

July 20, 2017

Mr. Rodney L. Miller LTC Supervisor Division of Long Term Care Office of Licensure & Certification Virginia Department of Health 9960 Maryland Avenue, Suite 401 Henrico, Virginia 23233-1485

RE: Plan of Correction for Hillsville Rehab and Healthcare Center Credible Allegation of Compliance

Dr. Mr. Miller:

Enclosed you will find the State of Deficiencies (CMS 2567) completed, with the Facilities POC for the deficiencies identified in the survey completed June 29, 2017.

Please consider this letter and Plan of Correction to be the Facility's' credible allegation of of compliance. The Facility asserts substantial compliance with the applicable certification requirements on July29, 2017.

This letter is also the Facility's' request for a re-survey, if is necessary, to verify the Facility has achieved substantial compliance with the applicable requirements as of the dates set forth in the Plan of Correction and credible allegation of compliance.

Thank you for your assistance in the matter.

Sincerely,

Jerry M. Carpenter, LNHA

Administrator

PRINTED: 07/13/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING		(X3) DATE SURVEY COMPLETED					
		495187	B. WING_			ŀ	C 29/2017
		400.01	1	CZCI	CET AND DECC OFFICE STREET	ים ט	29/2017
NAME OF PI	ROVIDER OR SUPPLIER		-		EET ADDRESS, CITY, STATE, ZIP CODE		
HILLSVILI	E REHABILITATION &	HEALTHCARE CENTER LLC			FULCHER STREET		
				HILE	LSVILLE, VA 24343		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000 F 241 SS=D	survey inspection wa 6/29/17. One complate the survey. Correction compliance with 42 (Term Care requirements survey/report will foll The census in this 60 at the time of the sur- consisted of 13 curre (Resident #1 through record reviews (Resident #16). 483.10(a)(1) DIGNIT INDIVIDUALITY	edicare/Medicaid standard as conducted 6/27/17 through aint was investigated during ans are required for CFR Part 483 Federal Long ents. The Life Safety Code ow. Dicertified bed facility was 57 vey. The survey sample		241	Preparation and submission of this plan of correction by Hillsville Rehabilitation and Healthcare Center, LLC, does not constitute admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the stater of deficiencies. The plan of correction is prepared and submit solely pursuant to the requirement under state and federal laws.	e an ment ted ts	
	resident in a manner promotes maintenan her quality of life rec individuality. The fact promote the rights of This REQUIREMEN by: Based on resident a document review and determined the facility and services to assis #1) to maintain and self-esteem and self-resident to urinate in come back and clear Findings: Facility staff failed to	and in an environment that ce or enhancement of his or ognizing each resident's illity must protect and if the resident. This not met as evidenced and staff interview, facility diclinical record review it was try staff failed to provide care at 1 of 16 residents (Resident enhance his/her dignity, eworth. The staff told the her brief and they would in her up later.		A CONTRACTOR OF THE RESEARCH CONTRACTOR OF THE C	1. Resident #1 was interviewed be Director of Nursing on 6/29/17 to ensure that nursing staff are meet her toileting needs and staff are providing care to maintain and enhance dignity, self-esteem and worth. 2. The current interviewable residuer interviewed by Staff Development Coordinator on 7/1 to ensure nursing staff are meeting their toileting needs and staff are providing care to maintain and enhance their dignity, self-esteer self- worth.	self-dents	(X8) DATE
ABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		Ival nwig

Any deficiency statement ending with an asterisk (*) deriotes 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.

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

Event ID 06XR11

Pagility ID. VA0082

ADM INISTRATOR

If continuation sheet Page 1 of 22

PRINTED: 07/13/2017 FORM APPROVED OMB NO. 0938-0391

			OATE SURVEY COMPLETED				
		495187	B. WING			l ne	C 5/29/2017
NAME OF B	ROVIDER OR SUPPLIER	1	1		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	3/23/2017
NAME OF P	KUNDER OR SUPPLIER				222 FULCHER STREET		
HILLSVIL	LE REHABILITATION	& HEALTHCARE CENTER LLC			HILLSVILLE, VA 24343		
		A DESCRIPTION OF REPORT OF			PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DÉFICI	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETION DATE
F 241	Continued From p	320e 1		241	3. The nursing staff will be		
1 4-71	•	1 to maintain and enhance	· · ·		reeducated by the Staff Develop	ment	
		If-esteem and self-worth. The			Coordinator by 7/28/17 related t		!
		record was reviewed on 6/27/17	İ		ensuring staff is providing care t		
	at 3:00 PM.	1000,0 1100 101,01100 07, 0.0	i		maintain and enhance resident	.0	į .
					dignity, self-esteem, and self-wo	ceth	
	Resident #1 was	admitted to the facility on					1
		gnoses included atrial fibrillation,			including assisting residents wit	11	į
		nic obstructive pulmonary			toileting needs as required.		
		hypertension. She was	i		1 771		
	-	cal aftercare and physical	i		4. The Assistant Director of Nur		
	therapy to restore	mobile function.			or the Unit Manager will comple		
	: : The initial MDS (r	ninimum data set) assessment			audit of 10 current residents wee	_	ļ
	dated 11/23/17 co	oded the resident with slight			for 4 weeks and monthly for 2 n		İ
	cognitive impairm	ent due to her inability to	: :		to ensure staff continue to provi		1
	consistently make	e herself understood and her			📑 care to maintain and enhance res	sident	f }
		tently understand others. Her	i		 dignity, self-esteem, and self-wo 	orth	:
	hearing was asse	ssed as adequate on this	:		including providing toileting		
	assessment. She	required assistance with all the	:		assistance as required. The Dire	ctor	
		f daily living) and was frequently	į		of Nursing will submit a report t		
	incontinent of boy	vel and bladder.	!		Quality Assurance Committee		
	The latest guarter	rly MDS (minimum data set)			monthly for 3 months. The Dire	ector	
	assessment date	ed 4/7/17, coded the resident			of Nursing will be responsible for		
	with moderate co	gnitive impairment due to her	İ		monitoring and follow up.		ì
	inability to recall i	tems during a short-term	•		momtoring and tonow up.		
	memory test to as	ssess mental status. Her	j		Compliance Date:		07/29/17
	memory was cod	ed as unimpaired. The resident	1		Compilance Date.		:
	was coded with s	ignificant hearing impairment on	:		İ		į
	this assessment. having a hearing	The resident was coded as not aid.	ĺ				1
	as requiring the a ADLs (activities of of eating, which r completely contin	issessment coded the resident issistance of nursing staff for all of daily living), with the exception equired set up only. She was sent of bowel, but her bladder ined to "always incontinent".					

