	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION HUMBER	(X2) MULTIF	LE CONSTRUCTION	ı	(X3) DATE SURVEY COMPLETED
		495156	B. WING			C 11/07/2022
	ROVIDER OR SUPPLIER	OKE		STREET ADDRESS, 324 KING GEORG ROANOKE, VA		717713022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACI	OVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIA DEFICIENCY)	
E 000	Initial Comments		E 00			
	Survey was conducted facility was in substant Part 483.73(b)(6) emergulations, and has in for Medicare & Medicare Disease Control recomprepare for COVID-19	9 certif ied bed facility was				
F 000	An unannounced Med and COVID-19 Focus was conducted at the facility was in substant Part 483.80 infection of implemented The Cer- Medicaid Services and	ficare/Medicaid aphreviated Infection Control survey facility on 11/07/22. The tial compliance with 42 CFR control regulations, and has sters for Medicare &	F 000			
F 584	CFR Part 483 Federal requirements and Virg for the Licensure of Nu survey, one complaint substantiated, no defic The census in this 109 53 at the time of the su consisted of 5 current record review.	inia Rules and Regulations ursing Facilities. During the (VA00056628-iency) was investigated. I certified bed facility was urvey. The survey sample residents, and 1 closed	F 584	with the surve was of an 10 feeding Centre comperside cleans 3. The A compension plants of the survey on plants of the survey on plants of the survey of the	dent #2 tube feeding was laid he date and time during the express. The tube feeding cleaned during the survey process of Nursing will complow audit of resident's tube fall supply Coordinator will real Supply Coordinator will lete a sanitation audit of all ent tube feeding pump for liness. Assistant Director of Nursing lete education will license nacing date and time hung or the Housekeeping Director of The Housekeeping Director of Nursing and The Housekeeping Director of Nursing Di	g pole rocess. plete The g will nurses in tube

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	N.	
	Date of compliance 12/12/22	
	5. All findings will be presented to QAPI. Date of compliance 12/12/22	
	weekly times six weeks then monthly times three months.	
	4. All audits will be conducted twice	
	the tube feeding poles.	
	complete education with the Central Supply Coordinator on cleanliness of	
CENTERS FOR MEDICARE & MEDICAID SERVICES	, OMB N	O. 0938-0391
DEPARTMENT OF HEALTH AND HUMAN SERVICES		=D: 11/21/2022 RM APPROVED

FORM CMS-2567(02-99) Previous Versions Obsolete

program participation.

