. viiite	3	STREET ADDRESS, CITY, STATE, ZIP CODE 324 KING GEORGE AVE SW ROANOKE, VA 24016	02/	11/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	) BE	(X5) COMPLETION DATE
F 760	the survey sample, Findings included:  1. Resident #5 was diagnoses including hemiplegia/hemipard disease, type II diatanxiety, pain, and data set assessmer date 8/12/2021, the brief interview for massessed as without or behaviors affecting.  Clinical record reviet for Novolog FlexPerunit/ml Inject 17 unit meals related to Type complications, hold.  The January 2022 record (MAR) docur on the following datanters of the following datanters of the following datanters of the concern of hold outside the physicial discussed with the acanterior of nursing, record of 11/22.	meters for 2 of 16 residents in Residents #5 and 14.  admitted to the facility with g dominant side resis, cardiopulmonary betes mellitus, hypertension, lysphagia. On the minimum at with assessment reference resident scored 14/15 on the mental status and was at signs of delirium, psychosis, and care.  Ew revealed a physician order in Solution Pen Injector 100 at subcutaneously before to 2 diabetes mellitus without if <150.  Interest and the insulin was held estern of 186 (coded 11= held per part of 192 (coded 11= held per part of 192 (coded 12= insulin the ordered parameters was administrative staff cor of nursing, assistant regional nurse consultant) on	F	760	1. Resident #5, #14 Orders verified. MD notified. No adveffects noted. No new orders. RP notes are further significant medication errors occurred.  3. All licensed nursing staff reeducated regarding medicadministration policy and medication error policy by Dof Nursing.  4. Director of Nursing/ or designandomly audit medication etwice weekly for six weeks the ensure no significant medical errors occur. Audits and audindings will be reported to the facility QAPI Committee monthree months to review the expectation of amendment of the plan.  5. Allegation of compliance set 03.28.2022	cation cation cation director ation dit he nthly for	
	<ol><li>Resident #14's fa</li></ol>	ce sheet listed diagnoses				1	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
	w v	495156	B. WING				C <b>11/2022</b>
	PROVIDER OR SUPPLIER HEALTHCARE AT RO	ANOKE		324	REET ADDRESS, CITY, STATE, ZIP CODE 4 KING GEORGE AVE SW DANOKE, VA 24016		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 760	hypothyroidism, hymagnesium metabolic magnesium metabolic magnesium metabolic magnesium metabolic magnesium metabolic magnesium metabolic magnesium data set) yreference date) of 0 a BIMS (brief interv 6 out of 15 in section indicating the reside impaired.  Resident #14's cliniphysician's order sufficient y 2022 which solution Pen-Injects subcutaneously befolic DIABETES MELLIT (E11.65) hold if <15 metabolic metabo	not limited to type 2 diabetes, pertension, disorders of polism, and constipation.  St recent quarterly MDS with an ARD (assessment 1/26/22 assigned the resident iew for mental status) score of an C, cognitive patterns, ent was moderately cognitively cal record included a ammary for the month of the documented, "Insulin Aspart for 100 UNIT/ML. Inject 10 unit fore meals related to TYPE 2 TUS WITH HYPOGLYCEMIA	F 7	760			
	and the entry for inscode "12" was defined.  The concern of hold outside the physicial discussed with the a					e Partie	
		ctor of nursing, assistant				-	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI		(X3) DATE SURVEY COMPLETED		
	20	495156	B. WING			C 02/11/2022	
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	OZI	11/2022
CHOICE	HEALTHCARE AT RO	DANOKE		3	24 KING GEORGE AVE SW ROANOKE, VA 24016		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	Continued From pa	ge 73	F	'60	F842	7.0	03.28.2022
	director of nursing, 02/11/22 at 11:55 a No further informati	regional nurse consultant) on		342	Resident #12, no longer facility, resident #7 no lor facility, resident #15 med received, MD notified. No	nger at lication	,
	CFR(s): 483.20(f)(5) §483.20(f)(5) Resid	ent-identifiable information. release information that is			further orders on received  2. Full facility audit to ensure medication availability for residents.	e e	
	resident-identifiable accordance with a cagrees not to use o	release information that is to an agent only in contract under which the agent r disclose the information t the facility itself is permitted			<ol> <li>All licensed nursing staff reeducated regarding medication administration unavailable medication p by Director of Nursing.</li> </ol>	n and	
