PRINTED: 04/29/2022 FORM APPROVED OMB NO. 0938-0391

I'v '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495002	B. WING		07/09/2019
	ROVIDER OR SUPPLIER DANOKE NURSING ANI	D REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014	·
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
E 000	Initial Comments		E 00	0	
E 006 SS=D	survey was conducted Corrections are required. CFR Part 483.73 Recars facilities. No ercomplaints were inverselled to All Hamiltonian Complaints with the Plan Based on All Hamiltonian Complaints were inverselled.	mergency Preparedness ed 7/7/19 through 7/9/19. ired for compliance with 42 quirements for Long Term mergency preparedness estigated during the survey. azards Risk Assessment)-(2)	E 00	6	8/23/19
	(1)-(2), §483.475(a)(§485.68(a)(1)-(2), §4 §485.727(a)(1)-(2), §	(441.184(a)(1)-(2), (482.15(a)(1)-(2), §483.73(a) 1)-(2), §484.102(a)(1)-(2), (485.625(a)(1)-(2),			
	and maintain an eme that must be reviewe	The [facility] must develop ergency preparedness plan ed, and updated at least every ust do the following:]			
	facility-based and co	include a documented, mmunity-based risk g an all-hazards approach.*			
	(2) Include strategies events identified by t	s for addressing emergency he risk assessment.			
	The Hospice must do emergency prepared reviewed, and updat plan must do the followed.	include a documented,			
AROBATORY		/SUPPLIER REPRESENTATIVE'S SIGNATUR	DE	TITI F	(X6) DATE

Electronically Signed 07/26/2019

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495002	B. WING _			07/	/09/2019
	ROVIDER OR SUPPLIER DANOKE NURSING AN	D REHABILITATION	•	3823	ET ADDRESS, CITY, STATE, ZIP CODE FRANKLIN RD, SW NOKE, VA 24014	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 006	(2) Include strategie events identified by including the managof power failures, not emergencies that wability to provide care *[For LTC facilities at Plan. The LTC facility events in the LTC facility and the strategies at the strategies at the strategies and the strategies at the	g an all-hazards approach. s for addressing emergency the risk assessment, lement of the consequences atural disasters, and other build affect the hospice's re. It §483.73(a):] Emergency by must develop and maintain	E	006			
	reviewed, and upda must do the followin (1) Be based on and facility-based and co assessment, utilizin- including missing re (2) Include strategie events identified by	d include a documented, ommunity-based risk g an all-hazards approach, sidents. s for addressing emergency the risk assessment.					
	The ICF/IID must de emergency prepare reviewed, and upda plan must do the fol (1) Be based on and facility-based and coassessment, utilizing including missing cli (2) Include strategie events identified by	d include a documented, ommunity-based risk g an all-hazards approach,					
	review, the facility s facility emergency p documented facility-	view and facility document taff failed to ensure that the reparedness plan included a based and community based t utilized an all hazards		C T P	E006 Corrective Action(s): The Facility⊡s Emergency Preparedr Plan has been revised and updated tilizing a documented facility-based		

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495002	B. WING		07/09/2019	
	ROVIDER OR SUPPLIER DANOKE NURSING AND	REHABILITATION	3	STREET ADDRESS, CITY, STATE, ZIP CODE 8823 FRANKLIN RD, SW ROANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	
E 006	facility-based and cor assessment that utiliz in the facility's emerge On 7/9/19 at 1:02 pm facility administrator v emergency prepared facility's emergency p facility administrator i the facility did not have facility-based and cor assessment that utiliz approach.included wi preparedness plan. On 7/9/19 at 1:20 pm was made aware of the	I to include a documented munity based risk red an all hazards approach ency preparedness plan. In, the surveyor and the who was responsible for the mess plan reviewed the preparedness plan. The informed the surveyor that we a documented munity based risk red an all hazards thin the facility emergency In, the administrative team the findings as stated above. In regarding this issue was y team prior to the exit	E 006	community based risk assessment all hazards approach Identification of Deficient Practice(s) & Corrective Action(s): The entire Emergency Preparedness I has been reviewed to identify any miss or incomplete required items in the Emergency Plan. Any/All negative find will be corrected at time of discovery a facility Incident and Accident form with completed for each negative finding. Systemic Change(s); Current facility policy & procedure for utilization of an all hazards facility and community based risk assessment has been reviewed and no changes are warranted at this time. The Administrations reviewed the Emergency Preparedness Plan and reviewed the required items and training to be completed for compliance. All staff will inserviced by the administrator/design on the Emergency Preparedness Plan Monitoring: The Administrator is responsible for maintaining compliance. The administrator will monitor and review to Emergency Preparedness Plan quarter with the QA committee to ensure the Emergency Preparedness Plan quarter with the QA committee to ensure the Emergency Preparedness.	Plan sing ings nd II be stor be see .	
E 007 SS=D	EP Program Patient F CFR(s): 483.73(a)(3) 8403.748(a)(3), 8416		E 007	·	8/23/19	
	9403.140(a)(3), 9416	.54(a)(3), §418.113(a)(3),				

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		495002	B. WING _		0	7/09/2019
	ROVIDER OR SUPPLIER DANOKE NURSING AN	D REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
E 007	§483.73(a)(3), §483 §485.68(a)(3), §485 §485.920(a)(3), §495 [(a) Emergency Plar and maintain an emithat must be reviewed 2 years. The plan m (3) Address [patient but not limited to, peservices the [facility] an emergency; and including delegation plans.** *[For LTC facilities a Plan. The LTC facilities an emergency prepareviewed, and updat plan must do all of the (3) Address resident limited to, persons a LTC facility has the attempt of the emergency; and corricce including delegation plans. *NOTE: ["Persons and hospice, PACE, HHARHC/FQHC, or ESET This REQUIREMEND by: Based on staff intersides."	60.84(a)(3), §482.15(a)(3), .475(a)(3), §484.102(a)(3), .625(a)(3), §485.727(a)(3), 1.12(a)(3), §494.62(a)(3). a. The [facility] must develop ergency preparedness plan ed, and updated at least every ust do the following:] [Client] population, including, rsons at-risk; the type of has the ability to provide in continuity of operations, s of authority and succession [It §483.73(a):] Emergency y must develop and maintain aredness plan that must be need at least annually. The ne following: [It population, including, but not trisk; the type of services the ability to provide in an antinuity of operations, s of authority and succession [It isk" does not apply to: ASC, A, CORF, CMCH,	EO	E007 Corrective Action(s):		
	emergency prepared Resident population	dness plan that addressed the , and included, but was not t-risk; the type of services the		The Facility□s Emergency Preparent Plan has been revised and updatensure that it addressed the resident Plan has been revised and updatensure that it addressed the resident Plan Plan Plan Plan Plan Plan Plan Plan	ated to	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495002	B. WING _			07/09/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	· · · · · · · · · · · · · · · · · · ·		
SOLITH D	OANOKE NURSING A	ND BEHARII ITATION		3823 FRANKLIN RD, SW			
300111 K	OANOKE NUKSING A	ND REHABILITATION		ROANOKE, VA 24014			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
E 007	Continued From pa	nge 4	EC	007			
	facility has the abili and continuity of op The findings includ			population including, but n persons at-risk; the types facility the ability to provide emergency; and continuity	of services the e in an		
	The facility staff fai emergency prepare Resident populatio limited to, persons facility has the ability and continuity of open of the facility administrate emergency prepare facility administrate emergency prepare facility administrate the facility administrate the facility did not a population, and incorpersons at-risk; the has the ability to precontinuity of operation of the facility at 1:20 was made aware of the facility at 1:20 was made aware of the facility staff.	ded to ensure that the facility edness plan addressed the n, and included, but was not at-risk; the type of services the ty to provide in an emergency; perations. In the surveyor and the provide the edness plan reviewed the proper paredness plan. The provide the surveyor that address the Resident luded, but was not limited to, at type of services the facility evide in an emergency; and dions. In the administrative team of the findings as stated above. In the findings as stated above.		Identification of Deficient F Corrective Action(s): The entire Emergency Pre has been reviewed to ider or incomplete required iter Emergency Plan. Any/All r will be corrected at time of a facility Incident and Acci completed for each negati Systemic Change(s); Current facility policy & pre ensuring that the resident including, but not limited to at-risk; the types of service has the ability to provide in and continuity of operation reviewed and no changes at this time. The Administ reviewed the Emergency F Plan and reviewed the req training to be completed fo All staff will be inserviced administrator/designee on Preparedness Plan. Monitoring: The Administrator is respon maintaining compliance. T administrator will monitor a Emergency Preparedness	eparedness Plan ntify any missing ms in the negative findings of discovery and dent form will be eive finding. occedure for population, o, persons es the facility on an emergency; on the beautive ditems and or compliance. By the on the Emergency		
	No further informat provided to the sur	ion regarding this issue was vey team prior to the exit		reviewed the Emergency I Plan and reviewed the requirement of training to be completed for All staff will be inserviced administrator/designee on Preparedness Plan. Monitoring: The Administrator is responsible administrator will monitor will will will be administrator will will will will be administrator will will will be administrator will be administration will be administrator will be administration	Preparedness quired items and or compliance. by the the Emergency onsible for The and review the Flan quarterly		

1, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495002	B. WING		07/09/2019
	ROVIDER OR SUPPLIER OANOKE NURSING AN	ID REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUNDER CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION
E 013 SS=D	CFR(s): 483.73(b) §403.748(b), §416.3 §441.184(b), §460.3 §483.475(b), §484. §485.625(b), §485. §486.360(b), §491. (b) Policies and proced plan set forth in parassessment at para and the communicathis section. The pobe reviewed and up *[For LTC facilities aprocedures. The LT implement emerger procedures, based forth in paragraph (assessment at para and the communicathis section. The pobe reviewed and up *Additional Require Facilities: *[For PACE at §460 procedures. The Podevelop and implement policies and procedures and procedures. The Podevelop and implement policies and procedures.	34(b), §482.15(b), §483.73(b), 102(b), §485.68(b), 727(b), §485.920(b),	E 01	3	8/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495002	B. WING _		07	7/09/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•	700/2010
SOLITH D	OVNORE NITESING	AND REHABILITATION		3823 FRANKLIN RD, SW		
30011110	CANORE NORSING	AND REHADILITATION		ROANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
E 013	equipment, power emergencies; and threaten the healt staff, or the public must be reviewed years. *[For ESRD Facili procedures. The	uding, but not limited to: Fire; c, or water failure; care-related I natural disasters likely to h or safety of the participants, . The policies and procedures and updated at least every 2 ties at §494.62(b):] Policies and dialysis facility must develop	EC	113		
	and procedures, to set forth in paragrassessment at paragrand the communication. The be reviewed and to these emergenciation, fire, equipment emergencies, was natural disasters to geographic area. This REQUIREMED by:	nergency preparedness policies based on the emergency plan aph (a) of this section, risk ragraph (a)(1) of this section, cation plan at paragraph (c) of policies and procedures must updated at least every 2 years. es include, but are not limited to r power failures, care-related er supply interruption, and ikely to occur in the facility's				
	Based on staff in review, the facility emergency prepa policies and proces based on the facil assessment and can all-hazards appoint The findings inclusing the facility staff facility emergency prepa and procedures the facility and co			E013 Corrective Action(s): The Facility s Emergency F Plan has been revised and t ensure that it included polici procedures that were development of the facility and community b assessment and communicate utilized an all-hazards appro- Identification of Deficient Procedures Action(s): The entire Emergency Prephas been reviewed to identification or incomplete required items	updated to es and oped based on ased risk ation plan that bach. actice(s) & aredness Plan fy any missing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495002	B. WING _			07/	09/2019		
	ROVIDER OR SUPPLIER DANOKE NURSING AND	REHABILITATION		38	TREET ADDRESS, CITY, STATE, ZIP CODE 123 FRANKLIN RD, SW OANOKE, VA 24014				
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 013	facility administrator vemergency preparedra facility's emergency proparedra facility administrator in the facility emergency include policies and propagation developed based on the based risk assessmenthat utilized an all-haze On 7/9/19 at 1:20 pm was made aware of the No further information	n, the surveyor and the who was responsible for the ness plan reviewed the reparedness plan. The informed the surveyor that were reparedness pan did not procedures that were the facility and community int and communication plan cards approach. In, the administrative team the findings as stated above. In regarding this issue was by team prior to the exit	EO	113	Emergency Plan. Any/All negative findi will be corrected at time of discovery ar a facility Incident and Accident form will completed for each negative finding. Systemic Change(s); Current facility policy & procedure for ensuring that the Emergency Preparedness Plan included policies ar procedures that were developed based the facility and community based risk assessment and communication plan the utilized an all-hazards approach have been reviewed. No changes are warranted at this time. The Administrativas reviewed the Emergency Preparedness Plan and reviewed the required items and training to be completed for compliance. All staff will inserviced by the administrator/designed on the Emergency Preparedness Plan. Monitoring: The Administrator is responsible for maintaining compliance. The administrator will monitor and review the Emergency Preparedness Plan quarter with the QA committee to ensure the En	nd be nd on nat tor be se			
E 015 SS=D	Subsistence Needs for CFR(s): 483.73(b)(1)	or Staff and Patients	E 0	15	is in compliance.		8/23/19		
		.113(b)(6)(iii), §441.184(b) 82.15(b)(1), §483.73(b)(1), .625(b)(1)							
	[(b) Policies and proc	edures. [Facilities] must							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495002	B. WING		07	/09/2019	
	ROVIDER OR SUPPLIER DANOKE NURSING AN	ND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014	·		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
E 015	policies and proceed plan set forth in part assessment at part and the communication this section. The probe reviewed and up for LTC facilities]. A procedures must act (1) The provision of and patients whether place, include, but a (i) Food, water, mer supplies (ii) Alternate source following: (A) Temperatures to safety and for the seprovisions. (B) Emergency light (C) Fire detection, and systems. (D) Sewage and water the policies and proceed (6) The following are hospice-operated in the policies and profollowing: (iii) The provision of hospice employees evacuate or shelter limited to the following.	nent emergency preparedness dures, based on the emergency ragraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of colicies and procedures must odated every 2 years [annually At a minimum, the policies and ddress the following: If subsistence needs for staff er they evacuate or shelter in are not limited to the following: dical and pharmaceutical es of energy to maintain the protect patient health and afe and sanitary storage of ting. Extinguishing, and alarm este disposal. Dice at §418.113(b)(6)(iii):] dures. The additional requirements for a patient care facilities only. The according of the subsistence needs for a subsistence needs for a and patients, whether they in place, include, but are not	E 01	5			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
		495002	B. WING	 	07/09/2019
	ROVIDER OR SUPPLIER DANOKE NURSING AN	D REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
E 015	safety and for the sa provisions. (2) Emergency light (3) Fire detection, exsystems. (C) Sewage and wa This REQUIREMEN by: Based on staff interreview, the facility semergency preparer policies and procedurand waste disposal. The findings include The facility staff failed procedures to provid disposal in the facility plan. On 7/9/19 at 1:02 pfacility administrator emergency preparer facility is emergency facility administrator the facility administrator the facility did not haprovide for sewage within the facility em	protect patient health and afe and sanitary storage of ang. Atinguishing, and alarm ste disposal. IT is not met as evidenced view and facility document taff failed to develop an dness plan that included ures to provide for sewage	E 01	E015 Corrective Action(s): The Facility s Emergency Prepare Plan has been revised and updated ensure that it included policies and procedures to provide for sewage a waste disposal. Identification of Deficient Practice(s Corrective Action(s): The entire Emergency Preparedneshas been reviewed to identify any ror incomplete required items in the Emergency Plan. Any/All negative will be corrected at time of discover a facility Incident and Accident form completed for each negative finding. Systemic Change(s); Current facility policy & procedure for ensuring that the Emergency Preparedness Plan included policies procedures to provide for sewage as	d to and s) & ss Plan nissing findings ry and n will be g. for es and and
		on regarding this issue was ey team prior to the exit 9.		waste disposal has been reviewed. changes are warranted at this time. Administrator has reviewed the Emergency Preparedness Plan and reviewed the required items and tra	. The

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER DANOKE NURSING AND	REHABILITATION		38	TREET ADDRESS, CITY, STATE, ZIP CODE 323 FRANKLIN RD, SW OANOKE, VA 24014	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 015	Continued From page	÷ 10	E	015	to be completed for compliance. All stawill be inserviced by the administrator/designee on the Emerge Preparedness Plan. Monitoring: The Administrator is responsible for maintaining compliance. The administrator will monitor and review the Emergency Preparedness Plan quarte with the QA committee to ensure the E is in compliance.	ncy ne rly	
E 018 SS=D	S403.748(b)(2), §416 and (v), §441.184(b)(§482.15(b)(2), §485.§494.62(b)(1). [(b) Policies and procedur plan set forth in paragand the communication this section. The policies and procedur plan set forth in paragand the communication this section. The policies and procedur plan set forth in paragand the communication that section is section. The policies and procedur following:] [(2) or (1)] A system to on-duty staff and she [facility's] care during staff and sheltered paragand she	P3(b)(2), §483.475(b)(2), .920(b)(1), §486.360(b)(1), .920(b)(1), §486.360(b)(1), .920(b)(1), §486.360(b)(1), .920(b)(1), §486.360(b)(1), .920(b)(1), §486.360(b)(1), .920(c)(1), .920(c)(E	018			8/23/19

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E 018	or other location. *[For PRTFs at §441 ICF/IIDs at §483.475 Policies and procedu location of on-duty st the [PRTF's, LTC, IC and after an emerger sheltered residents a emergency, the [PRT must document the sthe receiving facility of the receiving faci	cation of the receiving facility 184(b), LTC at §483.73(b), (b), PACE at §460.84(b):] res. (2) A system to track the aff and sheltered residents in F/IID or PACE] care during ncy. If on-duty staff and re relocated during the 'F's, LTC, ICF/IID or PACE] pecific name and location of or other location. The at §418.113(b)(6):] res. rom the hospice, which on of care and treatment staff responsibilities; fication of evacuation any and alternate means of external sources of the location of hospice and sheltered patients in the gran emergency. If the resheltered patients are emergency, the hospice pecific name and location of or other location. 5.920(b):] Policies and evacuation from the CMHC, deration of care and	E 01	8		