Event ID: GMYN11

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

Facility ID: VA0018

If continuation sheet Page 1 of 22

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A_BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495156	B. WING			C 11/07/2022	
	ROVIDER OR SUPPLIER	KE	-1	STREET ADDRESS, CITY, STATE, 324 KING GEORGE AVE SW ROANOKE, VA 24016	ZIP CODE	11/0//2022	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIA CIENCY)		
-	but not limited to receisupports for daily living. The facility must proving \$483.10(i)(1) A safe, or homelike environment use his or her personal possible. (i) This includes ensur receive care and serving physical layout of the findependence and docing. The facility shall exist the protection of the recor theft. \$483.10(i)(2) Houseke services necessary to and comfortable interior \$483.10(i)(3) Clean being good condition; \$483.10(i)(4) Private corresident room, as specified in all areas; \$483.10(i)(6) Comfortal levels. Facilities initially	comment. In the to a safe, clean, clike environment, including a safely. In the to a safe, clean, clike environment, including a safely. In the the resident to a safely and that the resident can clied the safely and that the sacility maximizes resident as not pose a safely risk. In the the test of the extent are safely and maintenance and maintenance maintain a sanitary, orderly, or; In the to a safe, clean, and a safely.	L.	584			
ļ.	§483.10(i)(7) For the m	aintenance of comfortable					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A BUILDING		(×	(X3) DATE SURVEY COMPLETED			
		495156	B. WING			C 11/07/2022
	ROVIDER OR SUPPLIER	DKE		STREET ADDRESS, CITY, STATE, Z 324 KING GEORGE AVE SW ROANOKE, VA 24016	IP CODE	11/07/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 584	by: Based on observation record review, the fact clean, sanitary, home residents in the surver Resident#4. The findings included 1. For Resident #2, a substance was visible feeding pump, pole, a Resident #2's diagnor which included, but in Damage, Persistent Quadriplegia, Chronic Paroxysmal Tachycai The most recent significant as et (MDS) with a date (ARD) of 9/12/22 being in a persistent of discernible conscious On 11/07/22 at 11:15 Resident #2 in bed refeeding (TF) formula of (ml) per hour. The Osliquid and light brown a dried light brown suthe base of the TF pole. On 11/07/22 at 5:00 p director of nursing (Do direct	is not met as evidenced n, staff interview, and clinical cility staff failed to ensure a slike environment for 2 of 6 by sample, Resident #2, and dried light brown and floor of their room. sis list indicated diagnoses, of limited to Anoxic Brain (regetative State, Functional of Respiratory Failure, and rolia. difficant change minimum of assessment reference of coded the resident as regetative state/no		584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1077	IPLE CONSTRUCTION NG			SURVEY PLETED
	495156	B. WING _			11	C /07/2022
NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT ROA	NOKE		STREET ADDRESS, CITY, STATE, ZIP COI 324 KING GEORGE AVE SW ROANOKE, VA 24016	DE	1 1	10112022
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BI E APPROPRIA		(X5) COMPLETION DATE
DON entered Resist the dried light brown at the base of the Tente the TF pole. On 11/07/22 at 5:2 with the facility man DON and assistant concern of dried light Resident #2's TF person. No further informating presented to the succonference on 11/0 2. For Resident #4 was visible on the repump electrical contheir room. Resident #4's diagrowhich included, but and Chronic Respire Hemiparesis following Myoneural Disorder The admission mining assessment reference assigned the reside status (BIMS) summindicating the reside impaired. On 11/07/22 at 11:3	3 pm, two surveyors and the dent #2's room and observed in substance on the TF pump. TF pole, and in the floor around 2 pm, the survey team met nagement team including the DON and discussed the the brown substance visible on tump, TF pole, and floor of their ion regarding this concern was trivey team prior to the exit 17/22. In a dried light brown substance esident's tube feeding pump, d, base of pole, and floor of the ion ion is list indicated diagnoses, not limited to Epilepsy, Acute atory Failure, Hemiplegia and ing Cerebral Infarction.	F 5	84			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X	3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	DKE		STREET ADDRESS, CITY, STATE, ZIP CO 324 KING GEORGE AVE SW ROANOKE, VA 24016	DDE	1170712022