	professional standa	ordance with accepted rds and practices, the facility cal records on each resident mented; ble; and			4. Director of Nursing/ or de will audit twice weekly fo weeks the resident's medications to ensure proadministration and documentation of residen medications. Audits and findings will be reported to facility QAPI Committee monthly for three months	or six oper  nt audit to the	
	all information conta regardless of the for records, except whe (i) To the individual, representative wher (ii) Required by Law (iii) For treatment, p	or their resident e permitted by applicable law; '; ayment, or health care			review the need for continuintervention or amendme the plan.  5. Allegation of compliance 03.28.2022	nued nt of	,
	with 45 CFR 164.50	nitted by and in compliance 16; n activities, reporting of abuse,				25	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495156	B. WING			1	C <b>11/2022</b>	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
TO THE OT T	NOVIDEN ON SOLT EIEN		1		24 KING GEORGE AVE SW			
CHOICE	HEALTHCARE AT RO	ANOKE			COANOKE, VA 24016			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	BE	(X5) COMPLETION DATE	
F 842	Continued From pa	ge 74	F 8	42				
	neglect, or domestic	c violence, health oversight						
	activities, judicial an	nd administrative proceedings,						
		irposes, organ donation						
		purposes, or to coroners,						
		funeral directors, and to avert nealth or safety as permitted						
		ce with 45 CFR 164.512.						
	\$400.70(i)(0) The fe							
		acility must safeguard medical against loss, destruction, or						
	unauthorized use.	agamet 1055, destruction, or				2.0		
	8483 70(i)(4) Medic	al records must be retained				m Er	= 5	
	for-	arrecords must be retained						
	(i) The period of tim	e required by State law; or						
		the date of discharge when						
	there is no requirem							
	legal age under Sta	ears after a resident reaches						
	logarage arraer ora	te law.						
		nedical record must contain-				B & #	7	
		ation to identify the resident;						
		esident's assessments;						
	provided;	sive plan of care and services						
		ny preadmission screening						
	and resident review	evaluations and						
	determinations cond						50	
		se's, and other licensed						
	professional's progr	ess notes; and ology and other diagnostic				3.77		
		required under §483.50.				11,711		
		IT is not met as evidenced						
	by:					46		
		ecord review and staff						
		staff failed to ensure a				7.2		
	residents, Resident	ate clinical record for 3 of 16 #12 #15 and #7						
	. coldonio, ricoldoni	n iz, n io, and nii.				7		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495156	B. WING			C /11/2022
	PROVIDER OR SUPPLIER HEALTHCARE AT RC	DANOKE		STREET ADDRESS, CITY, STATE, ZIP C 324 KING GEORGE AVE SW ROANOKE, VA 24016		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD BE	(X5) COMPLETION DATE
F 842	administration of m available.	ige 75 the facility staff documented edications when they were not the facility staff documented	F 8	42		
	administration of Continuous o	profloxacin antibiotic eye ) separate occasions prior to ng received from the				
		e facility staff failed to nt administration of tube lushes.				
	The findings include	ed:				
	which included but associated pneumo anxiety, motor and	ace sheet listed diagnoses not limited to ventilator nia, chronic respiratory failure, sensory neuropathy, s and precordial pain.				
	(minimum data set) v reference date) of 1 a BIMS (brief interv 15 out of 15 in secti	st recent quarterly MDS with an ARD (assessment 2/31/21 assigned the resident iew for mental status) score of ion C, cognitive patterns, ent was cognitively intact.				
	during a medication 7:50 am. LPN #1 w. medications. While medications, LPN # the resident's oxyco to administer due to the hospital, and ha morning". LPN #1 s	tical nurse) #1 was observed pass and pour on 02/09/22 at as preparing Resident #12's preparing the resident's 1 stated that they did not have be done or gabapentin available the resident having been in do only returned "early this tated they could not pull medications from the stat				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
	18,2	495156	B. WING		02	C /11/2022	
	PROVIDER OR SUPPLIER  HEALTHCARE AT RO	DANOKE		STREET ADDRESS, CITY, STATE, ZIP CO 324 KING GEORGE AVE SW ROANOKE, VA 24016	DE	2	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 842	Continued From pa	ge 76	F 8	42	-		
	script prior to giving medications. Upon LPN #1 asked anot resident had return	harmacy needing a new hard y an authorization code to pull exiting Resident #12's room, ther staff member when the ed from the hospital, and this " came back early Monday ."					
