STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 000 INITIAL COMMENTS

An unannounced Medicare/Medicaid abbreviated complaint survey was conducted 6/12/18 through 6/14/18. Corrections are required for compliance with 43 CFR Part 483 Federal Long Term Care requirements.

The census at the time of the survey in this 120 bed facility was 100 at the time of the survey. The survey sample consisted of 12 residents, seven current Residents #3, 6, 8, 9, 10, 11 and 12 and five closed resident reviews, Residents #1, 2, 4, 5 and 7.

F 550 SS=E Resident Rights/Exercise of Rights
CFR(s): 483.10(a)(1)(2)(b)(1)(2)

§483.10(a) Resident Rights.
The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.

§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

F 000

RECEIVED
VDH/OLC

Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of corrections prepared and executed as a means to continuously improve quality of care and to comply with applicable state and federal regulations.

F 550

1.Comprehensive care plans for residents #3, #8, #9, and #10 have been updated reflecting call light positioning and assurance of location in proximity to residents and call bells have been secured utilizing clips to ensure call bells remain in situ.
2. Residents that reside in this facility have the potential to be affected by this deficient practice.
3. Staff to be reeducated about ensuring call bell is in reach of resident by DON/designee.
Care keepers to audit 5 times per week with correction upon discovery x 4 weeks. Call bells not in reach will be reported by care keepers during morning start up meeting. The care keepers will follow up once per shift to ensure that call bell is maintained in resident reach and discuss results during afternoon stand down meeting x 4 weeks.
4. Results of audits will be brought to monthly/ quarterly Quality Assurance Performance Improvement (QAPI) Committee for trend analysis and review. Recommendations implemented as indicated. The plan of correction to be monitored until substantial consistent compliance has been met.
5. Correction to be completed by 7/14/2018.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Executive Director	7-5-18

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 550	Continued From page 1	F 550		

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure the accommodation of resident's needs for four of 12 residents in the survey sample, (Resident #3, 8, 9 and 10).

1. The facility staff failed to secure the call bell within Resident #3's reach.

2. The facility staff failed to secure the call bell within Resident #8's reach.

3. The facility staff failed to secure the call bell within Resident #9's reach.

4. The facility staff failed to secure the call bell within Resident #10's reach.

The findings include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 550	Continued From page 2	F 550		

1. Resident #3 was admitted to the facility on 1/8/15 and readmitted on 6/4/18 with diagnoses that included but were not limited to: diabetes, difficulty swallowing, heart failure, respiratory failure, high blood pressure, depression and arthritis.

The most recent MDS, (minimum data set), a five day assessment, with an ARD (assessment reference date) of 6/4/18 coded the resident as having scored a 14 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living except for eating which the resident could perform after the tray was prepared.

An observation was made on 6/12/18 at 11:25 a.m., of Resident #3. The resident was lying in bed with eyes closed. The call bell was lying on the floor next to the right side of the bed.

An observation was made on 6/13/18 at 10:25 a.m. of Resident #3. The resident was lying in bed on the left side with eyes closed. The call bell was lying on the floor.

Review of the resident's care plan initiated on 3/3/17 documented, "Focus. I have a physical functioning deficit related to: Mobility impairment, Self care impairment. Interventions. Call bell within reach."

An interview was conducted on 6/13/18 at 1:20 p.m. CNA (certified nursing assistant) #2. When asked what staff assess when checking on residents, CNA #2 stated, "One major thing I look

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 550	Continued From page 3	F 550		

for is to see if they are wet or dry. I see where their call light is and see if there's everything in reach." When asked why they checked that the call light was available to the resident, CNA #2 stated, "They need it in order to communicate with us or if there's an emergency too." When asked if the resident could reach the call bell if it was on the floor, CNA #2 stated, "No."

An interview was conducted on 6/13/18 at 2:35 p.m. with Resident #3. When asked if she was able to use her call bell, Resident #3 stated, "My call bell is on the floor a lot." When asked how long it took staff to answer her call bell, Resident #3 stated, "Maybe 40 minutes."

An interview was conducted on 6/13/18 at 2:30 p.m. with LPN #4. When asked how the resident's call lights were to be maintained, LPN #4 stated, "Within reach of the patient." When asked why, LPN #4 stated, "So they can let us know when they need help or assistance."

An interview was conducted on 6/13/18 at 3:20 p.m. with ASM (administrative staff member) #2, the director of nursing. When asked what staff assess when making rounds on the residents, ASM #2 stated, "They scan the resident, check that the linen is clean and the call bell is in reach and the bed control is also within reach."

On 6/13/18 at 5:10 p.m. ASM #1, the executive director, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the findings.

An interview was conducted on 6/14/18 at 10:05 a.m. with LPN #3. When asked how were call lights to be maintained, LPN #3 stated, "Close to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 550	Continued From page 4	F 550		

the patient." When asked if she had any residents who complained they did not have their call bells, or if she had noticed that residents did not have their call bells, LPN #3 stated, "Yes ma'am. Quite a bit." When asked who's responsible for ensuring the resident had their call bell, LPN #3 stated, "We are all responsible. It is not just one person. It's the CNA, the nurse." When asked why it was important for residents to have their call bells, LPN #3 stated, "Well, because if they need something. If they can't reach it and they don't have it they might try to get up and they may fall."

Review of the facility's policy titled, "Performance Improvement Care Keepers Program (Quality Assurance) documented, "POLICY: Monitor program will be implemented as a performance improvement activity to monitor and evaluate quality of care. PROCEDURE: 3. There will be at least two Care Keepers per unit and should visit rooms prior to morning meeting and one other time during the day, at a minimum. 5. Each Care Keeper will obtain information about their resident and complete the Resident Care Keepers form...CARE KEEPER ROUNDS (QUALITY ASSURANCE) Call bells attached and near residents."

No further information was provided prior to exit.

According to "Handbook of Nursing Procedures- Fall Prevention and Management- Correct potential dangers in the patient's room. Position the call light so that he can reach it..."(1)
(1) Handbook of Nursing Procedures Springhouse Corporation, Springhouse PA 2001, page 323- Fall Prevention and Management.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 550	Continued From page 5	F 550		

2. The facility staff failed to secure the call bell within Resident #8's reach.

Resident #8 was admitted to the facility on 4/20/18 with diagnoses that included but were not limited to: irregular heart beat, difficulty speaking, depression, lung disease and diabetes.

The most recent MDS, a 30 day assessment, with an ARD of 4/27/18 coded the resident as requiring assistance from staff for all activities of daily living. The resident was coded as having long and short-term memory problems, and was coded as severely impaired cognitively.

An observation was made on 6/12/18 at 11:15 a.m. of Resident #8. The resident was lying in bed. The call bell was behind the head of the bed lying on the floor.

An observation was made on 6/12/18 at 6:10 p.m. of Resident #8. The resident was lying in bed with a washcloth on her forehead. The call bell cord was tucked under the upper part of the pillow and the call bell was dangling over the head of the bed.

An observation was made on 6/13/18 at 10:17 of Resident #8. The resident was sitting up in a wheelchair on the right side of the bed. The call bell was on the floor on the left side of the bed.

Review of the care plan initiated on 4/20/18, documented, "Focus. At risk for falls related to New environment, meds (medications). Interventions. Call light or personal items available and in easy reach or provide reacher."

An interview was conducted on 6/13/18 at 2:30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 550	Continued From page 6	F 550		

p.m. with LPN #4. When asked how the resident's call bells were to be maintained, LPN #4 stated, "Within reach of the patient." When asked why, LPN #4 stated, "So they can let us know when they need help or assistance."

An interview was conducted on 6/13/18 at 3:20 p.m. with ASM (administrative staff member) #2, the director of nursing. When asked what staff assess when making rounds on the residents, ASM #2 stated, "They scan the resident, check that the linen is clean and the call bell is in reach and the bed control is also within reach."

On 6/13/18 at 5:10 p.m. ASM #1, the executive director, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the findings.

An interview was conducted on 6/14/18 at 10:05 a.m. with LPN #3. When asked how where call bells to be maintained, LPN #3 stated, "Close to the patient." When asked if she had any residents who complained they did not have their call bells, or if she had noticed that residents did not have their call bells, LPN #3 stated, "Yes ma'am. Quite a bit." When asked who is responsible for ensuring the resident had their call bell, LPN #3 stated, "We are all responsible. It is not just one person. It's the CNA, the nurse." When asked why it was important for residents to have their call bells. LPN #3 stated, "Well, because if they need something." If they can't reach it and they don't have it they might try to get up and they may fall."

3. The facility staff failed to secure the call bell within Resident #9's reach.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 550	Continued From page 7	F 550		

Resident #9 was admitted to the facility on 10/7/17 with diagnoses that included but were not limited to: irregular heart beat, dementia, enlarged prostate and communication deficit.

The most recent MDS, a quarterly assessment, with an ARD of 4/16/18 coded the resident, as having scored a three out of 15 on the BIMS indicting the resident was severely impaired cognitively. The resident was coded as requiring assistance for all activities of daily living except for eating which the resident could perform after the tray was prepared.

An observation was made on 6/13/18 at 10:18 a.m. of Resident #9. The resident was lying in bed with his back to the door. The call bell cord was clipped to the cushion of a chair approximately three feet from the bed. The call bell was lying on the floor.

An observation was made on 6/13/18 at 12:30 p.m. of Resident #9. The resident was lying in bed. The call bell was in the same position as observed at 10:18 a.m.

An observation was made on 6/13/8 at 12:44 p.m. with CNA #3, the resident's aide. When asked where the call bell was, CNA #3 picked the call bell off the floor and clipped it to the resident's bed.

Review of the care plan initiated on 11/8/17 documented, "Focus. At risk for falls related to: History of falls, unsteadiness. Interventions. Call light or personal items available in easy reach or provide reacher."

