

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495209	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/15/2024
NAME OF PROVIDER OR SUPPLIER  Raleigh Court Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1527 Grandin Road Southwest Roanoke, VA 24015	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>28169</p> <p>Based on staff interviews, clinical record review, and facility document review, facility staff failed to notify the resident representative of a change in condition requiring transfer for 1 of 4 closed records reviewed for the survey (Resident #113)</p> <p>The findings were:</p> <p>The facility staff failed to notify Resident #113's resident representative of the resident's change in condition. The resident was unresponsive and required a transfer to an acute care hospital.</p> <p>The minimum data set with an assessment reference date of 06/15/2023 assigned Resident #113 a brief interview for mental status score a 15 out of 15. The admission record listed the resident was his own responsible party and a family member as the emergency contact #1.</p> <p>The clinical record contained a licensed practical nurse (LPN) change of condition progress note dated 07/11/23 at 9:09 p.m. which read, pt. (patient) notice [sic] to be unresponsive to voice by writer, who attempted sternal rub with no response. vs (vital signs) 101/69 97.8 temp, 106 bpm (beats per minute), and 94% O2 (oximeter). md (medical doctor) was contacted for consultation at 2020 r/t LOC (8:20 p.m. related to level of consciousness) and BP (blood pressure) which read 86/58 approx ten minutes later. pt received IV bolus (intravenous fluids administered quickly) on previous shift, Narcan (opioid antagonist - used to reverse an opioid overdose) administered with little/no change per MD request. 911 contacted at 2030 (8:30 p.m.), sent to ED (emergency department) via ambulance at 2104 (9:04 p.m.). The same LPN wrote a Change of Condition Note on 07/11/23 at 9:20 p.m. which read, pt is own RP (Responsible Party), attempted to call emergency contact at 2119 (9:19 p.m.), busy tone received. A telehealth evaluation note with a date of service reading 07/11/23 at 7:28 p.m. central time (8:28 p.m. eastern time) read in part, Consent for telemedicine/virtual visit obtained from patient/POA: Yes. The LPN was not available for interview.</p> <p>A health status note dated 07/12/23 at 5:06 a.m. read the resident had been admitted to the acute care hospital. A registered nurse' health status note, written on 07/14/23 at 2:26 p.m., read the resident remained in the intensive care unit in stable condition.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The regional director of clinical services (RDCS) was interviewed on 08/15/24 at 11:50 a.m. The RDCS acknowledged the clinical record did not include evidence the facility staff successfully contacted Resident #113's emergency contact. The RDCS reported not knowing for sure but felt the reason there was no more attempts to call the emergency contact was that in communication with the hospital, it was determined the hospital had notified the resident's family member. The RDCS discussed the telehealth documentation that read the patient/POA gave consent that since the resident was unresponsive, it would make sense the emergency contact gave consent. The RDCS acknowledged not knowing for sure who gave consent.</p> <p>On 08/15/24 at 2:44 p.m. during a meeting with the assistant administrator, administrator, regional director of clinical services, assistant director of nursing, and regional minimum data set director, the concern of whether Resident #113's emergency contact/resident representative was notified of a significant change with the resident being unresponsive upon transfer was discussed.</p> <p>The administrator reported no further information would be presented prior to the exit conference.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>21227</p> <p>Based on staff interviews, facility document review, and clinical record review, the facility staff failed to develop a comprehensive care plan which addressed hypotension for one (1) of 23 sampled current residents (Resident #74).</p> <p>The findings include:</p> <p>Review of Resident #74's comprehensive care plan, on the morning of 8/14/24, fail to reveal evidence the resident was care planned to address low blood pressure (hypotension).</p> <p>Resident #74's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 5/9/24, was signed as completed on 5/16/24. Resident #74 was assessed as able to make self understood and as able to understand others. Resident #74's Brief Interview for Mental Status (BIMS) summary score was documented as an eight (8) out of 15; this indicated moderate cognitive impairment.</p> <p>Resident #74's clinical record included a medical provider order for midodrine 5 mg tablet dated 6/24/24. This order indicated the resident was to receive one (1) tablet two times a day for low blood pressure. This order indicated the medication should not be administered if the resident's blood pressure was greater than 110/50.