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	feeding (TF) formula (ml) per hour. The Os liquid and light brown a dried light brown su TF pole, down the put the floor around the TO 11/07/22 at 4:59 p director of nursing (DC room and observed the substance on the TF pump electrical cord, at TF pole. The DON stashould be checking and aily. On 11/07/22 at 5:22 p with the facility managed DON and assistant DC concern of the dried ligon Resident #4's TF pord, TF pole, and floor No further information presented to the surve conference on 11/07/24. For Resident #3 the ensure the feeding pur area was clean and free Resident #3's face she included but not limited respiratory failure, dys status. Resident #3's admission tyet completed; how	via pump at 80 milliliters smolite 1.5 TF formula was in color. Surveyor observed bstance on the TF pump, mp electrical cord, and in F pole. Im, two surveyors and the DN) entered the resident's redired light brown pump, TF pole, down the and in the floor around the ated central supply staff and cleaning the TF poles Im, the survey team met rement team including the DN and discussed the ght brown substance visible regarding this concern was by team prior to the exit set and surrounding the of dried feeding solution. In a set listed diagnoses which	F 5	84		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER A BUILDING			(X3) DATE SURVEY COMPLETED		
		495156	B_ WING_			C
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		11/07/2022
CHOICE	HEALTHCARE AT ROANC	OKE		324 KING GEORGE AVE SW ROANOKE, VA 24016		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	reviewed and contained dependent on nursing of daily living) care, hy hydration needs." Interinclude "Dependent in Surveyor observed Ref 11:45 and at 1:15 pm. bed, receiving Osmolifi pump at 65 cc/hour. The liquid and light brown is a dried brown substant down the tube feeding pole, and on the floor be Survey team conducted facility with the director 11/07/22 at 4:55 pm. Several residents with dried substance on an an an an an an an an and pumps, poles, and surrous asked DON how often poles were cleaned, ar be cleaned daily. Survey responsible for this clear "central supply takes of the concern of not enspoles, and surrounding was discussed with the	hensive care plan was ed a care plan for "is totally staff to meet ADL (activities rgiene, nutrition and rventions for this care plan inutrition via tube feeding." esident #3 on 11/07/22 at Resident was resting in the tube feeding solution via the Osmolite formula was in color. On both occasions, ce was observed on the pole, on the base of the poeside the bed. and a walking tour of the r of nursing (DON) on curveyors pointed out tube feedings that had door around tube feeding rounding area. Surveyor the feeding pumps and and DON stated they should eyor asked DON who was aning, and DON stated, are of that". suring feeding pumps, are kept free of debris DON, assistant director of	F	584		
	director of clinical servi educator on 11/07/22 a	or of operations, regional ces and regional nurse it 5:00 pm.				
ľ		• MS #805455				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			324 KING	ODRESS, CITY, STATE, ZIP CODE GEORGE AVE SW KE, VA 24016	1 133	/07/2022
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	8E	(X5) COMPLETION DATE
	(Includes naso-gastriboth percutaneous en percutaneous endoscenteral fluids). Based comprehensive assessensure that a resident §483.25(g)(1) Maintai of nutritional status, states desirable body weight balance, unless the redemonstrates that this preferences indicate of \$483.25(g)(2) Is offered maintain proper hydrates a nutritional provider orders a thereof there is a nutritional provider orders a thereof the provider orders a thereof the provider orders at the sufficient fluid intake to via enteral means for survey sample, Reside The findings included: For Resident #4, the facenteral water flushes a provider.	nutrition and hydration. c and gastrostomy tubes, idoscopic gastrostomy and copic jejunostomy, and on a resident's isment, the facility must chas usual body weight or trange and electrolyte esident's clinical condition is is not possible or resident otherwise; and a therapeutic diet when roblem and the health care apeutic diet. is not met as evidenced it, staff interview, and clinical lity staff failed to ensure or maintain proper hydration of 6 residents in the	F	1.7	complete an 100% audit of all water flushes with tube feeding orders for tube feeding. The C Supply Coordinator will complete sanitation audit of all resident's feeding poles for cleanliness. I housekeeping director will compare sanitation audit of all resident flushers who received tube feeding. The Assistant Director of Nursicomplete education with Licent Nurses on correctly placing in orders for water flushes and tufeeding orders. The Assistant I of Nursing will also complete elabeling time and date of tube when hung. The Director of Environmental Services will conclude the with tube feeding room floors. All Audits will be conducted twi weekly times six weeks then mutimes 3 months.	ocess. corrected g pole or cess. d time s. ignee will resident's g and MD entral ele a loors ng will sed MD be Director ducation deeding mplete esidents ce onthly	