An interview was conducted on 6/13/18 at 12:50

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 550	Continued From page 8	F 550		

p.m. with CNA #3. When asked why residents had call bells, CNA #3 stated, "So if they're in dire need they can call us and let us know they need us." When asked what staff look for when they make rounds on the residents, CNA #3 stated, "We check to see if they have any bruise, if they need to be cleaned up." When asked if they checked that the call bell within the resident's reach, CNA #3 stated, "Before I leave, yes."

An interview was conducted on 6/13/18 at 2:30 p.m. with LPN #4. When asked how the resident's call bells were to be maintained, LPN #4 stated, "Within reach of the patient." When asked why, LPN #4 stated, "So they can let us know when they need help or assistance."

An interview was conducted on 6/13/18 at 3:20 p.m. with ASM (administrative staff member) #2, the director of nursing. When asked what staff assess when making rounds on the residents, ASM #2 stated, "They scan the resident, check that the linen is clean and the call bell is in reach and the bed control is also within reach."

On 6/13/18 at 5:10 p.m. ASM #1, the executive director, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the findings.

No further information was provided prior to exit.

4. The facility staff failed to secure the call bell within Resident #10's reach.

Resident #10 was admitted to the facility on 5/31/13 with diagnoses that included but were not limited to: dementia, diabetes, stroke with left-sided paralysis, high blood pressure and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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) COMPLET ON DATE
F 550	Continued From page 9	F 550		

heart failure.

The most recent MDS, a quarterly assessment, with an ARD of 4/10/18 coded the resident as having both long and short-term memory problems and was moderately impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living.

An observation was made on 6/13/18 at 8:15 a.m. of Resident #10. The resident was lying in bed with the sheet over his head. The call bell was lying on the floor, behind the beside table.

An observation was made on 6/13/18 at 10:20 a.m. of Resident #10. The resident was lying in bed with the sheet over his head. The call bell way lying on the floor behind the beside table.

An observation was made on 6/13/18 at 12:15 p.m. of Resident #10. The resident was being fed lunch.

An observation was made on 6/13/18 at 12:40 p.m. of Resident #10 with LPN #4, the resident's nurse. When asked where the resident's care bell was, LPN #4 picked the call bell up off the floor and clipped it to the resident's bed.

Review of the care plan initiated on 12/26/14 documented, "Focus. At risk for falls related to Maxi-lift for transfer related to hx (history) of CVA ([cerebral vascular accident] stroke) with hemiplegia (paralysis) and dementia with decreased safety awareness. Interventions. Call light and water available and in easy reach at bedside."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 550	Continued From page 10	F 550		

An interview was conducted on 6/13/18 at 2:30 p.m. with LPN #4. When asked how the resident's call bells were to be maintained, LPN #4 stated, "Within reach of the patient." When asked why, LPN #4 stated, "So they can let us know when they need help or assistance." When asked if Resident #10's call bell had been within reach, LPN #4 stated no.

An interview was conducted on 6/13/18 at 3:20 p.m. with ASM (administrative staff member) #2, the director of nursing. When asked what staff assess when making rounds on the residents, ASM #2 stated, "They scan the resident, check that the linen is clean and the call bell is in reach and the bed control is also within reach."

On 6/13/18 at 5:10 p.m. ASM #1, the executive director, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the findings.

No further information was provided prior to exit.

COMPLAINT DEFICIENCY

F 607 SS=D Develop/Implement Abuse/Neglect Policies
CFR(s): 483.12(b)(1)-(3)

§483.12(b) The facility must develop and implement written policies and procedures that:

§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,

§483.12(b)(2) Establish policies and procedures to investigate any such allegations. and

Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of corrections prepared and executed as a means to continuously

F 607 improve quality of care and to comply with applicable state and federal regulations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 607	Continued From page 11 §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to implement their policies and procedures to investigate and report an allegation of abuse or neglect for two of 12 residents in the survey sample, Resident #5 and Resident #9. 1. The facility staff failed to immediately report and or report within 24 hours an allegation of neglect for Resident #5. 2. On 11/13/18, Resident #9 complained of acute rib pain. Resident #9 was evaluated in the emergency room on 1/14/18 and was diagnosed with multiple rib fractures. The facility staff failed to investigate Resident #9's rib fractures to rule out abuse. The findings include: 1. The resident no longer resided in the facility and assigned number five for means of identification. The closed clinical record was reviewed. Resident #5 was admitted to the facility on 4/16/18 with diagnoses that included but were not limited to: arthritis, weakness, depression, high blood pressure, pneumonia and high cholesterol. The most recent complete MDS (minimum data set), an admission assessment, with an ARD (assessment reference date) of 4/23/18 coded the resident as having scored a 14 out of 15 on the BIMS (brief interview for mental status)	F 607	1. Resident #5 has been discharged from the facility. Resident #9 did not have a thorough investigation completed after an injury of unknown origin occurred. Direct care staff in the facility were reeducated regarding abuse policy and reporting requirements. 2. The facility has determined that residents that reside here have the chance to be affected by this deficient practice. 3. Current employees will be reeducated on notifying the abuse coordinator/designee of any allegation of abuse immediately. New employees receive education on Resident rights, resident abuse, and abuse reporting during orientation and via Relias training annually thereafter. Re-education will be provided upon discovery of non-compliance with abuse reporting. 4. The DON/designee will conduct a random audit of 5 residents per week for 4 weeks. These residents will be assessed and interviewed to ensure that any alleged violations are identified, properly investigated and reported according to facility policy and procedures. The plan of correction will be monitored at the monthly/quarterly Quality Assurance Performance Improvement (QAPI) Committee for trend analysis and review until such time as consistent substantial compliance has been met. 5. 7/14/2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 607	Continued From page 12	F 607		

indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living except for eating which the resident could perform after the tray was prepared. The resident was coded as being incontinent of urine occasionally.

Review of the 4/18/18 facility FRI (reported incident report) documented, "Incident Date: 4/16/18. Describe incident, including location, and action taken: Resident informed Charge nurse that a CNA (certified nursing assistant) on 11p (11:00 p.m.) - 7a (7:00 a.m.) came into her room to assist her on using the bed pan and after she was done using it the CNA was removing the bed pan and some of it spilled on the bed. So, instead of change the sheets on the bed the CNA took a blanket off of the other bed in the room and placed it under the resident."

An interview was conducted on 6/13/18 at 1:14 p.m. with CNA #2, the 7:00 a.m. to 3:00 p.m. aide for Resident #5 on 4/16/18. When asked what occurred that day, CNA #2 stated, "I actually found it (the blanket under the resident). It happened on the night shift. I found it and I reported it." When asked who she reported it to, CNA #2 stated, "The charge nurse, I don't remember her name. They were coming and going all the time." CNA #2 stated, "The next day I went out on leave and was out for two months."

An interview was conducted on 6/14/18 at 8:30 a.m. with ASM (administrative staff member) #1, the executive director. When asked the process staff follow for an allegation of neglect, ASM #1 stated, "I investigate as soon as I hear about it." When asked the process the staff were to follow

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 607	Continued From page 13	F 607		

for a concern of neglect, ASM #1 stated, "My phone number is at every nursing station." ASM #1 stated he expected staff to notify the charge nurse and the charge nurse was to notify him any time. When asked why the incident for Resident #5 was not reported to the appropriate state agency on 4/16/18, ASM #1 stated, "I heard about it from the resident on the 18th (4/18/18) and I reported it right away. The CNA (from day shift on 4/16/18) told the charge nurse, but she (the nurse) didn't tell anyone and then the aide went out on leave the next day. She (the charge nurse) was an agency nurse and they are not very invested." ASM #1 was made aware of the concern at that time.

The nurse who cared for Resident #5 on 4/16/18, was no longer employed at the facility and was not able to be interviewed

An interview was conducted on 6/14/18 at 12:10 p.m. with CNA #4. When asked the process staff followed if there was a concern for abuse or neglect, CNA #4 stated, "If there's a bruise or if someone got hurt we immediately report it to the nurse." When asked if a resident was left wet, CNA #4 stated, "If they're wet you would change them first and then tell the nurse and document it." When asked where that would be documented, CNA#4 stated, "I'd write a note and give it to the nurse and maybe keep a note in my box."

An interview was conducted on 6/14/18 at 12:15 p.m. with LPN (licensed practical nurse) #5. When asked the process staff followed if there was a concern for abuse or neglect of a resident, LPN #5 stated, "If it's a bruise, I would go to the resident of course and assess of course. I would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 607	Continued From page 14	F 607		

call the MD (medical doctor), the POA (power of attorney) and my DON (director of nursing) because I don't know where it came from." When asked if a resident was left wet, LPN #5 stated, "I would pinpoint which aide, report it to my supervisor. It could be abuse, it could be neglect." When asked what timeframe this would be reported, LPN #5 stated, "Immediately." When asked if staff were educated on abuse reporting, LPN #5 stated, "Yes."