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DATE SURVEY COMPLETED		
	495002	B. WING		07/09/2019		
	D REHABILITATION	3	823 FRANKLIN RD, SW			
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETION		
*[For OPOs at § 486 procedures. (2) A sy documentation that donor information, potential and actual secures and mainta *[For ESRD at § 49 procedures. (2) Safe facility, which include needs of the patient This REQUIREMEN by: Based on staff interreview, the facility semergency prepare a tracking system to locations of resident emergency. The findings include The facility staff failed emergency prepare tracking system to be of Residents and state of Reside	6.360(b):] Policies and vistem of medical preserves potential and actual protects confidentiality of donor information, and ins the availability of records. 4.62(b):] Policies and evacuation from the dialysis es staff responsibilities, and staff responsibilities, and staff failed to develop an dness plan that that included to be used to document its and staff during an emergency. The surveyor and the who was responsible for the dness plan reviewed the preparedness plan did not vistem to be used to document.	E 018	E018 Corrective Action(s): The Facility s Emergency Preparedr Plan has been revised and updated to ensure that it included a tracking syst to be used to document locations of residents and staff during an emerger Identification of Deficient Practice(s) Corrective Action(s): The entire Emergency Preparedness has been reviewed to identify any mis or incomplete required items in the Emergency Plan. Any/All negative fin will be corrected at time of discovery a facility Incident and Accident form we completed for each negative finding. Systemic Change(s); Current facility policy & procedure for	Plan ssing dings and will be		
	SUMMARY S (EACH DEFICIEN REGULATORY OF REGULATORY OF Continued From page assistance. *[For OPOs at § 486 procedures. (2) A sy documentation that donor information, potential and actual secures and mainta *[For ESRD at § 494 procedures. (2) Safe facility, which include needs of the patient This REQUIREMEN by: Based on staff interreview, the facility semergency prepared a tracking system to locations of resident emergency. The findings included the facility staff failed emergency prepared tracking system to be of Residents and stafe of Resident	A95002 COVIDER OR SUPPLIER DANOKE NURSING AND REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to develop an emergency preparedness plan that that included a tracking system to be used to document locations of residents and staff during an emergency. The findings included: The facility staff failed to ensure that the facility emergency preparedness plan included a tracking system to be used to document locations of Residents and staff during an emergency. On 7/9/19 at 1:02 pm, the surveyor and the facility administrator who was responsible for the emergency preparedness plan reviewed the facility's deministrator who was responsible for the emergency preparedness plan reviewed the facility administrator informed the surveyor that the facility admini	A BUILDING 495002 B. WING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to develop an emergency preparedness plan that that included a tracking system to be used to document locations of residents and staff during an emergency. The findings included: The facility staff failed to ensure that the facility emergency preparedness plan included a tracking system to be used to document locations of Residents and staff during an emergency. On 7/9/19 at 1:02 pm, the surveyor and the facility administrator who was responsible for the emergency preparedness plan reviewed the facility administrator informed the surveyor that the facility administrator informed the surveyor that the facility emergency preparedness plan did not include a tracking system to be used to document locations of Residents and staff during an	A BUILDING 495002 STREET ADDRESS. CITY, STATE, 2IP CODE 323 FRANKLIN RD, SW ROANOKE, VA 24014 SUMMARY STATEMENT OF PERCEMORIES (EACH DEPTICIENCY MUST BE PRECEDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 assistance. "[For OPOs at § 486,360(b):] Policies and procedures, (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. "[For ESRD at § 494.62(b):] Policies and procedures, (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to develop an emergency preparedness plan that that included a tracking system to be used to document locations of residents and staff during an emergency. The findings included: The facility staff failed to ensure that the facility emergency preparedness plan included a tracking system to be used to document locations of residents and staff during an emergency. On 7/9/19 at 1:02 pm, the surveyor and the facility emergency preparedness plan mergency. On 7/9/19 at 1:02 pm, the surveyor and the facility emergency preparedness plan included the emergency preparedness plan to be used to document locations of residents and staff during an emergency. Systemic Change(s): Current facility policy & procedure for ensuring that the Emergency		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495002	B. WING			07/	/09/2019
	ROVIDER OR SUPPLIER DANOKE NURSING AND	REHABILITATION		38	TREET ADDRESS, CITY, STATE, ZIP CODE 323 FRANKLIN RD, SW OANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APP DEFICIENCY)			(X5) COMPLETION DATE
E 018	On 7/9/19 at 1:20 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 7/9/19. On 7/9/19 at 1:20 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 7/9/19. On 7/9/19 at 1:20 pm, the administrative deam was made aware of the findings as stated above. On 7/9/19 at 1:20 pm, the administrator has reviewed. No changes are warranted at this time. The Administrator has reviewed the Emergency Preparedness Plan and reviewed the required items and training to be completed for compliance. All staff will be inserviced by the administrator/designee on the Emergency Preparedness Plan. Monitoring: The Administrator is responsible for maintaining compliance. The administrator will monitor and review the Emergency Preparedness Plan quarterly with the QA committee to ensure the EOP is in compliance. Policies/Procedures for Sheltering in Place		ntinued From page 13 7/9/19 at 1:20 pm, the administrative team is made aware of the findings as stated above. further information regarding this issue was wided to the survey team prior to the exit inference on 7/9/19. E 018 E 018 of residents and staff during an emergency has been reviewed. No changes are warranted at this time. The Administrator has reviewed the Emergency Preparedness Plan and reviewed the required items and training to be completed for compliance. All staff will be inserviced by the administrator/designee on the Emergency Preparedness Plan. Monitoring: The Administrator is responsible for maintaining compliance. The administrator will monitor and review the Emergency Preparedness Plan quarterly with the QA committee to ensure the EOP is in compliance.		ng aff ncy ne rly	8/23/19	
	§483.73(b)(4), §483.4 §485.625(b)(4), §485.625(b)(4), §485.6491.12(b)(2), §494.6 (b) Policies and procedured plan set forth in paragasessment at paragand the communication this section. The policies and updates the policies and procedure	edures. The [facilities] must ent emergency preparedness res, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must ated at least every 2 years lities]. At a minimum, the					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER DANOKE NURSING AN	D REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014	,		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
E 022	Continued From pag	ge 14	E 0	22			
		A means to shelter in place nd volunteers who remain in					
	and procedures. (6) The following are hospice-operated in The policies and profollowing: (i) A means to shelte hospice employees This REQUIREMEN by: Based on staff interreview, the facility stemergency prepared policies and procedures and procedures and volunteers who an emergency. The findings include The facility staff failed emergency prepared and procedures that	e additional requirements for patient care facilities only. Incedures must address the cer in place for patients, who remain in the hospice. To is not met as evidenced wiew and facility document traff failed to develop an educes that are aligned with the plan and risk assessment the facility will provide a grin place for Residents, staff, remain in the facility during ed to ensure that the facility's eare aligned with the facility's ed risk assessment that		E022 Corrective Action(s): The Facility s Emergency Preplan has been revised and updensure that it addressed how the will provide a means for shelter place for residents, staff, and who remain in the facility during emergency. Identification of Deficient Practic Corrective Action(s): The entire Emergency Prepare has been reviewed to identify a or incomplete required items in Emergency Plan. Any/All negatives.	lated to the facility ring in colunteers g an lice(s) & lice(s) had been solutions.		
	for sheltering in place volunteers who remembers who remembers. On 7/9/19 at 1:02 p	facility will provide a means the for Residents, staff, and the facility during an means the surveyor and the who was responsible for the		will be corrected at time of disc a facility Incident and Accident completed for each negative fir Systemic Change(s); Current facility policy & procedu	form will be anding.		
		dness plan reviewed the		ensuring that the Emergency			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495002	B. WING _			07/	09/2019
	ROVIDER OR SUPPLIER DANOKE NURSING AND	REHABILITATION		3823 FR	ADDRESS, CITY, STATE, ZIP CODE RANKLIN RD, SW DKE, VA 24014		
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E 022 E 023 SS=D	facility administrator in the facility emergency include policies and point with the facility's eme assessment that addition provide a means for serior Residents, staff, and the facility during an example of the conference on 7/9/19.	preparedness plan. The informed the surveyor that by preparedness plan did not procedures that are aligned regency plan and risk resses how the facility will sheltering in place for volunteers who remain in emergency. In, the administrative team the findings as stated above. In regarding this issue was by team prior to the exit to the exit to the did not be the findings and the exit to	EC	Prefaci in p volu dur No The Em revi to b will adr Pre Mo The mai adr Em with is ir	eparedness Plan addressed how the ility will provide a means for shelterical place for residents, staff, and unteers who remain in the facility ring an emergency has been reviewed changes are warranted at this time. It is a Administrator has reviewed the pergency Preparedness Plan and rewed the required items and training the completed for compliance. All states to be inserviced by the ministrator/designee on the Emergency eparedness Plan. Initoring: The Administrator is responsible for intaining compliance. The ministrator will monitor and review the ergency Preparedness Plan quarter in the QA committee to ensure the En compliance.	ng ed. eg aff ncy	8/23/19
	§441.184(b)(5), §460 §483.73(b)(5), §483.4 §485.68(b)(3), §485.6	6.54(b)(4), §418.113(b)(3), .84(b)(6), §482.15(b)(5), .475(b)(5), §484.102(b)(4), .625(b)(5), §485.727(b)(3), .360(b)(2), §491.12(b)(3),					
	develop and impleme policies and procedur plan set forth in parag assessment at paragi	edures. The [facilities] must ent emergency preparedness res, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of					

L'S 2		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER OANOKE NURSING ANI	D REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP 3823 FRANKLIN RD, SW ROANOKE, VA 24014	CODE		
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E 023	this section. The pole reviewed and upole [annually for LTC fact policies and procedure following:] [(5) or (3),(4),(6)] As documentation that protects confidentialis secures and maintain *[For RNHCIs at §40 procedures. (5) A sy that does the followin (i) Preserves patient (ii) Protects confidentialis Secures and maintain records. *[For OPOs at §486. procedures. (2) A sy documentation that protection information, protential and actual secures and maintain this REQUIREMENT by: Based on staff interview, the facility stemergency prepared policies and procedured information, and secure availability of records.	icies and procedures must lated at least every 2 years ilities]. At a minimum, the res must address the ystem of medical preserves patient information, and ans availability of records. 3.748(b):] Policies and stem of care documentation and information. Itiality of patient information. Itiality of medical preserves potential and actual rotects confidentiality of records. It is not met as evidenced	E	E023 Corrective Action(s): The Facility s Emergency Plan has been revised and ensure that it included polyprocedures to preserve reinformation; protect the corresident information; and maintains availability of reemergency. Identification of Deficient I	d updated to licies and esident onfidentiality of secures and ecords during an		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495002	B. WING _			07/	09/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SOUTH R	DANOKE NURSING AND	REHABILITATION			323 FRANKLIN RD, SW OANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 023	procedures to present protect the confidential and secures and main during an emergency. On 7/9/19 at 1:02 pm facility administrator we emergency prepared facility's emergency pfacility administrator in the facility emergency include policies and procedure proce	and included policies and we Resident information, ality of Resident information, ntains availability of records In, the surveyor and the who was responsible for the ness plan reviewed the preparedness plan. The informed the surveyor that we preparedness plan did not procedures to preserve protect the confidentiality of and secures and maintains during an emergency. In, the administrative team the findings as stated above. In regarding this issue was by team prior to the exit	EC	023	Corrective Action(s): The entire Emergency Preparedness Phas been reviewed to identify any miss or incomplete required items in the Emergency Plan. Any/All negative finding will be corrected at time of discovery at a facility Incident and Accident form will completed for each negative finding. Systemic Change(s); Current facility policy & procedure for ensuring that the Emergency Preparedness Plan included policies at procedures to preserve resident information; protect the confidentiality or resident information; and secures and maintains availability of records during emergency has been reviewed. No changes are warranted at this time. The Administrator has reviewed the Emergency Preparedness Plan and reviewed the required items and training	ings ings nd I be of an ne	
E 024 SS=D	Policies/Procedures- CFR(s): 483.73(b)(6)	Volunteers and Staffing	to be completed for compliance. All staff will be inserviced by the administrator/designee on the Emergency Preparedness Plan. Monitoring: The Administrator is responsible for maintaining compliance. The administrator will monitor and review the Emergency Preparedness Plan quarterly with the QA committee to ensure the EOP is in compliance.		ncy ne rly OP	8/23/19	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER OANOKE NURSING AND	O REHABILITATION	•	STREET ADDRESS, CITY, STATE, Z 3823 FRANKLIN RD, SW ROANOKE, VA 24014	ZIP CODE		
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E 024	§403.748(b)(6), §416 §441.184(b)(6), §460 §483.73(b)(6), §483. §485.68(b)(4), §485. §485.920(b)(5), §491 [(b) Policies and procedure policies and procedure plan set forth in para assessment at paragand the communication this section. The policies and procedure following:] (6) [or (4), (5), or (7) volunteers in an emestaffing strategies, in for integration of State health care profession during an emergency and othe strategies to address emergency. *[For Hospice at §41 procedures. (4) The an emergency and ostrategies, including integration of State as states are procedured.	6.54(b)(5), §418.113(b)(4), 0.84(b)(7), §482.15(b)(6), 475(b)(6), §484.102(b)(5), 625(b)(6), §485.727(b)(4), 1.12(b)(4), §494.62(b)(5). Dedures. The [facilities] must ent emergency preparedness res, based on the emergency graph (a) of this section, risk graph (a)(1) of this section, ron plan at paragraph (c) of icies and procedures must lated at least every 2 years illities]. At a minimum, the res must address the as noted above] The use of ergency or other emergency cluding the process and role the and Federally designated enals to address surge needs of a surge needs during an and remergency staffing as surge needs during an and the process and role for more federally designated on the process and role for more federally designated on the process and role for more federally designated on the process and role for more federally designated on the federally designated the federally designated the federally designated the federally designat	E	024			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495002	B. WING _			07/	09/2019
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
SOUTH R	DANOKE NURSING AND	REHABILITATION			823 FRANKLIN RD, SW		
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E 024	Continued From page	e 19	E	024			
	This REQUIREMENT by:	is not met as evidenced					
	Based on staff intervreview, the facility statemergency prepared policies and procedure of volunteers and oth strategies to address emergency. The findings included The facility staff failed emergency prepared and procedures that a volunteers and other strategies to address emergency. On 7/9/19 at 1:02 pm facility administrator versions and statement of the strategies to address emergency.	I to ensure that the facility ness plan included policies addressed the use of			E024 Corrective Action(s): The Facility s Emergency Preparedne Plan has been revised and updated to ensure that it included policies and procedures that addressed the use of volunteers and other emergency staffir strategies to address surge needs duri an emergency. Identification of Deficient Practice(s) & Corrective Action(s): The entire Emergency Preparedness F has been reviewed to identify any miss or incomplete required items in the Emergency Plan. Any/All negative find will be corrected at time of discovery a a facility Incident and Accident form wi completed for each negative finding.	ng ng Plan sing ings nd	
	facility administrator in the facility emergency include policies and puthe use of volunteers staffing strategies to an emergency. On 7/9/19 at 1:20 pm was made aware of the strategies to the staffing strategies to a staffing strategies to sta	preparedness plan. The informed the surveyor that by preparedness plan did not procedures that addressed and other emergency address surge needs during in, the administrative teamine findings as stated above. In regarding this issue was by team prior to the exit in the information of the exit in the exit in the information of the exit in the ex	ot ng		Systemic Change(s); Current facility policy & procedure for ensuring that the Emergency Preparedness Plan included policies a procedures that addressed the use of volunteers and other emergency staffir strategies to address surge needs duri an emergency has been reviewed. No changes are warranted at this time. The Administrator has reviewed the Emergency Preparedness Plan and reviewed the required items and training to be completed for compliance. All stawill be inserviced by the administrator/designee on the Emerge Preparedness Plan.	ed policies and d the use of gency staffing e needs during eviewed. No this time. The d the Plan and as and training iance. All staff	

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	ROVIDER OR SUPPLIER DANOKE NURSING AND	REHABILITATION		3823	EET ADDRESS, CITY, STATE, ZIP CODE 3 FRANKLIN RD, SW ANOKE, VA 24014		
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E 024		e 20 r Declared by Secretary	EC		Monitoring: The Administrator is responsible for maintaining compliance. The administrator will monitor and review tl Emergency Preparedness Plan quarte with the QA committee to ensure the E is in compliance.	rly	8/23/19
SS=D	(iv), §441.184(b)(8), (8), §483.73(b)(8), §48(8), §485.920(b)(7), § [(b) Policies and procedure policies and procedure plan set forth in paragasessment at paragand the communication this section. The policies and procedure policies and procedure following:] (8) [(6), (6)(C)(iv), (7) [facility] under a waive in accordance with seprovision of care and care site identified by officials. *[For RNHCIs at §403 procedures. (8) The residue of the service of	edures. The [facilities] must int emergency preparedness res, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must rated at least every 2 years lities]. At a minimum, the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER DANOKE NURSING AND	REHABILITATION		38	TREET ADDRESS, CITY, STATE, ZIP CODE 323 FRANKLIN RD, SW OANOKE, VA 24014		
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E 026	REGULATORY OR LSC IDENTIFYING INFORMATION)		E	026	E026 Corrective Action(s): The Facility □s Emergency Preparedne Plan has been revised and updated to ensure that it addressed the facility □s in providing care and treatment at alternate care sites under an 1135 wai Identification of Deficient Practice(s) & Corrective Action(s): The entire Emergency Preparedness I has been reviewed to identify any miss or incomplete required items in the Emergency Plan. Any/All negative find will be corrected at time of discovery a facility Incident and Accident form wit completed for each negative finding. Systemic Change(s); Current facility policy & procedure for ensuring that the Emergency	role iver. Plan sing lings and ill be	
	1135 waiver. On 7/9/19 at 1:20 pn was made aware of the No further information.	n, the administrative team he findings as stated above. n regarding this issue was y team prior to the exit			Preparedness Plan included policies a procedures that addressed the facility role in providing care and treatment at alternate care sites under an 1135 was has been reviewed. No changes are warranted at this time. The Administratias reviewed the Emergency Preparedness Plan and reviewed the required items and training to be completed for compliance. All staff will inserviced by the administrator/design on the Emergency Preparedness Plan	s iver ator I be ee	