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		(X3) DATE SURVEY COMPLETED				
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	and Chronic Respirate Hemiparesis following Myoneural Disorder, at The admission minimal assessment reference assigned the resident status (BIMS) summal indicating the resident impaired. On 11/07/22 at 11:33 Resident #4 in bed redigeding (TF) formula with milliliters (ml) per hour set to deliver water flushours. Resident #4's current an order dated 9/26/22 ml every 4 hours and a order dated 10/05/22 flon 11/07/22 at 4:09 pridirector of nursing (DC two separate physician On 11/07/22 at 4:59 pridirector of nursing (DC two separate physician Con 11/07/22 at 4:59 pridirector of nursing (DC two separate physician Con 11/07/22 at 4:59 pridirector of nursing (DC two separate physician Con 11/07/22 at 4:59 pridirector of nursing (DC two separate physician Con 11/07/22 at 4:59 pridirector of nursing (DC two separate physician Con 11/07/22 at 4:59 pridirector of nursing (DC two separate physician Con 11/07/22 at 4:59 pridirector of nursing (DC two separate physician Con 11/07/22 at 4:59 pridirector of nursing (DC two separate physician Con 11/07/22 at 4:59 pridirector of nursing (DC two separate physician Con 11/07/22 at 4:59 pridirector of nursing (DC two separate physician Con 11/07/22 at 4:59 pridirector of nursing (DC two separate physician Con 11/07/22 at 4:59 pridirector of nursing (DC two separate physician Con 11/07/22 at 4:59 pridirector of nursing (DC two separate physician Con 11/07/22 at 4:59 pridirector of nursing (DC two separate physician Con 11/07/22 at 4:59 pridirector of nursing (DC two separate physician Con 11/07/22 at 4:59 pridirector of nursing (DC two separate physician Con 11/07/22 at 4:59 pridirector of nursing (DC two separate physician Con 11/07/22 at 4:59 pridirector of nursing (DC two separate physician Con 11/07/22 at 4:59 pridirector of nursing (DC two separate physician Con 11/07/22 at 4:59 pridirector of nursing (DC two separate physician Con 11/07/22 at 4:59 pridirector of nursing (DC two separate physician Con 11/07/22 at 4:59 pridirector of nursing (DC two separate physician Con 11/0	ot limited to Epilepsy, Acute by Failure, Hemiplegia and g Cerebral Infarction, and Dysphagia. Jum data set (MDS) with an edate (ARD) of 8/19/22 a brief interview for mental ry score of 0 out of 15 twas severely cognitively Jam, surveyor observed beiving Osmolite 1.5 tube ria enteral pump at 80 to The enteral pump was shes at 75 ml every 4 Physician's orders included 2 for water flushes at 200 an additional water flush for 100 ml every 4 hours. The enteral pump was shes at 75 ml every 4 hours. The enteral pump was shes at 75 ml every 4 hours. The enteral pump was shes at 75 ml every 4 hours. The enteral pump was shes at 75 ml every 4 hours. The enteral pump was shes at 75 ml every 4 hours. The enteral pump was shes at 75 ml every 4 hours. The enteral pump was shes at 200 an additional water flushes. The enteral pump was shes at 200 and additional water flushes. The enteral pump was shes at 200 and additional water flushes. The enteral pump was shes at 200 and additional water flushes. The enteral pump was shes at 200 and additional water flushes. The enteral pump was shes at 200 and additional water flushes. The enteral pump was shes at 200 and additional water flushes. The enteral pump was shes at 200 and additional water flushes at 200 and additional water flushes.	F	922			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL' A. BUILDI	TIPLE CONSTRUCT	ION	(X3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER	722130	0 111110			11	/07/2022
	HEALTHCARE AT ROANC	OKE		324 KING GEO ROANOKE, V			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI. TAG		PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD E DSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 692	Continued From page	8	F	692			
SS=D	presented to the survey conference on 11/07/7. Tube Feeding Mgmt/F CFR(s): 483.25(g)(4)(f) Enter (Includes naso-gastrict both percutaneous endoscenteral fluids). Based comprehensive assesses ensure that a resident seat enough alone or wenteral methods unlessed condition demonstrate clinically indicated and resident; and \$483.25(g)(5) A reside means receives the apservices to restore, if pand to prevent complicincluding but not limited diarrhea, vomiting, der abnormalities, and nas This REQUIREMENT by: Based on observation, record review, the facil that residents who are receives appropriate to	Restore Eating Skills 5) ral Nutrition and gastrostomy tubes, doscopic gastrostomy and opic jejunostomy, and on a resident's sment, the facility must ent who has been able to ith assistance is not fed by s the resident's clinical s that enteral feeding was I consented to by the ent who is fed by enteral epropriate treatment and cossible, oral eating skills cations of enteral feeding of to aspiration pneumonia, hydration, metabolic cal-pharyngeal uicers. is not met as evidenced staff interview, and clinical ity staff failed to ensure fed by enteral means eatment and services to of enteral feeding for 1 of 6	F €	593 2 3 4 5	labeled with the date and during the survey process tube feeding pole was cle during the survey process. The Director of Nursing we complete an 100% audit of resident's tube feeding for and time hung. The Central Supply Coordinator will consume a sanitation audit of all restube feeding pump for cleanliness. The Assistant Director of will complete education we license nurses on placing and time hung on tube feed with the Central Supply Coordinator on cleanlines tube feeding poles. All audits will be conducted weekly times six weeks the monthly times three months.	time s. The saned s. fill of r date ral omplete sident Nursing iil date eding, ental ucation s of the d twice en hs. ded in	

