STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495427	A. Building B. Wing	02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Star City Rehabilitation and Nursing	1047 Mecca Street Roanoke, VA 24012

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)
F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. 21227 Based on interviews and document review, the facility staff failed to ensure one (1) of 19 current sampled residents were able to access personal funds deposited with the facility (Resident #15). The findings include: Resident #15 was unable to access a sufficient amount of their personal funds in order to make desired purchases in November 2023. Resident #15's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 12/16/23, was signed as completed on 12/26/23. Resident #15 was assessed as being able to make self understood and as able to understand others. Resident #15's Brief Interview for Mental Status (BIMS) summary score was documented as a 15 out of 15; this indicated intact and/or borderline cognition. Resident #15 was assessed as being depended on others for eating, hygiene, dressing, and bathing. On the afternoon of 2/8/24, Resident #15 reported they were unable to obtain money from their personal funds deposited with the facility to make a purchase. On 2/9/24 at 8:40 a.m., the surveyor asked the facility's Administrator about the process for a resident obtaining a large amount of money from their personal funds deposited with the facility. The Administrator provided a copy of a facility document titled Resident Personal Funds (with a revised/reviewed date of 12/1/2022); this document included the following information: The resident has a right to manage his or her financial affairs . The Administrator provided a copy of a facility document titled Resident Trust Fund (with a revised/reviewed date of 12/1/22); this document detailed the need for the facility to have a minimum of 24-hour notice to issue a check for amounts greater than the monthly state allowable amount. The Administrator confirmed that, prior to the facility's change of ownership, Resident #15 had been unable to make a desired purchase, in November 2023, with their personal funds deposited with the facility. The survey team met with the facility's Administrator and Director of Nursing (DON) on 2/13/24 at 5:15 p.m. The surveyor discussed Resident #15 not being able to make a desired purchase, in November 2023, with their personal funds.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495427	A. Building B. Wing	02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Star City Rehabilitation and Nursing	1047 Mecca Street Roanoke, VA 24012

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)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 21227 Based on interviews and document review, the facility staff failed to provide a resident's responsible party and the ombudsman with written information related to a discharge/transfer for one (1) of 22 sampled residents (Resident #11). The findings include: The facility's staff failed to provide Resident #11's responsible party with a written transfer notice. The facility staff failed to provide the ombudsman with notice of facility transfers. Resident #11's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 11/22/23, was signed as completed on 11/30/23. Resident #11 was assessed as sometimes able to make self understood and as being rarely/never able to understand others. Resident #11 was assessed as having problems with both long-term memory and short-term memory. Resident #11 was assessed as requiring assistance with oral hygiene, dressing, toilet hygiene, and bathing. Resident #11's documentation indicated the resident was transferred to a local emergency department on 1/24/24, at a little after 12:00 noon, where the resident was subsequently admitted . Resident #11 was transported to the local emergency department via ambulance due to a change in condition which included altered mental status. No evidence of Resident #11's resident representative being provided written transfer notice/information was found by or provided to the surveyor. Medical provider documentation indicated Resident #11's family was aware of the transfer. On the afternoon of 2/13/24, the facility's Director of Nursing (DON) reported, at the time of transfer, the facility staff would have sent, with the resident, a document addressing the need for Resident #11 to have an emergent transfer. On 2/13/24 at 3:28 p.m., the facility's Director of Nursing (DON) was asked for ombudsman notification of Resident #11's discharge. On 2/13/24 at 4:06 p.m., the facility's Administrator reported that the facility's discharges had not been communicated with the ombudsman. The Administrator stated the failure to notify the ombudsman of facility discharges was identified in September 2023. The Administrator reported the facility's social services department was to submit the facility's discharges to the ombudsman quarterly; the Administrator stated these quarterly submissions had not yet started. The survey team met with the facility's Administrator and DON on 2/13/24 at 5:15 p.m. The surveyor discussed the absence of evidence that written information related to Resident #11's emergent transfer been provided to Resident #11's resident representative when the resident was admitted to the local hospital. The failure of the facility staff to notify the local ombudsman of the facility's discharges was also discussed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495427	A. Building B. Wing	02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Star City Rehabilitation and Nursing	1047 Mecca Street Roanoke, VA 24012

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)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 21227 Based on interviews and document review, the facility staff failed to provide a resident's responsible party with written bed hold information for one (1) of 22 sampled residents (Resident #11). The findings include: The facility's staff failed to provide Resident #11's responsible party with written bed hold information when the resident was admitted to a local hospital. Resident #11's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 11/22/23, was signed as completed on 11/30/23. Resident #11 was assessed as sometimes able to make self understood and as being rarely/never able to understand others. Resident #11 was assessed as having problems with both long-term memory and short-term memory. Resident #11 was assessed as requiring assistance with oral hygiene, dressing, toilet hygiene, and bathing. The following information was found in a facility document titled Bed Hold Notice Upon Transfer (with a reviewed/revised date of 12/1/22): - At the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed. - In the event of an emergency transfers [sic] of a resident, the facility will provide within 24 hours written notice of the facility's bed-hold policies, as stipulated in the State's plan. Resident #11's documentation indicated the resident was transferred to a local emergency department on 1/24/24, at a little after 12:00 noon, where the resident was subsequently admitted . No evidence of Resident #11's resident representative being provided written bed hold information was found by or provided to the surveyor. On the afternoon of 2/13/24, the facility's Director of Nursing (DON) reported, at the time of transfer, the facility staff would have sent a document addressing bed-holds with Resident #11. The survey team met with the facility's Administrator and DON on 2/13/24 at 5:15 p.m. The surveyor discussed the absence of evidence that written information related to bed-holds had been provided to Resident #11's resident representative when the resident was admitted to the local hospital.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495427	A. Building B. Wing	02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Star City Rehabilitation and Nursing	1047 Mecca Street Roanoke, VA 24012

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)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 42353 Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to review and revise the comprehensive person-centered care plan for 1 of 22 residents in the survey sample, Resident #54. The findings included: For Resident #54, the facility staff failed to revise the person-centered care plan to include the need for isolation precautions. Resident #54's diagnosis list indicated diagnoses, which included, but not limited to Alzheimer's Disease, Type 2 Diabetes Mellitus, Chronic Respiratory Failure with Hypoxia, and Hypothyroidism. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 11/05/23 assigned the resident a brief interview for mental status (BIMS) summary score of 2 out of 15 indicating Resident #54 was severely cognitively impaired. On 2/07/24 at 3:05 PM, surveyor observed a contact precautions isolation sign present on Resident #54's door and personal protective equipment (PPE) present. Resident #54's physician's orders included an order dated 1/30/24 for Contact Precautions for ESBL (extended-spectrum beta-lactamase) in the urine until 2/08/24. Surveyor reviewed Resident #54's comprehensive care plan and was unable to locate documentation of contact precautions. On 2/13/24 at 1:11 PM, surveyor spoke with the Director of Nursing (DON) regarding Resident #54's care plan. Surveyor informed the DON they were unable to locate evidence of the resident's care plan being revised to include the need for contact precautions. The DON returned to the surveyor at 1:36 PM and stated they also could not locate contact precautions on the care plan. Surveyor requested and received the facility policy titled Comprehensive Care Plans which read in part . 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . On 2/13/24 at 5:23 PM, the survey team met with the Administrator and DON and discussed the concern of staff failing to revise Resident #54's care plan to include the need for contact precautions. The DON again confirmed contact precautions were not on the resident's care plan. No further information regarding this concern was presented to the survey team prior to the exit conference on 2/14/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495427	A. Building B. Wing	02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Star City Rehabilitation and Nursing	1047 Mecca Street Roanoke, VA 24012

