DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/25/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495123	A. BUILDING _____ B. WING _____	R 07/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPEWELL HEALTH CARE CENTER	905 COUSINS AVENUE HOPEWELL, VA 23860

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{F 000}	INITIAL COMMENTS A Medicare/Medicaid revisit to the standard survey conducted through 6/1/16 to 6/3/16 and 6/6/16 and 6/8/16 was conducted 7/19/16 through 7/20/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. Corrected deficiencies are identified on the CMS 2567-B. No complaints were investigated during the survey. The census in this 130 certified bed facility was 93 at the time of the survey. The survey sample consisted of 11 current Resident reviews (Residents 101 through 111) and no closed record reviews.	{F 000}		
{F 279} SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under	{F 279}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Frederick W. Hook — TITLE: Administrator — (X6) DATE: 8/9/2016

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.

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{F 279}	Continued From page 1 §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and clinical record review the facility staff failed to develop a comprehensive care plan for a heel wound pressure reduction device for one Resident (Resident #111) in a survey sample of 11 residents. The facility staff failed to develop a care plan with measurable objectives and time tables for a pressure reduction boot device for Resident #111 Findings included: Resident #111 was admitted to the facility on 4-14-16. Diagnoses included diabetes, dementia, hypertension, gastro-esophageal refux disease (GERD), dysphagia, anemia, and depression. Resident #111's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 4-20-16 was coded as an admission full assessment. Resident #111 was coded a BIMS (Brief Interview of Mental Status) score of 1, indicating severe cognitive impairment. Resident #111 was also coded as needing extensive to total assistance of one staff member for activities of daily living and as being always incontinent of bowel and bladder. Futher the Resident was coded as having no limitation in range of motion in the upper or lower extremities. At section "M" skin assessment, the Resident was coded as having one stage 2 pressure ulcer that was 100% granulation tissue upon admission. This was documented in the clinical record as a sacral pressure ulcer. On 7-20-16 at 11:00 a.m. a review of the Resident's clinical record was conducted. This	{F 279}	F279 R#111 CP has been reviewed and updated. Physician order obtained with measureable objectives and time tables for heel wound pressure reduction boot device. Residents that also have pressure reduction boot device have been identified at risk from this alleged deficient practice. Nurse Managers and Licensed Nurses shall be in-serviced by DON/desginee on proper Care Planning process related to pressure reduction boot device. The DNS/designee shall audit up to 5 resident CP's weekly for measurable objectives for 4 weeks then monthly for 2 months. Concerns identified shall be taken to the facility QAPI for follow up and resolution. Date of Compliance 8-4-16	

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review revealed current physician's orders sheet (POS) signed and certified by the physician on 7-18-16. The POS revealed wound treatment orders (for a Right heel wound) that were to be discontinued after the Resident was seen by the wound specialist doctor, which occurred on 7-18-16.

The wound care specialist evaluation form, completed by the doctor for Resident #111's wound care revealed that the orders given by the wound care doctor's "Assessment and plan" included a change in treatment for the wound, and also to "float heels in bed", and to "off load wound".

Review of the July 2016 TAR (Treatment Administration Record) , telephone orders, and physician's orders sheet (POS) did not reflect any orders for offloading or floating of heels, and gave no instruction to staff on how to accomplish this or what devices to be used, nor time applied.

A complete review of the clinical record did not reveal any documentation regarding the application of the heel boots, what heel boots were to be used, or what schedule the boots would remain in place.

"Body audit" records, revealed no documentation of pressure reducing heel boots, however, on the "Pressure ulcer record" "Prevalon Boots to bilateral lower extremities" was documented on 7-4-16, and "boots" were documented on 7-11-16, and 7-18-16.

On 7-20-16 an interview was conducted with Resident #111 at 11:30 a.m., and the Resident was beginning to eat lunch. The Resident was talkative, responsive, and confused. The Resident was sitting on top of the dressed bed with street clothing on. The Residents feet were easily visualized uncovered at the foot of the bed, and wearing blue ankle top quilted booties with 3

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velcro straps holding them closed. The right foot was turned outward away from the midline of the body, and the left foot was turned inward toward the heel of the right foot, both laying partly on the heels and partly on the their outer (Right foot) and inner (Left foot) sides. The Resident was asked if her feet hurt, and she replied "yes". Licensed Practical Nurse (LPN) B (one of 2 nurses on duty that day who cared for Resident #111 daily) was approached at the nursing station, after seeing the Resident, and asked when the Resident was to wear the boots, and what kind of boots were ordered for Resident #111. LPN B responded "I don't know, I will have to ask someone." None of the staff were able to answer this question by the time of survey exit.