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	ROVIDER OR SUPPLIER DANOKE NURSING AND	REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CO 3823 FRANKLIN RD, SW ROANOKE, VA 24014	DDE	
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E 026	Continued From page		E	Monitoring: The Administrator is responsional maintaining compliance. The administrator will monitor and Emergency Preparedness F with the QA committee to eris in compliance.	e nd review the Plan quarterly	9/22/40
E 033 SS=D	(4)-(6), §441.184(c)(4) §441.184(c)(4)-(6), §441.184(c)(4)-(6), §483.73(c)(4) §484.102(c)(4)-(5), §4(4)-(6), §485.727(c)(4) §491.12(c)(4), §494.6 [(c) The [facility] must emergency prepared that complies with Fe and must be reviewed 2 years [annually for communication plan refollowing: (4) A method for shard documentation for pacare, as necessary, with maintain the continuit (5) A means, in the expression of the continuit (6) A means, in the continuit (7) A means	416.54(c)(4)-(6), §418.113(c) 416.54(c)(4)-(6), §418.113(c) 416.84(c)(4)-(6), §482.15(c) -(6), §483.475(c)(4)-(6), 485.68(c)(4), §485.625(c) 4), §485.920(c)(4)-(6), 52(c)(4)-(6). The develop and maintain an eness communication planderal, State and local laws and updated at least every and updated at least every and updated at least every and updated all of the enust include all of the enust include all of the ling information and medical tients under the [facility's] with other health providers to	EC			8/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495002	B. WING			7/09/2019	
	ROVIDER OR SUPPLIER) REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW	•	770072010	
				ROANOKE, VA 24014			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT 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	
E 033	Continued From page	e 23	E 03	33			
	about the general co	s of providing information and location of scility's] care as permitted 10(b)(4).					
	sharing information a patients under the RI with care providers to	3.748(c):] (4) A method for nd care documentation for NHCl's care, as necessary, o maintain the continuity of ritten election statement or his or her legal					
	of providing informatic condition and location facility's care as pern 164.510(b)(4). This REQUIREMENT by: Based on staff interverview, the facility statemergency prepared communication plants sharing information afor Residents under the statement of the statem	n of patients under the nitted under 45 CFR is not met as evidenced riew and facility document aff failed to develop an ness plan that included a that included a method for nd medical documentation he facility's care, as		E033 Corrective Action(s): The Facility□s Emergency Pre Plan has been revised and up ensure that it included a comm plan that included a method fo	dated to nunication or sharing		
	the continuity of care the facility will use to	r health providers to maintain , and to address the means release Resident information I conditon and location of		information and medical docur for residents under the facility! necessary, with other health p maintain the continuity of care address the means the facility release the resident informatic the general condition and local residents.	s care, as roviders to and to will use on to include		
	emergency prepared communication plan	d to ensure that the facility ness plan that included a that included a method for nd medical documentation he facility's care, as		Identification of Deficient Prac Corrective Action(s): The entire Emergency Prepare has been reviewed to identify	edness Plan		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
		495002	B. WING		0.	7/09/2019	
	ROVIDER OR SUPPLIER DANOKE NURSING AND) REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014		•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
E 033	the continuity of care the facility will use to to include the general Residents. On 7/9/19 at 1:02 pr facility administrator emergency prepared facility's emergency pfacility administrator the facility emergency include a communical method for sharing in documentation for Recare, as necessary, waintain the continuithe means the facility information to include location of Residents On 7/9/19 at 1:20 pr was made aware of the social social to the facility information to include the social social to the facility information to include the social terms of the social terms of the social terms of the facility information to include the social terms of the social	r health providers to maintain and to address the means release Resident information all condition and location of and the who was responsible for the preparedness plan. The informed the surveyor that by preparedness plan did not ation plan that included a information and medical esidents under the facility's with other health providers to the general condition and second the general condition and second the general condition and the general condition and the general condition and the findings as stated above.	EO	or incomplete required items in Emergency Plan. Any/All negar will be corrected at time of disc a facility Incident and Accident completed for each negative fir Systemic Change(s); Current facility policy & procedensuring that the Emergency Preparedness included a complant that included a method for information and medical documfor residents under the facility necessary, with other health promaintain the continuity of care, address the means the facility release the resident information the general condition and locat residents has been reviewed. Changes are warranted at this administrator has reviewed the Emergency Preparedness Plar reviewed the required items and to be completed for compliance will be inserviced by the administrator/designee on the Preparedness Plan. Monitoring: The Administrator is responsible maintaining compliance. The administrator will monitor and reference to ensure is in compliance.	tive findings covery and form will be nding. Jure for munication r sharing mentation s care, as roviders to will use in to include tion of No time. The en and indirating e. All staff Emergency		
E 035 SS=D	LTC and ICF/IID Sha CFR(s): 483.73(c)(8)	ring Plan with Patients	E 0	' ·		8/23/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONS	(X3) DATE SURVEY COMPLETED				
		495002	B. WING			07/09/2019		
	ROVIDER OR SUPPLIER DANOKE NURSING ANI	D REHABILITATION		3823 FR	ADDRESS, CITY, STATE, ZIP CODE CANKLIN RD, SW DKE, VA 24014	•		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
E 035	Continued From pag	e 25	E	35				
	§483.73(c)(8); §483. *[For LTC Facilities a							
	an emergency prepare that complies with Fe and must be reviewed	redness communication plan ederal, State and local laws ed and updated at least nunication plan must include						
	*[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:]							
	emergency plan, tha is appropriate, with r families or represent	ring information from the t the facility has determined esidents [or clients] and their atives. T is not met as evidenced						
	Based on staff inter- review, the facility st emergency prepared method for sharing in emergency plan, and determined it is appr	d that the facility has opriate with Residents or lilies or representatives.		The Plai ens sha plar is a	35 rective Action(s): e Facility□s Emergency Preparedn n has been revised and updated to sure that it included a method for aring information from the emergen n, and that the facility has determin appropriate with residents or clients ir families or representatives.	o ncy ned it		
	emergency prepared	d to ensure that the facility Iness plan included a method on from the emergency plan, as determined it is		Cor The	ntification of Deficient Practice(s) & rective Action(s): e entire Emergency Preparedness s been reviewed to identify any mis	Plan		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495002	B. WING _	B. WING			07/09/2019	
	ROVIDER OR SUPPLIER DANOKE NURSING AND	REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
E 035	appropriate with Resi families or representation on 7/9/19 at 1:02 pm facility administrator of the facility's emergency properly administrator in the facility administrator in the facility emergency plan, and determined it is appropriately and their familiary on 7/9/19 at 1:20 pm was made aware of the second	dents or clients and their stives. In, the surveyor and the who was responsible for the ness plan reviewed the reparedness plan. The informed the surveyor that or preparedness plan did not sharing information from the that the facility has periate with Residents or ites or representatives In, the administrative team the findings as stated above.	E	035	or incomplete required items in the Emergency Plan. Any/All negative find will be corrected at time of discovery a a facility Incident and Accident form will completed for each negative finding. Systemic Change(s); Current facility policy & procedure for ensuring that the Emergency Preparedness included a method for sharing information from the emergency plan, and that the facility has determine is appropriate with residents or clients their families or representatives has be reviewed. No changes are warranted this time. The Administrator has review the Emergency Preparedness Plan and reviewed the required items and training to be completed for compliance. All stawill be inserviced by the administrator/designee on the Emerge Preparedness Plan. Monitoring:	nd Il be Il be ed it and een at wed d ig		
F 000	survey was conducte	dicare/Medicaid standard d 7/7/19 through 7/9/19. red for compliance with 42 l Long Term Care	F	000	The Administrator is responsible for maintaining compliance. The administrator will monitor and review th Emergency Preparedness Plan quarte with the QA committee to ensure the E is in compliance.	rly		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495002	B. WING		07/09/2019
	ROVIDER OR SUPPLIER DANOKE NURSING AN	D REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014	·
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 000	at the time of the su	low. 8 certified bed facility was 86 rvey. The survey sample rent Resident reviews and 2	F 00		
F 578 SS=E	Request/Refuse/Dsc CFR(s): 483.10(c)(6) §483.10(c)(6) The ridiscontinue treatment to participate in experimental formulate an advance of the provision of medical construed as the rigital the provision of medical construed in the requirements specificated in the requirement concerning medical or surgical the resident's option, for (ii) This includes a wifacility's policies to it and applicable State (iii) Facilities are per entities to furnish the legally responsible for requirements of this (iv) If an adult individiting of admission are	contnue Trmnt; FormIte Adv Dir (8)(g)(12)(i)-(v) ght to request, refuse, and/or nt, to participate in or refuse erimental research, and to be directive. Ing in this paragraph should be not of the resident to receive lical treatment or medical edically unnecessary or facility must comply with the led in 42 CFR part 489, Directives). Into include provisions to written information to all adult go the right to accept or refuse reatment and, at the remulate an advance directive. Written description of the mplement advance directives a law. In information but are still or ensuring that the	F 578	3	8/23/19

		I DENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495002	B. WING		07/09/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0770372013	
				3823 FRANKLIN RD, SW		
SOUTH R	DANOKE NURSING AND	REHABILITATION		ROANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 578	Continued From pag	e 28	F 578	3		
	has executed an advimay give advance di individual's resident rivith State Law. (v) The facility is not provide this information she is able to receful or she is able to rec	ance directive, the facility rective information to the representative in accordance relieved of its obligation to on to the individual once he rive such information. Is must be in place to provide individual directly at the ris not met as evidenced riews, facility document ecord review, it was an experience of the such as a series of the		F578 Corrective Action(s): Resident #336 has had their DDNR for reviewed by the DON and the attending physician and it has been correctly completed in accordance with the facility sadvance directive process to	ng o	
	The findings include:			accurately reflect resident #336□s co status. An Incident and Accident form completed for this incident.		
	finding thirty (30) DD pre-signed by the fact These pre-signed DE patient information. If forms included the machine (printed) and the meanumber. Resident #336 was a 7/5/19. Resident #33 were not limited to: Phyperlipidemia, arthrighted.	volvement in the DNR forms as evidenced by NR forms that had been sility's medical director (MD). DNR forms did not include Eight (8) of the pre-signed redical director's name dical director's phone admitted to the facility on 36's diagnoses included, but barkinson's disease, tis, and thoracic		Resident #80 has had their DDNR for has been correctly completed in accordance with the facility sadvand directive process to accurately reflect resident #80 scode status. An Incid and Accident form was completed for incident. Identification of Deficient Practice(s) Corrective Action(s): All other residents may have been potentially affected. The Admission Director and/or Social Services Directive will review all resident smedical recomposition.	ce ent this	
		e. Resident #336's initial IDS) assessment had not yet		to ensure the DDNR is accurately completed and is completed in		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495002	B. WING _			07/	09/2019
	ROVIDER OR SUPPLIER DANOKE NURSING AND	REHABILITATION		38	TREET ADDRESS, CITY, STATE, ZIP CODE 323 FRANKLIN RD, SW OANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 578	indicated the resident impaired, did require bathing, and used as ambulating. Review of Resident # on the morning of 7/8 DDNR form that had and dated 7/5/19 but found of an 7/5/19 recompleted by the phyclinical documentation telephone/verbal order unless otherwise order indicted this order was physician who had sign DDNR. On 7/8/19 at practical nurse) #1 was physician completing writing a progress no #1 directed the surve Nursing). On 7/8/19 at 8:45 a.m about the facility's DE asked where the form provided the surveyo included thirty (30) Dipre-signed by the factor 7/8/19 at 9:30 a.m signature was on the interviewed via telephreported he did have forms at the facility for available.	other clinical documentation is was not cognitively assistance with hygiene and sistive devices when 336's clinical documentation /19 revealed a completed been signed by a physician no documentation was sident assessment resician. Resident #336's in included a er dated 7/5/19 for "Full code ered"; documentation is given by the same gned the aforementioned 8:35 a.m., LPN (licensed as asked about the the DDNR on 7/5/19 but not the or signing all orders. LPN grow to the DON (Director of the DON was asked DNR forms. The DON was as were kept. The DON in with a file folder which DNR forms which had been illity's Medical Director. 1., the physician whose aforementioned DDNR was	F	578	accordance with the facility sadvance directive process. An incident and accident form will be completed for earnegative finding. Systemic Change(s); The Facility policy and procedure was reviewed and no changes are warrante at this time. The Admissions Director and/or Social Worker, and nursing administration have been inserviced on the proper completion of a DDNR in accordance with the facility sadvance directive process. Monitoring: The Admission Director and/or Social Services Director are responsible for maintaining compliance. The Admission Director and/or Social Service Director audit all Residents medical records monthly to monitor compliance for have a current resuscitation order and/or advance directive. Any/all negative findings will be reported to the Administrator for immediate corrective action to include an investigation.	ed n e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495002	B. WING	 		7/09/2019	
	ROVIDER OR SUPPLIER OANOKE NURSING AND	REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP COD 3823 FRANKLIN RD, SW ROANOKE, VA 24014			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 578	The following informatitled, "DNR - DO NO approval date of 10/2 issued to the residenthe residenthe residenthas estaphysician/resident reor designee shall experson authorized to behalf, the alternative issuance of a DDNR DDNR is agreed upohas the following resignature of the residuto consent on the residutor consent of the residutor consent on the r	ation was found in a policy of RESUSCITATE" (with an 27/16): "A DDNR may be to by a physician, with whom oblished a bona fide lationship The physician oblain to the resident or the consent on the resident's es available, including the Order. If the option of a n, the physician or designee ponsibilities: 1. Obtain the lent or the person authorized obtained by the DDNR Order riginal DDNR Order form; to and who may revoke the DON explained to the survey entioned designee would be assistant (PA). In meeting with the facility's soultant (RNC), Director of Facility Administrator (FA) on 19, the DDNR forms that a physician were discussed dditional documentation was by team during this meeting. pre-signed DDNR forms had ailed to ensure the Virginia	F 57				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	(2	(X3) DATE SURVEY COMPLETED	
	495002 B. WING			07/09/2019			
	ROVIDER OR SUPPLIER DANOKE NURSING AND) REHABILITATION		STREET ADDRESS, CITY, STATE, 3823 FRANKLIN RD, SW ROANOKE, VA 24014	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 578	included but not limite comprehension and it and depression. Resident #80's admis (MDS) with an asses of 6/24/19 assessed (brief interview for me Resident #80's basel admissions identified The July 2019 physic #80's clinical record with #80's clinical record with #80 had an order that The Virginia Departm Not Resuscitate Orde incomplete. Section capable or incapable decision about health #80's was marked to	9. Resident #80 was y 6/17/19 with diagnoses that ed to dementia, decreased memory, pain, constipation, esion minimum data set sment reference date (ARD) the resident with a BIMS ental status) as 02/15. ine care plan for new Resident #80 was a "DNR." cian's orders in Resident were reviewed. Resident t read "DNR." ental of Health Durable Doer dated 6/17/19 was 1 certifies if the patient is of making an informed in care decisions. Resident was	F	578			
	certifies that A. an ad executed by the patie decision about life-pripatient has appointed make those decisions directive had not bee second option (B) was the order was signed authorized person but physician's printed mand the emergency purpose. The surveyor informed director of nursing, at	n executed in writing. The us marked for Resident #80. d by Resident #80's at did not include the mane, the physician signature					