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)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 22218 Based on resident interview, staff interview, and clinical record review, facility staff failed to provide pressure ulcer dressing changes as ordered for 1 of 22 residents in the survey sample (Resident #32). Resident #32 was admitted to the facility with diagnoses which included chronic congestive heart failure, essential hypertension, chronic kidney disease, generalized muscle weakness, clostridium difficile enterocolitis, and stage 3 sacral ulcer. On the Minimum Data Set Assessment with Assessment Reference Date 1/14/24, the resident scored 15/15 on the Brief Interview for Mental Status and was assessed as without signs of delirium, psychosis, or behaviors affecting care. During initial tour on 2/7/24, the resident reported being generally happy with care with the exception of wound care. The resident reported not having wound dressings changed on 2 night shifts the previous week. Clinical record review revealed a physician order dated 1/26/24 for Vashe Wound External Solution 0.033 % (Wound Cleansers) Apply to sacrum topically two times a day for sacral decubitus VASHE wet to dry: Place gauze in wound and undermining and cover with ABD pad secured with roll gauze or minimal tape BID. The resident's Treatment Administration Record (TAR) was blank for the 7 PM-7 AM shift on 2/6/24. The surveyor interviewed the RNCC (registered nurse clinical coordinator) on 2/13/24 at 10 AM concerning the resident's dressing changes. The RNCC stated the nurse who completed the dressing change on 2/7/24 noted excessive drainage and reported it. RNCC stated she had done a dressing change and assessment on 2/8 after there was a large amount of exudate on 2/7. The wound looks good now and wound bed is clean. Nursing progress notes on 2/7 and 2/8 matched the RNCC's statements. A nursing progress note dated 1/24/2024 20:28 Behavior Note-Note Text: Resident upset dressing change was not done during day shift. Resident states she asked several times throughout day shift to have this done. This nurse changed sacral wound dressing. Dressing had prior nights date and shift written on it. The RNCC acknowledged the MAR showed the January 24 day shift dressing change was signed as if complete. The surveyor spoke with the resident on 2/12/24. The resident stated that over the weekend, on the 9th and 10th, evening shift dressings were not done as ordered. The resident reported to the RNCC that evening dressings weren't done. The surveyor discussed the resident's statement with the RNCC. The RNCC stated the agency the nurses work for had been contacted and the 2 nurses would be reprimanded for charting treatments they did not do. The surveyor discussed the allegation with the director of nursing (DON) on 2/13/24. The DON stated it was not yet established that the nurses had not completed the treatments on on 2/9 and 2/10. The surveyor acknowledges that there is no staff corroboration of the resident's allegation, but the allegation is credible when taking 1/24 and 2/6 into account. The administrator and DON were notified of the deficient practice during a summary meeting on 2/13/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495427	A. Building B. Wing	02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Star City Rehabilitation and Nursing	1047 Mecca Street Roanoke, VA 24012

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)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21227 Based on interviews and document review, the facility staff failed to ensure residents' drug regimen were free from unnecessary drugs for two (2) of 22 sampled residents (Resident #24 and Resident #60). The findings include: 1. The facility staff failed to ensure Resident #24 was free of an unnecessary medication, sertraline. (Sertraline is an antidepressant medication.) Resident #24's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 1/9/24, was signed as completed on 1/26/24. Resident #24 was assessed as usually able to make self understood and as usually able to understand others. Resident #24 was assessed as having problems with both short-term memory and long-term memory. Resident #24 was assessed as being dependent on others for eating, oral hygiene, personal hygiene, dressing, and bathing. Resident #24's clinical record included a Consultant Pharmacist Medication Regimen Review form dated 12/14/23. This document indicated Resident #24 was receiving sertraline one (1) 50 mg tablet by mouth in the evening starting on 12/1/22. This document included the following statement: If an antidepressant is used for sleep or to manage behavior, stabilize mood, or treat a psychiatric disorder, it must be reviewed for a possible gradual dose reduction in an effort to find the lowest effective dose. If a dose reduction is deemed clinically contraindicated at this time, please state the rationale below and the risk vs. benefit of continuing the drug at the current dose. This document had a medical provider response, dated 12/18/23, to decrease the sertraline dosage to 25 mg. A medical provider order to increase Resident #24's sertraline dosage to 50 mg was placed by a medical provider on 2/9/24. No documentation to indicate the reason for this increase was found by or provided to the surveyor. This was updated in Resident #24's clinical record at the facility on 2/10/24. The following information was found in a revised medical provider note with an encounter date of 2/9/24: Medications were amended due to: When I initially signed into [sic] chart they were expired. I refilled expired medications. [NAME] [sic] City Health and Rehab did not update (medical provider group name omitted) on the new medications that their provider's [sic] wrote for. This was the discrepancy. This has now been righted. (The time and date to indicate when the addendum was made to this document was not included.) A medical provider order, dated 2/12/24 at 2:58 p.m., decreased Resident #24's sertraline back to 25 mg at bedtime. A medical provider progress note, dated 2/13/24 at 12:06 p.m., included the following statement: Of note, a MAR (medication administration record) reconciliation was completed by (medical provider group name omitted) nurse on 1/29/24, which apparently did not capture several adjustments (including reduced dose of sertraline .). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495427	A. Building B. Wing	02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Star City Rehabilitation and Nursing	1047 Mecca Street Roanoke, VA 24012

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)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #24's clinical documentation included an active order for sertraline to be provided by mouth in the evening for a diagnosis of Major Depressive Disorder. Resident #24's care plan addressed depression related to the following concerns: mood and activities. Resident #24 had an active order to monitor behaviors. This order was dated 9/20/21 at 3:53 p.m. This order included the following statement: BEHAVIORS - MONITOR FOR THE FOLLOWING: RESTLESSNESS (AGITATION), ELOPEMENT, STEALING, DELUSIONS, HALLUCINATIONS, PSYCHOSIS, AGGRESSION, REFUSING CARE. This did include restlessness but did not include other symptoms of depression such as fatigue, appetite changes, sleep changes, loss of interest in activities, and difficulty concentrating (Depression is Not a Normal Part of Growing Older, CDC, https://www.cdc.gov/aging/depression/index.html). On 2/12/24 at approximately 2:45 p.m., the facility's Director of Nursing (DON) was asked about Resident #24's symptom monitoring related to the resident's antidepressant medication. On 2/12/24 at 2:46 p.m., a medical provider gave an order for Behavior Monitoring Anti-Depressant (every) Shift: 0.None 1.Afraid 2. Agitated 3.Angry 4.Anxious 5.Mood change 6.Noisy 7.Restless 8.Withdrawn/depressed 9.Crying 10. Combative 11.other-specify in progress note. On 2/13/24 at 9:05 a.m., the surveyor notified the facility's Administrator and Director of Nursing (DON) of the absence of consistent symptom monitoring for Resident #24's antidepressant medication. On 2/14/24 at 12:03 p.m., the DON provided copies of the aforementioned behavior monitoring order; the DON reported these behaviors are monitored for all psychotropic medications. This monitoring did not address signs and symptoms of depression such as tearfulness, sluggishness, and decreased involvement in activities. 2. The facility staff failed to ensure Resident #60 was free of an unnecessary medication as evidenced by the absence of consistent symptom monitoring for depression. Resident #60's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 1/21/24, was signed as completed on 1/31/24. Resident #60 was assessed as able to make self understood and as able to understand others. Resident #60's Brief Interview for Mental Status (BIMS) summary score was documented as a six (6) out of 15; this indicated severe cognitive impairment. Resident #60 was assessed as requiring assistance with oral hygiene, toileting hygiene, dressing, and bathing. Resident #60's clinical documentation included an active order for sertraline (25mg tablet) to be provided by mouth in the evening for a diagnosis of Major Depressive Disorder. Resident #60's care plan addressed depression related to the following concerns: nutrition, mood, and activities. (Sertraline is an antidepressant medication.) Resident #60 had an active order to monitor behaviors. This order was dated 7/4/23 at 4:08 p.m. This order included the following statement: BEHAVIORS - MONITOR FOR THE FOLLOWING: RESTLESSNESS (AGITATION), ELOPEMENT, STEALING, DELUSIONS, HALLUCINATIONS, PSYCHOSIS, AGGRESSION, REFUSING CARE. This did include restlessness but did not include other symptoms of depression such as fatigue, appetite changes, sleep changes, loss of interest in activities, and difficulty concentrating (Depression is Not a Normal Part of Growing Older, CDC, https://www.cdc.gov/aging/depression/index.html). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495427	A. Building B. Wing	02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Star City Rehabilitation and Nursing	1047 Mecca Street Roanoke, VA 24012

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)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/14/24 at 11:50 a.m., the surveyor notified the facility's Administrator and Director of Nursing (DON) of the absence of consistent symptom monitoring for Resident #60's antidepressant medication. On 2/14/24 at 12:03 p.m., the DON provided copies of the aforementioned behavior monitoring order; the DON reported these behaviors are monitored for all psychotropic medications. This monitoring did not address signs and symptoms of depression such as tearfulness, sluggishness, and decreased involvement in activities.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495427	A. Building B. Wing	02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Star City Rehabilitation and Nursing	1047 Mecca Street Roanoke, VA 24012

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)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 42353 Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to ensure a medication error rate of less than 5%. There were two (2) medication errors in 37 opportunities for a medication error rate of 5.41%. These medication errors affected Resident #291. The findings included: For Resident #291, the facility staff failed to administer Aspirin and a Nicotine Patch as ordered by the physician. Resident #291's diagnosis list indicated diagnoses, which included, but not limited to Aftercare following Joint Replacement Surgery, Pneumonia, Generalized Muscle Weakness, Chronic Obstructive Pulmonary Disease, Essential Hypertension, and Hyperlipidemia. A 2/09/24, Admission/Re-Admission Screening form documented the resident as being lethargic and oriented to person only. On 2/13/24 at 9:28 AM, surveyor observed licensed practical nurse (LPN) #6 prepare and administer Resident #291's medications. LPN #6 applied a Nicotine 21 mg/24-hour Patch to the resident's left shoulder area. Surveyor reconciled Resident #291's administered medications with the physician's orders and noted a current order for Aspirin 81 mg by mouth one time a day for anticoagulant, according to the resident's February 2024 Medication Administration Record (MAR), Aspirin was scheduled to be administered every AM. Surveyor did not observe LPN #6 administer Aspirin to Resident #291. The resident's orders included a current order dated 2/09/24 for a Nicotine Patch 14 mg/24 hours apply one patch transdermally one time a day for smoking cessation, however, surveyor observed LPN #6 apply a 21 mg/24-hour Nicotine Patch. On 2/13/23 at 9:55 AM, surveyor spoke with LPN #6 regarding the Aspirin and LPN #6 stated I missed that one. When asked about the Nicotine Patch, LPN #6 stated they did use the 21 mg patch; LPN #6 looked in the medication cart and there were 14 mg/24-hour Nicotine Patches available for use. Surveyor requested and received the facility policy titled, Medication Administration which read in part Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection . On 2/13/24 at 5:18 PM, the survey team met with the Administrator and Director of Nursing and discussed the facility medication error rate of 5.41% and the errors affecting Resident #291. No further information regarding this concern was presented to the survey team prior to the exit conference on 2/14/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495427	A. Building B. Wing	02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Star City Rehabilitation and Nursing	1047 Mecca Street Roanoke, VA 24012

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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49622 Based on observation, staff interview and facility document review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. This requirement was not met as evidenced by the facility staff failed to discard out of date perishable food items, failed to store uncooked meat separately from other food, failed to cover, date and label perishable food items, and failed to store foods under sanitary conditions in the facility Main Kitchen and in 4 out of 4 unit kitchen service areas; Countryside (1st floor), Rainbow(1st floor), Emerald(2nd floor) and Juniper(2nd floor). The findings include: The facility staff failed to discard out of date perishable food items, failed to store uncooked meat separately from other food, failed to cover, date and label perishable food items, and failed to store foods under sanitary conditions in the facility Main Kitchen and in 4 out of 4 unit kitchen service areas; Countryside (1st floor), Rainbow(1st floor), Emerald(2nd floor) and Juniper(2nd floor). On 02/07/24 at 1:33 PM, surveyor performed initial observation of the facility main kitchen with Dietary Manager (DM). On 02/07/24 at 1:54 PM, surveyor and DM entered the walk-in refrigerator. Surveyor observed a package of sliced ham with a Best By (BB) date of 01/15/24. DM stated it must have been overlooked and threw ham away. On 02/07/24 at 1:55 PM, surveyor observed the lower shelf in the walk-in refrigerator with an open roll of ground beef on top of a box of ground beef rolls. A generous amount of red liquid was leaking from the open roll of ground beef onto the box it was sitting on. DM stated, That should have been put in a pan. DM removed the box with the roll of ground beef on it from the walk-in refrigerator and threw it away. DM stated he is working on a cleaning schedule for dietary staff, and he has only been in his position for a month. On 02/07/24 at 2:14 PM, surveyor observed (1st floor) Countryside unit kitchen and pantry. Two (2) boxes of grits were observed on the pantry shelf. One box of grits had a BB date of 07/30/22. The other box of grits had a BB date of 08/12/22. Dietary Aide #1(DA#1) stated she would throw them away. On 02/07/24 at 2:19 PM, surveyor observed (1st floor) Rainbow unit kitchen and pantry. A can of saute/grill spray with BB date of 05/08/23 was observed on the pantry shelf. Dietary Aide #2 (DA#2) stated he would throw it away. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495427	A. Building B. Wing	02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Star City Rehabilitation and Nursing	1047 Mecca Street Roanoke, VA 24012

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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/07/24 at 4:11 PM, surveyor observed (2nd floor) Juniper unit kitchen refrigerator. Surveyor observed a box on bottom shelf of refrigerator. The box contained a sealed package of sliced turkey lunch meat with, 1-24 written on the package. The turkey had white spots around the edges of the meat. The box contained an open package of sliced turkey. No date/label was observed on the open package of sliced turkey. The box contained an open package of sliced ham. The ham was partially covered with plastic wrap. Some of the ham was not covered. The package of sliced ham had BB date of 01/15/24. The package of sliced ham was leaking and dripping orange fluid when surveyor picked it up. The box contained a partially opened package of butter. Part of the butter was uncovered. An orange, wet, liquid was visible on the wrapper of the butter. No date/label was observed on the wrapper of the butter. The box contained an open package of sliced, mild cheddar cheese. The cheese was partially covered with plastic wrap. Some of the cheese was not covered. The uncovered corner of the cheese was dark orange, dried, and hard. A green, quarter-sized, fuzzy substance was visible through the wrapper on the bottom of the cheese. No date was observed on the package of cheese. The box contained another open package of cheddar cheese. The cheddar cheese was partially covered with plastic wrap. Some of the cheese was not covered. The cheese was dark orange, dried and hard. No date/label was observed on the package of cheese. The box contained another package of butter partially covered. Some of the butter was not covered. The butter was hard and tiny, black specks were observed inside of the wrapper. Tiny, black specks were observed inside of the butter. No date/label was observed on the butter. The box contained an open package of white cheese. The white cheese was observed partially covered with plastic wrap. Some of the white cheese was not covered. The exposed part of the cheese was dried and hard. No date/label was observed on the white cheese. The box the items were in was observed to have brown, wet stains. The box contained a moderate number of brown crumbs. A square plastic container was observed in the refrigerator. The container had a sticker, with, Prep 12/12, Use by 1/12 noted on the outside. The container contained a variety of salad dressing packets and sour cream packets. One (1) sour cream packet was observed with a BB date of 09/18/23. Three (3) sour cream packets were observed with BB dates of 09/25/23. There were no dates/labels on the other contents of the container. Dietary Aide #3 (DA#3), was present at time of observations in the refrigerator. DA#3 stated, I'm so embarrassed, I usually take care of the other side. DA#3 stated, I will clean that out. On 02/07/24 at 4:20 PM, surveyor observed Juniper unit kitchen pantry. An angel food cake mix was observed. The cake mix had a BB date of 08/10/22. Surveyor observed an open package of flour tortillas. The tortillas were exposed and hard. A BB date of 02/03/24 was observed on the wrapper of the tortillas. DA#3 stated she would throw the tortillas away. On 02/07/24 at 4:28 PM, surveyor observed (2nd floor) EMERALD unit kitchen pantry. An open box of buttermilk pancake mix was observed on the shelf. The buttermilk pancake mix had a BB date of 08/31/23. A box of angel food cake mix was observed on the shelf. The angel food cake mix had a BB date of 08/10/22. DA#3 stated, I will throw those away. Two (2) boxes of grits were observed on the shelf. One box of grits had BB date of 07/03/22. The other box of grits had a BB date of 08/12/22. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495427	A. Building B. Wing	02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Star City Rehabilitation and Nursing	1047 Mecca Street Roanoke, VA 24012

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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/07/24 at approximately 4:35 PM, surveyor observed Emerald unit kitchen refrigerator. DA#3 was present during observation. DA#3 stated, My side is cleaner. Surveyor observed a squeezable container of [NAME] Mayonnaise in the refrigerator. The mayonnaise had a BB date of 11/20/23. DA#3 threw the mayonnaise away. A package of sealed, sliced turkey was observed. A white substance was observed around the edges of the sliced turkey. 1-24, was observed to be written on the package of sliced turkey. DA#3 stated she would throw the sliced turkey away. On 02/08/24 at approximately 8:45 AM, surveyor requested facility policy on cleaning unit refrigerators and pantries. On 02/08/24 at 9:30 AM, Administrator (ADM), gave surveyor copy of, Sanitation Inspection Policy. The following information was found in the facility document titled Sanitation Inspection policy with a Review/revised date of, 12/1/2022. .2. The department shall establish a sanitation program for food services based on applicable state and federal requirements. 3. The sanitation program will provide for inspections to be conducted of the food service areas. 4. Sanitation inspections will be conducted in the following manner: a. Daily: Food service staff shall inspect refrigerators .storage area .daily. b. Weekly: The dietary manager shall inspect all food service areas weekly to ensure the areas are clean and comply with sanitation and food service regulations. 5. Inspections will be conducted but not limited to the following areas: a. Dry storage . c. Refrigerator . f. Main production area g. Food preparation area. On 02/08/24 at 1:41 PM, surveyor met with DM to discuss the observations and staff interviews of the facility main kitchen and in the unit kitchen service areas. DM reported when the building first opened, the staff would make breakfast in the unit kitchens. DM stated staff no longer make breakfast in the unit kitchens. DM stated the grits and pancake mix, were not in use and had not been used since the facility main kitchen began making breakfast. DM agreed the lunch meat in the Emerald and Juniper kitchen service areas would have been used for making sandwiches on the units. DM stated he cleaned the refrigerators in the unit kitchens. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495427	A. Building B. Wing	02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Star City Rehabilitation and Nursing	1047 Mecca Street Roanoke, VA 24012

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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/08/24 at 1:57 PM, surveyor met with the ADM to discuss findings from observations and staff interviews of the facility main kitchen and unit kitchen service areas. ADM stated the DM had only been at the facility for a month. ADM stated a dietary employee that took care of the Juniper kitchen, had recently quit about two (2) weeks ago. No further information regarding these concerns was presented to the survey team prior to the exit conference on 02/14/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495427	A. Building B. Wing	02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Star City Rehabilitation and Nursing	1047 Mecca Street Roanoke, VA 24012

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)
F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 28169 Based on staff interviews, clinical record review, and facility document review, the facility staff failed to provide the 2023-2024 COVID-19 vaccine to three (3) of five (5) residents sampled for immunization review, the three (3) who consented to receive the vaccine. (Resident #15, #63, and #65). The findings include: According to the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA) approved and authorized the 2023-2024 updated Covid-19 vaccine in September and October 2023. The CDC recommended everyone aged 5 years and older should get 1 (one) dose of an updated COVID-19 vaccine to protect against serious illness from COVID-19. The facility staff failed to provide the vaccine to three residents who affirmed their desire to receive the vaccine in October 2023. The five sampled residents' clinical records contained evidence that in October 2023, the facility staff contacted them and/or their representatives via email or phone for consent to participate in an upcoming COVID-19 vaccine clinic. Three of the five residents' clinical records (Residents #15, #63, and #65) contained evidence they agreed to receive the vaccine. None of the three residents' clinical records indicated they had received the 2023-2024 updated Covid vaccine. On 2/13/24 at 3:50 p.m., the infection preventionist (IP) reported that in the fall of 2023, the facility staff's plan to have a community pharmacy conduct a COVID-19 vaccine clinic at the facility, failed after not enough residents agreed to receive the vaccine. The IP acknowledged the facility staff did not immediately plan for administering the vaccine after the community pharmacy's clinic fell through. The IP reported the facility went through a corporate change around the same time. During an end of day meeting on 02/13/24 at 5:17 p.m., the director of nursing (DON) and administrator were informed of the concern related to the 2023-2024 updated Covid-19 vaccine availability for facility residents. The DON acknowledged the community pharmacy's clinic fell through after less than 30 residents were interested in receiving the vaccine. The IP provided a list of residents and staff who had tested positive for COVID-19 from July 2023 through the survey. None of the three residents (Residents #15, #63, and #65) had tested positive for COVID-19. There were no current residents or staff who were positive for COVID-19 throughout the survey. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495427	A. Building B. Wing	02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Star City Rehabilitation and Nursing	1047 Mecca Street Roanoke, VA 24012

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)
F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/14/24 at 10:30 a.m., the medical director was interviewed via phone in the DON's office with the DON present. The medical director reiterated the community pharmacy's COVID-19 vaccine clinic did not materialize and the facility was transitioning from one ownership company to another which left staff unsure of how the new corporation wanted it handled. The physician said they were not delaying care, they wanted it done correctly. The medical director reported he and the DON had recently discussed setting up a time for ordering and administering the vaccines. The administrator entered the conversation and reported she had just spoken with the corporate chief nursing officer (CNO) and according to the corporate policy and procedure, the facility can purchase the vaccine from their pharmacy and the facility staff can administer the vaccine; the IP was ordering the vaccine now. The facility's policy titled Coronavirus Prevention and Response implemented on 11/01/2020 and reviewed/revised on 10/30/23 was reviewed. The policy read in part, Policy: This facility will respond promptly upon suspicion of illness associated with a novel coronavirus in efforts to identify, treat, and prevent the spread of the virus. And . 11. Vaccination Planning . b. Each resident will be offered a Covid 19 immunization unless it is medically contraindicated, or the resident has already been immunized. Following assessment for any medical contraindications, the immunization may be administered in accordance with physician-approved 'standing orders' . f. The resident's medical record shall include documentation that indicates at a minimum, the following: a. The resident or resident's representative was provided education regarding the benefits and potential side effects of the Covid 19 immunization. b. The resident received the Covid 19 immunization or did not receive it due to medication contraindication or refusal. No further information was provided prior to the exit conference.