Event ID:06XR11

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION	, ,	DATE SURVEY COMPLETED
		495187	B. WING			06/29/2017
NAME OF PROVIDER OR SUPPLIER HILLSVILLE REHABILITATION & HEALTHCARE CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CO 222 FULCHER STREET HILLSVILLE, VA 24343	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	reviewed and revised resident had the folio the complaint allegat 1. Alteration in bowe decreased mobility. "Scheduled toileting 2. The resident has a performance deficit r Interventions: "Assis "The resident was toileting every two hos. Alteration in though related to a history of infections and believes he is not. Interventifollowed as closely a shiftProvide pleas reassure the resident check resident every for incontinence" On 6/28/17 at 11:00 interviewed. She told staff member had told she would come back resident said she was she had to pee and scall light. Resident #1 stated.	prehensive care plan) If on 4/11/17 documented the owing care issues concerning ion: I elimination r/t (related to) The interventions included program as ordered." In ADL self-care elated to recent surgery. It with ADLs as needed" I careplanned for scheduled ours or as needed. In the process (initiated 3/6/17) If hallucinations during ing she is wet when in reality ons: "Ensure routines are is possible on each ant interactions which it when confused Staff to two hours and as needed AM Resident #1 was if the surveyor that a nursing if the to "go in her pants and isk to clean her up later." The is calling for help because staff would not answer her	F:	241		
	because I was wet. I need somethingIt didn't say anything. I would they be so me you have to go.?" The she would sit in her a	never use the light unless I thurt my feelings. I cried. I never bother anyone. Why ean when you can't help when he resident told the surveyor chair and pray the girl would one without hurting their				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY
COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES

	CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED
			, , , , , , , , , , , , , , , , , , ,		С
		495187	B. WING	<u> </u>	06/29/2017
	ROVIDER OR SUPPLIER LE REHABILITATION 8	HEALTHCARE CENTER LLC	22:	REET ADDRESS, CITY, STATE, ZIP CODE 2 FULCHER STREET LLSVILLE, VA 24343	
(X4) ID PREFIX TAG	(EACH DEFICIE!	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 241	Continued From pa	ige 3	F 241		 - - -
	admission, she live when she had to us	ne surveyor that prior to her d at home by herself and knew se the bathroom. She never ad her daughters in the middle			
	interview. She told being asked to pee APS (Adult Protect	er #1) was present during this the surveyor the incident about in her pants was reported to ive Services) on 2/28/17. FMt in to investigate, but nothing			
	content living at ho	Resident #1 was happy and me prior to her admission. us crying or anxious like she			! ! ! ! !
	incident sent in by nursing) on 2/28/17 documented the re complained to APS incontinence care	wed the facility reported the ADON (assistant director of 7 and 3/4/17. The initial report sident and family members regarding the resident's not being performed and the resident to urinate in her brief y her to the toilet.			
	office by the ADON investigation had be allegation of "neglet follow-up statement	rt, transmitted to the surveyor's I on 3/4/17, indicated an een conducted and the ect" was unsubstantiated. The it did not address the staff to urinate in her pants.			
	The surveyor revie	wed the investigation results tements of the CNAs involved			

in her care.