1	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	ļ	TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
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	The findings included For Resident #4, the fresident's tube feedin time when initiated. Resident #4's diagnor which included, but not and Chronic Respirate Hemiparesis following Myoneural Disorder, at The admission minimassessment reference assigned the resident status (BIMS) summa indicating the resident impaired. On 11/07/22 at 11:33 Resident #4 in bed refeeding (TF) formula with the feeding (TF) formula with per hour. The 1-licontainer of Osmolite date or time when the administration began. milliliters remained in time of observation. On 11/07/22 at 4:59 produced in the proposition of the container now had "11 Surveyor informed the observation of Resider	facility staff failed to label the g formula with the date and sis list indicated diagnoses, of limited to Epilepsy. Acute bry Failure, Hemiptegia and g Cerebral Infarction, and Dysphagia. The date (ARD) of 8/19/22 a brief interview for mental ry score of 0 out of 15 to was severely cognitively am, surveyor observed being Osmolite 1.5 tube ria pump at 80 milliliters iter ready to hang prefilled 1.5 was not labeled with a container was opened, and Approximately 1000 the 1-liter container at the liter container of ria pump. The Osmolite 1.5 -7" written on the label. DON that the previous at #4's Osmolite 1.5	F	693			
	container was not labe time.	led with a start date or					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIF	PLE CONSTRUCTIO	ON	(X3) DATE COMP	SURVEY
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NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT ROANOR	KE		STREET ADDRES 324 KING GEOR ROANOKE, VA		1 11/	
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shorter hang time is sp manufacturer, hang professional standards	tt Product Information: ted 7/20/2022, "Unless a pecified by the set oduct for up to 48 hours when clean technique and sed. Otherwise hang for ". In, the survey team met ement team including the on and discussed the the Osmolite 1.5 tube ing dated and timed when regarding this concern was by team prior to the exit 2. Intifiable Information 83.70(i)(1)-(5) Identifiable information that is the public. It is an agent only in ract under which the agent sclose the information of facility itself is permitted and practices, the facility records on each resident	F 84		Resident #4 The order for the feeding corrected during the process. The Director of nursing or dwill complete an 100% audited resident tube feeding orders assure they are correct for signature in the MAR. The Assistant Director of Newill complete education with Licensed Nurses on correct placing in MD orders for tube feeding in the MAR. All Audits will be conducted weekly times six weeks the monthly times 3 months All findings will be presented QAPI times three months Date of compliance 12/12/2	e survey esignee t of all s to nursing ursing l ly e twice n	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER. 495156		IDENTIFICATION AND MODED		PLE CONSTRUCTION 3	(X3	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT ROANOKE				STREET ADDRESS, CITY, STATE, ZIP CODE 324 KING GEORGE AVE SW ROANOKE, VA 24016		11101/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	all information contain regardless of the form records, except when (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, pay operations, as permitt with 45 CFR 164.506; (iv) For public health an eglect, or domestic vactivities, judicial and law enforcement purp purposes, research purpour serious threat to head by and in compliance §483.70(i)(3) The facility record information again authorized use. §483.70(i)(4) Medical for- (ii) Five years from the there is no requirement (iii) For a minor, 3 years legal age under State §483.70(i)(5) The med (i) Sufficient information (ii) A record of the resi	lity must keep confidential and in the resident's records, or storage method of the release istrate in their resident permitted by applicable law; ment, or health care ed by and in compliance activities, reporting of abuse, folence, health oversight administrative proceedings, oses, organ donation arposes, or to coroners, meral directors, and to avertalth or safety as permitted with 45 CFR 164.512. Ity must safeguard medical ainst loss, destruction, or records must be retained equired by State law; or after a resident reaches law. It in State law; or a safter a resident reaches law.	F 84	2			
	(), The compressional	- France of only 2017 00171000					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER-			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
495156			B. WING			C 11/07/2022	
NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT ROANOKE				STREET ADDRESS, CITY, STATE, ZIP CODE 324 KING GEORGE AVE SW ROANOKE, VA 24016	-		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COM (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	-	(X5) COMPLETION DATE
	and resident review determinations con (v) Physician's, nur professional's prog (vi) Laboratory, rad services reports as This REQUIREMEI by: Based on observative record review, the formulate and accurrecord for 1 of 6 resident #4. The findings include For Resident #4, the document administrand water flushes in Resident #4's diagram which included, but and Chronic Respirational Chronic Respirational Profession minimassessment reference assigned the reside status (BIMS) summindicating the reside status (BIMS) summindicating the reside impaired. On 11/07/22 at 11:3 Resident #4 in bed refeeding (TF) formulations.	any preadmission screening view evaluations and ducted by the State; se's, and other licensed ress notes; and iology and other diagnostic required under §483.50. No is not met as evidenced diagnostic required under sevidenced diagnostic required to ensure a rately documented clinical sidents in the survey sample, and the resident's clinical record. The facility staff failed to retion of tube feeding formula in the resident's clinical record. The facility staff failed to retion of tube feeding formula in the resident's clinical record.	F 84				