	02/09/21. Resident summary for the mo- following, "Gabaper capsule by mouth to leg" and "oxyCODO	dications were reconciled on #12's physician's order onth of February contained the ntin Capsule 300 mg. Give 2 hree times a day for restless ONE HCI Tablet 10 mg. Give 1 or times a day for r/t (related to)					
	administration reco was reviewed and of Capsule 300 mg. G times a day for rest HCl Tablet 10 mg. G times a day for r/t (r	AR (electronic medication rd) for the month of February documented, "Gabapentin ive 2 capsule by mouth three less leg" and "oxyCODONE Give 1 tablet by mouth two related to) pain." The start cations was listed as					
	administered on 02, pm. On 02/08/22 at "9". The entry for ga administered on 02,						
	02/09/22 at 10:55 a	of nursing) was interviewed on m regarding Resident #12's ON stated they had faxed the		y an			

NAME OF PROVIDER OR SUPPLIER  CHOICE HEALTHCARE AT ROANOKE    SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MINE SECONT OF TAKE OF THE ADDRESS, CITY, STATE, ZIP CODE 324 KING GEORGE AVE SW ROANOKE, VA 24016   PREFIX (EACH DEFICIENCY MUST SE PRECEDED BY FULL TAG)   PREFIX (EACH DEFICIENCY MUST SE PRECEDED BY FULL TAG)   TAG   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)    F 842   Continued From page 77		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A CONTRACTOR OF THE CONTRACTOR	TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
CHOICE HEALTHCARE AT ROANOKE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 842 Continued From page 77 hard script to the pharmacy and confirmed that they were received. The DON stated they had obtained an authorization code to pull the medications from the stat supply this morning. The DON was asked about the medications that were signed as administered on 02/07 and 02/08, and the DON stated, "I believe it was a falsification of a record. I do not believe (Resident #12) received them at II. I destroyed the previous meds when (Resident #12) went in the hospital so there were none here to administer." The DON provided a copy of the resident's narcotics control record for each medication indicating that the medications, dated 01/19/22. The DON also provided a copy of the resident's narcotics control record for each medication indicating that the medications as administered when they were not available for administrative team (administrator, DON, ADON, regional nurse consultant) on 02/11/22 at 11.55 am.  No further information was provided prior to exit. 2. Resident #15's diagnosis list indicated diagnoses, which included, but not limited to Paranoid Schizophere, Bilateral Viteous			495156	B. WING	<u> </u>	
PRÉFIX TAG    CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PRÉFIX TAG			PANOKE		324 KING GEORGE AVE SW	
hard script to the pharmacy and confirmed that they were received. The DON stated they had obtained an authorization code to pull the medications from the stat supply this morning. The DON was asked about the medications that were signed as administered on 02/07 and 02/08, and the DON stated, "I believe it was a falsification of a record. I do not believe (Resident #12) received them at all. I destroyed the previous meds when (Resident #12) went in the hospital so there were none here to administer."  The DON provided a copy of the hard scripts for the medications, dated 01/19/22. The DON also provided a copy of the resident's narcotics control record for each medication indicating that the medications had been destroyed on 02/07/22 by the DON and ADON (assistant director of nursing).  The concern of documenting the resident's medications as administered when they were not available for administration was discussed with the administrative team (administrator, DON, ADON, regional nurse consultant) on 02/11/22 at 11:55 am.  No further information was provided prior to exit.  2. Resident #15's diagnosis list indicated diagnoses, which included, but not limited to Paranoid Schizophrenia, Alzheimer's Disease, Generalized Anxiety Disorder, Bilateral Vitreous	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI	X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE COMPLETION