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OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING __ 495187 B. WING 06/29/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 222 FULCHER STREET HILLSVILLE REHABILITATION & HEALTHCARE CENTER LLC HILLSVILLE, VA 24343 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 241 Continued From page 4 F 241 CNA I stated the following about the incident, which occurred on 2/27/17 during 3rd shift. "When I came in at 11 PM, after a few minutes (name of CNA II) came in and asked how (Resident #1) transferred. I questioned her why she was getting resident up, she told me in return that patient had requested to go to the bathroom, although she'd already told patient just to use her depend (name of briefs used) and she'd change her. She said resident told her she couldn't and requested to go again to the bathroom. I went down to assist her in transferring....." CNA It's statement on the same event, "....(Name of resident #1) put her call light on. I went back there to see what she needed and she said she wanted to get up to use the bathroom.....I told her I needed to first go get help because I did not know if she was a two-person assist....I told her if she needed to go really bad, that when I got back I would change her brief...." The facility investigation results included a mandatory in-service held for all nurses and CNAs on 3/3/17. The content and objectives included: "Under no circumstances are you allowed to instruct a resident to be incontinent. We are here to keep them continent! Not force them to be incontinent. This is unacceptable and if you are reported you will be written up" On 6/29/17 at 12:40 PM the facility administrator and DON were informed of the findings and asked if the matter had been taken to the QA (quality assurance) committee for review and follow-up. The DON said it had not, but they had started watching CNAs closer and popping in at different hours to check on care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '	E CONSTRUCTION	(X3) DATÉ SURVEY COMPLETED	
		495187	B. WING	<u> </u>	C 06/29/2017	
NAME OF PI	ROVIDER OR SUPPLIER	······································		STREET ADDRESS, CITY, STATE, ZIP CODE		
				222 FULCHER STREET		
HILLSVILI	E REHABILITATION	& HEALTHCARE CENTER LLC		HILLSVILLE, VA 24343		
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION}	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
F 241	Continued From p	age 5	F 24	1	: : :	
		mation was provided prior to xit. This was a deficiency based agation.		F 242		
F 242 SS=D	483.10(f)(1)-(3) SI RIGHT TO MAKE	ELF-DETERMINATION - CHOICES	F 24	1. Resident #1 was interviewed by Dietary Manager on 6/29/17 to er the resident's dietary request/cho	sure	
	schedules (includi	has a right to choose activities, ng sleeping and waking times), roviders of health care services		are honored.		
	consistent with his	or her interests, assessments, and other applicable provisions	:	2. An audit was completed on 6/3 by the Director of Nursing of the	10/1 /	
	of this part.			current residents' diet orders and dietary request/ choices to ensure	. i	
	' (f)(2) The resident about aspects of the are significant to the	thas a right to make choices his or her life in the facility that he resident.	! ! : !	resident diets are followed as required.		
	members of the community activitition facility.	t has a right to interact with ommunity and participate in es both inside and outside the ENT is not met as evidenced		The current residents were interviewed by the Director of Nursing on 6/30/17 to ensure any additional dietary request/ choice		
	by: Based on observ	ation, resident, family and staff		being addressed as required. 3. The nursing and dietary staff w	VATA	
	determined the fa	cal record review it was cility staff failed to tary requests/choices for 1 of ident #1).		reeducated by the Staff Developm Coordinator by 7/28/17 related to ensuring resident diet orders and	nent	
	Findings:		!	dietary request/choices are honor required.	ed as	
	choices for Resid	off failed to accommodate diet ent #1. The resident's clinical eved on 6/27/17 at 3:00 PM.		4. The Dietary Manager will interview 5 residents weekly for weeks and monthly for 2 months		
	11/16/16. Her diag	admitted to the facility on gnoses included atrial fibrillation, nic obstructive pulmonary		ensure resident diet orders and di request/choices continue to be honored as required.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A, BUILD		RIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED C	
		495187	B, WING_		0:	5/29/2017	
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODI	<u> </u>		
	e person cramos o	BEAUTICADE CENTED II C		222 FULCHER STREET			
HILLSVILI	E REHABILITATION &	HEALTHCARE CENTER LLC		HILLSVILLE, VA 24343			
(X4) IO PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BC	(X5) COMPLETION DATE	
F 242	admitted for surgical therapy to restore in The latest quarterly assessment, dated with moderate cogninability to recall iter memory test to assement coded assessment coded assistance of nursir of daily living), with required set up only Resident #1's CCP Resident #1's CCP Resident #1's physical dated 6/1/17 contain was for a regular disconsistency. On 6/28/17 at 11:00 interviewed regards choices/selections. loved buttermilk, but have any. She told have a glass of but On 6/28/17 at 11:45 resident's request for DM I (local dietary dietary manager). It resident's preference the resident was or restrictions. On 6/28/17 at 1:30	any pertension. She was all aftercare and physical mobile function. MDS (minimum data set) 4/7/17, coded the resident ditive impairment due to her man during a short-term ess mental status. Her as unimpaired. The MDS the resident as requiring the eng staff for all ADLs (activities the exception of eating, which for the exception of eating, which for the exception of eating and ined a dietary order. The order let, regular texture and regular so AM Resident #1 was ang her dietary. She told the surveyor she would like to the the surveyor she would like to termilk every day at lunch. AM the surveyor relayed the for buttermilk daily at lunch to manager) and DM II (corporate DM II told the surveyor the ce would not be a problem as a regular diet with no	F:	The Director of Nursing we report to the Quality Assure Committee monthly for 3. The Director of Nursing we responsible for monitoring up. Date of Compliance: 07/2	rance months. vitl be g and follow		
		eceived her buttermilk at				<u> </u>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/GLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING _ B. WING 495187 06/29/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 222 FILL CHER STREET HILLSVILLE REHABILITATION & HEALTHCARE CENTER LLC HILLSVILLE, VA 24343 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 242 F 242 Continued From page 7 lunch. She stated, "It was so good! I'm so happy they're going to let me have it." The resident actually clapped her hands with glee at the prospect. On 6/29/17 at 1:30 PM the surveyor spoke to Resident #1. Resident #1 told her she did not get her buttermilk on her lunch tray, she only got regular milk. On 6/29/17 at 2:18 PM DM I was informed of the surveyor's findings. DM I replied, "She should have gotten it at lunch. I will check on it." At 2:20 PM DM I returned to inform the surveyor that a dietary staff member informed him that they put buttermilk on her lunch tray that day. He told the surveyor it was not on her lunch tray ticket, but someone had remembered she wanted it-so they provided it. DM I added he had entered the request into the computer and it should, thereafter, appear as a resident choice on her meal ticket. On 6/29/17 at 2:25 PM the surveyor returned to Resident #1's room and again asked the resident and FM II (family member II) what kind of milk was on the lunch tray that day. The resident repeated "regular milk." FM II said she was in the room during lunch and the resident received sweet milk-no buttermilk. The DON was in the resident's room at this time and heard the conversation. She said she would check on it. On 6/29/17 at 2:45 PM the findings were reported to the facility administrator, DON and corporate nurse. No additional information was provided prior to the survey team exit.