Review of the facility's policy titled, "Resident Abuse" documented in part, "POLICY: It is inherent in the nature and dignity of each resident at Facility that he/she be afforded basic human right, including the right to be from abuse, neglect, mistreatment, and/or misappropriation of property. which results in the fair and timely treatment of occurrences of resident abuse. 1. All employees of Facility are charge with a continuing obligation to treat all resident in the most humane manner possible. PROCEDURE: IV. Employee Obligation. A. All employees have a duty to respect the rights of all residents, to treat them with dignity and to prevent other from violating their rights. Any employee who witnesses or has knowledge of an act of abuse to a resident is obligated to report such information to the Licensed Nurse in charge, Director of Nursing, or the Administrator. B. An employee shall be deemed to have violated his obligations in paragraph "IA) (above) if he does any of the following: 1. Fails to report an incident of abuse or by or known to him/her. VII. Procedure for Reporting Abuse. A. All incidents of resident abuse are to be reported immediately to the Licensed Nurse in Charge, Director of Nursing, or the Administrator. Once reported to one of those

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 607	Continued From page 15	F 607		

three officials, the prescribed forms are to be completed and delivered to the Abuse Coordinator or his/her designee for an investigation. B. The Abuse Coordinator of Facility will endeavor to protect the rights of residents and employees. The Administration recognizes that preliminary reports of abuse can sometimes be clouded by biases and other factors that are relevant and need to be explored during a full investigation in order to obtain a clear picture of what actually happened. Thus, while Administration reserves the right to suspend pending an investigation, such suspension is not to be deemed as an assessment of guilt. VIII. Investigation of Abuse. B. Investigation will be accomplished in the following manner: 1. a. Immediately upon report of an incident to the individual in charge, the suspect(s) shall be segregated from the resident. The factual basis for and credibility of the allegation shall be ascertained, and the Abuse Coordinator shall be notified. 2. Investigation. The Abuse Coordinator and/or director of Nursing shall take written statements from the victim, the suspect(s) and all possible witnesses including all other employees in the vicinity of the alleged abuse. He/she shall also secure all physical evident. Upon completion of the investigation, a detailed report shall be prepared. 4. Discipline: The Abuse Coordinator of Facility will refer any or all incidents and reports of resident abuse to the appropriate state agencies."

No further information was provided prior to exit.

2. On 11/13/18, Resident #9 complained of acute rib pain. Resident #9 was evaluated in the emergency room on 1/14/18 and was diagnosed with multiple rib fractures. The facility staff failed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 607	Continued From page 16	F 607		

to investigate Resident #9's rib fractures to rule out abuse.

Resident #9 was admitted to the facility on 10/7/17 with diagnoses that included but were not limited to: irregular heart beat, dementia, enlarged prostate and communication deficit.

The most recent MDS, a quarterly assessment, with an ARD of 4/16/18, coded the resident, as having scored a three out of 15 on the BIMS indicting the resident was severely impaired cognitively. The resident was coded as requiring assistance for all activities of daily living except for eating which the resident could perform after the tray was prepared.

Review of the 1/13/18 fall investigation documented, "Resident (Resident #9) told this writer that he fell in his room and rolled all the (sic) across the room. Upon asking more questions resident stated, "2 men ruffed me up and threw me in a rock pile." We continued conversation and at the end of talking with resident he stated "I was feeding the pigs and my feet slipped out from under me and I went rolling down the hill. I've never had this much pain the whole time I have been living as he is holding the right rib area." Body assessment performed and there is no red or bruised areas and no open areas noted." Further review of the investigation documented, "8. How many falls have they had in the last 30 days? None. 9. Is assistance required to transfer/ambulate? No. 11. Are they walking on a regular basis? Yes. (Indicate what may have caused the accident) Not Known if resident fell." The documentation that the resident ambulated independently is inconsistent with the documentation in the 4/16/18 MDS that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 607	Continued From page 17	F 607		

resident required assistance from staff for ambulation.

Review of the nurse's notes dated 1/14/18 at 1:30 p.m. documented, "Resident complained of increased pain insisting (sic) going to hospital...Walking in hallway asking staff and guest to help with his pain" (sic) points to right lower ribs, guards abdomen when this nurse attempted to palpate." *Note the Resident was sent to the emergency room but there is no documentation regarding this in the nurse's notes.

Review of the emergency room record dated 1/14/18 documented, "(Name of Resident #9) is a 73 y.o (year old) male who present to the ED (emergency department) with complaint of rib pain. Patient reports a complaint of right rib pain. Patient is vague and poor historian. He apparently fell at the nursing home yesterday. Radiologic Studies. Xr (x-ray) Ribs Right W (with) Pa (posterior/anterior) Chest. Result Date: 1/14/18, Multiple right rib fractures involving the 6th, 7, 9 and 10th ribs and questionably second, fifth and eight ribs."

An interview was conducted on 6/14/18 at 12:15 p.m. with LPN (licensed practical nurse) #5. When asked the process staff followed if there was a concern for abuse or neglect of a resident, LPN #5 stated, "If it's a bruise, I would go to that resident of course and assess of course. I would call the MD (medical doctor), the POA (power of attorney) and my DON (director of nursing) because I don't know where it came from." When asked what staff do, if a resident complains of acute rib pain, LPN #5 stated, "I would assess them and notify my DON (director of nursing)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 607	Continued From page 18	F 607		

because I don't know what happened."

The nurse involved was not available for interview.

The director of nursing no longer was employed at the facility and could not be interviewed.

Review of the FRI 1/14/2018 (facility reported incident) submitted to the state agency on 1/15/18 documented, "During the 11-7 (11:00 p.m. to 7:00 a.m. shift Saturday into Sunday morning this resident was complaining of pain in the right lower ribs. The patient has a BIMS [brief interview for mental status] of three. The attending nurse did an assessment and observed no bruising or open areas. The nurse administered medications per physician order, checked up on the pt. (patient) later and the patient did not have any complaints. On Sunday 7-3 (7:00 a.m. to 3:00 p.m.) shift, the patient complained about pain in the same area again. The facility sent the patient to the ER [emergency room] where it showed he had fractured ribs. The facility has implemented his bed to be in the low position and fall mats on both sides at night and frequent checks during the day. Statements regarding this incident are being gathered." There was no documentation of any statements or of a follow-up investigation.

A request for the investigation was made to ASM (administrative staff member) #1, the executive director on 6/12/18 at 4:45 p.m. ASM #1 stated the FRI was the only thing he could find. ASM #1 stated the incident occurred prior to his arrival in March of 2018. ASM #2, the director of nursing stated, "I may have seen something, I'll look for it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 607	Continued From page 19 On 6/13/18 at 8:45 a.m., ASM #2 stated she was not able to locate any investigation regarding the resident's fractured ribs. When asked if an investigation should have been done, ASM #2 stated, yes. No further information as obtained prior to exit.	F 607	Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of corrections prepared and executed as a means to continuously improve quality of care and to comply with applicable state and federal regulations.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 609	1. Resident #5 has been discharged from the facility. Resident #9 did not have a thorough investigation completed after an injury of unknown origin occurred. Direct care staff in the facility were reeducated regarding abuse policy and reporting. 2. The facility has determined that residents that reside here have the ability to be affected by this deficient practice. 3. Current employees will be reeducated on notifying abuse coordinator/designee of any allegation of abuse immediately. New employees receive education on Resident rights, resident abuse, and abuse reporting during orientation and via Relias training annually thereafter. Re-education will be provided upon discovery of non-compliance with abuse reporting. 4. The DON/designee will conduct a random audit of 5 residents per week for 4 weeks.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 609	Continued From page 20 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to immediately report and allegation of neglect to the administrator of the facility and to other officials (including to the State Survey Agency) in accordance with State law through established procedures for one of 12 residents in the survey sample, Resident #5. The facility staff failed to immediately report and or report within 24 hours an allegation of neglect for Resident #5. The findings include: The resident no longer resided in the facility and assigned number five for means of identification. The closed clinical record was reviewed. Resident #5 was admitted to the facility on 4/16/18 with diagnoses that included but were not limited to: arthritis, weakness, depression, high blood pressure, pneumonia and high cholesterol. The most recent complete MDS (minimum data set), an admission assessment, with an ARD (assessment reference date) of 4/23/18 coded the resident as having scored a 14 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living except for eating which the resident could perform after the tray was prepared. The resident was coded as being incontinent of urine	F 609	These residents will be assessed and interviewed to ensure that any alleged violations are identified, properly investigated and reported according to facility policy and procedures. The plan of correction will be monitored at the monthly/quarterly Quality Assurance Performance Improvement (QAPI) Committee for trend analysis and review until such time as consistent substantial compliance has been met. 5. 7/14/2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 609	Continued From page 21	F 609		

occasionally.

Review of the 4/18/18 facility FRI (reported incident report) documented, "Incident Date: 4/16/18. Describe incident, including location, and action taken: Resident informed Charge nurse that a CNA (certified nursing assistant) on 11p (11:00 p.m.) - 7a (7:00 a.m.) came into her room to assist her on using the bed pan and after she was done using it the CNA was removing the bed pan and some of it spilled on the bed. So, instead of change the sheets on the bed the CNA took a blanket off of the other bed in the room and placed it under the resident."

An interview was conducted on 6/13/18 at 1:14 p.m. with CNA #2, the 7:00 a.m. to 3:00 p.m. aide for Resident #5 on 4/16/18. When asked what occurred that day, CNA #2 stated, "I actually found it (the blanket under the resident). It happened on the night shift. I found it and I reported it." When asked who she reported it to, CNA #2 stated, "The charge nurse, I don't remember her name. They were coming and going all the time." CNA #2 stated, "The next day I went out on leave and was out for two months."

An interview was conducted on 6/14/18 at 8:30 a.m. with ASM (administrative staff member) #1, the executive director. When asked the process staff follow for an allegation of neglect, ASM #1 stated, "I investigate as soon as I hear about it." When asked the process the staff were to follow for a concern of neglect, ASM #1 stated, "My phone number is at every nursing station." ASM #1 stated he expected staff to notify the charge nurse and the charge nurse was to notify him any time. When asked why the incident for Resident #5 was not reported to the appropriate state

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 609	Continued From page 22	F 609		

agency on 4/16/18, ASM #1 stated, "I heard about it from the resident on the 18th (4/18/18) and I reported it right away. The CNA (from day shift on 4/16/18) told the charge nurse, but she (the nurse) didn't tell anyone and then the aide went out on leave the next day. She (the charge nurse) was an agency nurse and they are not very invested." ASM #1 was made aware of the concern at that time.

The nurse, who cared for Resident #5 on 4/16/18, was no longer employed at the facility and was not able to be interviewed

Review of the facility's policy titled, "Resident Abuse" documented in part, "POLICY: It is inherent in the nature and dignity of each resident at Facility that he/she be afforded basic human right, including the right to be from abuse, neglect, mistreatment, and/or misappropriation of property, which results in the fair and timely treatment of occurrences of resident abuse. 1. All employees of Facility are charge with a continuing obligation to treat all resident in the most humane manner possible. PROCEDURE: IV. Employee Obligation. A. All employees have a duty to respect the rights of all residents, to treat them with dignity and to prevent other from violating their rights. Any employee who witnesses or has knowledge of an act of abuse to a resident is obligated to report such information to the Licensed Nurse in charge, Director of Nursing, or the Administrator. B. An employee shall be deemed to have violated his obligations in paragraph "IA) (above) if he does any of the following: 1. Fails to report an incident of abuse or by or known to him/her. VII. Procedure for Reporting Abuse. A. All incidents of resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 609	Continued From page 23	F 609		

abuse are to be reported immediately to the Licensed Nurse in Charge, Director of Nursing, or the Administrator. Once reported to one of those three officials, the prescribed forms are to be completed and delivered to the Abuse Coordinator or his/her designee for an investigation. B. The Abuse Coordinator of Facility will endeavor to protect the rights of residents and employees. The Administration recognizes that preliminary reports of abuse can sometimes be clouded by biases and other factors that are relevant and need to be explored during a full investigation in order to obtain a clear picture of what actually happened. Thus, while Administration reserves the right to suspend pending an investigation, such suspension is not to be deemed as an assessment of guilt. VIII. Investigation of Abuse. B. Investigation will be accomplished in the following manner: 1. a. Immediately upon report of an incident to the individual in charge, the suspect(s) shall be segregated from the resident. The factual basis for and credibility of the allegation shall be ascertained, and the Abuse Coordinator shall be notified. 2. Investigation. The Abuse Coordinator and/or director of Nursing shall take written statements from the victim, the suspect(s) and all possible witnesses including all other employees in the vicinity of the alleged abuse. He/she shall also secure all physical evident. Upon completion of the investigation, a detailed report shall be prepared. 4. Discipline: The Abuse Coordinator of Facility will refer any or all incidents and reports of resident abuse to the appropriate state agencies."

No further information was provided prior to exit.

F 610 SS=D Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)

F 610

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 610	Continued From page 24	F 610		

§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.

§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to failed evidence that an injury of unknown origin was thoroughly investigated, for one of 12 residents in the survey sample, Resident #9.

On 11/13/18, Resident #9 complained of acute rib pain. Resident #9 was evaluated in the emergency room on 1/14/18 and was diagnosed with multiple rib fractures. The facility staff failed to investigate Resident #9's injury of unknown origin to rule out abuse.

The findings include:

On 11/13/18, Resident #9 complained of acute rib pain. Resident #9 was evaluated in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 610	Continued From page 25	F 610		

emergency room on 1/14/18 and was diagnosed with multiple rib fractures. The facility staff failed to investigate Resident #9's injury of unknown origin to rule out abuse.

Resident #9 was admitted to the facility on 10/7/17 with diagnoses that included but were not limited to: irregular heart beat, dementia, enlarged prostate and communication deficit.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 4/16/18, coded the resident, as having scored a three out of 15 on the BIMS (breif interview for mental status) indicting the resident was severely impaired cognitively. The resident was coded as requiring assistance for all activities of daily living except for eating which the resident could perform after the tray was prepared.

Review of the 1/13/18 fall investigation documented, "Resident (Resident #9) told this writer that he fell in his room and rolled all the (sic) across the room. Upon asking more questions resident stated, "2 men ruffed me up and threw me in a rock pile." We continued conversation and at the end of talking with resident he stated "I was feeding the pigs and my feet slipped out from under me and I went rolling down the hill. I've never had this much pain the whole time I have been living as he is holding the right rib area." Body assessment performed and there is no red or bruised areas and no open areas noted." Further review of the investigation documented, "8. How many falls have they had in the last 30 days? None. 9. Is assistance required to transfer/ambulate? No. 11. Are they walking on a regular basis? Yes. (Indicate what may have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 610	Continued From page 26	F 610		

caused the accident) Not Known if resident fell." The documentation that the resident ambulated independently is inconsistent with the documentation in the 4/16/18 MDS that the resident required assistance from staff for ambulation.

Review of the nurse's notes dated 1/14/18 at 1:30 p.m. documented, "Resident complained of increased pain insisting (sic) going to hospital...Walking in hallway asking staff and guest to help with his pain" (sic) points to right lower ribs, guards abdomen when this nurse attempted to palpate." *Note the Resident was sent to the emergency room but there is no documentation regarding this in the nurse's notes.

Review of the emergency room record dated 1/14/18 documented, "(Name of Resident #9) is a 73 y.o (year old) male who present to the ED (emergency department) with complaint of rib pain. Patient reports a complaint of right rib pain. Patient is vague and poor historian. He apparently fell at the nursing home yesterday. Radiologic Studies. Xr (x-ray) Ribs Right W (with) Pa (posterior/anterior) Chest. Result Date: 1/14/18, Multiple right rib fractures involving the 6th, 7, 9 and 10th ribs and questionably second, fifth and eight ribs."

An interview was conducted on 6/14/18 at 12:15 p.m. with LPN (licensed practical nurse) #5. When asked the process staff followed if there was a concern for abuse or neglect of a resident, LPN #5 stated, "If it's a bruise, I would go to that resident of course and assess of course. I would call the MD (medical doctor), the POA (power of attorney) and my DON (director of nursing)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 610	Continued From page 27	F 610		

because I don't know where it came from." When asked what staff do, if a resident complains of acute rib pain, LPN #5 stated, "I would assess them and notify my DON (director of nursing) because I don't know what happened."

The nurse involved was not available for interview.

The director of nursing no longer was employed at the facility and could not be interviewed.

Review of the FRI 1/14/2018 (facility reported incident) submitted to the state agency on 1/15/18 documented, "During the 11-7 (11:00 p.m. to 7:00 a.m. shift Saturday into Sunday morning this resident was complaining of pain in the right lower ribs. The patient has a BIMS [brief interview for mental status] of three. The attending nurse did an assessment and observed no bruising or open areas. The nurse administered medications per physician order, checked up on the pt. (patient) later and the patient did not have any complaints. On Sunday 7-3 (7:00 a.m. to 3:00 p.m.) shift, the patient complained about pain in the same area again. The facility sent the patient to the ER [emergency room] where it showed he had fractured ribs. The facility has implemented his bed to be in the low position and fall mats on both sides at night and frequent checks during the day. Statements regarding this incident are being gathered." There was no documentation of any statements or of a follow-up investigation.

A request for the investigation was made to ASM (administrative staff member) #1, the executive director on 6/12/18 at 4:45 p.m. ASM #1 stated the FRI was the only thing he could find. ASM #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 610 Continued From page 28

stated the incident occurred prior to his arrival in March of 2018. ASM #2, the director of nursing stated, "I may have seen something, I'll look for it.

On 6/13/18 at 8:45 a.m., ASM #2 stated she was not able to locate any investigation regarding the resident's fractured ribs. When asked if an investigation should have been done, ASM #2 stated, yes.

Review of the facility's policy titled, "Resident Abuse" documented in part the following, "POLICY: VIII. Investigation of Abuse. B. Investigation will be accomplished in the following manner: 1. a. Immediately upon report of an incident to the individual in charge, the suspect(s) shall be segregated from the resident. The factual basis for and credibility of the allegation shall be ascertained, and the Abuse Coordinator shall be notified. 2. Investigation. The Abuse Coordinator and/or director of Nursing shall take written statements from the victim, the suspect(s) and all possible witnesses including all other employees in the vicinity of the alleged abuse. He/she shall also secure all physical evident. Upon completion of the investigation, a detailed report shall be prepared. 4. Discipline: The Abuse Coordinator of Facility will refer any or all incidents and reports of resident abuse to the appropriate state agencies."

No further information was provided prior to exit.

F 610

Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of corrections prepared and executed as a means to continuously improve quality of care and to comply with applicable state and federal regulations.

F 646 SS=D MD/ID Significant Change Notification
CFR(s): 483.20(k)(4)

§483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical

F 646

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 646	Continued From page 29	F 646		

condition of a resident who has mental illness or intellectual disability for resident review.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, facility document review, and during the course of a complaint investigation, it was determined that the facility staff failed to notify the physician of a change in condition of the resident for one of 12 residents in the survey sample, Resident#3.

The facility staff failed to notify the physician Resident #3 refused ordered medications on multiple occasions during December 2017.

The findings include:

Resident #3 was admitted to the facility on 1/8/15 and readmitted on 6/4/18 with diagnoses that included but were not limited to: diabetes, difficulty swallowing, heart failure, respiratory failure, high blood pressure, depression and arthritis.

The most recent MDS, (minimum data set), a five day assessment, with an ARD (assessment reference date) of 6/4/18 coded the resident as having scored a 14 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living except for eating which the resident could perform after the tray was prepared.

Review of the resident's care plan initiated on 10/9/15 and revised on 6/4/18 documented, "Focus. Alteration in Respiratory Status Due to Chronic Obstructive Pulmonary Disease. refuses

F 646 1. Resident #3 comprehensive care plan updated on 6/4/2018 reflects that resident often refuses medications as ordered. After 2 consecutive doses of vital medication are withheld or refused, the physician or NP will be notified per pharmacy policy and procedure manual.
2. Residents that reside in the facility that frequently refuse medications or have vital medication held due to not being inside parameters have the potential to be affected by this deficient practice.
3. Nursing staff to be reeducated when to notify physician/NP when resident refuses vital medications utilizing pharmacy policy and procedure manual. DON/designee will audit documented refusals on Medication administration record 3 days per week for 4 weeks.
4. Results of audits will be discussed at the monthly/quarterly Quality Assurance Performance Improvement (QAPI) Committee for trend analysis and ensure substantial compliance has been maintained.
5. 7/14/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 646	Continued From page 30	F 646		

treatments at times...6/4/18. Interventions. Administer medications as ordered." There was no documentation regarding notifying the physician if the resident refused the medication.

Review of the December 2017 physician's orders documented, "Xopenex (1) Nebulization Solution 2 dose inhale orally via nebulizer four times a day for cough/dyspnea."

Review of the December 2017 (MAR) medication administration record documented, "Xopenex Nebulization Solution 2 dose inhale orally via nebulizer four times a day for cough/dyspnea." It was documented that the resident refused the nebulizer treatments on at least 17 occasions. Further review of the MAR did not evidence documentation that the physician or nurse practitioner were notified that the resident was refusing the treatments.

An interview was conducted on 6/13/18 at 1:35 p.m. with ASM (administrative staff member) #4, the nurse practitioner. When asked if staff notified her that Resident #3 refused medications at times, ASM #3 stated, "I know she refuses her liquid morphine sometimes." When asked when she would like to be notified if a resident was refusing medications, ASM #4 stated, "If they're refusing a couple days in a row I like them to let me know and then I can see if I can d/c (discontinue) it and I talk to them (the resident) about why they're refusing it." When asked if she was aware that the resident had been refusing the nebulizer treatments in December 2017, ASM #4 stated, "I won't swear to it but I only remember the morphine."

An interview was conducted on 6/14/18, with LPN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 646	Continued From page 31	F 646		

(licensed practical nurse) #3, a nurse who had cared for Resident #5. When asked the process staff followed when a resident refused medications, LPN #3 stated, "Well, if they're refusing we try at least three attempts (to get them to take them)." When asked what staff did if the resident continued to refuse the medications, LPN #3 stated, "I would document the refusal and I would notify the nurse practitioner and doctor and let the family know as well." When asked why the doctor was notified, LPN #3 stated, "If they still refuse after three days I'll talk to the doctor again to see if he wants to re-adjust (the medications)." When asked if staff documented that the physician was notified, LPN #3 stated, "Yes, ma'am." LPN #3 was asked to review the December 2017 nurses' notes for Resident #3. When asked if there was documentation that the physician had been notified, LPN #3 stated, "No ma'am. There's no note."

On 6/14/18 at 5:10 p.m. ASM #1, the executive director, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the findings.

Review of the facility's document for physician notification was the state regulation for notification, which documented it part, "Notification of changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family when there is -- (C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 646	Continued From page 32 No further information was obtained prior to exit. In Basic Nursing, Essential for Practice, 6th edition (Potter and Perry, 2007, pages 56-59), was a reference source for physician's orders and notification. Failure to monitor the patient's condition appropriately and communicate that information to the physician or health care provider are causes of negligent acts. The best way to avoid being liable for negligence is to follow standards of care, to give competent health care, and to communicate with other health care providers. The physician or health care provider is responsible for directing the medical treatment of a patient. 1. Xopenex -- Xopenex (levalbuterol HCl) Inhalation Solution is indicated for the treatment or prevention of bronchospasm in adults, adolescents, and children 6 years of age and older with reversible obstructive airway disease. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/druginfo.cfm?setid=1700a5b8-4029-424a-bfed-15f6737dd210	F 646	Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of corrections prepared and executed as a means to continuously improve quality of care and to comply with applicable state and federal regulations.	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 656 Continued From page 33

describe the following -
(i) 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 §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to follow the comprehensive care plan for four out of 12 residents in the survey sample, Residents #3, 8. 9 and 10.

F 656 1. Comprehensive care plan for resident #3. #8, #9, and #10 updated on 6/15/2018 reflecting call light positioning and assurance of location in proximity to resident.
2. Residents that reside in the facility have potential to be affected by this deficient practice.
3. Nursing staff will be re-educated on updating and implementing the comprehensive care plans by DON/designee. C.N.A.s will also be re-educated on the location of the resident plan of care on the kiosk by DON/designee. MDS coordinator/designee to audit completed comprehensive care plans 5 times per week for 4 weeks depending on care plan schedule to ensure facility develops and follows complete comprehensive care plans.
4. Results of audits will be reviewed by the monthly/ quarterly Quality Assurance Performance Improvement (QAPI) Committee for trend analysis and findings. Recommendations implemented as indicated.
5. Corrective action will be completed by 7/14/2018.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 656	Continued From page 34	F 656		

1. a. The facility staff failed to implement the comprehensive care plan to keep the care light within reach for Resident #3.

1.b. The facility staff failed to implement the comprehensive care plan and the physician's orders to administer oxygen at eight liters/minute.

2. The facility staff failed to implement the comprehensive care plan to keep the care light within reach for Resident #8.

3. The facility staff failed to implement the comprehensive care plan to keep the care light within reach for Resident #9.

4. The facility staff failed to implement the comprehensive care plan to keep the care light within reach for Resident #10.

The findings include:

1. a. The facility staff failed to implement the comprehensive care plan to keep the care light within reach for Resident #3.

Resident #3 was admitted to the facility on 1/8/15 and readmitted on 6/4/18 with diagnoses that included but were not limited to: diabetes, difficulty swallowing, heart failure, respiratory failure, high blood pressure, depression and arthritis.

The most recent MDS, (minimum data set), a five day assessment, with an ARD (assessment reference date) of 6/4/18 coded the resident as having scored a 14 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 656	Continued From page 35	F 656		

The resident was coded as requiring assistance from staff for all activities of daily living except for eating which the resident could perform after the tray was prepared.

An observation was made on 6/12/18 at 11:25 a.m., of Resident #3. The resident was lying in bed with eyes closed. The call bell was lying on the floor.

An observation was made on 6/13/18 at 10:25 a.m., of Resident #3. The resident was lying in bed on the left side with eyes closed. The call bell was lying on the floor.

Review of the resident's comprehensive care plan initiated on 3/3/17 documented, "Focus. I have a physical functioning deficit related to: Mobility impairment, Self care impairment. Interventions. Call bell within reach."

An interview was conducted on 6/13/18 at 2:25 p.m. with LPN (licensed practical nurse) #2. When asked why resident's had care plans, LPN #2 stated, to know the plan of care for the residents. When asked if care plans were to be followed, LPN #2 stated they were.

An interview was conducted on 6/13/18 at 4:27 p.m. with RN (registered nurse) #3, the resident's nurse. When asked why residents have care plans, RN #3 stated, so staff knew what a resident needed. When asked if the care plan was to be followed, RN #3 stated they should be.

On 6/13/18 at 5:10 p.m. ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 656	Continued From page 36	F 656		

the findings.

No further information was provided prior to exit.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." (1)

(1) Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia pages 65-77.

Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. "A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan communicates nursing care priorities to other health care professionals. The care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 656	Continued From page 37 1.b. The facility staff failed to implement the comprehensive care plan and the physician's orders to administer oxygen at eight liters/minute. An observation was made on 6/12/18 at 11:25 a.m., of Resident #3. The resident was lying in bed with eyes closed. The resident had a nasal cannula (soft plastic prongs that deliver oxygen in the nose) on and the oxygen was set at six liters per minute via oxygen concentrator. An observation was made on 6/13/18 at 10:25 a.m. of Resident #3. The resident was lying in bed with eyes closed. The resident had a nasal cannula on and the oxygen was set at five and one-half liters via oxygen concentrator. An observation was made on 6/13/18 at 12:30 p.m. of Resident #3. The resident was sitting up in bed, awake, alert and talkative. The resident had the nasal cannula on and the oxygen was set at six liters via oxygen concentrator. An observation was made on 6/13/18 at 2:35 p.m. of Resident #3. The resident had the nasal cannula on and the oxygen was set at six liters via oxygen concentrator. An observation was made on 6/13/18 at 4:27 p.m. of Resident #3's oxygen with RN (registered nurse) #3, the resident's nurse. When asked what the oxygen rate was set at, RN #3 stated, "Right now it's on six liters." When asked what rate the oxygen should be on, RN #3 stated, it should be set on eight liters. RN #3 adjusted the oxygen to eight liters at that time. When asked if the physician's orders were being followed, RN #3 stated, "No" When asked when staff would not	F 656	1. Comprehensive care plan for resident #3 updated 6/14/2018 reflecting order to administer oxygen continuously at eight liters/minute. 2. Residents residing in the facility receiving oxygen therapy have potential to be affected by this deficient practice. 3. Nursing staff will be re-educated on updating and implementing the comprehensive care plans by DON/designee. MDS coordinator/designee to audit completed comprehensive care plans 5 times per week for 4 weeks depending on care plan schedule to ensure facility develops and follows complete comprehensive care plans. 4. Results of audits will be reviewed during monthly/quarterly Quality Assurance Performance Improvement (QAPI) Committee for trend analysis and review. Recommendations implemented as indicated. 5. Corrective action will be completed by 7/14/2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 656	Continued From page 38	F 656		

follow a physician's order, RN #3 stated, "We follow the order, we have to." When asked why residents had care plans, RN #3 stated, to know the plan of care for the residents. When asked if the care plan should be followed, RN #3 stated it should.

Review of the care plan initiated on 6/4/18 documented, "Focus. Alteration in Respiratory Status Due to Chronic Obstructive Pulmonary Disease. Interventions. Administer oxygen as needed per Physician order. Monitor oxygen flow rate and response."

Review of the June 2018 physician's orders documented, "O2 via NC (nasal cannula -- soft prongs that fit in the nose to deliver oxygen) @ 8LPM (liters per minute) continuous.

Review of the June 2018 medication administration record (MAR) documented, "O2 via NC @ 8LPM continuous." It was documented that the oxygen was administered each day.

An interview was conducted on 6/13/18 at 2:25 p.m. with LPN (licensed practical nurse) #2. When asked why residents have care plans, LPN #2 stated, to know the plan of care for the residents. When asked if care plans were to be followed, LPN #2 stated they were.

On 6/13/18 at 5:10 p.m. ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the findings.

2. The facility staff failed to implement the comprehensive care plan to keep the care light

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 656	Continued From page 39	F 656		

within reach for Resident #8.

Resident #8 was admitted to the facility on 4/20/18 with diagnoses that included but were not limited to: irregular heart beat, difficulty speaking, depression, lung disease and diabetes.

The most recent MDS, a 30 day assessment, with an ARD of 4/27/18 coded the resident as requiring assistance from staff for all activities of daily living. The resident was coded as having both long and short-term memory problems and as being severely impaired cognitively.

An observation was made on 6/12/18 at 11:15 a.m. of Resident #8. The resident was lying in bed. The call bell was behind the head of the bed lying on the floor.

An observation was made on 6/12/18 at 6:10 p.m. of Resident #8. The resident was lying in bed with a washcloth on her forehead. The call bell cord was tucked under the upper part of the pillow and the call bell was dangling over the head of the bed.

An observation was made on 6/13/18 at 10:17 of Resident #8. The resident was sitting up in a wheelchair on the right side of the bed. The call bell was on the floor on the left side of the bed.

Review of the care plan initiated on 4/20/18 documented, "Focus. At risk for falls related to New environment, meds (medications). Interventions. Call light or personal items available and in easy reach or provide reacher."

An interview was conducted on 6/13/18 at 2:25 p.m. with LPN (licensed practical nurse) #2.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 656	Continued From page 40	F 656		

When asked why residents have care plans, LPN #2 stated, to know the plan of care for the residents. When asked if care plans were to be followed, LPN #2 stated they were.

On 6/13/18 at 5:10 p.m. ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the findings.

3. The facility staff failed to implement the comprehensive care plan to keep the care light within reach for Resident #9.

Resident #9 was admitted to the facility on 10/7/17 with diagnoses that included but were not limited to: irregular heart beat, dementia, enlarged prostate and communication deficit.

The most recent MDS, a quarterly assessment, with an ARD of 4/16/18 coded the resident, as having scored a three out of 15 on the BIMS indicting the resident was severely impaired cognitively. The resident was coded as requiring assistance for all activities of daily living except for eating which the resident could perform after the tray was prepared.

An observation was made on 6/13/18 at 10:18 a.m. of Resident #9. The resident was lying in bed with his back to the door. The call bell cord was clipped to the cushion of a chair approximately three feet from the bed. The call bell was lying on the floor.

An observation was made on 6/13/18 at 12:30 p.m. of Resident #9. The resident was lying in bed. The call bell was in the same position as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 656	Continued From page 41	F 656		

observed at 10:18 a.m.

An observation was made on 6/13/8 at 12:44 p.m. with CNA #3, the resident's aide. When asked where the call bell was, CNA #3 picked the call bell up off the floor and clipped it to the resident's bed.

Review of the care plan initiated on 11/8/17 documented, "Focus. At risk for falls related to: History of falls, unsteadiness. Interventions. Call light or personal items available in easy reach or provide reacher."

An interview was conducted on 6/13/18 at 2:25 p.m. with LPN (licensed practical nurse) #2. When asked why residents have care plans, LPN #2 stated, to know the plan of care for the residents. When asked if care plans were to be followed, LPN #2 stated they were.

On 6/13/18 at 5:10 p.m. ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the findings.

No further information was provided prior to exit.

4. The facility staff failed to implement the comprehensive care plan to keep the care light within reach for Resident #10.

Resident #10 was admitted to the facility on 5/31/13 with diagnoses that included but were not limited to: dementia, diabetes, stroke with left-sided paralysis, high blood pressure and heart failure.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 656	Continued From page 42	F 656		

The most recent MDS, a quarterly assessment, with an ARD of 4/10/18 coded the resident as having both long and short-term memory problems and was moderately impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living.

An observation was made on 6/13/18 at 8:15 a.m. of Resident #10. The resident was lying in bed with the sheet over his head. The call bell was lying on the floor behind the beside table out of reach of the resident.

An observation was made on 6/13/18 at 10:20 a.m. of Resident #10. The resident was lying in bed with the sheet over his head. The call bell way lying on the floor behind the beside table out of reach of the resident.

An observation was made on 6/13/18 at 12:15 p.m. of Resident #10. The resident was being fed lunch.

An observation was made on 6/13/18 at 12:40 p.m. of Resident #10 with LPN #4, the resident's nurse. When asked where the resident's care bell was, LPN #4 picked the call bell up off the floor and clipped it to the resident's bed.

Review of the care plan initiated on 12/26/14 documented, "Focus. At risk for falls related to Maxi-lift for transfer related to hx (history) of CVA ([cerebral vascular accident] stroke) with hemiplegia (paralysis) and dementia with decreased safety awareness. Interventions. Call light and water available and in easy reach at bedside."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 656	Continued From page 43 An interview was conducted on 6/13/18 at 2:25 p.m. with LPN (licensed practical nurse) #2. When asked why residents have care plans, LPN #2 stated, to know the plan of care for the residents. When asked if care plans were to be followed, LPN #2 stated they were. On 6/13/18 at 5:10 p.m. ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the findings. No further information was provided prior to exit.	F 656		
F 678 SS=G	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and complaint investigation, the facility staff failed to provide CPR (cardiopulmonary resuscitation) on a resident who was a full code for one of three residents in the survey sample, Resident #1. The facility staff failed to initiate and perform (cardiopulmonary resuscitation) CPR for Resident #1 after the resident was found without a pulse or respirations and the resident subsequently expirred in the facility on 5/30/18.	F 678	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 678	Continued From page 44	F 678		

The findings include:

Resident #1 was admitted to the facility on 2/12/13 with diagnoses that included but were not limited to: heart failure, lung disease, sleep apnea, anxiety, depression, high blood pressure and pain.

The most recent complete minimum data set, a quarterly assessment, with an assessment reference date of 3/8/18 coded the resident as having 15 out of 15 on the brief interview for mental status indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring set up assistance from staff for activities of daily living.

Review of the resident's care plan initiated on 12/30/14 documented, "Focus. My code status is Full code (administer cardiopulmonary resuscitation -- CPR). Interventions CPR will be performed as ordered."

Review of the facility's form titled, DNR (do not resuscitate)/CPR Status Order Form dated 10/20/15 evidenced documentation that the resident requested CPR to be initiated in the case of respiratory or cardiac arrest.

Review of the May 2018 physician's orders documented, "Full Code. Order Date: 12/30/2014." The record documented no advance directives or physician order prohibiting basic life support including CPR.

Review of the nurse's notes dated 5/30/18 at 5:50 a.m., documented no evidence that CPR was initiated or provided to Resident #1 or that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 678	Continued From page 45	F 678		

Emergency Medical Services (EMS) was called.

On 6/12/18 at 11:50 a.m., the facility investigation for Resident #1 was requested from ASM (administrative staff member) #1, the executive director. ASM #1 brought in the investigation, which included the plan of correction and stated, "The nurse called the DON (director of nursing) who was home sick. The DON said to call the family: she did not tell them to do CPR. Both were suspended because they didn't follow policy and procedure. I let the DON go but let the nurse come back because she was following what the DON said to do."

On 6/12/18 the facility's investigation of the events, surrounding Resident #1's death on 5/30/18 was reviewed. The investigation indicated RN (registered nurse) #1 failed to initiate and perform CPR for Resident #1 on 5/30/18. Their investigation included in part, the following documentation of events documented by the facility's administrator:

At approximately 5:40 a.m. on 5/30/18:
RN #1 was notified by CNA (certified nursing assistant) #1 that there was something wrong with Resident #1;
RN #1 entered the room found resident lying across the bed with eyes fixed with cold extremities, blue nail beds and RN #1 was unable to auscultate heart or breath sounds; did not initiate CRP (sic) and resident was full code;
RN #1 notified LPN (licensed practical nurse) #1, the supervisor and the nurse practitioner;
LPN #1 entered room and observed resident;
LPN #1 left room to verify code status;
LPN #1 called director of nursing (DON) to verify protocol:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 678	Continued From page 46	F 678		

DON stated that (LPN #1) informed her at 5:45am that (Resident #1) had expired. She also stated that he (Resident #1) was found unresponsive and cool to the touch without vital signs this morning;
DON stated to call family and pronounce death.

An interview statement was obtain from CNA (certified nursing assistant) #1 on 6/12/18 at 2:25 p.m. CNA #1, stated that around 5:40 to 5:50 a.m. The lab (laboratory) staff said something was wrong with him (Resident #1). I went over and shook him and I knew something was wrong he (Resident #1) was dead cold. I put my hand over his mouth and couldn't feel any breath and I ran to get the vital sign machine (automatic machine that measures blood pressure, pulse, temperature and oxygen saturation). When I ran down the hall I saw the nurse (RN [registered nurse] #1) and said (name of Resident #1) might have passed away and she said 'What?' CNA #1 stated, "I was running down the hall with the vital sign machine and the nurse, she was right behind me. I asked the nurse if he was a DNR (do not resuscitate) or a full resuscitation. I got no response." CNA #1 stated, "I checked his blood pressure but there wasn't one." When asked if he put the blood pressure cuff on the resident's arm, CNA #1 stated he did. When asked if he was able to straighten the resident's arm, CNA #1 stated, "Yes."