AND PLAN OF CORRECTION		IDENTIFICATION JUMBER: A. BUIL		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			C 11/07/2022	
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD B THE APPROPRIA		(X5) COMPLETION DATE	
F 842		ge 13 flushes at 75 ml every 4	F 8	142				
	Resident #4's currer an order dated 9/26 per G-Tube via pum and water flushes at order dated 10/23/2 1.5 in place of Jevity additional water flush flush with 100 ml water flush flush with 100 ml water flush flush with 100 ml water flush flu	nt physician's orders included /22 to administer Jevity 1.5 p at 80 milliliters (ml) per hour 200 ml every 4 hours. An 2 stated may use Osmolite of until Jevity available. An horder dated 10/05/22 stated after every 4 hours. It #4's November 2022 ration record (MAR) and ation record (TAR) revealed molite TF and water flushes mented as administered. It pm, surveyor spoke with the DON) and informed them of lite and water flushes not an the MAR or TAR. The resident's clinical record and water flushes were not the DON stated the order city and has been corrected						
	On 11/07/22 at 5:22 with the facility admit DON and assistant E concern of Resident flush administration administered.	pm, the survey team met nistrative team including the DON and discussed the #4's tube feeding and water not being documented as						
		vey team prior to the exit						

AND PLAN OF CORRECTION	IDENTIFICATION IN IMPED		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
			- 1	С		
	495156	B. WING		11/07/2022		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
CHOICE HEALTHCARE AT ROANOKE			324 KING GEORGE AVE SW			
			ROANOKE, VA 24016			
PREFIX (EACH DEFICIENCY MUS	IENT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	HD PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 883 Continued From page 14		F 88	83			
F 883 Influenza and Pneumococ CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pimmunizations §483.80(d)(1) Influenza. T policies and procedures to (i) Before offering the influence ach resident or the resident receives education regard potential side effects of the (ii) Each resident is offere immunization October 1 thannually, unless the immunized during this time (iii) The resident or the re	The facility must develop of ensure that- penza immunization, lent's representative ling the benefits and rough March 31 inization is medically dent has already been reperiod; sident's representative record includes rese immunization; and record includes representative regarding the benefits of influenza cal contraindications or received the influenza cal contraindications or received resident's representative regarding the benefits of influenza cal contraindications or received the influenza cal contraindications or received resident's representative received the influenza cal contraindications or received resident's representative received the influenza cal contraindications or received resident's representative received the influenza cal contraindications or received resident's representative received receiv	F 88		sident #5, monia rsing will sill residents complete Director of on offering a se weekly y times o QAPI		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	495156	B. WING	B. WING		C 11/07/2022	
NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT ROANG	324	EET ADDRESS, CITY, STATE, ZIP C KING GEORGE AVE SW ANOKE, VA 24016	ODE			
PREFIX (EACH DEFICIENC	FATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
immunization, unless medically contraindic already been immunit (iii) The resident or the has the opportunity to (iv)The resident's medocumentation that in following: (A) That the resident of was provided education and potential side effectimmunization; and (B) That the resident of pneumococcal immunitation or refective the pneumococcal immunitation of the vaccine for (Resident #2, #4, and immunizations. The findings included: 1. For Resident #2, the the pneumonia vaccine for (Resident #2, the pneumonia vaccine for the vaccine. Resident #2's diagnos which included, but no Damage, Persistent Value and pages presistent value and pages pre	offered a pneumococcal the immunization is ated or the resident has zed; e resident's representative orefuse immunization; and dical record includes adicates, at a minimum, the corresident's representative on regarding the benefits ects of pneumococcal either received the mization or did not receive munization due to medical fusal. The is not met as evidenced iew, clinical record review, review, the facility staff vide the resident and/or re education regarding the side effects of the or 3 of 5 sampled residents #5) reviewed for	F 883				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
			C		
		495156	B. WING		11/07/2022
	ROVIDER OR SUPPLIER	OKE	3241	EET ADDRESS, CITY, STATE, ZIP CODE KING GEORGE AVE SW ANOKE, VA 24016	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	#D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 883	Paroxysmal Tachycar The most recent signidata set (MDS) with a	dia. ficant change minimum n assessment reference coded the resident as regetative state/no	F 883		
	and was unable to loc resident's pneumocod documentation of the being offered and proving pneumonia vaccine. On 11/07/22 at 5:15 pt facility Infection Preversesident #2's pneumonia	coccal vaccination status.			
	to locate any documer was offered the vaccin also stated they were president pneumonia van November.	o fooked and were unable nation where the resident ation in the past. The IP planning to work on the accines during the month of			