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495002	B. WING		07	07/09/2019	
	ROVIDER OR SUPPLIER DANOKE NURSING AND	REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTI X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 578	on DNRs. The surveyor reviewed "DNR-Do Not Resusor read in part "A valid Dof the following: 1. Patient's Full Lega 2. Date of Issue 3. Either Block #1 or: 4. If Block #2 is checked 5. Physician's Signate 6. Either patient's significate checked or RP (respected) or RP (respected). No further information exit conference on 7/Notify of Changes (In CFR(s): 483.10(g)(14) §483.10(g)(14) Notification (i) A facility must immonsult with the residuents of the consistent with his or representative(s) where (A) An accident involves in injury and his physician intervention (B) A significant chanmental, or psychosocideterioration in health status in either life-the clinical complications (C) A need to alter the a need to discontinue.	ed the facility policy titled citate" on 7/9/19. The policy DDNR Form must include all I Name #2 is checked ked, then either Block #A, B, ure nature (if Block #1 is is is possible party) signature (if " nature (if Block #1) signature (i		580		8/23/19	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495002	B. WING		07/09/2019	
	ROVIDER OR SUPPLIER OANOKE NURSING AND) REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014	3170012010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	5.475	
F 580	(14)(i) of this section, all pertinent informati is available and provide physician. (iii) The facility must resident and the resident as specified in §483. (B) A change in resident (e)(10) of this section (iv) The facility must update the address (phone number of the representative(s). §483.10(g)(15) Admission to a competitation as a composite degree with the facility must discloss its physical configural locations that compripart, and must specifications that compribate general specifications and clinical regions and clin	in of treatment); or isfer or discharge the dility as specified in diffication under paragraph (g) is the facility must ensure that on specified in §483.15(c)(2) dided upon request to the dialso promptly notify the dent representative, if any, in or roommate assignment 10(e)(6); or ent rights under Federal or ons as specified in paragraph in the cord and periodically mailing and email) and resident distinct part (as defined in e in its admission agreement tion, including the various see the composite distinct by the policies that apply to en its different locations If is not met as evidenced friew, facility document ecord review, the facility staff ication of changes for 1 of 24 drey sample, Resident # 30.	F 580	F580 Corrective Action(s) Resident #30 s attending physician habeen notified of the resident s falls the occurred on 5/8/19, 5/31/19, 6/15/19, a 6/21/19. A Facility Incident & Accident	at and	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495002	B. WING		07/09/2019	
NAME OF P	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE	1 2	
				3823 FRANKLIN RD, SW		
SOUTH R	DANOKE NURSING AN	D REHABILITATION		ROANOKE, VA 24014		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 580	Continued From pag	ne 34	F 580			
	Continuou i rom pag	,	1 000	form has been completed for this incid	ent	
	The facility staff faile	ed to ensure that the physician		Torri rias been completed for this incid	Cit.	
	_	sident # 30 had falls.		Identification of Deficient Practices		
				& Corrective Action(s):		
	Resident #30 was a	92-year-old-female who was		All other residents experiencing falls m	nay	
		ity on 4/29/19. Diagnoses		have potentially been affected. The Do	-	
	included but were no	ot limited to, dementia,		and Unit Managerwill conduct a 100%		
	agitation, depression	n, and hypertension.		review of all incident and accident forn		
				for the last 30 days to identify resident		
		or Resident # 30 was		risk. An incident & accident form will be		
		at 1:59 pm. The most recent		completed for all negative findings and	l will	
		a set) assessment for		be corrected at time of discovery.		
		an admission assessment				
		sment reference date) of		Systemic Change(s):		
		the MDS assesses cognitive		The facility policy and procedures		
		C0500, the facility staff		havebeen reviewed and no changes a	re	
		esident # 30 had a BIMS (brief status) score of 7 out of 15,		warranted at this time. The 24 Hour	aal	
		Resident # 30's cognitive		Report and documentation in the medi record will serve as the source documentation		
	status was severely			for communicating changes in residen		
	otatao wao ooverery	impanoa.		condition/status, to include resident □s		
	The current plan of	care for Resident # 30 was		who experience a fall.		
		ed on 5/19/19. The facility staff		Licensed staff will be inserviced by the	,	
		s area for Resident # 30 as,		DON and/or Regional nurse consultan		
	"The resident is high	risk for falls r/t (related to)		the notification of physician □s regardir		
	dementia, weakness	s medications hx (history) of		changes in resident condition and		
	fall." Interventions in	cluded but were not limited		incidents involving a resident.		
	to, "Anticipate and n	neet the resident's needs."				
				Monitoring:		
	-	n, the surveyor observed a		The DON is responsible for maintainin	g	
		sident # 30 that had been		compliance. The DON will complete		
		19 at 7:00 pm. The nurse's		weekly chart audits coinciding with the		
		ed as, "Nurse entered room to		care plan calendar to monitor for	:	
		served resident lying on floor		compliance. Any/all negative findings v	VIII	
		joing home, I just slipped."		be corrected at time of discovery.	ho	
		it her head. Skin tear noted to ange of motion) of x 4		Aggregate findings of these audits will reported to the QA committee for review		
		(within normal limits).		analysis and recommendationfor chan	· ·	
		bed and CNA (certified		in facility policy, procedure and/or	900	
		, 204 dila 011, 1001 lillod	1	, in radinty policy, production aria/or	1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	MULTIPLE CONSTRUCTION JILDING			(X3) DATE SURVEY COMPLETED	
	495002 B. WING			07/0	09/2019			
	ROVIDER OR SUPPLIER DANOKE NURSING AND	REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP 3823 FRANKLIN RD, SW ROANOKE, VA 24014	CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIAT	E	(X5) COMPLETION DATE	
F 580	bed. Skin tear cleane Neuro checks put in p (Medical Director's na (Daughter's name with surveyor observed the nurse's note reflected director and Resident been notified, but the that reflected that the notified that Resident A nurse's note that we at 5:00 pm was documersident) room per Cobeing assisted to BR lying on her right side head on floor. Noted Assessed res, able to	ped prepare resident for d and dressed by nurse place. Fax written to ame withheld). Daughter hheld) notified." The lat the documentation in the lat the facility medical at # 30's representative had re was no documentation hospice physician had been	F 5	practice.				
	to BR Neuro checks in and reactive to light) stated that while amb O2 (oxygen) tubing with tried to move O2 tubile lost her balance and A nurse's note that what 5:30 pm was documented at the document of the compact o	nitiated PERL (pupils equal bilateral grips strong. CNA ulating with res to BR her was around her feet. CNA and out of the way and res fell." as documented on 5/31/19 mented as, "POA (power of all and fax written for ame withheld)." The surveyor cumentation in the nurse's er facility medical director and assentative had been notified, umentation that reflected ician had been notified that						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	, ,	ATE SURVEY OMPLETED	
		495002	B. WING _			07/09/2019
	ROVIDER OR SUPPLIER OANOKE NURSING AN	ID REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE
F 580	"Heard alarm and C floor. Noted lift chair Appears to have pit Unsure if hit forehead Neuro checks initiated 87- R (respirations) 193/83. Resident's withheld) notified." any documentation medical director or the been notified that R A nurse's note documented observed sitting on alarm sounding. Rs No apparent injuries written for (Medical 136/82, 88, 98.3, 20 not observe any dot the hospice physicial Resident # 30 fell of The "Nursing Facilit contained document not limited to,"4.2.3 Ensuring the with the Hospice Meattending physician participating in the pas needed to coord medical care provided On 7/8/19 at 3:15 p was made aware of On 7/9/19 at 1:20 p acknowledged that	in high position and forward. In hig	F 5			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495002	B. WING			07/	09/2019
	ROVIDER OR SUPPLIER DANOKE NURSING AND	REHABILITATION		STREET ADDRESS, CITY, STATE, ZIF 3823 FRANKLIN RD, SW ROANOKE, VA 24014	² CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIA		(X5) COMPLETION DATE
F 580	that Resident # 30 ha 6/15/19, and 6/21/19, documentation that re medical director had Resident # 30 had fall No further information	ician had been made aware and fallen on 5/8/19, 5/31/19, and there was no effected that the facility been made aware that llen on 6/15/19. In regarding this issue was y team prior to the exit	F	580			
F 622 SS=D	remain in the facility, discharge the resider (A) The transfer or discresident's welfare and cannot be met in the (B) The transfer or disbecause the resident sufficiently so the resservices provided by (C) The safety of indicendangered due to the status of the resident (D) The health of indicotherwise be endang (E) The resident has appropriate notice, to under Medicare or Med	in (ii)(ii)(2)(i)-(iii) and discharge- requirements- ermit each resident to and not transfer or at from the facility unless- scharge is necessary for the dithe resident's needs facility; scharge is appropriate descharge	F	622			8/23/19

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
		495002	B. WING		07/0	9/2019	
	ROVIDER OR SUPPLIER OANOKE NURSING A	ND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014	•		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 622	Continued From pa	age 38	F 62	22			
1 022	resident who becon admission to a faci resident only allow or (F) The facility cean (ii) The facility may resident while the a § 431.230 of this clexercises his or hed discharge notice from 431.220(a)(3) of the discharge or transfor safety of the resident under any in paragraphs (c)(1) section, the facility or discharge is door medical record and communicated to the institution or provide (i) Documentation in must include: (A) The basis for the case of proceedings of the section, the specific be met, facility attenteds, and the ser facility to meet the (ii) The documenta (2)(i) of this section (A) The resident's proceeding and the ser facility to meet the (ii) The documenta (2)(i) of this section (A) The resident's proceeding and the ser facility to meet the (iii) The documenta (2)(i) of this section (A) The resident's proceeding and the ser facility to meet the (iii) The documenta (2)(ii) of this section (A) The resident's proceeding and the ser facility to meet the (iii) The documenta (2)(ii) of this section (A) The resident's proceeding and the ser facility to meet the (iii) The documenta (2)(ii) of this section (A) The resident's proceeding and the ser facility to meet the (iii) The documenta (2)(ii) of this section (A) The resident's proceeding and the ser facility to meet the (iii) The documenta (2)(ii) of this section (A) The resident's proceeding and the ser facility to meet the (iii) The documenta (2)(ii) of this section (A) The resident's proceeding and the ser facility to meet the (iii) The documenta (2)(iii) of this section (A) The resident's proceeding and the ser facility the the ser	mes eligible for Medicaid after lity, the facility may charge a able charges under Medicaid; sees to operate. not transfer or discharge the appeal is pending, pursuant to napter, when a resident r right to appeal a transfer or om the facility pursuant to § is chapter, unless the failure to er would endanger the health ident or other individuals in the must document the danger fer or discharge would pose. Immentation. ansfers or discharges a of the circumstances specified ()(i)(A) through (F) of this must ensure that the transfer umented in the resident's appropriate information is ne receiving health care er. In the resident's medical record the transfer per paragraph (c)(1) (a) of this coresident need(s) that cannot mpts to meet the resident vice available at the receiving					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN			(X3) DATE SURVEY COMPLETED	
		495002	B. WING _			0	7/09/2019
	ROVIDER OR SUPPLIER DANOKE NURSING AN	D REHABILITATION	•	3823 F	ET ADDRESS, CITY, STATE, ZIP CODE FRANKLIN RD, SW NOKE, VA 24014	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SHO		_D BE	(X5) COMPLETION DATE
F 622	necessary under parthis section. (iii) Information provimust include a minin (A) Contact information responsible for the contact information (C) Advance Directive (D) All special instruongoing care, as apperent (E) Comprehensive (F) All other necess copy of the resident's consistent with §483 any other documents a safe and effective This REQUIREMEN by: Based on staff interreview, and clinical resident to provide the appropriate information the transfer, contact practitioner responsions resident, resident resincluding contact information, all spector ongoing care, contant and all other necess copy of the resident's facility failed to documents and all other necess copy of the resident's facility failed to documents.	tion; and in transfer or discharge is ragraph (c)(1)(i)(C) or (D) of dided to the receiving provider num of the following: ion of the practitioner are of the resident. The information including or information or precautions for propriate. The information including as discharge summary, and the information of care. The information of care. The information of the ble for the care of the expresentative information of the ble for the care of the expresentative information or precautions including a summary, and the ment information provided to	F6	FCGTH in properties 5/fo The in tra	622 orrective Action(s): ne facility staff failed to document formation was sent to the receivin rovider when Resident #37 was ansferred to the emergency room 24/19. A facility incident and acci rm has been completed for this in the facility staff failed to document formation was sent to the receivin rovider when Resident #34 was ansferred to the emergency room	g on dent cident. what g	
		er in the clinical record for 2 of ent #34 and Resident #37). d:		fo Id	29/19. A facility incident and acci rm has been completed for this in entification of Deficient ractices/Corrective Action(s):		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495002	B. WING _			07/	09/2019
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
SOUTH R	DANOKE NURSING AND	REHABILITATION			323 FRANKLIN RD, SW OANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 622	information was sent when Resident #37 wemergency room 5/24. The clinical record of 7/7/19 through 7/9/19 admitted to the facility 5/28/19 with diagnose limited to pneumonial gastroesophageal ref hypertension, hypothyneuropathy, anxiety, syncope, first degree hyperlipidemia, and concept with an assessm 5/16/19 assessed the interview for mental set. The nursing progress a.m. read, "Rsd (resident with an assessm 5/16/19 assessed the interview for mental set. The nursing progress a.m. read, "Rsd (resident with an assessm 5/16/19 assessed the interview for mental set. The nursing progress a.m. read, "Rsd (resident with an assessm 5/16/19 assessed the interview for mental set. The nursing progress a.m. read, "Rsd (resident with a severe discomfort tract infection) with Seand severe discomfort tract infection), 98.8 (to saturation level) 2L (If the clinical record did information was sent transferred to the host the surveyor interviee on 7/9/19 at 10:00 a.m.	iled to document what to the receiving provider was transferred to the 4/19. Resident #37 was reviewed Resident #37 was / 1/10/19 and readmitted es that included but not urinary tract infection, lux disease (GERD), yroidism, peripheral fibromyalgia, dementia, near AV (atrioventricular), thronic kidney disease. Berly MDS (minimum data ent reference date (ARD) of resident with a BIMS (brief tatus) as 15/15. Inote dated 5/24/19 at 9:00 dent) sent to hospital (name ughter's) request d/t (due to) y infection), UTI (urinary OB (shortness of breath) tt. VS (vital signs) @ (at) d pressure), 86 (pulse), 24 demperature), 93% (oxygen iters) O2 (oxygen)." Id not document what with Resident #37 when spital on 5/24/19. Wed the director of nursing m. The DON provided the	F	622	All other residents discharged and/or transferred from the facility may have been affected. The DON and/or design will conduct a 100% audit of all residen who have been discharged and/or transferred from the facility in the past 3 days to identify residents that did not had documentation regarding what informat was sent with the resident to the provid A facility Incident & Accident Form will completed for each negative finding. Systemic Change(s): Facility policy and procedures have beer eviewed. No revisions are warranted at this time. The DON and/or Regional Nurse Consultant will inservice facility licensed staff on the information require to be submitted to the receiving facility when a resident is being transferred or discharged to the hospital or other outs health care facility. The inservice will a include the requirement that there be documentation of that information being sent. Monitoring: The DON/designee will be responsible maintaining compliance. The DON and designee will conduct chart audits weel of all residents who have been discharged and/or transferred from the facility to monitor for compliance. Any/all negative findings and or errors will be corrected time of discovery. Aggregate findings of these audits will be reported to the Qual Assurance Committee quarterly for review analysis and recommendations.	ts 30 ave tion ler. be en at ed ide liso g for /or kly ged /e at of allity	
		ntation of the papers that			review, analysis, and recommendations for change in facility policy, procedure,	6	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495002	B. WING		07/09/2019
	ROVIDER OR SUPPLIER	ID REHABILITATION	•	STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 622	RN/LPNs (registere nurses) Any time a ER/Hospital, you me notes all papers you They will need the final form of the surveyor of their care. So Copy of MAR (morecord)/prn (as need 3. Copy of face shed). Copy of DNR (do have one 5. Copy of their care. You must document hospital when you of you talked with RP of the surveyor intervity of the surveyor interv	o the emergency form read "Attention all d nurses/licensed practical resident goes to the ust document in the nursing u sent with them. ollowing sent. edication administration ded) sheet et not resuscitate) form if they e plan t who you talked to at the hall to give report. Also that (responsible party)." g note did not have aper work sent to the hospital	F 62	and/or practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		495002	B. WING			7/09/2019	
	ROVIDER OR SUPPLIER	D REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP COD 3823 FRANKLIN RD, SW ROANOKE, VA 24014		7770072010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 622	transfers/ombudsmafrom the DON. The would expect the nuinformation was sent hospital. The DON's nurses to document they talked to at the The surveyor review transfers on 7/9/19. Discharge Notice" reand/or resident reprenotified in writing of a. The reason for the b. The effective date c. The location to what transferred or dischad. A statement of the transfer or dischad. A statement of the entity requests; (2) information abous submit an appeal for (3) how to get assist process; e. The facility bed-hospitals. The reasons for the documented in the No further information exit conference on 7.2. For Resident #34 document information provider when the R the hospital.	sted the facility policy for an notification, and bed hold DON was asked if he/she rsing staff to document what at with the resident to the stated he/she would expect in the clinical record who hospital and document such. The policy titled "Transfer or ead in part "3. The resident esentative (sponsor) will be the following information: the transfer or discharge of the transfer or discharge of the transfer or discharge expected in the information is being arged to resident's rights to appeal arge, including; as, email and telephone which receives such thow to obtain, complete and ance completing the appeal cold policy; the transfer or discharge will be resident's medical record."	F 62				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION B	(X3) DATE SURVEY COMPLETED
		495002	B. WING	 	07/09/2019
	ROVIDER OR SUPPLIER DANOKE NURSING A	ND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014	,
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 622	included but not lim mellitus, arthritis, d pulmonary disease. The admission MD ARD (assessment assigned the Resident status) scorn Resident #34's clin 07/09/19. It contain which read in part Resident's husband due to temp and fur from ER at (nam time." and "06/29/1 to hospital a copy of administration recowas sent." Surveyor spoke with nursing) on 07/08/2 was sent when a Resident which read as follor "Attention all RN/LI nurses/licensed proposition and the DON provided which read as follor "Attention all RN/LI nurses/licensed proposition and the sent with them They will need the 1. Transfer sheet 2. Copy of MAR/F 3. Copy of face st 4. Copy of DNR (cone 5. Copy of their contains the sent sent sent sent sent sent sent sen	mitted on 07/02/19. Diagnoses hited to hypertension, diabetes ementia, chronic obstructive, hip fracture and glaucoma. S (minimum data set) with an reference date) of 05/09/19 lent a BIMS (brief interview for e of 15 out of 15. ical record was reviewed on need a nurse's progress note, 106/29/19 1:30 pmcalled d. She was sent to ER for eval ll code. Have not had anything e omitted) or husband at this 9 2 pm When Resident went of meds/MARS (medication rd), face sheet, transfer sheet the DON (director of 19 and asked what information esident was transferred and the surveyor with a checklist, ws: PNs (registered actical nurse) t goes to the ER/Hospital, you the nursing notes all papers following sent. PRN (as needed) sheet neet do not resuscitate) if they have	F 62		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG	(X3)	3) DATE : COMPI	SURVEY LETED
		495002	B. WING			07/0	09/2019
	ROVIDER OR SUPPLIER DANOKE NURSING AND	REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		JLD BE		(X5) COMPLETION DATE
F 623 SS=D	you talked with RP (real There was no document of a report given to the spoken with at the horogonal decoration of a report given to the spoken with at the horogonal decoration of a report given to the hospital was disadministrative team of at approximately 1:20. No further information Notice Requirements CFR(s): 483.15(c)(3). Sequence a facility transport resident, the facility modified in the reasons for the manual decoration of the Long-Term Care Ombound (ii) Record the reason discharge in the resident and	Il to give report. Also that esponsible party)." entation in the clinical record e hospital or the person spital. There was also no copy of the Resident's care ne DON stated that she ses to document whom they pital. commenting information sent scussed with the luring a meeting on 07/09/19 pm n was provided prior to exit. Before Transfer/Discharge e-(6)(8) before transfer or discharge and ove in writing and in a r they understand. The copy of the notice to a Office of the State oudsman. In sefor the transfer or lent's medical record in legraph (c)(2) of this section; ce the items described in its section.		623			8/23/19