</p> <p>On 8/14/24 at 9:10 a.m., the Regional Minimum Data Set (MDS) staff member confirmed Resident #74's comprehensive care plan did not address hypotension.</p> <p>The following information was found in a facility policy titled Care Planning (with an effective date of 11/1/19): A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health-related care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being of the patient.</p> <p>On 8/15/24 at 2:42 p.m., the survey team met with the facility's Administrator, Assistant Administrator, Assistant Director of Nursing, and Regional Minimum Data Set (MDS) staff member. During this meeting, the surveyor discussed Resident #74's comprehensive care plan not addressing hypotension.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 28169</p> <p>Based on observation, staff interview, and clinical record review, facility staff failed to provide adequate supervision to ensure the resident environment remained free of accident hazards for 2 of 23 current residents in the survey sample (Resident #107 and #62).</p> <p>The findings were:</p> <ol style="list-style-type: none"> <li>For Resident #107, the facility staff failed to maintain the resident's cigarettes and lighters.</li> </ol> <p>The most recent minimum data set with an assessment reference date of 07/17/24 assigned Resident # 107 a brief interview for mental status score a 10 out of 15. The care plan included a focus area which read the resident was a smoker, the goal read the resident will smoke safely. For interventions, the care plan read educate on facility smoking policy, OT referral as needed, smoking apron, smoking assessment as needed.</p> <p>During the initial tour on 08/11/24 at 3:10 p.m., Resident #107 was lying in bed with the overbed table beside the bed. The surveyor observed one (1) pack of cigarettes and two (2) blue lighters on the overbed table. On 08/14/24 at 2:56 p.m., the surveyor observed two packs of cigarettes and a lighter on the over-the-bed table sitting beside the bed. When asked about having the cigarettes and lighter with him, Resident #107 stated the nurses took him to smoke but not always during the designated smoking times. He was not sure of the smoking times and reported there were multiple smoking areas outside.</p> <p>On 08/14/24 at 3:06 p.m., the surveyor notified the administrator of observing Resident #107's smoking paraphernalia (pack of cigarettes and lighters) on overbed table located beside the resident's bed. The administrator did not comment.</p> <p>Resident #107's clinical record contained a smoking assessment dated [DATE] at 11:22 a.m. which assigned the resident a 9.0 score. Within the smoking assessment, a score of 5 or greater, Requires supervision with smoking.</p> <p>The administrator provided policy #1019 titled, Patient Smoking with an effective date of 01/29/2024. The policy read in part, Procedure 7. The center will maintain all smoking paraphernalia for patients who require supervision with smoking</p> <p>On 08/14/24 at 4:32 p.m. during an end of day meeting with the assistant administrator, administrator, regional director of clinical services, assistant director of nursing, and regional minimum data set director, the observations of Resident #107's cigarettes and lighters at the resident's bedside were discussed.</p> <p>No further information was provided prior to the exit conference.</p> <p>22218</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. For Resident #62, facility staff failed to ensure medications were secured as evidenced by medications left unattended on the resident's tray table.</p> <p>Resident #62 was admitted to the facility with diagnoses which included dysphagia, cognitive deficit after cerebral infarction, type 2 diabetes mellitus, generalized muscle weakness, and major depression. On the most recent Minimum Data Set assessment, the resident scored</p> <p>On 8/11/24 approximately 2:15 PM. A medication cup with 2 pills was on the overbed table. The resident said they leave them a lot. He said he would take them later. There was one chewable ASA 81 mg (milligram) and an oval capsule stamped with G 12 and scored for halving which Drugs.com suggests is metformin 1000 mg from Igneus pharmaceuticals. Clinical record review revealed that the resident had orders for aspirin 81 mg and metformin 1000 mg.</p> <p>On 08/14/24 at 2:30 PM Surveyor spoke with LPN #1, who was responsible for the resident on 8/11. LPN #1 was aware that the resident should be watched while taking medications because he sometimes does not take them. LPN #1 stated she had watched the resident take the noon medications on 8/11/24 (Sunday). The surveyor asked who might have left the medications in the resident's room. LPN #1 did not offer a possible name.</p> <p>,</p> <p>08/14/24 03:30 PM Surveyor spoke with ADON and regional director of clinical services about the medications found on the table on 8/11/24. They did not offer an explanation.</p> <p>During a summary meeting on 8/14/2024 which included the administrator, assistant administrator, and assistant director of nursing, the surveyor stated issue remained a concern.