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STATEMENT OF DEFICIENCIES () AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495187	B. WING		C 06/29/2017
	ROVIDER OR SUPPLIER LE REHABILITATION	& HEALTHCARE CENTER LLC	2:	TREET ADDRESS, CITY, STATE, ZIP CODE 22 FULCHER STREET IILLSVILLE, VA 24343	
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPA DEFICIENCY)	BE COMPLETION
F 272 SS=D	must make a comresident's needs, preferences, usin instrument (RAI) as assessment must (i) Identification (ii) Customary ro (iii) Cognitive partivo Communicati (v) Vision. (vi) Mood and be (vii) Psychological (viii) Physical problems. (ix) Continence. (x) Disease diag (xi) Dental and no (xii) Skin Condition (xiii) Activity (xiv) Medicati (xvi) Medicati (xvi) Discharg (xvii) Docume regarding the add on the care and of the Minimum Docume assessment. The	re Assessments ressment Instrument. A facility operhensive assessment of a strengths, goals, life history and gothe resident assessment specified by CMS. The include at least the following: and demographic information outline. Iterns. Identify patterns. In well-being. Infunctioning and structural Inosis and health conditions. Intuitional status. Inc. Inc. Inc. Inc. Inc. Inc. Inc. Inc	F 272	1. Resident #7 had a new Comprehensive MDS with ARI 7/24/17 completed by the MDS by 7/28/17 to include the date a location of the CAA informatio included on section V as require 2. An audit was completed by the Clinical Reimbursement Special 07/05/17 of the current resident Comprehensive MDS Assessmensure section V has been compto include the date and the location the CAA information. 3. The MDS Coordinator will be reeducated by the Clinical Reimbursement Specialist by 07/25/17 related to ensuring the section V of the MDS is complianced the date and the location the CAA information.	nurse nd the n ed. he llist on ts' last ent to pleted tion of
	include direct observa	ation and communication with	<u>:</u>	· :	<u>!</u>

Facility ID VA0082

495187 B. WING 06/29/20	2017
	2011
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 222 FULCHER STREET HILLSVILLE REHABILITATION & HEALTHCARE CENTER LLC HILLSVILLE, VA 24343	
	(XS) COMPLETION DATE
F 272 Continued From page 9 the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This RECUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure a complete and accurate Care Area Assessment (CAA's) for 1 of 16 Residents, Resident #7. The findings included: For Resident #7 the facility staff tailed to accurately name the date and location of CAA (care area assessment) documentation. Rasident #7 was admitted to the facility on 09/15/15 and readmitted on 02/09/17. Diagnoses included but not limited to Alzheimer's disease, anxiety, depression, gastroesophageal reflux disease, hypertension, and thyroid disorder. The most recent comprehensive MDS with an ARD (assessment reference date) of 02/13/17 coded the Resident as having both short and long term memory impairment with severely impaired skills for daily decision making. This is a significant change MDS. Section V of the MDS, care area assessment, was reviewed. The facility staff had not identified	/29/17

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIP! A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 272	communication. The "see CAA worksheets were re could not be located." The concern of the	re plans for cognitive loss or e only documentation was at dated 02/21/17". The CAA viewed and the information	F 27	2	
F 309 SS=D	No further informati 483.24, 483.25(k)(l) FOR HIGHEST WE 483.24 Quality of lif		F 30	 F 309 I. Resident #4 was checked Director of Nursing on 6/28 	
	applies to all care a residents. Each res facility must provide services to attain or practicable physica well-being, consiste	and services provided to facility sident must receive and the the necessary care and maintain the highest I, mental, and psychosocial ent with the resident's ressment and plan of care.		ensure that the TED hose w place as required. An extra TED Hose were ordered on 7/17/17 by Central Supply. 2. An audit was completed of	pair of
	applies to all treatm facility residents. Be assessment of a re that residents recei accordance with pre- practice, the compr	fundamental principle that nent and care provided to assed on the comprehensive sident, the facility must ensure we treatment and care in ofessional standards of ehensive person-centered residents' choices, including		6/28/17 of the current reside the Director of Nursing to e treatments and care is provi ordered to include the applie of TED hose.	nsure ded as
	(k) Pain Manageme The facility must er provided to residen	ent. isure that pain management is its who require such services,			