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		495002	B. WING			07/	09/2019
	ROVIDER OR SUPPLIER DANOKE NURSING AND	REHABILITATION	•	STREET ADDRESS, 3823 FRANKLIN RI ROANOKE, VA 2		•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	(c)(8) of this section, discharge required un made by the facility a resident is transferred (ii) Notice must be made before transfer or disc (A) The safety of individual be endangered under this section; (B) The health of individual be endangered, under this section; (C) The resident's heallow a more immedia under paragraph (c)(10) An immediate transferred by the residual under paragraph (c)(10) An immediate transferred by the resideunder paragraph (c)(10) A resident has not days. §483.15(c)(5) Contennotice specified in paramust include the follo (i) The reason for tra (ii) The effective date (iii) The location to what transferred or discharative (iv) A statement of the including the name, and telephone number receives such request to obtain an appeal for completing the form a hearing request; (v) The name, address	d in paragraphs (c)(4)(ii) and the notice of transfer or or order this section must be to least 30 days before the door discharged. ade as soon as practicable charge when-viduals in the facility would reparagraph (c)(1)(i)(C) of viduals in the facility would reparagraph (c)(1)(i)(D) of viduals in the facility for 30 viduals of the notice. The written regraph (c)(3) of this section wing: Instead of the notice. The written regraph (c)(3) of this section wing: Instead of the notice of the section viduals in the resident is reged; In resident is appeal rights, address (mailing and email), we of the entity which ts; and information on how	F	523			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495002	B. WING _			07/09/2019	
	ROVIDER OR SUPPLIER OANOKE NURSING AN	D REHABILITATION	•	STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 623	Long-Term Care Orr (vi) For nursing faciliand developmental of disabilities, the mailitelephone number of the protection and a developmental disabilities. The protection and a developmental disabilities of the Developmental disabilities of the Developmental disabilities. Coffice of the Developmental disabilities of the Developmental disabilities of the Long-Term Cathe facility, and the residence of the State Survey of State Long-Term Cathe facility, and the residence of the Institute of the State Survey of the State Surv	nbudsman; ity residents with intellectual disabilities or related ng and email address and if the agency responsible for dvocacy of individuals with bilities established under Part ntal Disabilities Assistance t of 2000 (Pub. L. 106-402, . 15001 et seq.); and lity residents with a mental isabilities, the mailing and elephone number of the for the protection and lals with a mental disorder lee Protection and Advocacy duals Act.	F 6	F623 Corrective Action(s):			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	MULTIPLE CONSTRUCTION JILDING		(X3) DATE SURVEY COMPLETED	
		495002	B. WING _			07/	09/2019
NAME OF PR	ROVIDER OR SUPPLIER		<u> </u>	S1	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
				38	323 FRANKLIN RD, SW		
SOUTH RO	DANOKE NURSING AN	D REHABILITATION			OANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	Continued From pag	ge 47	F 6	323			
	Resident's RP (resp				Resident #34\squares responsible party and state ombudsman office have been notified that the facility failed to provide discharge/transfer notice for the resident\squares transfer to the hospital on 6/28/19.		
	the local state ombubeen transferred to the Resident #34 was at 05/02/19 and readm	the facility staff failed to notify dsman that the Resident had the hospital. dmitted to the facility on itted on 07/02/19. Diagnoses ted to hypertension, diabetes			Resident #37 s responsible party and state ombudsman office have been notified that the facility failed to provide written discharge/transfer notice for the resident s transfer to the hospital on 5/24/19.	e a	
	mellitus, arthritis, de pulmonary disease,	mentia, chronic obstructive hip fracture and glaucoma.			Identification of Deficient Practices/Corrective Action(s): All other residents discharged and/or		
	ARD (assessment re	(minimum data set) with an eference date) of 05/09/19 ent a BIMS (brief interview for a first out of 15.			transferred from the facility may have been affected. The Social Services Director and/or Admissions Director wi conduct a 100% audit of all residents whave been discharged and/or transferr	vho	
	07/09/19. It contains which read in part "CResident's husband due to temp and full from ER at (name time." and "06/29/19	cal record was reviewed on ed a nurse's progress note, 106/29/19 1:30 pmcalled . She was sent to ER for eval code. Have not had anything e omitted) or husband at this 12 pm When Resident went meds/MARS (medication	risk will be corrected at time and the required notification residents□ responsible part anything ombudsman will be made. A lncident & Accident Form w completed for each negative		in the past 60 days. Residents identifier risk will be corrected at time of discover and the required notifications to the residents responsible party and the sombudsman will be made. A facility Incident & Accident Form will be completed for each negative finding.	ery	
	administration record was sent." Surveyor spoke with nursing) on 07/09/19 regarding notification ombudsman. DON sethe ombudsman. Su	d), face sheet, transfer sheet the DON (director of at approximately 11 am			Systemic Change(s): Facility policy and procedures have be reviewed. No revisions are warranted this time. The Administrator and/or Regional Nurse Consultant will inservie the facility social worker(s) and nurse administration on the requirement that resident sresponsible party and the sombudsman be notified of resident	at ce sing a	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED		
		495002	B. WING		0.	7/09/2019
	ROVIDER OR SUPPLIER) REHABILITATION	:	STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014	<u>, </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 623	the ombudsman, and of it". The surveyor request facility policy entitled Notice" which read in provide a Resident a representative (sponwritten notice of an indischarge. 2. Under the notice will be given but before the transfer is necessary and the Resident's manager is necessary and the Resident's necessary and the administrative (Ombudsman." The concern of not no ombudsman of Residenting the administrative (O7/09/19) at approximation 2. The facility staff factor of transfer to the residenting the nesident's appeal information on how the hospital, failed the resident's appeal information on how the notification when Residenting the nospital. The clinical record of 7/7/19 through 7/9/15	ted that she did not notify I "This is the first I've heard ted and was provided with a "Transfer or Discharge part, "Our facility shall ind/or the Resident's sor) with a thirty (30)-day impending transfer or the following circumstances, en as soon as it is practicable er or discharge: a. The for the Resident's welfare eeds cannot be met in the the notice will be sent to the ong-Term Care otifying the local state dent transfers was discussed we team during a meeting on nately 1:20 pm. In was provided prior to exit. ailed to provide written notice dent and the resident the resident was transferred to provide a statement of rights, failed to provide to obtain an appeal form and stion of such and failed to lical record ombudsman sident #37 was reviewed	F 623	discharges/transfers. Monitoring: The Social Services Director wiresponsible for maintaining com The Social worker, and/or Admi Director will conduct chart audit of all residents who have been and/or transferred from the facil negative findings and or errors corrected at time of discovery a disciplinary action will be taken needed. Aggregate findings of taudits will be reported to the Quassurance Committee quarterly review, analysis, and recommen for change in facility policy, productive.	npliance. issions is weekly discharged lity. Any/all will be nd as these uality ofor	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
		495002	B. WING _		0	7/09/2019
	ROVIDER OR SUPPLIER DANOKE NURSING ANI	D REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP COD 3823 FRANKLIN RD, SW ROANOKE, VA 24014)E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 623	limited to pneumonia gastroesophageal re hypertension, hypoth neuropathy, anxiety, syncope, first degree hyperlipidemia, and Resident #37's quart set) with an assessm 5/16/19 assessed thinterview for mental structure for full structure for mental structure for full structure for mental structure for full structure for	ses that included but not a, urinary tract infection, flux disease (GERD), hyroidism, peripheral fibromyalgia, dementia, near a AV (atrioventricular), chronic kidney disease. Serly MDS (minimum data nent reference date (ARD) of the resident with a BIMS (brief status) as 15/15. Is note dated 5/24/19 at 9:00 (dent) sent to hospital (name nughter's) request d/t (due to) ry infection), UTI (urinary SOB (shortness of breath) (art. VS (vital signs) @ (at) (at) (at) (at) (at) (at) (at) (at)	F 6	23		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		495002	B. WING		07/09/2019		
	ROVIDER OR SUPPLIER DANOKE NURSING AN	ND REHABILITATION	:	STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUNDER CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION		
F 623	record)/prn (as nee 3. Copy of face she 4. Copy of DNR (do have one 5. Copy of their care You must documen hospital when you of you talked with RP. The 5/24/19 nursing documentation that provided to the resire representative, the and documentation ombudsman was in The surveyor interve 7/9/19 at 11:00 a.m ombudsman was in transfer to the hospital she had not informed transfers to the hospital she ponditional transfers to the ponditional transfers. The ponditional transfers to the ponditional transfer	edication administration ded) sheet et o not resuscitate) form if they e plan It who you talked to at the call to give report. Also that (responsible party)." g note did not have written notice of transfer was dent and resident appeals process information that the state long-term care formed of the transfer. iewed the social worker on . if the state long-term care formed of Resident #37's ital. The social worker stated ed the ombudsman of pital. "First I've heard of it." interviewed on 7/9/19 at 12:01 notice provided to the resident presentative about the stated the resident's families d given a copy of the transfer	F 623	*			
	The surveyor review transfers on 7/9/19. Discharge Notice" r and/or resident reprinotified in writing of a. The reason for the	wed the facility policy on The policy titled "Transfer or ead in part "3. The resident resentative (sponsor) will be the following information: the transfer or discharge e of the transfer or discharge					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495002	B. WING _			07/	09/2019
	ROVIDER OR SUPPLIER DANOKE NURSING AND	REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014	Ē		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF COR X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 625 SS=D	transferred or dischard. A statement of the the transfer or dischard. (1) the name, address number of the entity virequests; (2) information about submit an appeal form (3) how to get assistate process; e. The facility bed-hold. The reasons for the bedocumented in the bedocumented in the No further information exit conference on 7/8 Notice of Bed Hold Poce (5): 483.15(d)(1) (1) (2) (3) (4) (4) (4) (4) (4) (4) (4) (5) (4) (5) (6) (6) (6) (6) (6) (6) (7) (7) (7) (7) (7) (7) (7) (7) (7) (7	ch the information is being ged resident's rights to appeal rge, including; s, email and telephone which receives such how to obtain, complete and in; and ince completing the appeal d policy; e transfer or discharge will e resident's medical record." In was provided prior to the 19/19. Colicy Before/Upon Trinsfr (2) in bed-hold policy and returnations a resident to a hospital or therapeutic leave, the provide written information to intrepresentative that the state bed-hold policy, if resident is permitted to sidence in the nursing anyment policy in the state of this chapter, if any; y's policies regarding ch must be consistent with is section, permitting a		625			8/23/19

DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		' '	E SURVEY IPLETED	
	495002	B. WING		07	7/09/2019	
	D REHABILITATION	•	STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014			
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION DATE	
(iv) The information of this section. §483.15(d)(2) Bed-h the time of transfer of hospitalization or the facility must provide resident representat specifies the duratio described in paragra. This REQUIREMEN by: Based on staff inter and clinical record reto provide to the res representative at the written notice that sped-hold policy for 2 #34 and Resident #3. The findings include 1. The facility staff f and the resident repinformation about be was transferred to the the clinical record of 7/7/19 through 7/9/1 admitted to the facility 5/28/19 with diagnost limited to pneumonia gastroesophageal rehypertension, hypotlineuropathy, anxiety, syncope, first degree	specified in paragraph (e)(1) cold notice upon transfer. At of a resident for erapeutic leave, a nursing to the resident and the ive written notice which n of the bed-hold policy aph (d)(1) of this section. T is not met as evidenced view, facility document review eview, the facility staff failed ident and the resident etime of transfer/discharge pecifies the duration of the et of 24 residents (Resident 87). d: cailed to provide Resident #37 resentative written ed-hold when the resident he hospital 5/24/19. f Resident #37 was reviewed 9. Resident #37 was ty 1/10/19 and readmitted sees that included but not a, urinary tract infection, effux disease (GERD), hyroidism, peripheral fibromyalgia, dementia, near et AV (atrioventricular),	F 62	F625 Corrective Action(s): Resident #37 and their RP have I notified that the facility failed to re offer notice of bed-hold when Re: #37 was transferred to the hospit 5/24/19. An Incident and Acciden has been completed for this resid Resident #34 and their RP have I notified that the facility failed to re offer notice of bed-hold when Re: #34 was transferred to the hospit 6/29/19. An Incident and Acciden has been completed for this resid Identification of Deficient Practice Corrective Action(s): All other residents could potential affected. The Bed-Hold policy and are now kept at the nursing static after hour stransfers to the hosp completed by the charge nurse. Social Services director/Admission	eview and sident al on t form lent. been eview and sident al on t form lent. e(s) and lly be d forms on for bital to be The ons		
Resident #37's quar	terly MDS (minimum data					
	CONTINUED OR SUPPLIER SUMMARY S (EACH DEFICIEN REGULATORY OF SUPPLIER Continued From page (iv) The information of this section. §483.15(d)(2) Bed-h the time of transfer of hospitalization or the facility must provide resident representat specifies the duration described in paragra. This REQUIREMEN by: Based on staff inter and clinical record reto provide to the resident representative at the written notice that sped-hold policy for 2 #34 and Resident #35. The findings include 1. The facility staff fand the resident repinformation about be was transferred to the facility of the clinical record of 7/7/19 through 7/9/1 admitted to the facility staff fand the resident repinformation about be was transferred to the facility of the clinical record of 7/7/19 through 7/9/1 admitted to pneumonic gastroesophageal resident repinformation, hypotineuropathy, anxiety, syncope, first degree hyperlipidemia, and	A95002 ROVIDER OR SUPPLIER DANOKE NURSING AND REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 52 (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced	A BUILDING 495002 ROVIDER OR SUPPLIER DANOKE NURSING AND REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 52 (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to provide to the resident and the resident representative at the time of transfer/discharge written notice that specifies the duration of the bed-hold policy for 2 of 24 residents (Resident #34 and Resident #37). The findings included: 1. The facility staff failed to provide Resident #37 and the resident representative written information about bed-hold when the resident was transferred to the hospital 5/24/19. The clinical record of Resident #37 was reviewed 7/7/19 through 7/9/19. Resident #37 was admitted to the facility 1/10/19 and readmitted 5/28/19 with diagnoses that included but not limited to pneumonia, urinary tract infection, gastroesophageal reflux disease (GERD), hypertension, hypothyroidism, peripheral neuropathy, anxiety, fibromyalgia, dementia, near syncope, first degree AV (atrioventricular), hyperlipidemia, and chronic kidney disease.	A BUILDING 495002 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, WA 24014 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR I.S.C IDENTIFYING INFORMATION) Continued From page 52 (iv) The information specified in paragraph (e)(1) of this section. \$483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to provide to the resident and the resident representative at the time of transfer/discharge written notice that specifies the duration of the bed-hold policy for 2 of 24 residents (Resident #37 and their RP have notified that the facility failed to refer notice of bed-hold when Reference to the hospit 5/24/19. An incident and Acciden has been completed for this resident was transferred to the hospit 5/24/19. Resident #37 was transferred to the hospit 6/29/19 with diagnoses that included but not imformation about bed-hold when the resident was transferred to the hospit 16/29/19 with diagnoses that included but not imited to pneumonia, urinary tract infection, gastroesophageal reflux disease (GERD), hyperfension, hypothyroidism, peripheral neuropathy, anxiety, fibrovaylajia, dementia, near syncope, first degree AV (atrioventricular), hyperfipidemia, and chronic kidney disease.	A BUILDING A STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY YULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 52 (iv) The information specified in paragraph (e)(1) of this section. S483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to provide to the resident representative written notice that specifies the duration of the bed-hold policy of the resident state of the section. This REQUIREMENT is not met as evidenced by: The findings included: The findings included: The findings included: The facility staff failed to provide Resident #37 was transferred to the hospital on 5/24/19. An Included but not limited to the facility 1/10/19 and readmitted 7/29/19. An Included but not limited to preumonia, urinary tract infection, gastroesophageal reflux disease (GERD), hypertension, hypothyroidism, peripheral neuropathy, anxiety, fibromyalgia, dementia, near syncope, first degree AV (atrioventricular), hyperlipidemia, and chronic kidney disease.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G		TE SURVEY MPLETED
		495002	B. WING		0	7/09/2019
	ROVIDER OR SUPPLIER DANOKE NURSING ANI	DREHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 625	set) with an assessm 5/16/19 assessed the interview for mental state of the nursing progress a.m. read, "Rsd (resionitted) per dtr's (da URI (upper respirato tract infection) with Stand severe discomfortransfer 129/70 (block (respirations), 98.8 (staturation level) 2L (The clinical record distant written notice of provided to the resid representative when transferred to the hormore than the properties of the DON was interview p.m. about written not and the resident representative than the done. The DON stated as a done of the surveyor review transfers on 7/9/19. Discharge Notice" reand/or resident representified in writing of the surveyor stated and the resident representified in writing of the surveyor review transfers on 7/9/19.	nent reference date (ARD) of the resident with a BIMS (brief status) as 15/15. Is note dated 5/24/19 at 9:00 dent) sent to hospital (name aughter's) request d/t (due to) ry infection), UTI (urinary BOB (shortness of breath) and pressure), 86 (pulse), 24 temperature), 93% (oxygen liters) O2 (oxygen)." Ind not have documentation bed hold information was ent and the resident Resident #37 was spital 5/24/19. Indexed on 7/9/19 at 12:01 of the provided to the resident resentative about bed holds. Of 6/1/19, bed holds are being the date of the surveyor requested the	F 62	,	s are cial Director nserviced e Regional hold e and licy. Dr Social le for harges from by the Social cions hold the time of Any/all cted at time ese audits y Assurance y, analysis, nge in	
	c. The location to wh transferred or discha	of the transfer or discharge ich the information is being rged resident's rights to appeal				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495002	B. WING		07/09/2019
	ROVIDER OR SUPPLIER OANOKE NURSING A	ND REHABILITATION		,	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 625	the transfer or disci (1) the name, addronumber of the entity requests; (2) information about submit an appeal of (3) how to get assist process; e. The facility bed-15. The reasons for be documented in the entity conference on the commentation of the document of the entity conference on the entity of the enti	harge, including; ess, email and telephone y which receives such ut how to obtain, complete and orm; and stance completing the appeal hold policy; the transfer or discharge will the resident's medical record." ion was provided prior to the 7/9/19. At the facility staff failed to fication of a bed hold offer was transferred to the admitted to the facility on mitted on 07/02/19. Diagnoses hited to hypertension, diabetes ementia, chronic obstructive, hip fracture and glaucoma. S (minimum data set) with an reference date) of 05/09/19 lent a BIMS (brief interview for	F 62	5	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495002	B. WING		07/09/2019
	ROVIDER OR SUPPLIER DANOKE NURSING AND	REHABILITATION	:	STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 625	was sent." The surve information regarding Surveyor spoke with nursing) on 07/09/19 regarding the offer of #34. The DON stated until we are told other The concern of not of discussed with the acmeeting on 07/09/19 No further information Quality of Care), face sheet, transfer sheet eyor could not locate the offer of a bed hold.	F 625		8/23/19
SS=D	applies to all treatment facility residents. Base assessment of a resident residents received accordance with profestate, the comprehestate plan, and the resident re	ndamental principle that and care provided to ed on the comprehensive dent, the facility must ensure treatment and care in essional standards of tensive person-centered sidents' choices. This is not met as evidenced liew, clinical record review, ion pass and pour ty staff failed to follow of 24 Residents, Resident		F684 Corrective Action(s): Resident #49□s attending physician w notified that the facility failed to admini eye ointment as ordered. A facility Medication Error form was completed this incident. Identification of Deficient	ster