</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>21227</p> <p>Based on observations, staff interviews, and facility document review, the facility staff failed to ensure the posting of the required daily nurse staffing information.</p> <p>The findings include:</p> <p>On 8/13/24 at approximately 10:25 a.m., the surveyor observed the posted daily nurse staffing information did not include the facility's census. The Assistant Administrator was informed the posting did not include the census.</p> <p>The form used to post the daily nurse staffing information was titled DAILY NURSE STAFFING SUMMARY. This form included the following statements:</p> <ul style="list-style-type: none"> <li>- Post this document in a prominent place; accessible to patients and visitors. Complete at the beginning of each shift; update any changes to information as needed.</li> <li>- Retain Nursing Staffing Data for 18 months.</li> </ul> <p>On 8/13/24 at 10:44 a.m., the surveyor reviewed the facility's retained documentation of posted daily nurse staffing information with the Administrator. These documents were kept in a binder but were not organized by date. The surveyor noted multiple documents were missing some of the required information. The following dates failed to include the facility's census: 2/26/24, 8/20/23, 8/19/23, and September 4, (no year was documented). The following dates only had the day shift (7:00 a.m. - 3:00 p.m.) information documented: 8/8/24, 8/6/24, 8/2/24, 7/29/24, 7/17/24, 7/8/24, 6/28/24, 6/24/24, 6/18/24, 5/21/24, 5/17/24, 4/15/24, 4/4/24, 4/2/24, 1/23/24, 1/16/24, and 11/27/23.</p> <p>On 8/14/24 at 8:46, the surveyor, with the Administrator present, reviewed the facility's retained DAILY NURSE STAFFING SUMMARY documents. The following dates did not have a DAILY NURSE STAFFING SUMMARY document: 8/11/24, 8/9/24, 8/4/24, 8/3/24, 8/1/24, 7/28/24, 7/22/24, and 7/20/24.</p> <p>On 8/15/24 at 2:42 p.m., the survey team met with the facility's Administrator, Assistant Administrator, Assistant Director of Nursing, and Regional Minimum Data Set (MDS) staff member. During this meeting, the surveyor reviewed the concern of the facility's DAILY NURSE STAFFING SUMMARY documents having incomplete and/or missing information.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>21227</p> <p>Based on staff interviews, facility document review, and clinical record review, the facility staff failed to ensure one (1) of 23 sampled current residents was free from unnecessary medications (Resident #74).</p> <p>The findings include:</p> <p>The facility staff failed to hold Resident #74's midodrine according to the medical provider's ordered parameters. Midodrine is a medication used to treat low blood pressure (hypotension). Midodrine works by constricting blood vessels to increase an individual's blood pressure.</p> <p>Resident #74's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 5/9/24, was signed as completed on 5/16/24. Resident #74 was assessed as able to make self understood and as able to understand others. Resident #74's Brief Interview for Mental Status (BIMS) summary score was documented as an eight (8) out of 15; this indicated moderate cognitive impairment.</p> <p>Resident #74's clinical record included a medical provider order for midodrine 5 mg tablet dated 6/24/24. This order indicated the resident was to receive one (1) tablet two (2) times a day for low blood pressure. This order indicated the medication should not be administered if the resident's blood pressure was greater than 110/50.</p> <p>Resident #74's Medication Administration Record (MAR) for August 2024 was reviewed on the morning of 8/14/24. It was noted that Resident #74's August 2024 MAR included documentation to indicate the resident's midodrine was administered, 20 times, when the resident's blood pressure would have required the medication to be held (not administered).</p> <p>The following information was found in a document titled General Guidelines for Medication Administration (with an effective date of 9-2018):</p> <ul style="list-style-type: none"> <li>- Medications are administered as prescribed in accordance with good nursing principles and practices .</li> <li>- Medications are administered in accordance with written orders of the prescriber.</li> </ul> <p>On 8/15/24 at 2:42 p.m., the survey team met with the facility's Administrator, Assistant Administrator, Assistant Director of Nursing, and Regional Minimum Data Set (MDS) staff member. During this meeting, the surveyor discussed the findings of facility staff administering Resident #74's midodrine when the parameters indicated it should not have been administered.</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>49622</p> <p>Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure that residents are free of any significant medication errors for 1 of 23 sampled residents, Resident #105.