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F 309	the comprehensive and the residents." (I) Dialysis. The faresidents who requiservices, consister of practice, the concare plan, and the preferences. This REQUIREMED by: Based on observate record review, it with staff failed to follow Residents in the second review, it with staff failed to follow Residents in the second review and the physician ordered Resident #4 was a admitted on 9/9/16 included, but were behaviors, dysphate depression, anxiet and a cerebral infarence in the clinical assessment with a (ARD) of 6/8/17. Resident #4 had second recomplete in the clinical record review in the clinical record review.	offessional standards of practice, a person-centered care plan, goals and preferences. Incility must ensure that the dialysis receive such at with professional standards in more than the professional standards in more than the preference of the present of the	F	3. The nursing staff veducated by the State Development Coordin 06/28/17 related to entreatments and care is ordered to include the of TED hose. 4. The Assistant Dire Nursing will complet 10 resident's weekly and monthly for 4 meansure treatments and continues to be proviordered to include the of TED hose. The As Director of Nursing verport to the Quality Committee monthly for The Director of Nursing versponsible for monit follow up. Date of Compliance:	aff nator on asuring s provided as e application ector of te an audit of for 4 weeks onths to d care ded as e application esistant will submit a Assurance for 3 months. ing is	07/29/17

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER AND PLAN OF CORRECTION A, BUILDING _ B. WING 495187 06/29/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 222 FULCHER STREET HILLSVILLE REHABILITATION & HEALTHCARE CENTER LLC HILLSVILLE, VA 24343 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY F 309 F 309 Continued From page 12 On June 27, 2017 at 2:35 p.m. the surveyor observed Resident #4 lying on her bed on top of the bed linens. The surveyor did not observe that Resident #4 had on TED hose. On June 27, 2017 at 3 p.m. the surveyor observed Resident #4 lying in her bed and on top of the bed linens. The surveyor did not observe that Resident #4 had on TED hose. On June 27, 2017 at 3:30 p.m. the surveyor reviewed Resident #4's clinical record, Review of the clinical record produced signed physician orders dated 6/1/17. Signed physician orders included, but were not limited to: "TED hose to bilateral lower extremities at all times. To be removed Q HS (every evening at bedtime) every shift for edema." (sic) On June 27, 2017 at 4:10 p.m. the surveyor observed Resident #4 sitting in her wheelchair. The surveyor did not observe that Resident #4 had on the physician ordered TED hose. The surveyor observed that Resident #4 had on white socks that came up just above her ankles. On June 28, 2017 at 9:45 a.m. the surveyor notified the Director of Nurses (DON) that Resident #4 had a physician order for TED hose to be applied to bilateral extremities for edema. The surveyor notified the DON that on multiple occasions on June 26, 2017, Resident #4 did not have on the physician ordered TED hose. On June 29, 2017 at 9:45 a.m. the survey team met with the Administrator (Adm), DON, and the Human Resources/Payroll Department Head. The surveyor notified the Administrative Team

(AT) that Resident #4 had a physician order for

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER HILLSVILLE REHABILITATION & HEALTHCARE CENTER LLC		;	STREET ADDRESS, CITY, STATE, ZIP CODE 222 FULCHER STREET HILLSVILLE, VA 24343			
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F 319	The surveyor notifier not have on the phy multiple observation. No additional inform exiting the facility as to apply the physician Resident #4, 483.40(b)(1) TX/SV MENTAL/PSYCHOST 483.40(b) Based on assessment of a resident whith mental disorder difficulty, or who had post-traumatic stress appropriate treatment assessed problem of practicable mental and the record review it was failed to provide treatment of the recessary to address (failure to adjust to	ateral lower legs for edema. d the AT that Resident #4 did sician ordered TED hose on as on June 27, 2017. nation was provided prior to a to why the facility staff failed an ordered TED hose to C FOR SOCIAL DIFFICULTIES I the comprehensive sident, the facility must ensure o displays or is diagnosed or or psychosocial adjustment as a history of trauma and/or as disorder, receives and services to correct the or to attain the highest and psychosocial well-being. IT is not met as evidenced ion, resident, family and staff cument review and clinical a determined the facility staff atment and services as the psychosocial issues the facility, anxiety, fear and bass of independence/dignity)	F 309	F 319 1. The Director of Nursing met with Resident #1 and her famil on 6/29/17 to address the resid psychosocial/ adjustment issue and the resident's plan of care reviewed and revised by the interdisciplinary team. 2. An audit was completed of tourrent residents on 7/14/17 by Director of Nursing to ensure resident psychosocial/ adjustment issue are being addressed. 3. The Social Worker was reeducated on 7/12/17 by the Director of Nursing related to ensuring that the residents' placare address resident psychosocial.	y ent s was he the ent	
	:	ed to provide treatment and to address the		and adjustment issues.		

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(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING __ B. WING 495187 06/29/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 222 FULCHER STREET HILLSVILLE REHABILITATION & HEALTHCARE CENTER LLC HILLSVILLE, VA 24343 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 319 4. The Director of Nursing will F 319 Continued From page 14 psychosocial/adjustment issues for Resident #1. complete an audit of 5 residents The resident's clinical record was reviewed on weekly for 4 weeks and monthly 6/27/17 at 3:00 PM. for 2 months to ensure resident psychosocial / adjustment issues Resident #1 was admitted to the facility on 11/16/16. Her diagnoses included atrial fibrillation, continue to be addressed as heart failure, chronic obstructive pulmonary required. The Director of Nursing disease, gout and hypertension. She was will submit a report to the Quality admitted for surgical aftercare and physical Assurance Committee monthly for therapy to restore mobile function. The resident had a history of respiratory failure. 3 months. The Administrator is responsible for monitoring and The initial MDS (minimum data set) assessment follow up. dated 11/23/17 coded the resident with slight cognitive impairment due to her inability to consistently make herself understood and her 07/29/17 Date of Compliance: inability to consistently understand others. Her hearing was assessed as adequate on this assessment. She required assistance with all the ADLs (activities of daily living) and was frequently incontinent of bowel and bladder. The latest quarterly MDS (minimum data set) assessment, dated 4/7/17, coded the resident with moderate cognitive impairment due to her inability to recall items during a short-term memory test to assess mental status. Her memory was coded as unimpaired. The resident was coded with significant hearing impairment on this assessment. The resident was coded as not having a hearing aid. The latest MDS assessment coded the resident as requiring the assistance of nursing staff for all ADLs (activities of daily living), with the exception of eating, which required set up only. She was completely continent of bowel, but her bladder function had declined to "always incontinent".

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DESAR IMENT OF DEVELOAR	ID HOMIVIA PELLAIOFO		LOMMULITORE
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F 319	Continued From pa		F 319		
	The latest CCP (co	mprehensive care plan)	i		:
		ed on 4/11/17 documented the			:
	resident had the fo	llowing care issues concerning			:
	the complaint alleg				
		vet elimination r/t (related to)			: :
	decreased mobility	. The interventions included:	i i		:
	"Scheduled toiletin	g program as ordered."	1		
	2. The resident has				:
	performance defici	t related to recent surgery.	1		
		ist with ADLs as needed"			
	***The resident wa	s careplanned for scheduled			:
	toileting (in bathroo	om) every two hours or as			:
	needed-but there	was no documented evidence			
	this schedule was		:		:
	3. Alteration in thor	ught process (initiated 3/6/17)			1
	related to a history	of hallucinations during			
	infections and belie	eving she is wet when in reality			Ì
	she is not. Interver	ntions: "Ensure routines are			ļ
	followed as closely	as possible on each	;		}
	shiftProvide plea	asant interactions which			•
		ent when confusedStaff to			\$ •
		ery two hours and as needed			:
	for incontinence) Pr 			!
	4, Alteration in beh	navior (initiated 3/6/17) related			i
	to history of makin	g false accusations against	1		į
	staff regarding car	e received. Interventions:	: [
	"Cries often and	l speaks in high pitched			
	squeaky voice who	en requesting assistance,			
	provide assistance	as needed and speak to			
	resident in normal	voicesocial services to visit			!
	frequently to asset	ss/review any concerns the			:
	resident might hav	re			
	5. Resident is afra	id of dark. The interventions			
	included: "Staff to	leave the light on at all times			
İ	per the resident's	request." (Subsequent			!
	interviews with the	resident and family members			
	indicate this was n	ot consistently implemented.			
	6. Alteration in boy	wel elimination r/t (related to)			
	decreased mobility	y. The interventions included:			<u> </u>