Nursing progress notes revealed no documentation regarding the application, order or instructions on what devices were to be applied to the Resident's feet, other than "Boots".

On 7-20-16 at approximately 1:30 p.m. the Director of Nursing (DON), and the "Director of Rehab" Occupational Therapist" supplied the manufacturer's "Instructions for Use" guide on the "Prevalon Pressure Relieving Heel Protector with integrated foot and leg stabilizer wedge". This device showed a boot with a wedge which stabilized the leg and prevented the foot from rolling onto it's side. The boots Resident #111 was observed wearing had no wedge stabilization device, and the Resident's heels were not stabilized. Admin C (the Rehab Director) stated that the wedge stabilization device was not needed by Resident #111, because the Resident could move her feet independently.

Research conducted online for the "Sage Prevalon" manufacturer site revealed 4 different kinds of Prevalon boots that were available from the company. No assessment or order revealed

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that Resident #111 had been assessed for, or a doctor had prescribed which device was appropriate for this Resident. The manufacturer did recommend that the boot should be worn at all times when the individual wearing them had their feet and legs in a pressure producing posture, such as lying down. The stabilization device restricts foot drop and foot rolling, while the wearer is sleeping, or laying down in a relaxed position, as it is normal for the foot to drop or roll while relaxed.

Review of the most recent skin care plan last updated on 7-11-16 revealed interventions for "heel lift boots as tolerated", "suspend/float heels as able", "use pillows and/or positioning devices as needed." The skin care plan was instituted on 5-2-16. No indication of what type of boot or device to use, other than "Prevalon" was given to staff, and no indication of what times the boots were to be worn was given, nor how to care for the boots nor when to check or release them was given. There were no measurable objectives or time tables to describe or guide the services that were to be furnished to the Resident, so that staff could provide those services in a comprehensive way.

The Director of Nursing (DON) was interviewed at 3:00 p.m. on 7-20-16, in the conference room with 4 surveyors, and asked why the interventions were not individualized and had measurable goals, her response was "We keep the care plans very generic." She went on to say that they do not put the kind of boot, or time of day, or when the boot should be on, or off, they like to keep it simple. She was asked if it is appropriate to not use measurable goals like quantity of time for each residents individual needs, and her response was "Oh, I see what you mean, Like at all times, or on at blank hour, and off at blank

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hour." "We don't do that."
No documentation existed in the clinical record to indicate when the boots were applied, how to care for the boots, or what type of Prevalon boot was to be used. The staff did not obtain an order or assessment to clarify the pressure reduction boot treatment, and did not document that the treatment was performed consistently.
The facility policy entitled "Skin Integrity Program: Identification and Prevention" stated the following: "Plan and Implement Care"
And under item #5, "A comprehensive, interdisciplinary, resident centered plan of care will be developed and implemented based on identified risks and individual needs, to avoid skin breakdown and treat impaired skin integrity and existing ulcers. The effectiveness of the interventions will be evaluated and the plan of care will be reviewed and revised as needed".
The Administration was informed of the findings on 7-20-16 at 4:00 p.m. at the end of day debrief.
No further information was provided

{F 279}

{F 281} SS=D 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS

{F 281}

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and clinical record review, the facility staff failed for 2 residents (Resident #107 and #111) of 11 residents in the survey sample to follow professional standards of nursing for medication and treatment administration.