.

An interview was conducted on 6/13/18 at 8:32 a.m. with RN (registered nurse) #1, the resident's nurse. When asked if she had seen the resident the night of 5/30/18, RN #1 stated, "That night I saw him. I was back there once that night." When asked if she assessed the resident, RN #1 stated,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 678	Continued From page 47	F 678		

"He had his curtain pulled, he had a CPAP machine and I could hear it running but when we found him that morning the CPAP was on the floor running." When asked if she had put the CPAP on the resident, RN #1 stated the resident did that independently. When asked if she had actually seen the resident, RN #1 stated she had not. When asked what occurred next, RN #1 stated, "I had started my med (medication) pass. It was a lab morning so the lab lady was there and he (Resident #1) was going to have blood drawn. All of a sudden (CNA #1) came running up the hall and said, 'there's something wrong with (Resident #1)' and then the lab lady said there was something wrong with (Resident #1)." When asked what she did next, RN #1 stated she went into the resident's room and determined the resident had been dead and had been "dead for several hours." RN #1 stated she ran to get her stethoscope and returned to the room. She was not able to hear heart or lung sounds and instead of starting CPR, she called the supervisor. When asked if she knew how to determine the resident's code status, RN #1 stated she could check the chart. When asked why she did not check the chart, RN #1 didn't have an answer. RN #1 stated, "It was a mistake. I didn't know the policies." When asked if she had been educated on the CPR policy at the time of the incident, RN #1 stated, "No." When asked if a nurse needed a policy to initiate CPR on a full code RN #1 stated no.

An interview was conducted on 6/13/18 at 8:55 a.m. with LPN (licensed practical nurse) #1, the supervisor on 5/30/18. LPN #1 stated that RN #1 had called her to check on the resident. I got to the room and he was cold. They (RN #1 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 678	Continued From page 48	F 678		

CNA#1) had the vital sign machine in there and he didn't have any BP (blood pressure), pulse. LPN #1 stated she checked the code status and determined the resident was a full code. LPN #1 stated we weren't sure what to do if the resident was cold and blue so she called the director of nursing for guidance. When asked what would normally occur if a resident was found dead, LPN #1 stated, "Normally somebody would have called a code (that a resident needed CPR), she (RN #1) would have initiated CPR. I would have grabbed the crash cart and then it would have been both of us. Looking back on it, it was poor judgement."

Review of the nurse's notes dated 5/30/18 at 5:50 a.m. documented, "Upon entering room, resident lying horizontally across bed without pulse or breath sounds. Could not auscultate heart sounds or breathe sounds. Pronounced at 0550 am (a.m.) NP (nurse practitioner) on call notified and emergency contacts called and messages left." Review of the nurses' notes and clinical record failed to reveal any documented evidence that the resident was cold or blue.

A telephone interview was conducted on 6/14/18 at 11:30 a.m. with RN #2, the facility director of nursing (DON) on 5/3/18. When asked what occurred the morning of 5/30/18, RN #2 stated, "I got the phone call around 5:40 that morning. I was home very sick. (LPN #1) told me that (Resident #1) had passed. That his arms were blue and he had been gone for some time. She asked me what time she would use for time of death. I told her to check the heart sounds and asked if there was an RN in the building. She said yes (RN #1) was here. I told her to call the family.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 678	Continued From page 49	F 678		

I don't recall speaking about code status. I don't recall telling them to call 911." When asked if that would be what would normally occur, RN #2 stated that staff would do CPR until relieved by EMS (emergency medical services).

The nurse practitioner, who was covering the facility on 5/30/18, for another nurse practitioner, was not available for interview during the survey.

Review of the facility's policy titled, "Cardiopulmonary Resuscitation (CPR)" documented, "POLICY: Cardiopulmonary Resuscitation (CPR) is initiated to support the ventilation and circulation function until: aid arrives and the resident is place on advanced life support systems; he/she is stimulated to function on his/her own; and/or he/she is pronounce dead. 1. Cardiopulmonary resuscitation is initiated on all residents except those with a "no code" order and appropriate documentation. 2. Cardiopulmonary resuscitation is performed only by individual certified in CPR. 3. All licensed nurse are to be certified in CPR and must be re-certified as needed."

The facility implemented a plan of correction effective on 5/30/18 regarding the failure to perform CPR on 5/30/18. The plan of correction included the following interventions.

1. Statements obtained and investigation completed. (Completed 5/30/18)
2. Audit of current in-house resident code status. (Completed 5/30/18)
3. Completed verification of current staff CPR certification.
4. Reeducation (sic) for current staff of policy and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 678	Continued From page 50	F 678		

procedures for the code blue process.
5. AD HOC (when necessary) meeting with administrator, medical director and adon [assistant director of nursing] (sic) held on 5/30/18 for review and discussion of corrective action for incident. (Completed 5/30/18)
6. Audits of any code blues to be evaluated during the monthly and quarterly QAPI (quality assurance and performance improvement) meeting.

On 6/12/18 at approximately 10:45 a.m., entrance to the facility a list of all residents who were a full code and had expired in the facility was requested from ASM #1, the executive director. On 6/12/18 at 11:10 a.m., a list of residents was received. The list documented two additional residents who were full codes and had expired. Review of the records documented the residents had received CPR as ordered.

Review of the 5/30/18 in service attendance documented, "SUBJECT Code initiation & CPR." It was documented that eleven nurses had attended the inservice. When asked if all nurses had been educated on CPR as documented in the plan of correction, ASM #1 stated, "Yes." ASM #2 stated, "I know, I was here until 3:30 in the morning and I educated, (name of RN #1, LPN #1 and another nurse who's name she could not recall.)."

An interview was conducted on 6/13/18 at 2:25 p.m. with LPN #2. When asked what staff were to do if they found without a heartbeat or respirations, LPN #2 stated, "First check the vital signs. Check the code status. If they're a full code immediately start CPR." When asked what staff did if the resident felt cold and was blue, LPN #2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 678	Continued From page 51	F 678		

stated, "Exactly the same thing. We immediately start CPR."

An interview was conducted on 6/14/18 at 10:05 a.m. with LPN #3. When asked what staff were to do if they found without a heartbeat or respirations, LPN #3 stated, "Look at the chart. If you're at the cart (medication cart) you can go into their record it says if they're a full code or DNR." When asked what staff did if the resident was found to be cold and blue, LPN #3 stated, "Start a code blue." LPN #3 stated, "They're a full code. Someone starts it (CPR) and we continue the code until the EMT (emergency medical technicians) get here."

No further information was provided prior to exit.

COMPLAINT DEFICIENCY

According to "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 1126. "Cardiopulmonary resuscitation. Cardiac arrest is characterized by an absence of pulse and respiration. If the nurse determines that a client has cardiac arrest, cardiopulmonary resuscitation (CPR) must be initiated. CPR is a basic emergency procedure of artificial respiration and manual external cardiac massage... The purpose of CPR is to circulate oxygenated blood to the brain to prevent permanent tissue damage (AHA, 2001).

F 695 SS=D Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) — F 695

§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.
The facility must ensure that a resident who

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 695 Continued From page 52

needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide treatment and services for respiratory therapy for one of 12 residents in the survey sample, Resident #3.

The facility staff failed to administered oxygen as ordered by the physician for Resident #3.

The findings include:

Resident #3 was admitted to the facility on 1/8/15 and readmitted on 6/4/18 with diagnoses that included but were not limited to: diabetes, difficulty swallowing, heart failure, respiratory failure, high blood pressure, depression and arthritis.

The most recent MDS, (minimum data set), a five day assessment, with an ARD (assessment reference date) of 6/4/18 coded the resident as having scored a 14 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living except for eating which the resident could perform after the tray was prepared. The resident was coded as receiving oxygen therapy.

F 695 Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of corrections prepared and executed as a means to continuously improve quality of care and to comply with applicable state and federal regulations.

1. Physician orders for Oxygen administration to resident #3 appear on Treatment administration record. Comprehensive care plan was updated on 6/14/2018 reflecting order to administer Oxygen continuously at eight liters/minute.
2. Residents that reside in the facility receiving Oxygen therapy have the potential to be affected by this deficient practice.
3. Nursing staff will be reeducated about Oxygen, its definition as a medication, safe usage, how to verify settings visually on Oxygen concentrators and Oxygen canisters before being signed as administered on the Treatment administration record. Care keepers to audit oxygen settings visually 5 times per week for 4 weeks to ensure facility follows physician orders.
4. Results of audits will be brought to monthly/quarterly Quality Assurance Performance Improvement (QAPI) Committee for trend analysis and review. Recommendations implemented as indicated.
5.Corrective action will be completed by 7/14/2018.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 695	Continued From page 53	F 695		

An observation was made on 6/12/18 at 11:25 a.m. of Resident #3. The resident was lying in bed with eyes closed. The resident had a nasal cannula (soft plastic prongs that deliver oxygen in the nose) on and the oxygen was set at six liters per minute via oxygen concentrator.

An observation was made on 6/13/18 at 10:25 a.m. of Resident #3. The resident was lying in bed with eyes closed. The resident had a nasal cannula on and the oxygen was set at five and one-half liters via oxygen concentrator.

An observation was made on 6/13/18 at 12:30 p.m. of Resident #3. The resident was sitting up in bed, awake, alert and talkative. The resident had the nasal cannula on and the oxygen was set at six liters via oxygen concentrator.

An observation was made on 6/13/18 at 2:35 p.m. of Resident #3. The resident was interviewed at that time. The resident had the nasal cannula on and the oxygen was set at six liters via oxygen concentrator.

Review of the care plan initiated on 6/4/18 documented, "Focus. Alteration in Respiratory Status Due to Chronic Obstructive Pulmonary Disease. Interventions. Administer oxygen as needed per Physician order. Monitor oxygen flow rate and response."

Review of the June 2018 physician's orders documented, "O2 via NC (nasal cannula -- soft prongs that fit in the nose to deliver oxygen) @ 8LPM (liters per minute) continuous.

Review of the June 2018 medication administration record (MAR) documented, "O2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 695	Continued From page 54	F 695		

via NC @ 8LPM continuous." It was documented that the oxygen was administered each day.

An interview was conducted on 6/13/18 at 4:47 p.m. with RN #3. When asked when staff assess the resident, RN #3 stated, "Whenever we go in the first time." When asked if she had seen Resident #3 that day, RN #3 stated, "Yes. I gave her Tylenol." When asked oxygen rate Resident #3's physician ordered, RN #3 stated, "It isn't written here but I believe its two liters?" When asked how she would know the resident's oxygen rate, RN #3 stated, "Look at the order." When asked to look at the order, RN #3 stated, "She's to have it on eight liters continuous. I didn't look at it yet."

An observation was made on 6/13/18 at 4:27 p.m. of Resident #3's oxygen with RN (registered nurse) #3, the resident's nurse. When asked what the rate the oxygen was set at, RN #3 stated, "Right now it's on six liters." RN #3 adjusted the oxygen to eight liters at that time. When asked if the physician's orders were being followed, RN #3 stated, "No" When asked when staff would not follow a physician's order, RN #3 stated, "We follow the order, we have to."

On 6/13/18 at 5:10 p.m. ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the findings.

An interview was conducted on 6/14/18 at 10:05 a.m. with LPN #3. When asked when were residents assessed, LPN #3 stated, "I normally assess my resident's right after report." When asked what process staff follow to assess a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 695	Continued From page 55	F 695		

resident on oxygen, LPN #3 stated, "When I assess I'm looking at their breathing and see if they recognize me and are alert and oriented." When asked what staff did if a resident had oxygen, LPN #3 stated, "When I go in and check my vitals (vital signs -- blood pressure, pulse, respirations and temperature) I check that the tubing is on correctly and the rate is correct." When asked if it was important to give the oxygen as ordered, LPN #3 stated, "Yes. You want to make sure they are getting what they are supposed to be getting." When asked if oxygen was considered a medication, LPN #3 stated, "Yes."

Review of the facility's policy titled, "OXYGEN ADMINISTRATION" documented, "A patient will need oxygen when hypoxemia (low oxygen level) results from a respirator or cardiac emergency or an increase in metabolic function. IMPLEMENTATION. Verify the doctor's order for oxygen therapy.

No further information was provided prior to exit.

According to Fundamentals of Nursing, Perry and Potter, 6th edition, page 1122, Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration."

F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 761	Continued From page 56 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review, it was determined the facility staff failed to store medications in a safe manner for one of eight facility medication carts, the North unit cart. The facility staff failed to lock the north unit medication on 6/13/18 at 4:10 p.m. The findings include:	F 761	Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of corrections prepared and executed as a means to continuously improve quality of care and to comply with applicable state and federal regulations. 1. The deficient practice of unsecured medications has been corrected by reeducating staff nurses regarding the importance of securing medications for resident safety. Auditing and correcting unlocked medication carts when visualized. 2. No residents have been identified that have been affected by this deficient practice. 3. Nurses will be reeducated on proper storage of medications to maintain compliance and safety by DON/designee. Auditing by Care keepers will occur 5 times per week for 4 weeks and then ongoing with repeat visualization if cart is noted to be unlocked at any time to ensure facility is maintaining safety of residents and ensuring medications are stored appropriately. 4. Results of audits will be brought to the monthly/quarterly Quality Assurance Performance Improvement (QAPI) Committee for trend analysis and review. Recommendations implemented as indicated. 5. Corrective action will be completed by 7/14/2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 761	Continued From page 57	F 761		

On 6/13/18 at 4:10 p.m., the north unit - medication cart was observed. The cart was in the hallway pushed against the wall outside a resident's room. The cart was unlocked. There were no staff or residents in the hall at the time. RN (registered nurse) #3 came out of the resident's room at 4:11 p.m., took a plastic cup off the cart and returned to the resident's room. The nurse did not lock the cart at that time. The medication cart was not in the nurse's line of sight, while the nurse was in the resident's room. The nurse came out of the resident's room 30 seconds later and pushed the cart down the hall. RN #3 then took medications out of the cart and took the medications into a resident's room. The nurse did not lock the cart. The nurse was in the resident's room for approximately 1 and 1/2 minutes. During that time, the medication cart was out of the nurse's line of sight. There were no other staff or residents observed in the area during that time.

An interview was conducted on 6/13/18 at 4:25 p.m. with RN #3. When asked about the process staff follows when they leave the medication cart unattended, RN #3 stated, "We are not supposed to leave it unlocked." When asked if she had left the medication cart unlocked, RN #3 stated she had. When asked why the carts are to be locked, RN #3 stated, "It's unsafe."

On 6/13/18 at 5:10 p.m. ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the findings.

Review of the facility's policy titled, "STORAGE OF MEDICATION" documented, "POLICY.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 761	Continued From page 58 Medications and biologicals are stored properly, following manufacturer's or provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration. The medication supply shall only be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. PROCEDURES. 1. The provider pharmacy dispenses medication in containers that meet state and federal labeling requirements, including requirements of good manufacturing practices established by the United States Pharmacopeia (USP). Medications are to remain in these containers and stored in a controlled environment. This may include such containers as medication carts, medication room, medication cabinets, or other suitable containers." No further information was provided prior to exit.	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880	Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of corrections prepared and executed as a means to continuously improve quality of care and to comply with applicable state and federal regulations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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) COMPLET ON DATE

F 880 Continued From page 59

and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

F 880

1. Resident #3 was affected by cross contamination reflected by CNA placing a roll of trash bags onto resident's bed and then replacing them into her pocket after providing care.
2. Residents that reside in the facility that require any assistance with activities of daily living are at risk of deficient infection control/ cross contamination.
3. Nursing Assistants will receive reeducation regarding proper infection control practices and how to avoid cross contaminating multi use items by DON/designee. DON/ designee to audit Nursing assistants providing ADL care to residents 3 times per week for 4 weeks. This is to ensure that deficient practice has been corrected.
4. Results of audits will be brought to monthly/ quarterly Quality Assurance Performance Improvement (QAPI)Committee for trend analysis and review. Further auditing will be implemented as recommended.
5. Corrective action will be completed by 7/14/2018 with reeducation and correction upon discovery of any infection control issues.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 880	Continued From page 60	F 880		

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to maintain infection control practices for one of 12 residents in the survey sample, Resident #3.

The facility staff failed to keep a roll of plastic bags used for multiple residents off Resident #3's bed.

The findings include:

Resident #3 was admitted to the facility on 1/8/15 and readmitted on 6/4/18 with diagnoses that included but were not limited to: diabetes, difficulty swallowing, heart failure, respiratory failure, high blood pressure, depression and arthritis.

The most recent MDS, minimum data set, a five day assessment, with an ARD (assessment reference date) of 6/4/18 coded the resident as having scored a 14 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions.

An observation of incontinence care was made on 6/13/18 at 2:10 p.m., with CNA (certified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 880	Continued From page 61	F 880		

nursing assistant) #5 and CNA #6 both CNAs were wearing gloves. CNA #6 pulled two plastic bags from a roll of bags she had in her pocket. CNA #6 laid the roll of bags on the resident's bed. After placing the soiled brief in one bag and the soiled washcloths in the other bag. CNA #6 tied the bags up, picked up the roll of plastic bags with her gloved hand, and put it back into her pocket.

An interview was conducted on 6/13/18 at 2:20 p.m., with CNA #5. When asked about the process staff follows when obtaining supplies, CNA #5 stated, "She shouldn't have taken the bags out of her pocket with her gloves on." When asked what CNA #6 did next, CNA #5 stated, "She put them back in her pocket." When asked if this was acceptable practice, CNA #5 stated, "No." When asked why, CNA #5 stated, "its cross-contamination."

An interview was conducted on 6/13/18 at 2:25 p.m. with CNA #6. When asked about the process staff follows when obtaining supplies, CNA #6 stated, "You're supposed to take the gloves off, wash your hands, put on new gloves and do what you need to do." When asked what process staff follow if they put supplies on a resident's bed, CNA #6 stated, "It's contaminated. Throw it away." When asked if she had put the plastic bags back into her pocket, CNA #6 stated, "Yes." When asked if she had used those bags with another resident, CNA #6 stated, "Yes." When asked what that meant, CNA #6 stated, "Cross contamination."

An interview was conducted on 6/13/18 at 3:10 p.m. with ASM (administrative staff member) #2, the director of nursing. When asked about the process staff follows if they needed additional

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 880	Continued From page 62	F 880		

supplies during care, ASM #2 stated, "They're supposed to take their gloves off, wash their hands, put on new gloves and then do what they need to do." When asked what supplies were considered if they were laid on the resident's bed, ASM #2 stated, "It's dirty, soiled." When asked what staff should do if they lay a roll of plastic bags on a resident's bed, ASM #2 stated, "Trash them." ASM #2 was made aware of the findings at that time.

On 6/13/18 at 5:10 p.m. ASM #1, executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services were made aware of the findings.

Review of the facility's policy titled, "Standard Precautions" documented, "POLICY: Standard Precautions will apply to all residents receiving care in all facilities regardless of their diagnosis or presumed infection status...Standard Precautions are designed to reduce the risk of transmission of microorganism from both recognized and unrecognized sources of infection in health care facilities. PROCEDURE: Resident Care Equipment. a. Reusable equipment is not to be used for the care of another resident until it has been cleaned and processed appropriately."

No further information was obtained prior to exit.