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HILLSVILLE REHABILITATION & HEALTHCARE CENTER LLC 222 FULCHER STREET HILLSVILLE, VA. 24343 PRICED PRICED HILLSVILLE, VA. 24343 DANID SUMMARY STATEMENT OF DESIGNATION HEALTHCARE BEACH DEFICIENCY MUST BE PRECEDED BY FULL FREGULATORY OR LSO IDENTIFYING REPORTATION TAG F319 Continued From page 15 "Scheduled tolleting program as ordered." 7. The resident will be a long term care individual. Interventions did not include plans to address her problems adjusting to loss of independence/wish to return home or inability to adjust to long term care, (There was nothing in the CCP to address these nogoing issues.) 8. Moderately impaired hearing. Does not wear hearing aide (initiated 4/12/17). Interventions: " Speak directly with resident in clear audible tones. Speak slightly slower and enunciate words" 9. The resident uses antidepressant medication related to insomnia. Interventions: " Promote quiet environment to allow sleep." "***The CCP, at no time, addressed the resident's actual antiety/depression over being admitted permanently to the facility. The CCP did not address spychiatric intervention for her on-oging psyche-social adjustment issues—other than to document her "undestrable behaviors" which were symptoms of depression and anxiety. (These "behaviors" were actually only assessed and care planned after APS (Adult Protective Services) investigated an incident on 2/28/17 that the resident had been told by a staff member to urinate in her brief instead of assisting her to the tolet. The allegation was substantiated by this surveyor's office.) She was initially admitted for affercare and physical threapy following surgery for injuries			495187	B. WING	, , ,		017	
F 319 Continued From page 16 "Scheduled tolleting program as ordered." 7. The resident will be a long term care individual. Interventions did not include plans to address her problems adjusting to loss of independence/wish to return home or inability to adjust to long term care. (There was nothing in the CCP to address these ongoing issues.) 8. Moderately impaired hearing. Does not wear hearing aide (initiated 41/21/7). Interventions: "Speak directly with resident in clear audible tones. Speak slightly slower and enunciate words" 9. The resident uses antidepressant medication related to inspannia. Interventions: "Speak directly with resident in clear audible tones. Speak slightly slower and enunciate words" 10. The resident uses antidepressant medication related to inspannia. Interventions: "Promote quiet environment to allow sleep." *****The CCP, a no time, addresses dhe resident's actual anxiety/depression over being admitted permanently to the facility. The CCP did not address psychiatric intervention for her on-going psycho-social adjustment issues—other than to document her "undestrable behaviors" which were symptoms of depression and anxiety. (These "behaviors" were actually only assessed and care planned after APS (Adult Protective Services) investigated an incident on 2/20/17 that the resident had been told by a staff member to urinate in her brief instead of assisting her to the tolet. The allegation was substantiated by this surveyor-but reported to be unsubstantiated to this surveyor's office.) She was initially admitted for aftercare and physical therapy following surgery for injuries	NAME OF PROVIDER OR SUPPLIER			<u> </u>	222 FULCHER STREET	CODE		
"Scheduled toileting program as ordered." 7. The resident will be a long term care individual. Interventions did not include plans to address her problems adjusting to loss of independence/wish to return home or inability to adjust to long term care. (There was nothing in the CCP to address these ongoing issues.) 8. Moderately impaired hearing. Does not wear hearing aide (initiated 4/12/17). Interventions: "Speak directly with resident in clear audible tones. Speak slightly slower and enunciate words" 9. The resident has an ADL self-care performance deficit related to recent surgery. Interventions: "Assist with ADLs as needed" 10. The resident uses antidepressant medication related to insomnia. Interventions: "Promote quiet environment to allow sleep." *****The CCP, at no time, addressed the resident's actual anxiety/depression over being admitted permanently to the facility. The CCP did not address psychiatric intervention for her on-going psycho-social adjustment issues—other than to document her "undestrable behaviors" which were symptoms of depression and anxiety. (These "behaviors" were actually only assessed and care planned after APS (Adult Protective Services) investigated an incident on 2/28/17 that the resident had been told by a staff member to urinate in her brief instead of assisting her to the toilet. The allegation was substantiated by this surveyor-but reported to be unsubstantiated to this surveyor-but reported to be unsubstantiated to this surveyor's office.)	PREFIX	(EACH DEFIGIENC	Y MUST BE PRECEDED BY FULL	PREF	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE CONTINUE APPROPRIATE	NCITELIAN	
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she was careplanned for eventual return to her home, but, since then has become a permanent		7. The resident will be Interventions did not problems adjusting to to return home or inaccare. (There was not these ongoing issues 8. Moderately impair hearing aide (initiate "Speak directly words" 9. The resident has a performance deficit interventions: "Assis 10. The resident use related to insomnia. quiet environment to """The CCP, at not resident's actual anxiadmitted permanent not address psychia on-going psycho-soot than to document he which were symptom (These "behaviors" vand care planned aff Services) investigate the resident had bee urinate in her brief in toilet. The allegation surveyor—but reporte this surveyor's office. She was initially adriphysical therapy follows sustained from a fall she was careplanne	e a long term care individual, include plans to address her o loss of independence/wish ability to adjust to long term thing in the CCP to address is.) ed hearing. Does not wear d 4/12/17). Interventions: ith resident in clear audible is slower and enunciate an ADL self-care elated to recent surgery. It with ADLs as needed" is antidepressant medication interventions: "Promote allow sleep." of time, addressed the diety/depression over being by to the facility. The CCP did tric intervention for her dial adjustment issues—other in "undestrable behaviors" in sof depression and anxiety. It were actually only assessed the an incident on 2/28/17 that are told by a staff member to instead of assisting her to the was substantiated by this ed to be unsubstantiated to all in her home. On admission, did for eventual return to her					

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FORM APPROVED OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER HILLSVILLE REHABILITATION & HEALTHCARE CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 222 FULCHER STREET HILLSVILLE, VA 24343				
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	Continued From page resident due to lack with her daily care resident her daily care resident due to lack with her daily care resident due to following 1. 2/9/17 - Ativan table by mouth every 12 heroson outh at bedtime resident above 90%. On 6/28/17 at 11:00 interviewed. She tolister member had to she would come bace resident said she was she had to pee and call light. Resident #1 stated, because I was wet, need somethingI didn't say anything, would they be so may you have to go?" The she would sit in her learn to talk to some	of home services to assist equirements. ers, signed and dated 6/1/17, g medications: olet 0.5 mg. Give one tablet tours for anxiety. The HCL tablet. Give 75 mg by lated to insomnia. The experimental of the experimental of the surveyor that a nursing lid her to "go in her pants and ock to clean her up later." The as calling for help because staff would not answer her "They told me to shut-up it never use the light unless it thurt my feelings. I cried. I inever bother anyone. Why ean when you can't help when he resident told the surveyor chair and pray the girl would cone without hurting their was no longer at the facility	F:	319	DEFICIENCY)		
de de	admission, she lived when she had to us got anxious or called	e surveyor that prior to her if at home by herself and knew to the bathroom. She never if her daughters in the middle arfully, told the surveyor she ome".	1				