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{F 281}	Continued From page 6 1. For Resident #107, the facility staff failed to correctly transcribe the physician order to administer Vitamin C every day. The MAR (medication administration record) had documented to administer every other day. 2. For Resident #111, the facility staff failed to obtain a physician's order for, or to clarify the directions for use, of "Prevalon Boots" to be worn by the Resident to protect the Resident's heels from pressure. Further there were no directions to staff as to when the Resident would wear the boots, or what type of "Prevalon boots" should be applied. The findings included: 1. For Resident #107, the facility staff failed to transcribe correctly the physician order to administer Vitamin C every day. The MAR (medication administration record) had to administer every other day. Resident #107, a 73 year old, was admitted to the facility on 1/15/16. His diagnoses included dysphagia, end stage renal disease, diabetes, bilateral below the knee amputation, hypertension, glaucoma, and dialysis. Resident #107's most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 4/20/16. Resident #107 was coded with a Brief Interview of Mental Status score of 12 indicating moderate cognitive impairment. He required extensive assistance with his activities of daily living. Resident #107's clinical record included a	{F 281}	F281 R#107 & R#111 clinical record has been updated with clarification orders and plans of care reflect current needs of the residents. Current Residents that have Supplements and Pressure reduction boots ordered by their physician were identified as those at risk from this alleged practice. The nurse managers, and Licensed Nurse) shall be educated on accurately transcribing physician orders.	

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{F 281}	Continued From page 7 telephone order dated 7/13/16 for Vitamin C. The order read "Vitamin C 500 mg (milligram) po (by mouth) QD (every day) x 90 d (day)." The order was included on the July 2016 Medication Administration Record (MAR) as "Vitamin C 500 mg (milligram) po (by mouth) qod (every other day)." According to the July MAR documentation, Resident #107 received Vitamin C on 7/14/16, 7/16/16, and 7/18/16. The Vitamin C issue was reviewed with Licensed Practical Nurse A (LPN A) on 7/20/16 at 12:45 p.m. She stated that she would notify the physician. Lippincott, Williams and Wilkins, Fundamentals of Nursing, 2007, Ambler, PA, page 181 reads "Nurses carry a great deal of responsibility for making sure that patients get the right drugs at the right time, in the right dose and by the right routes ...this includes accurate documentation and explanation ... " The Administrator and Director of Nursing were notified of the issue at the end of day meeting on 7/20/16. The Director of Nursing stated that the facility used Lippencott as their nursing standard reference. No further information was provided.	{F 281}	Audits of Physican orders for accuracy and directions for use shall be completed for up to 10 records weekly for 4 weeks then monthly for 3 months by the DON/designee. Concerns identified from the audits shall be taken to the facility QAPI Committee for follow up and resolution. Date of Compliance 8-4-16	

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2. For Resident #111, the facility staff failed to obtain a physician's order for, or to clarify the directions for use, of "Prevalon Boots" to be worn by the Resident to protect the Resident's heels from pressure. Further there were no directions to staff as to when the Resident would wear the boots, or what type of "Prevalon boots" should be applied.

Resident #111 was admitted to the facility on 4-14-16. Diagnoses included diabetes, dementia, hypertension, gastro-esophageal refux disease (GERD), dysphagia, anemia, and depression. Resident #111's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 4-20-16 was coded as an admission full assessment. Resident #111 was coded a BIMS (Brief Interview of Mental Status) score of 1, indicating severe cognitive impairment. Resident #111 was also coded as needing extensive to total assistance of one staff member for activities of daily living and as being always incontinent of bowel and bladder. Further the Resident was coded as having no limitation in range of motion in the upper or lower extremities. At section "M" skin assessment, the Resident was coded as having one stage 2 pressure ulcer that was 100% granulation tissue upon admission. This was documented in the clinical record as a sacral pressure ulcer.
On 7-20-16 at 11:00 a.m. a thorough focused review of the Resident's clinical record was conducted. This review revealed current physician's orders sheet (POS) signed and certified by the physician on 7-18-16. The POS revealed wound treatment orders (for a Right heel wound) that were to be discontinued after the