Degeneration, and Essential Hypertension.  The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 1/04/22 coded the resident as being severely cognitively impaired with short-term and long-term memory problems.	F 842	hard script to the plant they were received obtained an authorism medications from the DON was asked were signed as adniand the DON stated falsification of a recipitation of	narmacy and confirmed that a The DON stated they had ization code to pull the set at supply this morning. It about the medications that ministered on 02/07 and 02/08, d, "I believe it was a ord. I do not believe (Resident at all. I destroyed the in (Resident #12) went in the ere none here to administer." a copy of the hard scripts for ited 01/19/22. The DON also the resident's narcotics control dication indicating that the ere not destroyed on 02/07/22 by (assistant director of the doministered when they were not stration was discussed with eam (administrator, DON, is econsultant) on 02/11/22 at on was provided prior to exit. It is a provided prior to exit. It i	F 8	342	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495156	B. WING				C <b>11/2022</b>	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 324 KING GEORGE AVE SW ROANOKE, VA 24016	CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 842	revealed a physicia start on 2/04/22 at HCL Ointment 0.3% every 4 hours for be Resident #15's Feb administration reconot administered or 2/04/22 and 2/08/22 the pharmacy.  However, Ciproflox as being administe 2/05/22 4:00 am, 2/am, 2/06/22 4:00 at 12:00 pm, 2/06/22 do 12:00 pm, 2/07/22 but was time of delivery.  The facility listing of in the Cubex syster ointment was not list On 2/10/22 at 3:08 of the medication la Ciloxan Oin 0.3% Cointment) with a disnext available refill of the DON also proving the control of the province of the provi	ant #15's clinical record an's order dated 2/03/22 to 12:00 pm for Ciprofloxacin 6 instill 1 ribbon in both eyes acterial infection for 14 days.  Druary 2022 MAR (medication and) revealed Ciprofloxacin was an multiple occasions between 2 due to awaiting delivery from  Pacin was signed on the MAR ared on 2/05/22 12:00 am, ared on 2/05/22 12:00 am, ared on 2/05/22 8:00 pm, 2/06/22 12:00 an, 2/06/22 8:00 pm. by and 2/06/22 8:00 pm. by by and 2/06/22 8:00 pm. by and 2/06/22 8:00 pm. by and 2/06/22 8:00 pm. by by and 2/06/22 8:00 pm. by and 2/06/22 12:00 am. by a	F	342				
	Resident #15's "Cild	dated 2/03/22 regarding exan oin 0.3% OP" icine is on order and will be						

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
	55	495156	B. WING		- 1	C 02/11/2022			
F	PROVIDER OR SUPPLIER	DANOKE		324	EET ADDRESS, CI KING GEORGE ANOKE, VA 24	AVE SW	CODE		1112022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)				BE	(X5) COMPLETION DATE
F 842	The DON stated the was delivered to the was delivered to the The three nurses wadministering Cipro 2/06/22 were not avon 2/10/22 at 3:29 ADON, and the regiservices, were infor Resident #15's MAR received Ciprofloxal pharmacy.  No further information presented to the suit conference on 2/11/3. Resident #7's diadiagnoses, which in Hemiplegia and Hei Unspecified Cerebro Left Non-Dominant Chronic Viral Hepat Systolic Congestive	ey believed the medication of facility on 2/04/22.  Tho signed the MAR as floxacin on 2/05/22 and vailable for interview.  The administrator, DON, ional director of clinical med of the concern of R indicating the resident cin prior to delivery from the concern was rivey team prior to the exit /22.  The gnosis list indicated cluded, but not limited to miparesis following ovascular Disease Affecting Side, Dysphagia, Aphasia, itis C, Acute on Chronic Heart Failure, Essential	F 8	342					
	Dementia, Anxiety Disorder.  The most recent quaset) with an ARD (a: 1/12/22 assigned th interview for mental	ysmal Atrial Fibrillation, Disorder, and Bipolar arterly MDS (minimum data assessment reference date) of e resident a BIMS (brief status) summary score of 10 Resident #7 was moderately							
1 12	On 2/08/22 at 11:45	am, Resident #7 was							a s

	FEMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL <sup>*</sup> A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
-31-4		495156	B. WING		02/1	) 1/2022	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
CHOICE	HEALTHCARE AT RO	DANOKE		324 KING GEORGE AVE SW			
GHOIGE	TIERETTOAKE AT KE	ANORE		ROANOKE, VA 24016			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI ( (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 842	Continued From pa	ge 80	F 84	42			
1.0		th Jevity 1.5 tube feeding		, talk a			
		55 ml/hour via pump and a					
		place with the pump set to table 175 ml/hour every 4 hours.		2 4 Ti x			
-	run water nusnes a	175 mi/flour every 4 flours.			-		
	Resident #7's curre	nt physician's orders included		and the state of t	- 1		
		ift continuous tube feeding:		ALC: NO PRODUCT			
		.5 per pediatric 'button' via					
		nr for 24 hours. Administer q. (every) 4 hrs. (hours) for					
	adequate nutritiona				n e 85.	90	
				profit Tile and Tile		2	
		t #7's February 2022 MAR			7		
		stration record) revealed the at 55 ml/hour continuous via					
		shes of 175 ml every 4 hours					
		ned on the MAR as being					
	administered once	daily at 12:00 pm.					