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OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER COMPLETED AND PLAN OF CORRECTION A, BUILDING _ С B. WING 495187 06/29/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 222 FULCHER STREET HILLSVILLE REHABILITATION & HEALTHCARE CENTER LLC HILLSVILLE, VA 24343 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 319 F 319 | Continued From page 18 FMI (family member #1) was present during this interview. She told the surveyor the incident about being asked to pee in her pants was reported to APS (Adult Protective Services) on 2/28/17. FMI stated, "They came in to investigate, but nothing was done." FMI acknowledged Resident #1 was happy and content living at home prior to her admission. "She never called us crying or anxious like she does now." FM I said she and other family members had talked to the staff about the issues that began on her admission, and just didn't know what to do at this point. The surveyor reviewed a facility reported incident and the subsequent investigation results sent in by the ADON (assistant director of nursing) on 2/28/17 and 3/4/17. The initial report documented the resident and family members complained to APS regarding the resident's incontinence care not being performed and the staff instructing the resident to urinate in her brief instead of assisting her to the toilet. The follow-up report, transmitted to the surveyor's

in her care.

office by the ADON on 3/4/17, indicated an investigation had been conducted and the allegation of "neglect" was unsubstantiated. The follow-up statement did not address the staff telling the resident to urinate in her pants.

The surveyor reviewed the investigation results and the written statements of the CNAs involved

CNA I stated the following about the incident, which occurred on 2/27/17 during 3rd shift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A. BUILDI	NPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	(name of CNA II) of (Resident #1) transishe was getting rethat patient had realthough she'd alredepend (name of the said resident #1) put there to see what wanted to get up to know if she was a	t 11 PM, after a few minutes came in and asked how aferred. I questioned her why sident up, she told me in return quested to go to the bathroom, eady told patient just to use her priefs used) and she'd change dent told her she couldn't and gain to the bathroom. I went	F	319	
	The facility investimandatory in-service CNAs on 3/3/17. I included: "Under rallowed to instruct We are here to ke them to be incontify you are reported On 6/29/17 at 8:01 the SW (Social Wegarding the resissues and her foll incident. The SW since she first cardaughters to comstated, "She's had				

NAME OF PROVIDER OR SUPPLIER HILLSVILLE REHABILITATION & HEALTHCARE CENTER LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES B. WING STREET ADDRESS, CITY, STATE, ZIP 222 FULCHER STREET HILLSVILLE, VA 24343	OF CORRECTION CTION SHOULD BE	C 06/29/2017
MAME OF PROVIDER OR SUPPLIER HILLSVILLE REHABILITATION & HEALTHCARE CENTER LLC STREET ADDRESS, CITY, STATE, ZIP 222 FULCHER STREET HILLSVILLE, VA 24343 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLANCE	OF CORRECTION CTION SHOULD BE	
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(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN C	CTION SHOULD BE	:
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PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACT TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO DEFICIENT TAG CROSS-REFERENCED TAG C		(X5) COMPLETION DATE
F 319 Continued From page 20 F 319 happy."		
The SW was asked if she'd provided counseling or comfort to the resident since her admission or the February incident. She told the surveyor, she hadn't really documented anything or actually counseled the resident, "I knew the nurses had her on rounds and she should have medication for anxiety by now. I felt she needed medication to adjust, but I haven't addressed thatI don't feel like we've done all we can for her. She should've had psych services." The SW notes were reviewed. She had addressed the family's concerns and documented them. There was no documentation she provided any support to Resident #1. On 6/29/17 at 11:00 AM, FM II was interviewed. She had numerous complaints and was primarily focused on the on-going adjustment issues and the lack of staff support and psychiatric services at the facility. FM II stated, "I have asked them if they could schedule a psychiatric eval for her. I think she needs it. She's just not happy and I'm unable to take her home and care for her by myself. They told me they are in the process of that, but its a long, drawn out process." FM II told the surveyor she asked if she could bring in a psychiatrist herself and was told she could not. She said the facility, currently, had no one to provide psychiatric services to the residents. She said the Ativan had helped some, but the resident was still anxious and fearful of being in the facility alone. She said, "They tell her to shut-up when she calls out for help. One night		

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OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A. BUILDING ____

AND PLAN OF CORRECTION B. WING 06/29/2017 495187 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 222 FULCHER STREET HILLSVILLE REHABILITATION & HEALTHCARE CENTER LLC HILLSVILLE, VA 24343 PROVIDER'S PLAN OF CORRECTION ID SUMMARY STATEMENT OF DEFICIENCIES COMPLETION (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 319 F 319 Continued From page 21 answered her call light. They finally came in and put her oxygen back on and told her only to call if it was an emergency. Isn't it an emergency if you can't breath?" FM II said most of Resident #1's anxiety/fears focused on the night shift (3rd) after the family was gone. She told the surveyor she didn't know what else to do because she couldn't stay at the facility 24 hours a day. FM II stated, "It's always her fault, and I'm tired of them blaming it on her behaviors...They want to keep her quiet, but they are not addressing her issues." On 6/29/17 at 12:40 PM the facility administrator and DON were informed of the findings and asked for evidence the facility had provided psychosocial support to address Resident #1's anxiety, fears and adjustment issues. The DON stated, "We have been trying to get psychiatric services for quite some time. We're changing our doctor services but it's a long process. The new doctor is going to be more help with psychiatric services." The DON added they had started watching CNAs closer and popping in at different hours to check on care since the February incident. No additional information was provided prior to the survey team exit. This was a complaint allegation deficiency.