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Resident was seen by the wound specialist doctor, which occurred on 7-18-16.
The wound care specialist evaluation form, completed by the doctor for Resident #111's wound care revealed that the orders given by the wound care doctor's "Assessment and plan" included a change in treatment for the wound, and also to "float heels in bed", and to "off load wound".
Review of the July 2016 TAR (Treatment Administration Record) , telephone orders, and physician's orders sheet (POS) did not reflect any orders for offloading or floating of heels, and gave no instruction to staff on how to accomplish this or what devices to be used, nor time applied.
A complete review of the clinical record did not reveal any documentation regarding the application of the heel boots, what heel boots were to be used, or what schedule the boots would remain in place.
"Body audit" records, revealed no documentation of pressure reducing heel boots, however, on the "Pressure ulcer record" "Prevalon Boots to bilateral lower extremities" was documented on 7-4-16, and "boots" were documented on 7-11-16, and 7-18-16.
On 7-20-16 an interview was conducted with Resident #111 at 11:30 a.m., and the Resident was beginning to eat lunch. The Resident was talkative, responsive, and confused. The Resident was sitting on top of the dressed bed with street clothing on. The Resident's feet were easily visualized uncovered at the foot of the bed, and wearing blue ankle top quilted booties with 3 velcro straps holding them closed. The right foot was turned outward away from the midline of the body, and the left foot was turned inward toward the heel of the right foot, both laying partly on the heels and partly on the their outer (Right foot) and

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inner (Left foot) sides. The Resident was asked if her feet hurt, and she replied "yes". (Licensed Practical Nurse) LPN B (one of 2 nurses on duty that day who cared for Resident #111 daily) was approached at the nursing station, after seeing the Resident, and asked when the Resident was to wear the boots, and what kind of boots were ordered for Resident #111. LPN B responded "I don't know, I will have to ask someone." None of the staff were able to answer this question by the time of survey exit.

Nursing progress notes revealed no documentation regarding the application, order or instructions on what devices were to be applied to the Resident's feet, other than "Boots".

On 7-20-16 at approximately 1:30 p.m. the Director of Nursing (DON), and the "Director of Rehab" Occupational Therapist" supplied the manufacturer's "Instructions for Use" guide on the "Prevalon Pressure Relieving Heel Protector with integrated foot and leg stabilizer wedge". This device showed a boot with a wedge which stabilized the leg and prevented the foot from rolling onto it's side. The boots Resident #111 was observed wearing had no wedge stabilization device, and the Resident's heels were not stabilized. Admin C (the Rehab Director) stated that the wedge stabilization device was not needed by Resident #111, because the Resident could move her feet independently.

Research conducted online for the "Sage Prevalon" manufacturer site revealed 4 different kinds of Prevalon boots that were available from the company. No assessment or order revealed that Resident #111 had been assessed for, or a doctor had prescribed which device was appropriate for this Resident. The manufacturer did recommend that the boot should be worn at all times when the individual wearing them had

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their feet and legs in a pressure producing posture, such as lying down. The stabilization device restricts foot drop and foot rolling, while the wearer is sleeping, or laying down in a relaxed position, as it is normal for the foot to drop or roll while relaxed.

Review of the most recent skin care plan last updated on 7-11-16 revealed interventions for "heel lift boots as tolerated", "suspend/float heels as able", "use pillows and/or positioning devices as needed." The skin care plan was instituted on 5-2-16. No indication of what type of boot or device to use, other than "Prevalon" was given to staff, and no indication of what times the boots were to be worn was given, nor how to care for the boots nor when to check or release them was given. There were no measurable objectives or time tables to describe or guide the services that were to be furnished to the Resident, so that staff could provide those services in a comprehensive way.

The Director of Nursing (DON) was interviewed at 3:00 p.m. on 7-20-16, in the conference room with 4 surveyors, and asked why the interventions were not individualized and had measurable goals, her response was "We keep the care plans very generic." She went on to say that they do not put the kind of boot, or time of day, or when the boot should be on, or off, they like to keep it simple. She was asked if it is appropriate to not use measurable goals like quantity of time for each residents individual needs, and her response was "Oh, I see what you mean, Like at all times, or on at blank hour, and off at blank hour." "We don't do that."