PRINTED: 04/29/2022 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495002	B. WING _			07	7/09/2019
NAME OF P	ROVIDER OR SUPPLIER	L	<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 07	103/2013
					23 FRANKLIN RD, SW		
SOUTH R	OANOKE NURSING	AND REHABILITATION			OANOKE, VA 24014		
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG	(EACH DEFIC	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	Х	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	COMPLETION DATE
F 684	Continued From p	page 56	F	684			
	eye ointment as o	ordered by the physician. The			Practices/Corrective Action(s):		
	order read to adm	ninister to the left eye when in			All other residents receiving medicati	ons	
		ministered the medication to			may have potentially been affected.		
	both eyes.				DON and/or designee will conduct a		
					audit of all resident s current physici		
		v revealed that Resident #49			orders and MARs to identify resident		
		d to the facility on 03/01/19. ed, but were not limited to,			risk. Residents identified at risk will b corrected at time of discovery and	3	
	•	er eyelid, dementia without			theattending physicians will be notifie	d of	
		pance, hypertension, dry eyes,			each negative finding and a facility	u oi	
		epression, and insomnia.			Incident & Accident Form will be		
	, ,	,			completed for each negative finding.		
	Section C (cognit	ive patterns) of the Residents					
	quarterly MDS (m	inimum data set) assessment			Systemic Change(s):		
	1	essment reference date) of			Facility policy and procedures have b		
		I a BIMS (brief interview for			reviewed. No revisions are warrante	d at	
	,	mmary score of 6 out of a			this time. The nursing assessment		
	possible 15 points	5.			process as evidenced by the 24 Hour		
	On 07/09/10 hagi	nning at approximately 9:24			Report and documentation in the med		
	_	nning at approximately 8:34 rs observed RN (registered			record and physician orders remains source document for the developmen		
		e and administer Resident #49's			and monitoring of the provision of car		
	, , ,	ons. During this observation RN			which includes, obtaining, transcribin		
		administering the Residents			completing physician medication &	j and	
		cial eye ointment (refresh pm			treatment orders. The DON and/or		
		N #1 was observed to administer			Regional nurse consultant will inservi	ce all	
	this medication to	both eyes.			licensed staff on the procedure for		
					obtaining, transcribing, and completing	ıg	
		nical record included orders for			physician ordered medication and		
		by ophthalmic route 2-3 times			treatment orders.		
	every day into the	e left eye.			NA iA ia		
	During on intervie	w with PN #1 on 07/09/10 of			Monitoring:		
	_	ew with RN #1 on 07/08/19 at 28 a.m., RN #1 verbalized to the			The DON will be responsible for maintaining compliance. The DON ar	nd/or	
		had administered this			designee will perform weekly MAR at		
	medication into be				coinciding with the care plan calenda		
	oaioation into bi	54. 5,56.			monitor for compliance. Any/all negati		
	The administrative	e staff were notified of the			findings and or errors will be correcte		
		during a meeting with the survey			time of discovery and disciplinary act		

Facility ID: VA0230

	DF DEFICIENCIES CORRECTION				TE SURVEY MPLETED	
		495002	B. WING			7/09/2019
	ROVIDER OR SUPPLIER DANOKE NURSING AND	REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 684 F 695 SS=D	No further information provided to the survey conference.	approximately 3:09 p.m. In regarding this issue was by team prior to the exit stormy Care and Suctioning	F 68	will be taken as needed. Aggregating findings of these audits will be repethe Quality Assurance Committee quarterly for review, analysis, and recommendations for change in foolicy, procedure, and/or practices.	ported to e d acility	8/23/19
	tracheostomy care and The facility must ensure needs respiratory care care and tracheal succare, consistent with practice, the compreheare plan, the resider and 483.65 of this sull This REQUIREMENT by: Based on observation record review, the fact that 1 of 24 Residents received respiratory of professional standard. The findings included The facility staff failed 30 received 3 liters of orders. Resident #30 was a 9	and tracheal suctioning. The that a resident who e, including tracheostomy stioning, is provided such professional standards of the sive person-centered that' goals and preferences, topart. This is not met as evidenced In, staff interview, and clinical consistent with the survey sample that consistent with the of practice, Resident # Toxygen per physician's 1 to ensure that Resident # Toxygen per physician's 1 to ensure that Resident # Toxygen per physician's 1 to ensure that Resident # Toxygen per physician's 1 to ensure that Resident # Toxygen per physician's		F 695 Corrective Action(s): Resident #30 has had their oxyge administration orders clarified wit attending physician. The attendin physician has been notified that F #30 did not receive oxygen at the flow rate as ordered by the physic facility Incident & Accident form h completed for this incident. Identification of Deficient Practice Corrective Action(s): All residents receiving oxygen the may have potentially been affected 100% review of all resident □s oxyorders will be conducted by the D and/or designee to identify reside	h the g Resident e correct cian. A has been es & erapy ed. A ygen DON	

	TEMENT OF DEFICIENCIES OPLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED		
		495002	B. WING _			07/09/2019
	ROVIDER OR SUPPLIER OANOKE NURSING AN	D REHABILITATION	•	STREET ADDRESS, CITY, STATE, Z 3823 FRANKLIN RD, SW ROANOKE, VA 24014	IP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ((EACH CORRECTIVE CROSS-REFERENCED DEFICE)	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 695	MDS (minimum data Resident # 30 was a with an ARD (assess 5/6/19. Section C of patterns. In Section documented that Reinterview for mental which indicated that status was severely MDS assesses speciand programs. In Sedocumented that Reoxygen within the last back period for the 5 Resident # 30 had c signed by the physic 30's orders included (oxygen) ae 3L/min (nasal cannula) at all showers only." On 7/7/19 at 1:32 pm Resident # 30's room representative intervidaughter. The surve 30 was receiving oxysurveyor observed the delivered oxygen to deliver 2 liters of oxy On 7/9/19 at 9:03 am (registered nurse) of room as she received The surveyor and RI concentrator that deliver concentrator that deliver concentrator that deliver concentrator oxygen concentrator	at 1:59 pm. The most recent set) assessment for admission assessment sment reference date) of the MDS assesses cognitive C0500, the facility staff sident # 30 had a BIMS (brief status) score of 7 out of 15, Resident # 30's cognitive impaired. Section O of the ial treatments, procedures, ction O0100, the facility staff sident # 30 had received at 14 days during the look /6/19 ARD. Jurrent orders that were ian on 7/1/19. Resident # but were not limited to, "O2 is liters per minute) via NC is times may remove for an, the surveyor was in a conducting a Resident iew with Resident # 30's yor observed that Resident # ygen via nasal cannula. The nat the concentrator that Resident # 30 was set to	F6	risk. Residents found to corrected at the time of facility Incident & Accide completed for each item. Systemic Change(s): The facility policy and proxygen administration hand no changes were we time. All licensed nursing inserviced by the DON and Nurse Consultant on the procedure for accurate administration and moniphysician order. Inserviced delivery of oxygen per procedure for accurate administration and moniphysician order. Inserviced delivery of oxygen per procedure for accurate administration and moniphysician order. Inserviced delivery of oxygen per procedure for accurate administration and moniphysician order. Inserviced delivery of oxygen per procedure for oxygen per procedure for discovery and application of the DON and addisciplinary action will be needed. All negative fine to the Quality Assurance review, analysis, and refor change in facility pol and/or practice.	discovery. A ent form will be n discovered. rocedure for has been reviewed varranted at this g staff will be and/or Regional e facility policy and oxygen itoring per ces will include the ohysician order. e for maintaining and/or designee of all residents r for compliance. I be corrected at ppropriate e taken as dings will reported e Committee for ecommendations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
	495002	B. WING _			07/09/2019
NAME OF PROVIDER OR SUPPLIER SOUTH ROANOKE NURSING A	ND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	
Resident # 30. RN was not receiving or ordered rate of 3 lit "I will fix it." On 7/9/19 at 1:20 p was made aware or No further informat presented to the suconference on 7/9/Pharmacy Srvcs/Pr CFR(s): 483.45(a)(§483.45 Pharmacy The facility must predrugs and biological them under an agreg §483.70(g). The faresonnel to admin permits, but only ureal licensed nurse. §483.45(a) Proceding pharmaceutical serthat assure the accordispensing, and additional biologicals of the must employ or obligher maceist who- §483.45(b) Service must employ or obligher maceist who-	wed the current orders for # 1 agreed that Resident # 30 baygen at the physician ers per minute. RN # 1 stated, om, the administrative team of the findings as stated above. It ion regarding this issue was survey team prior to the exit 19. rocedures/Pharmacist/Records b)(1)-(3)		755		8/23/19

PRINTED: 04/29/2022 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495002	B. WING _			07/	09/2019
NAME OF PI	ROVIDER OR SUPPLIER	-		ST	REET ADDRESS, CITY, STATE, ZIP CODE		00.20.10
COUTU D	DANOKE MUDSING A	ND DELIABILITATION		38	23 FRANKLIN RD, SW		
5001H K	DANOKE NURSING A	ND REHABILITATION		R	OANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 755	Continued From pa	age 60	F	755			
	§483.45(b)(2) Esta	blishes a system of records of tion of all controlled drugs in					
	order and that an a is maintained and p	ermines that drug records are in account of all controlled drugs periodically reconciled. NT is not met as evidenced					
	Based on staff inte facility document re pass and pour obset to ensure a medica	erview, clinical record review, eview, and during a medication ervation, the facility staff failed ation was available for of 24 Residents, Resident			F755 Corrective Action(s): Resident 49 □s attending physician has been notified that the facility failed to ensure that the physician ordered Namzaric medication was available from pharmacy for administration to Resider	m	
	The findings includ	ed:			#49. A facility Incident and Accident for has been completed for this incident.		
	The facility staff did	I not have the physician					
		refresh tears available for			Identification of Deficient Practices &		
		s resulted in Resident #49			Corrective Action(s):		
	missing their sched	luled dose at 9:00 a.m.			All residents may have potentially been affected. A 100% review of all resident		
	The record review	revealed that Resident #49			medication orders has been conducted		
		to the facility on 03/01/19.			the DON/designee to identify residents		
		d, but were not limited to,			risk. Residents found to be at risk due t		
	_	eyelid, dementia without			medications being unavailable from the	,	
		ince, hypertension, dry eyes,			pharmacy will be corrected at time of		
	bladder spasms, de	epression, and insomnia.			discovery and their attending physician	s	
					will be notified. A facility Incident and		
	, -	e patterns) of the Residents			Accident form has been completed for		
		nimum data set) assessment			each.		
	,	ssment reference date) of					
		a BIMS (brief interview for			Systemic Changes:		
		mary score of 6 out of a			The Pharmacy Policy and Procedure h	as	
	possible 15 points.				been reviewed and no changes are		
	The Decidents slimi	inal report included a			warranted. All licensed nursing staff ha		
	i i ne residents cim	cal record included a			been inserviced by DON and/or Region	ıaı	

Facility ID: VA0230

PRINTED: 04/29/2022 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495002	B. WING _		07/09/2019
	ROVIDER OR SUPPLIER	AND REHABILITATION	•	STREET ADDRESS, CITY, STATE, ZIP 3823 FRANKLIN RD, SW ROANOKE, VA 24014	CODE
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLETION THE APPROPRIATE COMPLETION DATE
F 755	drop into both eye The administration 9:00 a.m., 12:00 p On 07/08/19 begin a.m. the surveyor #1 during a medic observation. Durind did not observe the Residents refresh Surveyor that she refresh tears for a obtain them from dispensing system. On 07/08/19 at 10 the surveyor that in the facility system pharmacy would shose, and the phy Indicating Resider a.m. dose. The administrative regarding the Resimeeting with the sp.m. The facility policy Shortages/UnavairUpon discovery supply of a medication from the medication from the medication from the surveyor the medication from the medication from the surveyor supplementation from the surveyor	or refresh tears instill one 1 as four times daily for dry eyes. In times were documented as 5.m., 5:00 p.m., and 9:00 p.m. Inning at approximately 8:34 abserved RN (registered nurse) action pass and pouring this observation, the surveyor in the nurse administer the tears. 28 a.m., RN #1 verbalized to the did not have the Residents dministration and she would their automatic medication in. 243 a.m., RN #1 verbalized to the eye drops were not available term for administration, the send before the next scheduled resician had been notified. In the eye drops were not available that the eye drops were not available to the eye drops were not available to the eye drops were not available that the eye drops were not available to the eye drops were not available that the eye drops were n	F 7	Nurse Consultant on the I Procedure for medication to included medications the unavailable or do not arrivitimely from the pharmacy administration. The inservathe steps the nurses show medication not be delivered the pharmacy. Monitoring: The DON is responsible frompliance. The DON and will conductweekly audits MAR and seach week to consultability of all ordered of negative findings will be of time of discovery. Result will be reported to the Quantity of the Committee for review, and recommendations for charpolicy, procedure, and/or	administration nat are ye at the facility for rice will include ald take should a ed timely from or maintaining d/or designee of resident ofirm the drugs. All corrected at the s of the reviews ality Assurance alysis, and nge in facility

Facility ID: VA0230

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	FIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		495002	B. WING _		C	7/09/2019
	ROVIDER OR SUPPLIER DANOKE NURSING AND	REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CO 3823 FRANKLIN RD, SW ROANOKE, VA 24014	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 755	from the pharmacy Si the medication is not the nurse will notify p emergency delivery of (back-up) third party	esident's medication vill obtain the medication TAT box/med dispense. If available in the STAT box, harmacy and arrange for an or use of an emergency	F.	755		
F 758 SS=D	conference.		F	758		8/23/19
	§483.45(c)(3) A psyc affects brain activities processes and behave	hotropic drug is any drug that sassociated with mental vior. These drugs include, drugs in the following				
	resident, the facility no \$483.45(e)(1) Resided psychotropic drugs and unless the medication specific condition as a in the clinical record; \$483.45(e)(2) Resided drugs receive gradual behavioral intervention	ents who have not used re not given these drugs in is necessary to treat a diagnosed and documented ents who use psychotropic I dose reductions, and				

FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F758 Continued From page 63 drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and sare limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure that 2 of 24 Residents in the survey sample were free of unnecessary psychotropic medications, Resident # 13 and Resident # 14. The findings included: 1. The facility staff failed to appropriately monitor Resident # 13 for behaviors, side effects, and effectiveness associated with the use of Risperidone. Resident # 13 was an 87-year-old-female who		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
SOUTH ROANOKE NURSING AND REHABILITATION SOUTH ROANOKE NURSING AND REHABILITATION (MA) ID SEAMMARY STATEMENT OF DEFICIENCIES SEAMMARY STATEMENT OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SEAMMARY STATEMENT OF DEFICIENCIES SEAMMARY STATEMENT OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SEAMMARY STATEMENT OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SEAMMARY STATEMENT OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SEAMMARY STATEMENT OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SEAMMARY STATEMENT OF CROSS-REFERENCED TO THE APPROPRIATE SEAMMARY STATEMENT OF THE APPROPRIATE SEAMMARY SHAPPENDED SEAMMARY SHA			495002	B. WING		07/09/2019
FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 758 Continued From page 63 drugs; \$483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and \$483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in \$483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order. \$483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the residents or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure that 2 of 24 Residents in the survey sample were free of unnecessary psychotropic medications, Resident # 13 and Resident # 14. The findings included: 1. The facility staff failed to appropriately monitor Resident # 13 for behaviors, side effects, and effectiveness associated with the use of Risperidone. Resident # 13 was an 87-year-old-female who			ND REHABILITATION		3823 FRANKLIN RD, SW	,
drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure that 2 of 24 Residents in the survey sample were free of unnecessary psychotropic medications, Resident # 13 and Resident # 14. The findings included: 1. The facility staff failed to appropriately monitor Resident # 13 for behaviors, side effects, and effectiveness associated with the use of Risperidone. Resident # 13 was an 87-year-old-female who	PRÉFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES	D BE COMPLETION
Risperidone. Resident # 13 was an 87-year-old-female who	F 758	systems of the control of the contro	dents do not receive pursuant to a PRN order tion is necessary to treat a condition that is documented d; and orders for psychotropic drugs tys. Except as provided in the attending physician or the period or she should document their dent's medical record and the for the PRN order. orders for anti-psychotic to 14 days and cannot be the attending physician or the eattending physician or the	F 75	F 758 Corrective Action(s): Resident 13□s attending physician a consulting pharmacist was notified to resident #13 did not receive appropaint psychotropic drug monitoring for the physician ordered Risperidone. Resident #13□s physician and consulting pharmatic has reviewed resident 13□s medical regime and made adjustments to the	hat riate sident macist tion
was admitted to the facility on 9/1/16. Diagnoses Resident #14□s attending physician and		Risperidone. Resident # 13 was	an 87-year-old-female who		Accident form was completed for thi incident.	s

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		SURVEY PLETED
		495002	B. WING _			07	/09/2019
NAME OF PR	ROVIDER OR SUPPLIER		1	ST	REET ADDRESS, CITY, STATE, ZIP CODE	,	00/2010
				38	23 FRANKLIN RD, SW		
SOUTH RO	DANOKE NURSING AN	D REHABILITATION			DANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	Continued From pag	ge 64	F 7	758			
F 758	included but were not disease, dementia, I with behavioral dison. The clinical record for reviewed on 7/7/19 and MDS (minimum data quarterly assessmentererence date) of 40 assesses cognitive the facility staff docucognitive status was Section N of the MD Section N0410, the Resident # 13 had remedication for 7 day for the 4/16/19 ARD. The plan of care for and revised on 4/23 documented a focus "The resident has in function/dementia or r/t (related to) dx (disease." Interventic limited to, "Observe antipsychotic and residence."	ot limited to, Alzheimer's hallucinations, and psychosis rder. or Resident # 13 was at 2:20 pm. The most recent a set) assessment was a nt with an ARD (assessment 1/16/19. Section C of the MDS patterns. In Section C1000, amented that Resident # 13's a moderately impaired. S assesses medications. In facility staff documented that eccived an antipsychotic as during the look back period with the section of the moderately staff of the section of the moderately impaired. Resident # 13 was reviewed 1/19. The facility staff area for Resident # 13 as,	F 7	758	consulting pharmacist was notified that the facility staff failed to document behaviors for Resident #14 that justified an increase in the dosage of Seroquel facility Incident & Accident form was completed for this incident. Identification of Deficient Practice(s) at Corrective Action(s): All other residents receiving psychotromedications may have been potentiall affected. The DON, designee, and/or Pharmacy consultant will review the medication orders of all residents receiving psychotropic medication to identify residents without appropriate psychotropic medication monitoring or without proper documentation in the presence of a dosage increase. Any/anegative findings will be communicate the attending physicians for corrective action. A Facility Incident & Accident finding. Systemic Change(s): The facility Policy and Procedure has	ed I. A Ind Opic Y	
	promptly."	d resident # 13's current			been reviewed. No revisions are warranted at this time. All nursing sta will be inserviced by the DON and/or	ff	
	orders on 7/1/19. Or limited to, "Risperido milliliter) oral solutio every morning for ps On 7/7/19 at 3:05 pr	ders included but were not one 1 mg/ml (milligram per n. Take 0.5 ml by mouth sychosis/mood."			regional nurse consultant and issued a copy of the facility policy and procedur for proper administration and monitoring of psychotropic medication. Additionally, the inservice will include documentation standards for residents	re ng	
	Resident # 13. The	ehavior monitoring sheets for surveyor observed that the monitor Resident # 13 for			receiving psychotropic medications Monitoring:		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		E SURVEY PLETED
		495002	B. WING		0.7	//09/2019
	ROVIDER OR SUPPLIER) REHABILITATION	:	STREET ADDRESS, CITY, STATE, ZIP COD 3823 FRANKLIN RD, SW ROANOKE, VA 24014		703/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 758	following dates: 4/3/19-evening shift 4/4/19- evening shift 4/7/19-evening shift 4/11/19-evening shift 4/19/19-day shift 4/20/19-day shift 4/22/19-day and eve 4/25/19-day shift 4/28/19-day shift 4/30/19-evening shift 5/2/19-day shift 5/3/19-day shift 5/30/19-evening shift 5/24/19-night shift 5/30/19-day shift 7/9/19 at 7:29 and facility "Behavior/Inter Record" for April 201 director of nursing. To reviewed the April 201 director of nursing st holes and agreed that monitor Resident # 1 and effectiveness as Risperidone. The facility policy on contained documenta not limited to,"Monitoring of Effe Effects of Psychoact	ts, and effectiveness use of Risperidone on the surveyor reviewed the ervention Monthly Flow 9 and May 2019 with the he director of nursing 19 and May 2019 monthly flow record for with the surveyor. The ated, "Yes there are several at the facility staff failed to 3 for behaviors, side effects, sociated with the use of "Psychoactive Medications" ation that included but was ectiveness and Adverse	F 758	The DON is responsible for m compliance. The DON and/or will complete weekly physicia MAR audits coinciding with the calendar to monitor compliant negative findings will be corresimmediately and appropriate action will be taken as necess Aggregate findings of these aprovided to the Quality Assura Committee for review, analysis recommendations for change policy, procedure, and/or practice.	designee n orders and le Care plan lected disciplinary leary. ledits will be lance lis, and in facility	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495002	B. WING _			07/	09/2019
	ROVIDER OR SUPPLIER DANOKE NURSING AND	REHABILITATION		STREET ADDRESS, CIT 3823 FRANKLIN RD, S ROANOKE, VA 240	sw		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD E FERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 758	Continued From page	e 66	F 7	58			
	as long as resident is medication. 4. Behavioral sheets daily."	on the psychoactive					
		, the administrative team he findings as stated above.					
		n regarding this issue was ey team prior to the exit					
		led document behaviors for stified an increase in the					
	MDS (minimum data Resident # 14 was a an ARD (assessment Section C of the MDS patterns. In Section C documented that Resinterview for mental swhich indicated that I status was severely in MDS assesses medic the facility staff docur has antipsychotic methe look back period for the status was severely in the facility staff docur has antipsychotic methe look back period for the status was severely in the status was severely in the facility staff docur has antipsychotic methelook back period for the status was severely in the status	t 9:11 am. The most recent set) assessment for quarterly assessment with reference date) of 4/17/19. Sassesses cognitive c0500, the facility staff sident # 14 had a BIMS (brief tatus) score of 6 out of 15, Resident # 14's cognitive mpaired. Section N of the cations. In Section N0410, mented that Resident # 14 dication for 7 days during for the 4/17/19 ARD.					
		are for Resident # 14 was on 6/10/19. The facility staff					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY
		495002	B. WING			07/	09/2019
	ROVIDER OR SUPPLIER DANOKE NURSING AN	D REHABILITATION	·	382	REET ADDRESS, CITY, STATE, ZIP CODE 23 FRANKLIN RD, SW DANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	"The resident has in function/dementia or r/t (related to) dx (disos bims score of 6 Interventions include "Administer medicat Monitor/document for effectiveness." Resident # 14 had or but were not limited mg (milligram) table three times daily for initiated by the physical commented on 4/17 note was documented on 4/17 note was documented in ame withheld) in si (discontinue) Lexapt Seroquel to 50 mg prodaily). Wife requeste surveyor reviewed the surveyor re	s area for Resident # 14 as, inpaired cognitive r impaired thought processes agnosis) of dementia memory on admission mds." ed but were not limited to, ions as ordered. or side effects and eurrent orders that included to, "Quetiapine (Seroquel) 50 t take one tablet by mouth psychosis," which was	F	758			
	notes for Resident # nurse's note that ha	ved the April 2019 nurse's 4 14 further and observed a d been documented on b. The nurse's note was					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495002	B. WING		07/09/2019
	ROVIDER OR SUPPLIER DANOKE NURSING A	ND REHABILITATION	;	STREET ADDRESS, CITY, STATE, ZIP CODE 1823 FRANKLIN RD, SW ROANOKE, VA 24014	,
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETION
F 758	going in residents drawers. He is look (sunglasses) He we residents rooms. We (bedtime) med, not on his bedside table them to the desk. It turn off her overbed 14's sunglasses or those and put them table." The surveyed documentation that displayed by Residual self or others nor of documentation of the pharmacological in wandering episode 4/12/19. The surveyor reviee "Behavior/Interven Resident # 14. The staff documented to behavioral episode and/or threatening staff documented and Resident # 14 to his Upon further review record, the surveyed documented behavior in the dosage of Se 4/17/19. On 7/9/19 at 7:55 at	Resident has been observed rooms and going through the king for "his glasses" as on unit 1 going in other When I gave him his hs ted a pair of womens bifocals le. Took those and brought went to resident 112-A room to d light and found Resident # her bedside table. I took in on Resident # 14's bedside or did not observe any treflected that behavior lent # 14 presented a danger to lid the surveyor observe unsuccessful non atterventions associated with the endisplayed by Resident # 14 on whether the surveyor observed that facility that Resident # 12 had 1 only the of being verbally abusive to staff on 4/12/19. The facility an intervention of returning its room. We of Resident # 14's clinical or did not locate any who is the surveyor interviewed at more than the surveyor interviewed.	F 758		
	regarding the ration of Seroquel for Res	ing to obtain information nale for the increase in dosage sident # 14. The director of she would look into it and			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		495002	B. WING _		07/09/2019	
	ROVIDER OR SUPPLIER DANOKE NURSING AN	D REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014	·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 758	contained document not limited to,"Policy Statement This facility's policy effective administrat medications at the lo medication with the receive psychoactive medically necessary ensure that resident of the medications a effects of the medications a effects of the medical. Antipsychotic M. The clinical reconditions and/or dia antipsychotic medications are preductions are preductions are preductions and environmental of the medications are preductions and for the director of nursing consultant. The survey will be not some the director of nursing consultant. The survey will be not some the director of nursing consultant. The survey will be not some the director of nursing consultant. The survey will be not some the director of nursing consultant. The survey will be not some the director of nursing consultant. The survey will be not some the director of nursing consultant. The survey will be not some the director of nursing consultant. The survey will be not some the director of nursing consultant. The survey will be not some the director of nursing consultant. The survey will be not some the director of nursing consultant. The survey will be not some the director of nursing consultant. The survey will be not some the director of nursing consultant. The survey will be not some the director of nursing consultant.	"Psychoactive Medications" ration that included but was as to ensure the safe and ion of psychoactive owest possible dose of least side effects. Residents are medications only when with every effort made to a receive the intended benefit and to minimize the unwanted ation. It is included be a receive the intended benefit and to minimize the unwanted ation. It is included to must reflect the specific agnosis appropriate for a receive the intended benefit and to modify the resident's concerning the modify the resident's concerning staff approaches to care changes, to the largest degree codate the resident's ces." In the surveyor spoke with any and regional nurse reyor reviewed that Resident and documented behavioral wandering during the month	F 7			
	4/17/19. The survey nursing if it could be episode of wanderin on 4/12/19 was not an underlying condit	the increase of Seroquel on or asked the director of verified that behavioral g displayed by Resident # 14 associated with dementia or ion. The surveyor informed og that after a review of				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG	((X3) DATE SURVEY COMPLETED	
		495002	B. WING _			07/	09/2019
	ROVIDER OR SUPPLIER DANOKE NURSING AND	REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE		(X5) COMPLETION DATE
F 761 SS=D	documentation of behincrease in the dosage 14 on 4/17/19. The did the surveyor that it concentrated and agreed that there documentation to supplied to dementiate and agreed that there documentation to supplied to the surveyor that 1:20 pm was made aware of the No further information provided to the surveyor conference on 7/9/19 Label/Store Drugs and CFR(s): 483.45(g)(h) \$483.45(g) Labeling of Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the eapplicable. §483.45(h) Storage of \$483.45(h)(1) In acceptable appropriate accessor instructions, and the eapplicable appropriate accessor instructions, and the eapplicable.	al record, there was no naviors that supported an se of Seroquel for Resident # rector of nursing informed build not be ruled out that side of wandering was not a or an underlying cause, a was not appropriate oport and increase in the for Resident # 14. In the administrative team the findings as stated above. In regarding this issue was by team prior to the exit of Biologicals (1)(2) In Drugs and Biologicals as used in the facility must be seen with currently accepted so, and include the yeard cautionary expiration date when the formula of Drugs and Biologicals ordance with State and lity must store all drugs and compartments under proper and permit only authorized		761			8/23/19

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495002	B. WING		07/09/2019
	ROVIDER OR SUPPLIER OANOKE NURSING AN	ID REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 761	Continued From pa	ge 71	F 76	61	
	the Comprehensive Control Act of 1976 abuse, except when package drug distrik quantity stored is m be readily detected. This REQUIREMEN by: Based on observati document review, th a narcotic medication potential for abuse of permanently affixed The findings include The medication refri medication room co lorazepam. This box and was able to be On 07/08/19 at appr surveyor checked th wing 2. This refriger with a plastic breaks surveyor observed to The surveyor was a and remove it from the The facility policy tit read in part, "The fa biological's in a safe manner"	igerator in the wing 2 ntained two-2 mg vials of x was not permanency affixed removed from the refrigerator. roximately 2:00 p.m., the ne medication refrigerator on rator contained a plastic box away lock. Inside this box, the wo-2 mg vials of lorazepam. ble to pick this plastic box up		F761 Corrective Action(s): The refrigerator narcotic box in the W med room refrigerator has been permanently affixed to the medication refrigerator. A facility Incident and Accident form has been completed for incident. Identification of Deficient Practices & Corrective Action(s): All unit medication rooms refrigerators with narcotic boxes may have been potentially affected. The DON and/or designee will conduct a 100% review the medication room refrigerators to identify any narcotic boxes that are not permanently affixed. Any/all negative findings will be corrected at time of discovery. A Facility Incident and Acc Form will be completed for each incididentified. Systemic Change(s): Facility policy and procedure for medication and biological storage has been reviewed and no changes are warranted at this time. All licensed nu will be inserviced by the DON on the facility policy and procedure for storin	r this of ot ident ent /e

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION AND MED		(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
		495002	B. WING			07/09/2019		
	ROVIDER OR SUPPLIER DANOKE NURSING AND	REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO			(X5) COMPLETION DATE	
F 761	m?setid=89057c93-8 4c accessed 07/10/19 medicine used: to tredisordersATIVAN is substancebecause dependence. Keep A prevent misuse and a No further information	ute of health website nih.gov/dailymed/drugInfo.cf 155-4040-acec-64e877bd2b D-"ATIVAN is a prescription at anxiety a federal controlled it can be abused or lead to IIVAN in a safe place to	F7	761	medications and biologicals. The nursing staff will also be inserviced on the Medication Administration Policy and Procedure to include narcotics which must be stored in refrigerators. In addition, The Pharmacy consultant will check each medication room refrigerators during scheduled visits. Monitoring: The DON is responsible for maintaining compliance. The DON and/or designed will perform weekly Medication room at Medication cartaudits to monitor for compliance. All discrepancies found in these audits will be corrected at the time of discovery and disciplinary action take as appropriate. Results of these audits be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.	nust The g e nd ne een		
F 812 SS=F	CFR(s): 483.60(i)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	re food from sources ed satisfactory by federal, es. cood items obtained directly subject to applicable State ulations. s not prohibit or prevent roduce grown in facility compliance with applicable	F	112			8/23/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495002	B. WING		07/09/2019		
	ROVIDER OR SUPPLIER DANOKE NURSING AND	REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014	1110012010		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRING DEFICIENCY)	BE COMPLÉTION		
F 812	Continued From page		F 812	2			
		es not preclude residents s not procured by the facility.					
	serve food in accorda standards for food se This REQUIREMENT by: Based on observatio document review, the	is not met as evidenced on, staff interview, and facility		F 812 Corrective Action(s): The water bottle was removed from the counter in the kitchen.	ne		
	The findings included			The Aquafiina water bottle was remove from the pots/pans storage area.	ed		
	perishable food items appropriately labeled	failed to ensure that		The counters, floors, refrigerators, freezers, and equipment in the kitcher have been thoroughly cleaned.	n		
	appropriately. c. The facility staff failed to ensure that facial hair was secured with a chin guard. d. The facility staff failed to ensure a clean and sanitary working environment in the facility			The open lettuce bag; bag of carrots; container of strawberries; and molded tomatoes were discarded from the wal cooler.			
	kitchen.	failed to ensure that personal		Dietary staff member #2 put a hair restraint in place and has received one education regarding the requirement for the use of hair restraint.			
	an initial tour of the k During the initial kitch observed and empty	16-ounce water bottle on the		The pans in the pots/pans storage are have all been washed and dried appropriately.	a		
	surveyor observed th of red liquid left in the observed a large amo and white debris on t	ee maker and spices. The at there was a small amount be bottle. The surveyor also bount of dried brown, yellow, the stand beneath the tray s were stored. The surveyor		Identification of Deficient Practices & Corrective Action(s): All other residents may have been potentially affected. The Food Service Manager, and/or Registered Dietician			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	` ,	(X3) DATE SURVEY COMPLETED	
		495002	B. WING _		0	7/09/2019	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	•		
				3823 FRANKLIN RD, SW			
SOUTH R	OANOKE NURSING AN	ID REHABILITATION		ROANOKE, VA 24014			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 812	observed a large ar build up on the floor was located next to held large cans of for that the can opener brown and black de observed all areas in the surveyor and ag should not be kept in that the areas ment cleaned. On 7/7/19 at 12:05 cook # 1 entered the observed an opened been secured and vopened and discard that the lettuce had surveyor also observed and the opened and discard that the lettuce had surveyor also observed and the opened and discard container of strawbord The surveyor observed and had dark significant from the coobserved 3 tomatoe had molded areas of agreed that all items been labeled appropriate of the coobserved appropriate of the coobserved and the coobserved appropriate of the cookserved and the cook	ge 74 nount of black and brown runderneath a large rack that the reach in refrigerator that bod. The surveyor observed was heavily soiled with dark bris. Dietary cook # 1 mentioned above along with greed that personal items in the kitchen work area and ioned above needed to be pm, the surveyor and dietary was walk in cooler. The surveyor d bag of lettuce that had not was not labeled with an date. The surveyor observed several brown spots. The ved an opened bag of carrots contained two. The bag was bag was not labeled an the surveyor observed a erries that had 4 strawberries. ved that the strawberries were bots and red liquid was softainer. The surveyor also ses in the walk in cooler that on them. Dietary cook # 1 se mentioned should have priately and/or discarded. pm, the surveyor observed a f keys, and bottle of seltzer ed the on the soft drink mix	F8		chen preparation identify any as identified to be discarded and a dent form will be tive finding re findings may an. Trocedure has langes are the consulting inservice the and dietary staff and serving the ce. The Food and food storage and dating of and disposal of monitor and the results of these the Quality review, tions for change		
	boxes. Dietary cook items should not ha removed the items.	# 1 agreed that the personal ve been in the work area and am, the surveyor observed					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED
		495002	B. WING	·····	07/09/2019
	ROVIDER OR SUPPLIER OANOKE NURSING AN	ND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 812	dietary staff # 2 in tobserved that dieta was not wearing a lasked dietary staff; beard guard. Dietar should have been were trieved a beard growall and applied it to beard. On 7/8/19 at 11:20 Aquafina water bott liquid substance in and pans. The surve Cook # 1 removed discarded it into the Con 7/8/19 at 11:30 dietary staff # 3 lift contained the dried several drops of was a agreed that the path of the dry pan rack was The facility policy of documentation that to,"Allow all dishes towels." The facility policy of Storage" contained but was not limited"Procedure 1. All perishable for labeled with the iter and discarded appression.	he kitchen. The surveyor ry staff # 2 had a beard and beard guard. The surveyor # 2 if he should be wearing a ry staff # 2 agreed that he wearing a beard guard and beard from the holder on the so his face and covered his am, the surveyor observed and the that was half-full with a red it on the stand with the pots eyor observed that dietary the Aquafina bottle and that trash. am, the surveyor observed and the apan from the rack that pans. The surveyor observed that other and that she had retrieved from the sactually still wet. In "Dishwashing" contained included but was not limited to air dry. Do not dry with the "Labeling, Dating, & documentation that included to, soods will be appropriately in description, "use by" date	F 8 ²		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495002	B. WING _			07/	09/2019
	ROVIDER OR SUPPLIER OANOKE NURSING AND) REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014	Ē		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 812 F 842 SS=D	Guidelines" contained included but was not" Hair- ALL hair mu (No pieces or bangs facial hair is not kept chin guard." On 7/8/19 at 3:15 pm was made aware of the No further information presented to the surviconference on 7/9/19	epartment "Dress Code d documentation that limited to, ust be covered by a hair net. hanging out.) No Beards! If trimmed you must wear a n, the administrative team he findings as stated above. In regarding this issue was vey team prior to the exit oldentifiable Information		812			8/23/19
	§483.20(f)(5) Resider (i) A facility may not resident-identifiable to (ii) The facility may represident-identifiable to accordance with a coagrees not to use or except to the extent to do so. §483.70(i) Medical re §483.70(i)(1) In accordance professional standard	nt-identifiable information. release information that is to the public. release information that is to an agent only in the part on the agent disclose the information the facility itself is permitted records. rdance with accepted distance with accepted distance on each resident records on each resident					

The state of the s		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	ECONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED		
		495002	B. WING			7/09/2019		
	ROVIDER OR SUPPLIER DANOKE NURSING AN	D REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 842	all information contaregardless of the for records, except when (i) To the individual, representative where (ii) Required by Law (iii) For treatment, poperations, as permy with 45 CFR 164.50 (iv) For public health neglect, or domestic activities, judicial and law enforcement pupurposes, research medical examiners, a serious threat to he by and in compliance §483.70(i)(3) The farecord information a unauthorized use. §483.70(i)(4) Medic for- (i) The period of tim (ii) Five years from there is no requirem (iii) For a minor, 3 yiegal age under State §483.70(i)(5) The minor (i) Sufficient information of the comprehence of the comprehenc	cility must keep confidential ained in the resident's records, and or storage method of the en release issor their resident e permitted by applicable law; or ayment, or health care itted by and in compliance 6; or activities, reporting of abuse, eviolence, health oversight diadministrative proceedings, reposes, organ donation purposes, or to coroners, funeral directors, and to avert ealth or safety as permitted are with 45 CFR 164.512. cility must safeguard medical against loss, destruction, or all records must be retained be required by State law; or the date of discharge when the state law; or th	F 84					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495002	B. WING		07/09/2019		
	ROVIDER OR SUPPLIER OANOKE NURSING A	ND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP COD 3823 FRANKLIN RD, SW ROANOKE, VA 24014			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 842	(v) Physician's, nur professional's prog (vi) Laboratory, rad services reports as This REQUIREME by: Based on staff intereview the facility sand accurate clinic Resident #22 and I The findings includ For Resident #22 t daily CNA (certified were completed. Resident #22 was 808/21/17 and readincluded but not linfailure, aphasia, deand glaucoma. The most recent quest) with an ARD (a04/23/19 assigned interview for mental section C, cognitive Resident #22's clin 07/09/19. It contain Resident Care Ros February, March, A2019. These forms food/fluid intake, to (activities of daily line services reports as a service of the services of daily line for	ducted by the State; se's, and other licensed ress notes; and biology and other diagnostic required under §483.50. NT is not met as evidenced serview and clinical record taff failed to ensure a complete al record for 2 of 24 Residents, Resident #30. ed: the facility staff failed to ensure I nursing assistant) flow sheets admitted to the facility on mitted on 02/01/18. Diagnoses hited to congestive heart rementia, anxiety, depression, warterly MDS (minimum data assessment reference date) of the Resident a BIMS (brief II status) score of 4 out of 15 in	F 84	F842 Corrective Action(s): Resident #22 s attending ph been notified that facility staff ensure daily CNA flow sheets accurately completed. A facil and Accident Form has been for this incident. Resident #30 s attending ph been notified that the facility s include an advance directive/ had been properly signed by in the resident s record. A fa and Accident Form has been for this incident. Identification of Deficient Practice Corrective Action(s): All other residents may have been affected. A 100% review residents medical records will conducted by the DON and/o identify residents at risk for in CNA flow sheets or missing/in advance directives/DDNRs. findings will be clarified and/of time of discovery. A facility In Accident form will be completing negative finding. Systemic Change(s):	failed to s were lity Incident completed sysician has staff failed to (DDNR which the physician acility Incident completed ctices & potentially w of all I be or designee to acomplete all negative or correct at cident &		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495002	B. WING			07/	09/2019	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
SOUTH R	DANOKE NURSING AND	REHABILITATION			823 FRANKLIN RD, SW ROANOKE, VA 24014			
(X4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID				(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG	×	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 842	Continued From page	e 79	F 8	342				
	was discussed with the ameeting on 07/07/1 No further information	complete CNA flowsheets ne administrative staff during 9 at approximately 1:20 PM. n was provided prior to exit. led to ensure that Resident			The facility policy and procedure has be reviewed and no changes are warrant at this time. All licensed nursing staff a C.N.A's will be inserviced by the DON regional nurse consultant on the clinical documentation standards per facility	ed ind or		
		included an advanced			policy and procedure. Monitoring:			
		•			The DON is responsible for maintainin compliance. The DON and/or designe will audit medical records weekly coinciding with the care plan calendar monitor for compliance. Any/all negative	to		
	MDS (minimum data Resident # 30 was ar with an ARD (assess 5/6/19. Section C of t patterns. In Section C documented that Res interview for mental s	t 1:59 pm. The most recent set) assessment for admission assessment ment reference date) of the MDS assesses cognitive c0500, the facility staff sident # 30 had a BIMS (brief tatus) score of 7 out of 15, Resident # 30's cognitive			findings will be clarified and corrected time of discovery and disciplinary action will be taken as needed. The results of this audit will be provided to the Quality Assurance Committee for analysis and recommendations for change in facility policy, procedure, and/or practice.	at on f y I		
	not limited to, "DNR (company's name with antibiotics, hospitaliza (intravenous) fluid, No	ders that included but were do not resuscitate) (Hospice iheld) Hospice-No ations unless major injury, IV o lab (per family) weights, was signed by the physician						
	durable do not resuso The surveyor observe documented nest to "							

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDI		IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		495002	B. WING _			07/09/2019	
	ROVIDER OR SUPPLIER DANOKE NURSING AN	D REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014		•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOWS CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 842	specific medical treat treatment because he understand the natural ternatives to that of documented a hand capable of making a patient has executed which appoints a "Poon the Patient's Behthat life-prolonging powithdrawn. (Signatur consent on the Paties surveyor reviewed the 30 further and did directive for Resider On 7/8/19 at 3:15 preadministrative team copy of the written at Resident # 30.	anholding, or withdrawing a street or course of medical ne/she is unable to re, extent or probable ecision." The surveyor also written X next to "B. While in informed decision, the dia written advanced directive erson Authorized to Consent alf" with authority to direct procedures be withheld or re of Person Authorized to ent's Behalf is required.)" The ine clinical record for Resident not locate a written advanced at # 30. In, the surveyor asked the to provide the surveyor with a dvanced directive for	F8	42			
F 880	that had been docur The social progress "Social worker left pi daughter (Daughter' Arizona, asking her POA (power of attori On 7/9/19 at 1:20 pr was made aware of		F 8	80		8/23/19	
SS=F							

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		495002	B. WING _		07/09/2019		
	ROVIDER OR SUPPLIER OANOKE NURSING AN	ND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014	·		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHORE) CROSS-REFERENCED TO THE APPLICATION OF THE APPLI	IOULD BE COMPLETION		
F 880	infection prevention designed to provide comfortable enviror development and tr diseases and infect §483.80(a) Infection program. The facility must es and control program a minimum, the follo §483.80(a)(1) A system of survival and communicable staff, volunteers, visproviding services arrangement based conducted accordinaccepted national signature of survival and communicable staff, volunteers, visproviding services arrangement based conducted accordinaccepted national signature of survival and to the persons in the facili (ii) A system of survival are not limited to (i) A system of survival are not limited to (ii) When and to who communicable disereported; (iii) Standard and tr to be followed to provide the provided to provided	ontrol tablish and maintain an and control program a safe, sanitary and ament 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: Stem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual upon the facility assessment g to §483.70(e) and following tandards; en standards, policies, and program, which must include, oce eillance designed to identify able diseases or ey can spread to other	F8				

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495002		IG		(X3) DATE SURVEY COMPLETED				
				07/09/2019					
NAME OF PROVIDER OR SUPPLIER SOUTH ROANOKE NURSING AND REHABI	LITATION		STREET ADDRESS, CITY, STATE, ZIP CO 3823 FRANKLIN RD, SW ROANOKE, VA 24014	•					
PREFIX (EACH DEFICIENCY MUST BE	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI		PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
resident; including but not limit (A) The type and duration of the depending upon the infectious involved, and (B) A requirement that the iso least restrictive possible for the circumstances. (v) The circumstances under the must prohibit employees with disease or infected skin lesion contact with residents or their contact will transmit the disea (vi)The hand hygiene proceduby staff involved in direct residentified under the facility's If corrective actions taken by the §483.80(a)(4) A system for reidentified under the facility's If corrective actions taken by the §483.80(e) Linens. Personnel must handle, store transport linens so as to preven infection. §483.80(f) Annual review. The facility will conduct an an IPCP and update their program. This REQUIREMENT is not report to the program of the program for 1 of 24 Reference of the program for 1 of	the isolation, is agent or organism agent	F	F880 Corrective Action(s): LPN #1 involved in the Medi Administration Observation f Resident s #18 has receive inservice training on proper i control practices to be follow medication administration. A Incident & Accident form was for this incident.	for d one-on-one infection red during v Facility					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495002	B. WING			07/0	9/2019	
NAME OF P	ROVIDER OR SUPPLIER		,	STREET ADDRESS, CITY, STATE	, ZIP CODE			
COUTU D	DANOKE MUDOMO AND	DELIA DII ITATIONI		3823 FRANKLIN RD, SW				
5001H K	DANOKE NURSING AND	REHABILITATION		ROANOKE, VA 24014				
(X4) ID PREFIX TAG			ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 880	Continued From page	e 83	F8	80				
	1. For Resident #18, the facility staff dropped 2 medication capsules on the top of the medication cart, picked them up with their bare hands, and administered them to the Resident. The clinical record review revealed that Resident #18 had been admitted to the facility 04/15/19. Diagnoses included, but were not limited to, Parkinson's disease, hypertension, osteopenia, gait difficulties, and frequent falls. Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 04/22/19 included a BIMS (brief interview for mental status) summary score of 13 out of a possible 15 points. On 07/08/19 at approximately 9:02 a.m., during a medication pass and pour observation LPN (licensed practical nurse) #1 was observed preparing Resident #18's morning medications for administration. When removing the Residents amantadine and potassium from their medication cassette (packaging system) LPN #1 was			The Medical Director that the facility failed to control program in reg SBAR criteria workshinfection as outlined in infection control program Identification of Defici Corrective Action(s): All other residents material been affected. The Deconduct a 100% audit pass medications to its medication administration practices. Negative fir reviewed with each number of the facility Incident and completed for each new The facility IP/designed complete review of the program to identify of which have not been Systemic Change(s): The facility policy and	to follow its infection of follow its infection and the facility seam. The seam of the facility seam. The seam of the facility seam. The seam of the facility seam of the faci	on trol I be		
	medication cart causi their individual cassed medication cart. LPN pick up the capsules			been reviewed and no warranted at this time will be inserviced on t procedure for proper i practices during medi by the DON and/or ReConsultant. The facility infection of	c changes are . All licensed staff he facility policy a infection control cation administrat egional Nurse	f and tion		
	LPN #1, LPN #1 state capsules and she sho	a.m., during an interview with ed she had picked up the ould have used a glove or l used the spares that were		been reviewed and no warranted at this time nursing staff have bee use of the SBAR crite	o changes are . All licensed en inserviced on t	he		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495002	B. WING		0.	7/09/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
SOUTH R	OANOKE NURSING AN	D REHARII ITATION		3823 FRANKLIN RD, SW			
30011110	CANORE NORSING AN	D REHABIEHATION		ROANOKE, VA 24014			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 880	Continued From pag	ge 84	F 88	infections and not just UTI⊡s	S.		
	infection control nur stated LPN #1 shou discard the medicati spare medication fro new medications fro unit.	4 a.m., the designated se was interviewed and ld have used the red box to ions and either used the om the cassettes or obtained om their automatic dispensing		Monitoring: The DON is responsible for a compliance. The DON/design perform 2 random weekly Maudits to monitor nursing statements of the IP/designer each documented infection to compliance. Findings of the reported to the QA Committee.	nee will ed Pass ff for ee will review o monitor for audits will be		
	07/08/19 at 3:09 p.n	ing with the survey team on n. on regarding this issue was ey team prior to the exit		analysis, and recommendati change in facility policy, prod practice.	ons for		
	control program/plan (Situation, Backgrou Recommendation - to facilitate commun resident's symptoms suspected infections	to follow their infection in in regards to using an SBAR and, Assessment, a technique/worksheet used ication to a physician about a s) criteria worksheet for s. The facility only had this rinary tract infections (UTI).					
	designated infection interviewed by two (8:49 a.m. in their off nurse consultant wa interview. The facili antibiotic stewardsh reviewed which inclution util SBAR." During review, the DON was a surveillance too other than UTIs. The	ing (DON) who was the a preventionist (IP) was 2) surveyors on 7/09/19 at ince. The facility's regional as present during the ty's infection control and ip program binder was uded a form titled, "Suspected to the discussion and program as asked what the facility uses of for suspected infections are DON acknowledged there available at this time and					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER 1		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495002	B. WING		07/	/09/2019
NAME OF PROVIDER OR SUPPLIER SOUTH ROANOKE NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	how to assess reside assessments to phys infections such as up The regional nurse convidence of the facility. The facility's documents to evidence of the facility. The facility's documents to evidence of the facility. The facility's documents to evidence of the program 07/09/19. The documents of the documents of the pool of the the DON and/or IP with the DON and/or IP with the pool of the the providence of patient response to the evaluations of patient response to treatment medical record. The the expected action wassessment and communicating suspected of having a SBAR/McGeer's." The administrative standministrator, the direct regional nurse consultant acknowledges of SBAR tools for the other than UTIs during team on 07/09/19 at nurse consultant acknowledges of nursing communicating suspected to the survey of the physicians/	f (nurses) were educated on ints and report their icians for other suspected per respiratory infections. Insultant would provide y nurses' education if found. Int titled, "Antibiotic in (ASP)" was reviewed on ment read in part that program rests partially with the was expected to work in that SBAR/McGeer's in communicate relevant ers, and that nursing it clinical status and patient it were documented in the ASP document also read was to "Utilize a standard imunication tool for patients an infection - aff consisting of the ector of nursing and the litant were informed of the rany suspected infection g a meeting with the survey 1:20 p.m. The regional mowledged there had been ag education on ected infections other than	F 88			
F 926 SS=D	conference. Smoking Policies		F 92	6		8/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED		
	495002	B. WING		07/09/2019	
NAME OF PROVIDER OR SUPPLIER SOUTH ROANOKE NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
with applicable Feder regulations, regarding and smoking safety the nonsmoking residents. This REQUIREMENT by: Based on observation interviews, clinical recodocument review the their policy and proce Residents smoking sure Residents, Resident # The findings: The facility's smoking Residents who desire smoking related mate pipes, tobacco, lighter their person when not Resident #38 kept the them at all times. During an interview wo 07/08/19 at 12:20 p.m they kept their own cip bag they kept at their #38 showed the bag they kept at their stated they had permis supervision. The sure	h policies, in accordance al, State, and local laws and psmoking, smoking areas, nat also take into account is. It is not met as evidenced ans, resident interview, staff cord review, and facility facility staff failed to follow dure regarding the applies for 1 (one) of 24 \$\frac{1}{2}\$38. policy indicated that to smoke may not keep rials (cigarettes, cigars, r, lighter fluid, match etc.) on a smoking or in their room.	F 926	F926 Corrective Action(s): Resident #38 surrendered the lighter a cigarettes they had in their possession the time of the observation. A facility Incident and Accident form has been completed for this incident. Identification of Deficient Practice(s) at Corrective Action(s): All other residents who smoke may habeen affected. Resident #38 has a grandfathered status regarding smoking. Systemic Change(s): The facility smoking policy has been reviewed and updated to address Resident #38 signandfathered status. The revised smoking policy has been reviewed with Resident #38 and facility administration. Monitoring: The Admission director is responsible maintaining compliance by educating newly admitted residents about the facismoking policy. The QA Program includes facility audit tools for monitori	nd ve ng. n	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE COMF	SURVEY	
		495002	B. WING _			07/	/09/2019	
NAME OF PROVIDER OR SUPPLIER SOUTH ROANOKE NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014		•	0.7.00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 926	Their diagnoses included hypertension, polyosobstructive pulmonar dependence. Section C (cognitive quarterly MDS (minimizerly MDS (minimizerly MDS) (minimi	the facility on 12/17/12. Inded, but were not limited to teoarthritis, chronic ry disease, and nicotine patterns) of the Resident's mum data set) assessment sment reference date) of BIMS (brief interview for eary score of 15 out of a Section O (special res, and programs) had been a resident had oxygen plan, dated 05/21/19, rea "(Resident's first name) is a for being able to smoke as ad." Interventions included to, "Instruct resident about smoking: locations, times, a "Notify charge nurse ispected resident has ing policy." (electronic health record) G-SAFETY SCREEN" dated then completed by facility staff. Incument read in part, Can garette? Yes. Does resident lighter and cigarettes? No. Ito assure resident is safe. The Smoking - Safety	F 9	26	Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice.	,		
	team decision was "s supervision." The so rationale/conditions:	ore of "1" which indicated the Safe to smoke without creen also read under "Does become SOB (short ropelling w/c (wheelchair),						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BU	LDING COMPLETED
495002 B. WII	IG07/09/2019
NAME OF PROVIDER OR SUPPLIER SOUTH ROANOKE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 3823 FRANKLIN RD, SW ROANOKE, VA 24014
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PF	D PROVIDER'S PLAN OF CORRECTION (X5) EFIX (EACH CORRECTIVE ACTION SHOULD BE AG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
F 926 Continued From page 88 opening door but waits a while before lighting cig., able to bring self back in doorway." The EHR also contained a physician's order last dated and signed by the physician on 07/01/19 for "nasal O2 (oxygen) at 2L (liters) as needed." The facility policy related to smoking read in part, "Procedure: 2. Residents who desire to smoke may not keep smoking related materials (cigarettes, cigars, pipes, tobacco, lighter, lighter fluid, match etc.) on their person when not smoking or in their room. 3. Residents will be assessed for their ability to smoke independently. Assessments will be reviewed by the interdisciplinary team at least quarterly and as the resident's condition or behavior changes that impacts the ability to smoke safely. a) Residents who are determined by the interdisciplinary team as safe for independent smoking will request smoking materials when desiring to smoke and will return them upon completion of the smoking session." The administrative staff consisting of the administrator, the director of nursing and the regional nurse consultant were informed of the issues regarding Resident #38 having their smoking supplies at all times during a meeting with the survey team on 07/08/19 at 3:10 p.m. and again on 07/09/19 at 1:20 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 926