	On 2/09/22 at 4:21	pm, surveyor met with the					
	administrator, direct	tor of nursing, assistant		real arms graphs and			
		and the regional director of					
	Resident #7's contin	d discussed the concern of					
		every 4 hour water flushes					
	only being documer	nted once daily on the			1.3.,5	× .	
	resident's MAR.						
	No further information	on regarding this concern was					
	presented to the su	rvey team prior to the exit					
	conference on 2/11/				2-9		
	Infection Prevention CFR(s): 483.80(a)(1		F 88	30		10 10 10 10	
	§483.80 Infection C	ontrol					
		ablish and maintain an				-	
	infection prevention	and control program			g,= - 1		
	designed to provide	a safe, sanitary and	*		6.1		
				The state of the s	1		

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1000000		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495156	B. WING _	=327,040	3	1	C
NAME OF	PROVIDER OR SUPPLIER				ET ADDRESS SITV STATE TID SODE	02/11/2022	
	HEALTHCARE AT RO	ANOKE	x	324 I	ET ADDRESS, CITY, STATE, ZIP CODE KING GEORGE AVE SW NOKE, VA 24016		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	comfortable enviror development and tr diseases and infect §483.80(a) Infection program.  The facility must est and control program a minimum, the following services the providing services for the providing the providing services for the providing the providing the provided services in the facility (ii) A system of survey possible communications before the persons in the facility (iii) When and to who communicable disease reported; (iii) Standard and tratto be followed to president; including the provided provided and (b) A requirement the involved, and (c) A requirement the services and infections before the persons in the facility (iii) Standard and tratto be followed to president; including the provided provided and (c) A requirement the involved, and (d) A requirement the services and infections before the persons in the facility (iii) Standard and tratto be followed to president; including the provided and (d) A requirement the involved and (e) A requirement	anment and to help prevent the ansmission of communicable ions.  In prevention and control tablish an infection prevention in (IPCP) that must include, at owing elements:  The for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals upon the facility assessment g to §483.70(e) and following tandards;  The standards, policies, and program, which must include, or elillance designed to identify able diseases or ey can spread to other ty;  Tom possible incidents of asse or infections should be used for a	F 88	2.	Housekeeper #1, LPN #2 education proper infection control/isolation/contact precaution following infection control/isolation/contact precaution control/isolation/contact precaution and isolation/ Infection Control Policippe policy.  Director of Nursing/ or designee audit twice weekly for six weeks isolation/ contact precautions. And audit findings will be reported the facility QAPI Committee more for three months to review the number of the plan.  Allegation of compliance set for 03.28.2022	aff tions.  ag y and will s on Audits ed to nthly eed for	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			0 150	TIPLE CONSTRUCTION	91	(X3) DATE SURVEY COMPLETED	
		495156	B. WING		_	I =	C <b>11/2022</b>
5500 10	PROVIDER OR SUPPLIER	DANOKE		STREET ADDRESS, CITY, S' 324 KING GEORGE AVE ROANOKE, VA 24016	AND DESCRIPTION OF THE PROPERTY OF THE PROPERT	02/	11/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT) CROSS-REFERENCE	AN OF CORRECTION SHOULD BE TO THE APPROPRICIENCY)	BE	(X5) COMPLETION DATE
F 880	circumstances.  (v) The circumstance must prohibit employed disease or infected contact with resider contact will transmit (vi) The hand hygier by staff involved in expression of infection.  §483.80(a)(4) A systidentified under the corrective actions to the corrective actions to the corrective actions to the facility will contact transport linens so a infection.  §483.80(f) Annual resident from the facility will contact the facility that the course of the	ces under which the facility byees with a communicable skin lesions from direct at the disease; and the procedures to be followed direct resident contact.  The for recording incidents facility's IPCP and the taken by the facility.  The facility of the spread of the series of the se	F	380			
	For Resident #15, the isolation gown prior requiring contact progremove gloves and exiting the room. Staresident's room while	Resident #15 and #13.  ne facility staff failed to don an to entering a resident's room ecautions and failed to perform hand hygiene prior to aff then entered another e carrying a used garbage at precautions room into the m.					

AND PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495156	B. WING		C 02/11/2022		
NAME OF PROVIDER OR SUPPLIER  CHOICE HEALTHCARE AT ROANOKE				STREET ADDRESS, CITY, STATE, ZIP CODE 324 KING GEORGE AVE SW ROANOKE, VA 24016	8		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 880	Continued From pa	ge 83	F 8	80			
	infection control pro administration.	he facility staff failed to follow ocedures during medication					
	diagnoses, which in Paranoid Schizoph Generalized Anxiety	ed: liagnosis list indicated ncluded, but not limited to renia, Alzheimer's Disease, y Disorder, Bilateral Vitreous Essential Hypertension.				9	
	set) with an ARD (a 1/04/22 coded the r	parterly MDS (minimum data assessment reference date) of resident as being severely a with short-term and problems.					
	Staff Member) #1 w #15's room wearing trash from the resid #1 was not wearing exited Resident #18 garbage bag, did no hand hygiene. HSM	D am, HSM (Housekeeping vas observed in Resident g gloves and collecting the lent's waste container. HSM an isolation gown. HSM #1 5's room carrying the used of remove gloves or perform M #1 then entered an adjacent ing the same gloves and used garbage bag.					
	the door documenti Hand Hygiene0 entries, regardless of A three-drawer cadd Resident #15's doo sanitizer, and dispo	m had a white sign taped to ng, "Contact Precautions Gown Gloves On all room of anticipated patient contact." by was located to the right of r containing gloves, hand sable isolation gowns.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	89 650	TIPLE CONSTRUCTION DING	(X3	(X3) DATE SURVEY COMPLETED		
	495156	B. WING			C 02/11/2022		
NAME OF PROVIDER OR SUPPLIER  CHOICE HEALTHCARE AT ROANOKE			STREET ADDRESS, CITY, STATE, ZIP CODE  324 KING GEORGE AVE SW  ROANOKE, VA 24016				
PREFIX (EACH DEFICIE	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
adjacent reside aware Resident HSM #1 stated usually worked trash." The IP (inotified of the one of the office of the office of the office of the office of the observation of the obser	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 84 adjacent resident room and asked if they were aware Resident #15 required contact precautions. HSM #1 stated "I didn't know," and that they usually worked the back hall and was "just getting trash." The IP (infection preventionist) was notified of the observation of HSM #1.  A review of Resident #15's clinical record revealed a current physician's order dated 2/08/22 stating in part, "Contact Precautions for		880				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  II		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495156	B. WING		C 02/11/2022			
NAME OF PROVIDER OR SUPPLIER  CHOICE HEALTHCARE AT ROANOKE				STREET ADDRESS, CITY, STATE, ZIP CODE 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)			X (EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 880	with the patient or penvironmental surfa proximity to the patient or proximity to the patient of the room or cultivation of the room	othing will have direct contact potentially contaminated aces or equipment in close ient. Don gown upon entry bicle."  Ion regarding this issue was arvey team prior to the exit /22.  ace sheet listed diagnoses not limited to congestive heart are disease, atrial fibrillation, glaucoma, polyneuropathy, er feeding difficulties.  Interest MDS (minimum data assessment reference date) of a resident as having both long mory problems and moderately skills for daily decision making.  Itical nurse) #2 was observed cations to Resident #13 during and pour on 02/09/22 at 8:15	F8	80				
		irector of nursing, regional						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING			(X3) DAT COM	(X3) DATE SURVEY COMPLETED	
		495156				C <b>02/11/2022</b>		
NAME OF PROVIDER OR SUPPLIER  CHOICE HEALTHCARE AT ROANOKE			STREET ADDRESS, CITY, STATE, ZIP CODE  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)			IX (EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 880		age 86 in 02/11/22 at 11:55 am. ion was provided prior to exit.	F 8	880				