No documentation existed in the clinical record to indicate when the boots were applied, how to care for the boots, or what type of Prevalon boot was to be used. The staff did not obtain an order

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPEWELL HEALTH CARE CENTER	905 COUSINS AVENUE HOPEWELL, VA 23860

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 281}	Continued From page 12	{F 281}		

or assessment to clarify the pressure reduction boot treatment, and did not document that the treatment was performed consistently.
The facility cited Lippincott as the resource used for professional nursing standards references. Guidance was given from Lippincott, Fundamentals of Nursing, which states that prevention of medication and treatment errors, is achieved by following the "8 rights of any treatment and medication administration consistently every time.... Lippincott refers to the Rights of medication administration in the decision making paradigm for treatments." Lippincott stated that these rights are a nursing standard that exist for both treatments and medication administration. Lippincott goes on to say that many errors can be linked, in some way, to an inconsistency in adhering to these rights. These rights follow:
"Rights of Medication Administration
1. Right patient - Check the name on the order and the patient, Use 2 identifiers, Ask patient to identify himself/herself, When available, use technology (for example, bar-code system).
2. Right medication - Check the medication label, Check the order.
3. Right dose - Check the order, Confirm appropriateness of the dose using a current reference, If necessary, calculate the dose and have another nurse calculate the dose as well.
4. Right route - Again, check the order and appropriateness of the route ordered, Confirm that the patient can take or receive the medication by the ordered route.
5. Right time - Check the frequency of the ordered medication, Double-check that you are giving the ordered dose at the correct time, Confirm when the last dose was given.
6. Right documentation - Document

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	495123	A. BUILDING _____ B. WING _____	R-C 07/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 281}	Continued From page 13	{F 281}		

administration AFTER giving the ordered medication, Chart the time, route, and any other specific information as necessary. For example, the site of an injection or any laboratory value or vital sign that needed to be checked before giving the drug.
7. Right reason - Confirm the rationale for the ordered medication, What is the patient ' s history? Why is he/she taking this medication? Revisit the reasons for long-term use.
8. Right response - Make sure that the drug led to the desired effect. If an antihypertensive was given, has his/her blood pressure improved? Be sure to document your monitoring of the patient and any other nursing interventions that are applicable."

The Administration was informed of the findings on 7-20-16 at 4:00 p.m. at the end of day debrief. No further information was provided

COMMONWEALTH of VIRGINIA

Department of Health

Office of Licensure and Certification

Marissa J. Levine, MD, MPH, FAAFP
State Health Commissioner

TYY 7-1-1 OR
1-800-828-1120
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233-1485
Fax (804) 527-4502

July 25, 2016

Mr. Frederick Storck, Administrator
Hopewell Health Care Center
905 Cousins Avenue
Hopewell, VA 23860

RE: Hopewell Health Care Center
CCN: 495123

Dear Mr. Storck:

Based on deficiencies cited during the survey ending June 8, 2016, your facility was found not to be in compliance with Federal participation requirements for the long term care Medicare and/or Medicaid programs. On July 19 through July 20, 2016, surveyors from the Virginia Department of Health's Office of Licensure and Certification conducted an unannounced revisit to verify that your facility had achieved and maintained compliance for deficiencies cited during the previous survey. No complaints were investigated during the survey.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Survey Results

The survey findings are reflected on the enclosed Statement of Isolated Deficiencies ("A" Form) and/or the Statement of Deficiencies and Plan of Correction (CMS-2567) and/or the Post-Certification Revisit Report (CMS-2567). All survey findings generated on these forms (including the most recent standard survey and any subsequent revisits or complaint investigations) constitute the facility's current survey report. In accordance with §483.10(g) of the Federal requirements, the current survey report must be made available for examination in a place readily accessible to residents and is disclosable to all interested parties.

We had presumed, based on your allegation of compliance, that your facility was in substantial compliance. The July 20, 2016 revisit established the facility continues noncompliance with program requirements, including an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy (S/S of D), as evidenced by the attached CMS-2567L, whereby corrections are required.

Plan of Correction (PoC)

A PoC is not required for deficiencies cited on the Statement of Isolated Deficiencies, "A" Form. Nevertheless, the facility is expected to address and correct all areas of concern noted on this form.

Unless specifically otherwise indicated, a PoC for all certification and licensure deficiencies cited on the Statement of Deficiencies and Plan of Correction (CMS-2567) must be submitted within ten (10) calendar days of receipt of these survey findings to Elaine Cacciatore, LTC Supervisor, at: Office of Licensure and Certification, Division of Long Term Care Services, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. To be considered acceptable, the PoC must:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and
5. Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)

The PoC will serve as the facility's allegation of compliance. If an acceptable plan is not submitted, the State Survey Agency may propose to the Center for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid agency that remedies be imposed immediately within applicable notice requirements.