</p> <p>The findings included:</p> <p>For Resident #105, the facility staff failed to follow provider orders for the administration of the medication, Cephalexin four times a day for two days as indicated. Cephalexin is indicated for the treatment of patients with certain infections caused by bacteria such as urinary tract infections.</p> <p>Resident #105's diagnosis list indicated diagnoses, which included, but not limited to, Traumatic Subdural Hematoma, Muscle Weakness, Urinary Tract Infection (UTI), Delirium, End Stage Renal Disease, and Dependence on Renal Dialysis.</p> <p>Resident #105's most recent minimum data set (MDS) with an assessment reference (ARD) of 6/13/24 assigned the resident a brief interview for mental status (BIMS) summary score of 12 out of 15 for cognitive abilities, indicating the resident is moderately cognitively impaired.</p> <p>A provider's order dated 6/7/24, read in part, .Cephalexin Oral Capsule 500 MG (milligrams) (Cephalexin) Give one capsule by mouth four times a day for UTI for 2 (two) days .Start Date 6/7/2024 .End Date 6/9/2024 . Further review of the provider orders read in part, Supply .Date Dispensed 6/7/2024 .Status On Hand .</p> <p>A reviewed of Resident #105's June 2024 MAR (medication administration record) revealed for Cephalexin on 6/7/2024 at 2100 (9:00 PM) and on 6/8/2024 at 0900 (9:00 AM) a code of 9, which indicated to see Other/Progress Note. A review of the progress note dated 6/7/2024 read in part, .pending pharm (pharmacy) delivery . A review of the 6/8/2024 progress note read in part, Orders-Administration Note .Cephalexin Oral Capsule 500 MG Give 1 (one) capsule by mouth four times a day for UTI for 2 Days Rsd (resident) oof (out of facility) at dialysis .</p> <p>According to the provider's orders and the June 2024 MAR, the medication was not given as ordered every four hours for two days. The resident received six doses of Cephalexin and the provider's order indicated the resident should have received eight doses.</p> <p>On 08/14/24 at 2:53 PM, the administrator (ADM#1) informed surveyor the medication was available in the omnicell (an automated medication management system), and the nurse did not pull the medication. ADM#1 did not know the reason why the nurse did not get the medication from the omnicell.</p> <p>This concern was discussed on 8/14/24 at 4:32 PM at the end of day meeting with the administrator, assistant administrator, regional director of clinical services, assistant director of nursing and the regional director of mds and again at the pre-exit meeting on 8/15/24 at 2:41 PM.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Surveyor requested and received the facility policy titled, General Guidelines for Medication Administration, which read in part, .Medications are administered as prescribed .I .5. Always employ the MAR during medication administration .if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule .II .2. Medications are administered in accordance with written orders of the prescriber .IV .1 .the person administering the medications reviews the MAR to ensure that necessary doses were administered and documented .</p> <p>No further information regarding this concern was presented to the survey team prior to the exit conference on 8/15/24.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>28169</p> <p>Based on observation, staff interview, and facility document review, facility staff failed to prepare, distribute, and serve food in accordance with professional standards for food service safety.</p> <p>The findings were:</p> <p>Facility staff stacked food storage containers one on top of each other after being washed and remained wet. Facility staff left the ice scoop inside the ice machine.</p> <p>On 08/11/24 at 1:15 p.m. during the initial tour of the kitchen, three (3) stacks of food storage containers were observed wet. A dietary aide who accompanied the surveyor during the tour acknowledged the containers had been washed and stacked, one on top of the other, to dry. The dietary aide unstacked the containers to dry separately. The ice scoop was observed inside the ice machine. The dietary aide removed the scoop, placed it in the holder attached to the wall beside the ice machine and stated, They know not to do that.</p> <p>On 08/14/24 at 4:32 p.m. during an end of day meeting with the assistant administrator, administrator, regional director of clinical services, assistant director of nursing, and regional minimum data set director, the kitchen observations were discussed.</p> <p>The administrator provided two policies. Both policies were from the facility's contracted hospitality services (dietary services), and both read the revision history date was October 2019. The first policy titled, Ware washing and policy 22 read in part, Action Steps 4. The Dining Services Director ensures that all dishware is air dried and properly stored. The second policy titled, Manual Ware Washing and policy 23 read in part, Action Steps 3. The Dining Services Director insures [sic] that all service ware and cook ware are air dried prior and storage [sic].</p> <p>No further information was provided prior to the exit conference.</p>