	which read in part: 2. Each resident will be immunization unless it contraindicated or the dimmunized. Following medical contraindicated be administered in accephysician-approved "state". Prior to offering the immunization, each resident will be a contraindicated.	e offered a pneumococcal is medically resident has already been assessment for any ordance with anding orders". pneumococcal sident or the resident's ive education regarding			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495156	B. WING		C 11/07/2022		
NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT ROANOKE			324	REET ADDRESS, CITY, STATE, ZIP CODE KING GEORGE AVE SW ANOKE, VA 24016			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING MECREPATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION		
F 883	immunization. 8. The resident's m documentation that following: a. The resident or reprovided education potential side effects immunization. b. The resident recimmunization or did contraindication or recimmunization or did contraindication or recimmunization or following the facility admit director of nursing a nursing and discuss #2's pneumococcal No further information presented to the surconference on 11/07. 2. For Resident #4, the pneumonia vaccing regarding the benefit of the vaccine. Resident #4's diagnowhich included, but reand Chronic Respiral Hemiparesis following Myoneural Disorder, The admission minimassessment reference assigned the resident status (BIMS) summinimassessment support the summan support of the resident status (BIMS) summinimassessment support of the	edical record shall include indicated at a minimum the esident's representative was regarding the benefits and sof pneumococcal not receive due to medical efusal. pm, the survey team met nistrative team including the nd the assistant director of ed the concern of Resident vaccination status. On regarding this concern was vey team prior to the exit 7/22. the facility staff failed to offer the and provide education ts and potential side effects psis list indicated diagnoses, not limited to Epilepsy, Acute tory Failure, Hemiplegia and and Cerebral Infarction.	F 883				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION HUMBER		2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		495156	B. WING			C 11/07/2022	
	ROVIDER OR SUPPLIER	OKE		STREET ADDRESS, CITY, STATE, ZIP 324 KING GEORGE AVE SW ROANOKE, VA 24016	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CEACH CORRECTIVE ACCURATE CONTROL TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
	and was unable to lo resident's pneumoco documentation of the being offered and proposed pneumonia vaccine. On 11/07/22 at 5:15 facility Infection Prev Resident #4's pneum The IP stated they al to locate any docume was offered the vacci also stated they were resident pneumonia vaccine. Surveyor requested a policy entitled "Pneumonia vaccine in part: 2. Each resident will immunization unless contraindicated or the immunized. Followin medical contraindicate administered in accomplysician approved "sale in proposed in the immunization, each representative will recommunization. 8. The resident in medical contraindicate administered in accomplysician approved in the immunization. 8. The resident's medical contraindical contraindical contraindical contraindical contraindicate administered in accomplysician approved in the immunization. 8. The resident or resi	Resident #4's clinical record cate documentation of the occal vaccination status or a resident's representative divided education regarding a pm, surveyor spoke with the rentionist (IP) regarding mococcal vaccination status, so looked and were unable centation where the resident ination in the past. The IP ce planning to work on the vaccines during the month of and received the facility mococcal Vaccine (Series)" be offered a pneumococcal at it is medically a resident has already been grassessment for any coordance with standing orders", see pneumococcal esident or the resident's ceive education regarding intial side effects of the dical record shall include indicated at a minimum the sident's representative was egarding the benefits and	F	383			
	immunization.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUBPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
		495156	495156 B. WING		C	
NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT ROANOKE			STR 324	EET ADDRESS, CITY, STATE, ZIP CODE KING GEORGE AVE SW ANOKE, VA 24016	11/07/2022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEPTEMENTES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING IMPORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 883	immunization or did contraindication or or on 11/07/22 at 5:22 with the facility admit director of nursing a nursing and discuss #4's pneumococcal. No further informatic presented to the sur conference on 11/07. 3. For Resident #5, the pneumonia vaccing the benefit of the vaccine. Resident #5's diagnowhich included, but in Hemiparesis following Essential Hypertens Stenosis of Right Cathering With an assess of 10/25/22 assigned for mental status (BII of 15 indicating the incognitively impaired. Surveyor reviewed Rand was unable to lo resident's pneumocodocumentation of the representative being	pm, the survey team met mistrative team including the nd the assistant director of ed the concern of Resident vaccination status. on regarding this concern was evey team prior to the exit 7/22. the facility staff failed to offer ine and provide education its and potential side effects osis list indicated diagnoses, not limited to Hen iplegia and ing Cerebral Infarction, ion, and Occlusion and	F 883			

		AND HUMAN SERVICES & MEDICAID SERVICES			FC	TED: 11/21/2022 DRM APPROVED NO: 0938-0391
		(X1) PROVIDER SUP LIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) D/	ATE SURVEY DMPLETED
		495156	B. WING			C
NAME OF P	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		11/07/2022
CHOICE H	HEALTHCARE AT ROA	ANOKE	324 K	KING GEORGE AVE SW NOKE, VA 24016		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEPICE NOIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING WEOPMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPROPRICIENCY)	ULD BE	(X5) COMPLETION DATE
	On 11/07/22 at 5:1 facility Infection Pr Resident #5's pnet The IP stated they to locate any docu was offered the variation also stated they we resident pneumoni November. Surveyor requeste policy entitled "Pnet which read in part 2. Each resident with immunization unless contraindicated or immunized. Follow medical contraindic be administered in physician-approved 3. Prior to offering immunization, each representative will representative will represent the benefits and point immunization. 8. The resident or reprovided education potential side effect immunization. b. The resident recimmunization or did contraindication or did contraindication or did contraindication did contraindic	Is pm, surveyor spake with the reventionist (IP) regarding umococcal vaccination status, also looked and were unable mentation where the resident occination in the past. The IP ere planning to work on the in vaccines during the month of the dark and received the facility sumococcal vaccine (Series)" will be offered a prococcal sist is medically the resident has also dy been wing assessment for any accordance with the series of the medical receive education and rearding stential side effects of the medical record shall include a indicated at a minimum the resident's representative was regarding the benefits and its of pneumococcal series due to medical receive due to medical refusal.	F 883			
	On 11/07/22 at 5:22	pm, the survey team met				

with the facility administrative team including the director of nursing and the assistant director of

PRINTED: 11/21/2022

PRINTED: 11/21/2022 **DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIT PLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING _ С 495156 B. WING 11/07/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 324 KING GEORGE AVE SW CHOICE HEALTHCARE AT ROANOKE ROANOKE, VA 24016 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 883 Continued From page 21 F 883 nursing and discussed the concern of Pesident #5's pneumococcal vaccination status. No further information regarding this concern was presented to the survey team prior to the exit conference on 11/07/22.