Informal Dispute Resolution

Following the receipt and review of your survey report, please contact the assigned supervisor to attempt to resolve any problems or concerns you may have about the citations. If those concerns are not resolved, in accordance with §488.331, you have one opportunity to question cited federal certification deficiencies through the Officer's Informal Dispute Resolution Process, which may be accessed at http://www.vdh.state.va.us/OLC/longtermcare/ To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: Director, Division of Long Term Care, Office of Licensure and Certification, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. To be considered, the IDR request must follow the IDR guidelines and be received at the Office within 10 calendar days of your receipt of the enclosed survey findings. **An incomplete informal dispute resolution process will not delay the effective date of the imposition of any enforcement actions.**

In regards to previously listed potential remedies, by copy of this letter we are notifying the Centers for Medicare and Medicaid Services (CMS) Regional Office and the State Medicaid Agency (DMAS) that this revisit found your facility was not in in substantial compliance with the participation requirements.

Recommended Remedies

The results of the June 8, 2016 survey were forwarded to you under the June 21, 2016 initial letter. At that time, we indicated several remedies could be imposed by the Centers for Medicare and Medicaid Services (CMS) Regional Office and the State Medicaid Agency (Virginia Department of Medical Assistance Services) if compliance was not achieved. We are, by copy of this letter, notifying the CMS Regional Office and Virginia DMAS that the facility had not achieved compliance with program requirements at the time of the July 20, 2016 revisit. Those agencies will notify you about any remedy they intend to impose.

Please be advised: The facility must maintain compliance with both the Health and the Life Safety Code requirements in order to continue provider certification.

Survey Response Form

The Survey Response Form is offered as a method to share your review of the onsite survey process. Please take a moment to complete this evaluation, which is available at: http://www.vdh.virginia.gov/OLC/Downloadables/documents/2011/pdf/LTC%20facility%20survey%20response%20form.pdf We will appreciate your participation.

If you have any questions concerning the content of this letter, please contact me at 804/367-2100.

Sincerely,

Elaine Cacciatore, LTC Supervisor
Division of Long Term Care Services

Enclosures

cc: Joani Latimer, State Ombudsman
Jaime Desper, D M A S (Sent Electronically)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
495123 Y1	A. Building B. Wing	Y2 7/20/2016 Y3

RECEIVED
AUG 03 2016
VDH/OLC

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPEWELL HEALTH CARE CENTER	905 COUSINS AVENUE HOPEWELL, VA 23860

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0225	Correction	ID Prefix F0252	Correction	ID Prefix F0280	Correction
Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg. # 483.15(h)(1)	Completed	Reg. # 483.20(d)(3), 483.10(k)(2)	Completed
LSC	07/13/2016	LSC	07/13/2016	LSC	07/13/2016
ID Prefix F0309	Correction	ID Prefix F0312	Correction	ID Prefix F0314	Correction
Reg. # 483.25	Completed	Reg. # 483.25(a)(3)	Completed	Reg. # 483.25(c)	Completed
LSC	07/13/2016	LSC	07/13/2016	LSC	07/13/2016
ID Prefix F0323	Correction	ID Prefix F0325	Correction	ID Prefix F0329	Correction
Reg. # 483.25(h)	Completed	Reg. # 483.25(i)	Completed	Reg. # 483.25(l)	Completed
LSC	07/13/2016	LSC	07/13/2016	LSC	07/13/2016
ID Prefix F0367	Correction	ID Prefix F0386	Correction	ID Prefix F0425	Correction
Reg. # 483.35(e)	Completed	Reg. # 483.40(b)	Completed	Reg. # 483.60(a),(b)	Completed
LSC	07/13/2016	LSC	07/13/2016	LSC	07/13/2016
ID Prefix F0431	Correction	ID Prefix F0441	Correction	ID Prefix F0514	Correction
Reg. # 483.60(b), (d), (e)	Completed	Reg. # 483.65	Completed	Reg. # 483.75(l)(1)	Completed
LSC	07/13/2016	LSC	07/13/2016	LSC	07/13/2016

REVIEWED BY STATE AGENCY ☑	REVIEWED BY (INITIALS) EC	DATE 7/25/16	SIGNATURE OF SURVEYOR R Turnham & C Carrington	DATE 7/25/16
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 6/8/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO