PRINTED: 06/26/2018 FORM APPROVED OMB NO. 0938-0391

CENTERS	FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		Market Mark and Mark	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		495140	B. WING	i nee	C 06/14/2018
	VIDER OR SUPPLIER	В	111	REET ADDRESS, CITY, STATE, ZIP CODE O CHALMERS COURT ERRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 000 11	NITIAL COMMENT	S	F 000	-0.750	

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 Resident Rights/Exercise of Rights SS=E 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.



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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

5. Correction to be completed by 7/14/2018.

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-039
STATEMENT (DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY STATE ZIP CODE	
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F 550	Continued From page	e 1	F 550		
		right to exercise his or her fthe facility and as a citizen			
	resident can exercise	cility must ensure that the his or her rights without h, discrimination, or reprisal			
	free of interference, or reprisal from the facil rights and to be supp exercise of his or her subpart.	sident has the right to be coercion, discrimination, and ity in exercising his or her corted by the facility in the rights as required under this			
	interview, facility doc record review, it was	on, resident interview, staff ument review and clinical determined the facility staff accommodation of resident's			
		residents in the survey			
	The facility staff fa within Resident #3's	iled to secure the call bell reach.			
	2. The facility staff fa within Resident #8's	iled to secure the call bell reach.			
	3. The facility staff fa within Resident #9's	iled to secure the call beil reach.			
	4. The facility staff fa within Resident #10's	iled to secure the call bell s reach.			

The findings include:

EDADTMENT OF HEALTH AND HUMAN OFFICE

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		MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
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	<u> </u>	495140	B. WING		C 06/14/2018
	ROVIDER OR SUPPLIER L HEALTH AND REHAB		~	STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611	
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F 550	Continued From page	2	F	550	
	1/8/15 and readmitted that included but were difficulty swallowing, I failure, high blood pre arthritis.	,			
	day assessment, with reference date) of 6/4, having scored a 14 or interview for mental st was cognitively intact. The resident was codfrom staff for all activities.	i, (minimum data set), a five an ARD (assessment /18 coded the resident as it of 15 on the BIMS (brief tatus) indicating the resident to make daily decisions. ed as requiring assistance lies of daily living except for ent could perform after the			
	a.m., of Resident #3.	nade on 6/12/18 at 11:25 The resident was lying in The call bell was lying on ght side of the bed.			
	a.m. of Resident #3. 1	nade on 6/13/18 at 10:25 The resident was lying in th eyes closed. The call bell			

within reach."

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

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

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OM	B NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			ISTRUCTION		DATE SURVEY COMPLETED
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NAME OF P	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY STATE, ZIP CODE	-	
ROSE HIL	L HEALTH AND REHAB				HALMERS COURT RYVILLE, VA 22611		
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F.550	their call light is and s reach." When asked call light was available stated, "They need it with us or if there's are asked if the resident was on the floor, CNA. An interview was comp.m. with Resident #3 able to use her call be call bell is on the floor long it took staff to an #3 stated, "Maybe 40 An interview was comp.m. with LPN #4. Where sident's call lights we #4 stated, "Within real asked why, LPN #4 s	e wet or dry. I see where see if there's everything in why they checked that the e to the resident, CNA #2 in order to communicate in emergency too." When could reach the call bell if it A #2 stated, "No." ducted on 6/13/18 at 2:35 at When asked if she was ell, Resident #3 stated, "My r a lot." When asked how iswer her call bell, Resident minutes." ducted on 6/13/18 at 2:30 inen asked how the vere to be maintained, LPN inch of the patient." When tated, "So they can let us	F	550			
	p.m. with ASM (admir the director of nursing assess when making ASM #2 stated, "They that the linen is clean and the bed control is On 6/13/18 at 5:10 p. director, ASM #2, the #3, the regional direct made aware of the fir	ducted on 6/13/18 at 3:20 histrative staff member) #2. g. When asked what staff rounds on the residents, y scan the resident, check and the call bell is in reach also within reach." m. ASM #1, the executive director of nursing and ASM tor of clinical services were addings.					
	An interview was con	ducted 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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		ST 55	(X3) DATE SURVEY COMPLETED	
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		495140	B. WING		9	06/14/2018	
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ROSE HILL HI	EALTH AND REH	АВ		BERRYVILLE, VA 22611			
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F 550 Co	ontinued From p	age 4	F	550			

the nation! "When asked

the patient." When asked if she had any residents who complained they did not have their call belis, 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.

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

Event ID: 1BPH11

Facility ID: VA0210

If continuation sheet Page 5 of 63



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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ROSE HIL	L HEALTH AND REHAB			BERRYVILLE, VA 22611	
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F 550	Continued From pag 2. The facility staff fa within Resident #8's	iled to secure the call bell	F 55	50	
	4/20/18 with diagnos	nitted to the facility on es that included but were not eart beat, difficulty speaking, ease and diabetes.			
	with an ARD of 4/27/ requiring assistance daily living. The resid	S, a 30 day assessment, 18 coded the resident as from staff for all activities of lent was coded as having memory problems, and was apaired cognitively.			
	a.m. of Resident #8.	made on 6/12/18 at 11:15 The resident was lying in s behind the head of the bed			
	of Resident #8. The a washcloth on her for was tucked under the	made on 6/12/18 at 6:10 p.m. resident was lying in bed with prehead. The call bell cord be upper part of the pillow and gling over the head of the			
	Resident #8. The res wheelchair on the rig	made on 6/13/18 at 10:17 of sident was sitting up in a tht side of the bed. The call on the left side of the bed.			
	documented, "Focus New environment, m Interventions. Call lig	lan initiated on 4/20/18, . At risk for falls related to leds (medications). It or personal items or provide reacher."			

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

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	RS FOR MEDICARE & I	MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
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		495140	B. WING _		C 06/14/2018
NAME OF P	ROVIDER OR SUPPLIER	333		STREET ADDRESS, CITY, STATE, ZIP CODE	
ROSE HIL	L HEALTH AND REHAB			110 CHALMERS COURT BERRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPLICATION DEFICIENCY)	OULD BE COMPLETION
F 550	p.m. with LPN #4. Wh resident's call bells we #4 stated, "Within rea asked why, LPN #4 st know when they need An interview was cone p.m. with ASM (admin the director of nursing assess when making ASM #2 stated, "They	ten asked how the ere to be maintained, LPN ch of the patient." When tated, "So they can let us I help or assistance." ducted on 6/13/18 at 3:20 histrative staff member) #2, when asked what staff rounds on the residents, or scan the resident, check and the call bell is in reach	F 5:	50	
	director, ASM #2, the #3, the regional direct made aware of the fin An interview was cond a.m. with LPN #3. Who bells to be maintained	m. ASM #1, the executive director of nursing and ASM or of clinical services were dings. ducted on 6/14/18 at 10:05 len asked how where call the LPN #3 stated, "Close to ked if she had any residents"			

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.

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES	7000		OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495140	B. WING		C 06/14/2018
NAME OF P	ROVIDER OR SUPPLIER		STI	REET ADDRESS, CITY, STATE, ZIP CODE	
ROSE HIL	L HEALTH AND REHAB		100000	CHALMERS COURT CRRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 550	Continued From page	e 7	F 550		
	Resident #9 was adn 10/7/17 with diagnose limited to: irregular he	nitted to the facility on es that included but were not			
	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				
	a.m. of Resident #9. bed with his back to t was clipped to the cu	made on 6/13/18 at 10:18 The resident was lying in the door. The call bell cord			
	bell was lying on the				
	p.m. of Resident #9.	made on 6/13/18 at 12:30 The resident was lying in s in the same position as m.			
	with CNA #3, the res where the call bell wa	made on 6/13/8 at 12:44 p.m. ident's aide. When asked as, CNA #3 picked the call clipped it to the resident's			
	documented, "Focus History of falls, unste	lan initiated on 11/8/17 At risk for falls related to: eadiness. Interventions. Call is available in easy reach or			

provide reacher."

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

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF P	ROVIDER OR SUPPLIER		Jac.8	STREET ADDRESS, CITY, STATE, ZIP CODE	
ROSE HIL	L HEALTH AND REHAB			110 CHALMERS COURT BERRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 550	p.m. with CNA #3. Wi had call bells, CNA # need they can call us us." When asked what make rounds on the r "We check to see if the need to be cleaned us checked that the call reach, CNA #3 stated. An interview was comp.m. with LPN #4. Where ident's call bells with #4 stated, "Within reach asked why, LPN #4 sknow when they need. An interview was comp.m. with ASM (admitted director of nursing assess when making ASM #2 stated, "They that the linen is clean and the bed control is On 6/13/18 at 5:10 p. director, ASM #2, the #3, the regional direct made aware of the firm. No further information."	hen asked why residents a stated, "So if they're in dire and let us know they need at staff look for when they residents, CNA #3 stated, hey have any bruise, if they p." When asked if they bell within the resident's I, "Before I leave, yes." ducted on 6/13/18 at 2:30 hen asked how the ere to be maintained, LPN inch of the patient." When stated, "So they can let us I help or assistance." ducted on 6/13/18 at 3:20 histrative staff member) #2, g. When asked what staff rounds on the residents, y scan the resident, check and the call bell is in reach also within reach." m. ASM #1, the executive director of nursing and ASM tor of clinical services were indings. In was provided prior to exit.	F 5	50	
	Resident #10 was ad	mitted 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

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER-	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF P	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	ST	REET ADDRESS, CITY, STATE, ZIP CODE	
ROSE HIL	L HEALTH AND REHAB			0 CHALMERS COURT ERRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS REFERENCED TO THE APPROF DEFICIENCY)	DIBE COMPLETION
F 550	Continued From page heart failure.	9	F 550		
	with an ARD of 4/10/1 having both long and problems and was mo cognitively. The reside				
	of Resident #10. The	nade on 6/13/18 at 8:15 a.m. resident was lying in bed s head. The call bell was ind the beside table.			
	a.m. of Resident #10. bed with the sheet ov	nade on 6/13/18 at 10:20 The resident was lying in er his head. The call bell behind the beside table.			
		nade on 6/13/18 at 12:15 The resident was being fed			
	p.m. of Resident #10 nurse. When asked w	nade on 6/13/18 at 12:40 with LPN #4, the resident's there the resident's care bell the call bell up off the floor esident's bed.			
	documented, "Focus. Maxi-lift for transfer re ([cerebral vascular ac hemiplegia (paralysis)				

bedside."

light and water available and in easy reach at

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		MEDIONID OCIVIOCO			OIVID NO. 0330-0331
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PE	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP COL	
100 <u>- 101</u> - 101				110 CHALMERS COURT	
ROSE HILI	L HEALTH AND REHAB			BERRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION DATE
F 550	Continued From page	e 10	F 55	50	
	14 N	ducted on 6/13/18 at 2:30			
	p.m. with LPN #4. WI				
	resident's call bells w	ere to be maintained, LPN			
		ich of the patient." When			
	Contract to the Property of the Contract of th	tated, "So they can let us			
	And the state of t	d help or assistance." When D's call bell had been within			
	reach, LPN #4 stated				
		ducted on 6/13/18 at 3:20			
	An extraction representation to a provide a service and a	nistrative staff member) #2, g. When asked what staff			
		rounds on the residents,			
		y scan the resident, check			
	MENTAL STREET,	and the call bell is in reach			
	and the bed control is	s also within reach."			
	On 6/13/18 at 5:10 p.	m. ASM #1, the executive			
	Wit 22 100 100 100 100 100 100 100 100 100	director of nursing and ASM			
	- 3/2	tor of clinical services were			
	made aware of the fir	ndings.		Preparation, submission and imp	
	No further information	n was provided prior to exit.		plan of correction does not const of or agreement with the facts an	
	COMPLAINT DEFICI	FNCV		forth on the survey report. Our prepared and executed as a mean	
F 607		Abuse/Neglect Policies	F 60	j7 improve quality of care and to ec	
	CFR(s): 483.12(b)(1)		, ,	applicable state and federal regul	
	§483.12(b) The facilit	y must develop and			
	implement written po	licies and procedures that:			
	§483.12(b)(1) Prohib	it and prevent abuse,			
	neglect, and exploita				
	misappropriation of re	esident property,			
	§483.12(b)(2) Establi	sh policies and procedures			

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		495140	B. WING_		06	C 6/14/2018
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ROSE HILL H	HEALTH AND REHAE	3		110 CHALMERS COURT BERRYVILLE, VA 22611		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
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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

/DH/OLC

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CENTER	ENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPE A BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495140	B. WING		C 06/14/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	
ROSE HIL	L HEALTH AND REHAB			110 CHALMERS COURT BERRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 607	Continued From page	e 12	F 60	7	
	make daily decisions requiring assistance daily living except for could perform after the resident was coded a occasionally.	at was cognitively intact to . The resident was coded as from staff for all activities of eating which the resident he tray was prepared. The has being incontinent of urine			
	incident report) docut 4/16/18. Describe inco action taken: Resider that a CNA (certified (11:00 p.m.) - 7a (7:0 to assist her on using was done using it the pan and some of it sp of change the sheets	B facility FRI (reported mented, "Incident Date: ident, including location, and int informed Charge nurse nursing assistant) on 11p 0 a.m.) came into her room in the bed pan and after she is CNA was removing the bed on the bed. So, instead on the bed the CNA took a per bed in the room and issident."			
	p.m. with CNA #2, the for Resident #5 on 4/ occurred that day, Cl found it (the blanket thappened on the night reported it." When as CNA #2 stated, "The remember her name, going all the time." C	nt shift. I found it and I ked who she reported it to,			
	a.m. with ASM (admi the executive directo	ducted on 6/14/18 at 8:30 nistrative staff member) #1, r. When asked the process gation of neglect, ASM #1			

stated, "I investigate as soon as I hear about it." When asked the process the staff were to follow

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES	W		OMB NO. 0938-0391
1000 전 2 : 100 (100 H) 100 H		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTI A BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495140	B. WING _		C 06/14/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 110 CHALMERS COURT BERRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 607	for a concern of negle phone number is at e #1 stated he expecte nurse and the charge time. When asked wh #5 was not reported to agency on 4/16/18, A it from the resident or reported it right away 4/16/18) told the charnurse) didn't tell anycout on leave the next was an agency nurse invested." ASM #1 was concern at that time. The nurse who cared was no longer employnot able to be intervied. An interview was conp.m. with CNA #4. W followed if there was neglect, CNA #4 state someone got hurt we nurse." When asked CNA #4 stated, "If the them first and then te it." When asked when documented, CNA#4 give it to the nurse ar box."	ect, ASM #1 stated, "My very nursing station." ASM d staff to notify the charge increase was to notify him any by the incident for Resident to the appropriate state asM #1 stated, "I heard about in the 18th (4/18/18) and I. The CNA (from day shift on age nurse, but she (the one and then the aide went day. She (the charge nurse) and they are not very as made aware of the and the facility and was awed ducted on 6/14/18 at 12:10 hen asked the process staff a concern for abuse or ed, "If there's a bruise or if immediately report it to the if a resident was left wet, ey're wet you would change all the nurse and document	F 6	07	
	When asked the proc was a concern for ab	sess staff followed if there use or neglect of a resident, a bruise, I would go to the			

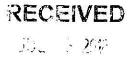
FORM CMS-2567(02-99) Previous Versions Obsolete

resident of course and assess of course. I would

Event ID: 18PH11

Facility ID: VA0210

If continuation sheet Page 14 of 63



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING C (X3) DATE SURVEY COMPLETED C	CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-0391
NAME OF PROVIDER OR SUPPLIER ROSE HILL HEALTH AND REHAB SITE TADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	55 10 BANK 10		(X3) DATE SURVEY
ROSE HILL HEALTH AND REHAB			495140	B. WING	- A-2	C 06/14/2018
ROSE HILL HEALTH AND REHAB	NAME OF P	ROVIDER OR SUPPLIER	100	STF	REET ADDRESS, CITY, STATE, ZIP CODE	*
	ROSE HIL	L HEALTH AND REHAB				
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS REFERENCED TO THE APP	OULD BE COMPLETION
all the MD (medical doctor), the POA (power of altorney) 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 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 duly 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 "Na') (above) if he doces 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	F 607	call the MD (medical attorney) and my DO because I don't know asked if a resident would pinpoint which supervisor. It could be When asked what tin reported, LPN #5 states asked if staff were extended in the states of the facility. Abuse documented inherent in the nature at Facility that he/she right, including the right, including the right eatment of occurrence employees of Facility obligation to treat all manner possible. PR Obligation. A. All emprespect the rights of with dignity and to provide the rights. Any empknowledge of an action obligated to report subject to the Administrator. B. deemed to have violated paragraph "IA) (abovious following: 1. Fails to be or known to him/h	doctor), the POA (power of N (director of nursing) where it came from." When as left wet, LPN #5 stated, "I aide, report it to my e abuse, it could be neglect." neframe this would be ted, "Immediately." When ducated on abuse reporting, " Is policy titled, "Resident in part, "POLICY: It is and dignity of each resident in be afforded basic human ght to be from abuse, t, and/or misappropriation of ts in the fair and timely nees of resident abuse. 1. All are charge with a continuing resident in the most humane OCEDURE: IV. Employee ployees have a duty to all residents, to treat them event other from violating loyee who witnesses or has of abuse to a resident is uch information to the large, Director of Nursing, or An employee shall be ated his obligations in the information in charge of the report an incident of abuse or er. VII. Procedure for	F 607		

Licensed Nurse in Charge, Director of Nursing, or the Administrator. Once reported to one of those

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		D HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT OF AND PLAN OF C	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495140	B. WING		C 06/14/2018
NAME OF PRO	/IDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/1-1/2010
ROSE HILL I	IEALTH AND REHAB			110 CHALMERS COURT BERRYVILLE, VA 22611	
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tt c C ir w e p c re ir w A p td a Ir ir s f c a n a s f c a n a ir a a n a ir a a a n a a a a a a a a a a a a a a a	ompleted and deliver coordinator or his/her vestigation. B. The Aill endeavor to protein mployees. The Admireliminary reports of ouded by biases and elevant and need to be vestigation in order that actually happened dinistration reserved ending an investigation be deemed as an a vestigation of Abuse complished in the formediately upon republished from the formediately upon th	scribed forms are to be red to the Abuse designee for an Abuse Coordinator of Facility of the rights of residents and nistration recognizes that abuse can sometimes be dother factors that are be explored during a full to obtain a clear picture of	F	607	
p F re	repared. 4. Discipline acility will refer any consident abuse to the	detailed report shall be as: The Abuse Coordinator of all incidents and reports of appropriate state agencies." 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

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CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES						NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	4x 40x1 0005K		ISTRUCTION		ATE SURVEY DMPLETED
		495140	B. WING				C 06/14/201 8
NAME OF PI	ROVIDER OR SUPPLIER		3.130.11	STREE	T ADDRESS, CITY, STATE, ZIP CODE		
ROSE HIL	L HEALTH AND REHAB				HALMERS COURT RYVILLE, VA 22611		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETION DATE
F 607	Continued From page to investigate Resider out abuse.	e 16 nt #9's rib fractures to rule	F	607			
	Resident #9 was adm 10/7/17 with diagnose limited to: irregular he enlarged prostate and						
	with an ARD of 4/16/ having scored a three indicting the resident cognitively. The resid assistance for all active	6, a quarterly assessment, 18, coded the resident, as a out of 15 on the BIMS was severely impaired ent was coded as requiring vities of daily living except esident could perform after d.					
	writer that he fell in his (sic) across the room questions resident stand threw me in a roc conversation and at the resident he stated "I will be feet slipped out from down the hill. I've new whole time I have beer right rib area." Body at there is no red or bruareas noted." Further documented, "8. How the last 30 days? Not to transfer/ambulate?	ent (Resident #9) told this is room and rolled all the . Upon asking more ated, "2 men ruffed me up ick pile." We continued					
	caused the accident)	Not Known if resident fell." nat the resident ambulated					

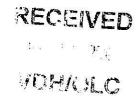
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independently is inconsistent with the documentation in the 4/16/18 MDS that the

Event ID: 18PH11

Facility ID: VA0210

If continuation sheet Page 17 of 63



		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/26/2018 FORM APPROVED OMB NO. 0938-0391
and the second s	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	5200 S 55585	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	,	495140	B. WING _		C 06/14/2018
	ROVIDER OR SUPPLIER L HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 607	p.m. documented, "Ri increased pain insistii hospitalWalking in higuest to help with his lower ribs, guards about attempted to palpate, sent to the emergency documentation regard notes.	istance from staff for inotes dated 1/14/18 at 1:30 esident complained of ing (sic) going to hallway asking staff and pain" (sic) points to right domen when this nurse " *Note the Resident was	F 6	607	

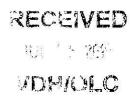
1/14/18 documented, "(Name of Resident #9) is a 73 y.o (year old) male who present to the ED (emergency department) with complaint of rib pain. Patient reports a complaint of right rib pain. Patient is vague and poor historian. He apparently fell at the nursing home yesterday. Radiologic Studies. Xr (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)

Event ID: 1BPH11

Facility ID: VA0210

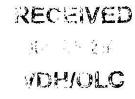
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DEIMIN	WENT OF HEALTHAD	TOWART SERVICES			FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES	338		OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	80 8	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495140	B. WING	76.00 00 12	C 06/14/2018
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/14/2010
ROSE HIL	L HEALTH AND REHAB			0 CHALMERS COURT ERRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DIBE COMPLETION
F 607	Continued From page	∍ 18	F 607		10
	because I don't know	what happened."			
	The nurse involved w interview.	as not available for			
	The director of nursin at the facility and cou	g no longer was employed ld not be interviewed.			
	Review of the FRI 1/1	14/2018 (facility reported			
	incident) submitted to	· · · · · · · · · · · · · · · · · · ·			
		"During the 11-7 (11:00			
	M.	t Saturday into Sunday			
	N-BC	was complaining of pain in he patient has a BIMS [brief			
	interview for mental s				
		n assessment and observed			
	no bruising or open a	reas. The nurse			
		tions per physician order,			
		(patient) later and the			
	6	nny complaints. On Sunday			
	À.	p.m.) shift, the patient in the same area again.			
	AT	atient to the ER [emergency			
		d he had fractured ribs. The			
	facility has implement	ted his bed to be in the low			
		оп both sides at night and			
		ng the day. Statements			
	- 150 S	it are being gathered." There			
	follow-up investigation	n of any statements or of a n.			
	A request for the inve	stigation was made to ASM			
	1	nember) #1, the executive			
		4:45 p.m. ASM #1 stated			
	12	thing he could find. ASM #1			
		curred prior to his arrival in #2, the director of nursing			

stated, "I may have seen something, I'll look for it.



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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391
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		495140	B WING			C
NAME OF P				9	FREET ADDRESS, CITY, STATE, ZIP CODE	06/14/2018
1001120111	(O TIDEIX OT TOO IN ELET				ID CHALMERS COURT	
ROSE HIL	L HEALTH AND REHAB				ERRYVILLE, VA 22611	
100	O B M & DV OT	TELEVIT DE DECIDIENCE				
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F 607	Continued From page	s 19	F	607		
1 007	180 170	m., ASM #2 stated she was	3 .	JUT		
		investigation regarding the				
	resident's fractured ril					
		lave been done, ASM #2				
	stated, yes.	-			Preparation, submission and implemen	tation
					of this plan of correction does not cons	1
					admission of or agreement with the fac	
		as obtained prior to exit.		0.255.5275.02	conclusions set forth on the survey rep	
	Reporting of Alleged		F	609	Our plan of corrections prepared and e	
SS=D	CFR(s): 483.12(c)(1)(4)			as a means to continuously improve qu	W-007 1994
	8/18/3 12/c) In respons	se to allegations of abuse,			care and to comply with applicable sta	140
		or mistreatment, the facility			federal regulations.	ic and
	involving abuse, negli- mistreatment, includir source and misappro- are reported immedia hours after the allega that cause the allegat serious bodily injury, the events that cause abuse and do not res the administrator of the officials (including to the adult protective service for jurisdiction in long	ng injuries of unknown priation of resident property, tely, but not later than 2 tion is made, if the events ion involve abuse or result in or not later than 24 hours if the allegation do not involve ult in serious bodily injury, to			1. Resident #5 has been discharged fr facility. Resident #9 did not have a th investigation completed after an injury unknown origin occurred. Direct care the facility were reeducated regarding policy and reporting. 2. The facility has determined that rest that reside here have the ability to be a by this deficient practice. 3. Current employees will be reeduca notifying abuse coordinator/designee callegation of abuse immediately. New employees receive education on Resid rights, resident abuse, and abuse report	orough or of staff in abuse sidents affected ted on of any tent tting
	designated represent accordance with State Survey Agency, within	the results of all administrator or his or her ative and to other officials in a law, including to the State of 5 working days of the aged violation is verified			during orientation and via Relias train annually thereafter. Re-education will provided upon discovery of non-comp with abuse reporting. 4. The DON/designee will conduct a guid of 5 residents per week for 4 weeks.	l be oliance random

audit of 5 residents per week for 4 weeks.

PRINTED: 06/26/2018 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938	-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	to statement was		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	âŝ
		495140	B. WING		<u> </u>	06/14/2018	8
NAME OF PI	ROVIDER OR SUPPLIER	1		ST	REET ADDRESS, CITY STATE, ZIP CODE	1 00/14/20/1	
ROSE HIL	L HEALTH AND REHAB				0 CHALMERS COURT		
		Marie Commission Commi		B	ERRYVILLE, VA 22611	Alex.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPL	ETION
				4000000	These residents will be assessed and		
F 609	Continued From page		F	609	interviewed to ensure that any alleged	j	
		e action must be taken.			violations are identified, properly inv	estigated	
	This REQUIREMENT			and reported according to facility pol	icy and		
	by:	in Francisco			procedures. The plan of correction w	ill be	
		iew, facility document review view, it was determined the			monitored at the monthly/quarterly Q	uality	
	facility staff failed to in			Assurance Performance Improvemen	t (QAPI)		
	allegation of neglect t			Committee for trend analysis and rev	iew until		
	facility and to other of			such time as consistent substantial co			
	Survey Agency) in ac			has been met.			
	through established p			5. 7/14/2018			
	residents in the surve						
T		d to immediately report and ours an allegation of neglect					
	The findings include:						
		er resided in the facility and for means of identification.					
	D :	sitted to the feelith, on					
		nitted to the facility on es that included but were not					
		eakness, depression, high					
		monia and high cholesterol.					
	The most recent com	plete MDS (minimum data					
	set), an admission as	ssessment, with an ARD					
	11 to 12 to	ce date) of 4/23/18 coded					
		g scored a 14 out of 15 on					
		riew for mental status)					
	이 전 되는데 이렇게 되어 어느면서 가는 하는 것은 그는 그는 그는 그들이 되었다면 되었다.	nt was cognitively intact to					
		. The resident was coded as from staff for all activities of					
		eating which the resident					
		ne tray was prepared. The					

resident was coded as being incontinent of urine

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DETAIL	WENT OF FIERENTAL	ID HOWAIT BEITVICES		iii	F(ORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES		- H	OMB	NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) D	OATE SURVEY OMPLETED
		495140	B. WING_			C 06/14/2018
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE		00.11.2010
ROSE HILL HEALTH AND REHAB				110 CHALMERS COURT BERRYVILLE, VA 22611		
.V.4.V.ID	SUMMARY STATEMENT OF DEFICIENCIES			Suprise Server (1770) - Serving destricts of the Serving Server Server Server Serving Server		Carlos
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (HOULD BE	(X5) COMPLETION DATE
F 609	Continued From page	e 21	F6	-09		
	occasionally.					
	incident report) docur 4/16/18. Describe inc action taken: Resider that a CNA (certified (11:00 p.m.) - 7a (7:0 to assist her on using was done using it the pan and some of it sp of change the sheets	B facility FRI (reported mented, "Incident Date: ident, including location, and not informed Charge nurse nursing assistant) on 11p 0 a.m.) came into her room the bed pan and after she cNA was removing the bed on the bed. So, instead on the bed the CNA took a per bed in the room and esident."				
	p.m. with CNA #2, the for Resident #5 on 4/ occurred that day, CN found it (the blanket uhappened on the night reported it." When as CNA #2 stated, "The remember her name. going all the time." Cl	nt shift. I found it and I ked who she reported it to,				
	a.m. with ASM (admin the executive director staff follow for an alle stated, "I investigate a When asked the proof for a concern of negle phone number is at e #1 stated he expecte	ducted on 6/14/18 at 8:30 nistrative staff member) #1, r. When asked the process gation of neglect, ASM #1 as soon as I hear about it." ess the staff were to follow ect, ASM #1 stated, "My every nursing station." ASM d staff to notify the charge enurse was to notify him any				

time. When asked why the incident for Resident #5 was not reported to the appropriate state

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DEFART	VIENT OF HEALTH AN	ND HOWAIN SERVICES					FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					OMB NO. 0938-0391
	DF DÉFICIÉNCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONS			(X3) DATE SURVEY COMPLETED
		495140	B WING_				C 06/14/2018
NAME OF PE	ROVIDER OR SUPPLIER	 		STREET	ADDRESS, CITY, STATE, ZIP CODE		00/14/2010
				110 CH.	ALMERS COURT		:
ROSE HILL HEALTH AND REHAB					YVILLE, VA 22611		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	
F 609	it from the resident or reported it right away 4/16/18) told the charnurse) didn't tell anyout on leave the next was an agency nurse invested." ASM #1 was concern at that time. The nurse, who cared was no longer employ not able to be intervied. Review of the facility' Abuse" documented inherent in the nature at Facility that he/she right, including the rigneglect, mistreatment.	aSM #1 stated, "I heard about in the 18th (4/18/18) and I in the CNA (from day shift on age nurse, but she (the one and then the aide went in day. She (the charge nurse) is and they are not very as made aware of the individual of the facility and was exwed in part, "POLICY: It is and dignity of each resident in part, "POLICY: It is and dignity of each resident in the be afforded basic human ight to be from abuse, t, and/or misappropriation of	F	609			
	treatment of occurrent employees of Facility	ts in the fair and timely nees of resident abuse. 1. All are charge with a continuing resident in the most humane					
	manner possible. PR Obligation. A. All emp	OCEDURE: IV. Employee ployees have a duty to					
	with dignity and to pro	all residents, to treat them event other from violating loyee who witnesses or has					
		of abuse to a resident is					
	Licensed Nurse in ch the Administrator. B.	arge, Director of Nursing, or An employee shall be					
	paragraph "IA) (abov	ated his obligations in e) if he does any of the report an incident of abuse or					

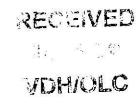
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by or known to him/her. VII. Procedure for Reporting Abuse. A. All incidents of resident

Event ID 1BPH11

Facility ID. VA0210

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CENTER	RS FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ar manasan nam	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
) 		495140	B WING_		C 06/14/2018
NAME OF F	PROVIDER OR SUPPLIER	<u>-</u>		STREET ADDRESS, CITY, STATE, ZIP CODE	1 ++
ROSE HIL	LL HEALTH AND REHAB			110 CHALMERS COURT BERRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 609	Licensed Nurse in Ch the Administrator. One three officials, the pre completed and deliver Coordinator or his/her investigation. B. The A will endeavor to prote- employees. The Admi preliminary reports of clouded by biases and relevant and need to be investigation in order to what actually happene Administration reserve pending an investigation to be deemed as an a Investigation of Abuse accomplished in the for Immediately upon rep- individual in charge, the segregated from the re- for and credibility of the ascertained, and the A notified. 2. Investigation and/or director of Nurs statements from the vi- possible witnesses inci in the vicinity of the all also secure all physica of the investigation, a prepared. 4. Discipline Facility will refer any o resident abuse to the a	rted immediately to the harge, Director of Nursing, or ce reported to one of those escribed forms are to be red to the Abuse of designee for an Abuse Coordinator of Facility and the rights of residents and inistration recognizes that abuse can sometimes be dother factors that are be explored during a full to obtain a clear picture of ed. Thus, while est he right to suspendion, such suspension is not assessment of guilt. VIII. e. B. Investigation will be collowing manner: 1. a. Fort of an incident to the he suspect(s) shall be resident. The factual basis he allegation shall be abuse Coordinator shall be and. The Abuse Coordinator	F 60)9	
F 610		orrect Alleged Violation	F 61	0	

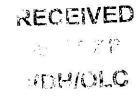
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SS=D CFR(s): 483.12(c)(2)-(4)

Event ID: 1BPH11

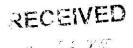
Facility ID VA0210

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		MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		20 M 15	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED C	
		495140	B WING_	The second second	06/14/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ROSE HIL	L HEALTH AND REHAB			110 CHALMERS COURT BERRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE COMPLETION
F 610	Continued From page	24	F	610	
	2.5	se to allegations of abuse, or mistreatment, the facility			
	§483.12(c)(2) Have eviolations are thoroug	vidence that all alleged hly investigated.			
	1/2	t further potential abuse, or mistreatment while the gress.			
	designated represents accordance with State Survey Agency, within incident, and if the alleappropriate corrective This REQUIREMENT by: Based on staff interviand clinical record reviand staff failed to fa of unknown origin was	the results of all administrator or his or her ative and to other officials in a law, including to the State of 5 working days of the aged violation is verified a action must be taken. It is not met as evidenced sew, facility document review view, it was determined the ailed evidence that an injury is thoroughly investigated, in the survey sample,			
	pain. Resident #9 wa emergency room on 1 with multiple rib fractu	l/14/18 and was diagnosed ires. The facility staff failed nt #9's injury of unknown			
	The findings include:				



Facility ID: VA0210

Event ID: 1BPH11

On 11/13/18, Resident #9 complained of acute rib

pain. Resident #9 was evaluated in the

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		ID HUMAN SERVICES MEDICAID SERVICES	Œ		FOI	ED: 06/26/2018 RM APPROVED VO. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	20 10	IPLE CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
		495140	B. WING _		0	C 6/14/2018	
ACOTADE PREMION FOR AMOUNTS FO	ROVIDER OR SUPPLIER L HEALTH AND REHAB	500	300	STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611		St. Adda	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 610	with multiple rib fractuto investigate Resider origin to rule out abust Resident #9 was adm 10/7/17 with diagnose limited to: irregular he enlarged prostate and The most recent MDS quarterly assessment reference date) of 4/1 having scored a three (breif interview for me	1/14/18 and was diagnosed ures. The facility staff failed nt #9's injury of unknown se. nitted to the facility on ses that included but were not	F 6	110			

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

resident was coded as requiring assistance for all activities of daily living except for eating which the

resident could perform after the tray was

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prepared.

Event ID: 1BPH15

Facility ID: VA0210

If continuation sheet Page 26 of 63



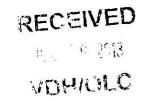
PRINTED: 06/26/2018

	WEIT OF THE TETT	NO HOW WY DERVICES			FORM APPROVE
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
22 1922 1922		495140	B. WING	·	C 06/14/2018
NAME OF PI	ROVIDER OR SUPPLIER		ŞTF	REET ADDRESS, CITY, STATE, ZIP CODE	
	es transconsidera-una tropolos reconstruironosce		110	CHALMERS COURT	
ROSE HIL	L HEALTH AND REHAE	3	BE	RRYVILLE, VA 22611	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	sNI Wes
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	DBE COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE DATE
				BEHOLINGTY	
E 610	Continued From pag	so 26	E 640		
1 010	A S		F 610		
) Not Known if resident fell."			
	independently is inco	that the resident ambulated			
		e 4/16/18 MDS that the			
		sistance from staff for			
	ambulation.	sistance nom stan for			
	Review of the nurse'	s notes dated 1/14/18 at 1:30			
	p.m. documented, "F	Resident complained of			
	increased pain insist	ing (sic) going to			
		hallway asking staff and		是	
	1.7	s pain" (sic) points to right			
		odomen when this nurse			
		." *Note the Resident was			
		cy room but there is no			
	\$500.	ding this in the nurse's			
	notes.				
	Review of the emero	ency room record dated			
	-	, "(Name of Resident #9) is a			
		e who present to the ED			
	(5 15.0 07	nent) 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)			
	881	r) Chest. Result Date:			
		nt rib fractures involving the			
		s and questionably second,			
	fifth and eight ribs."				
	An interview was cor	nducted on 6/14/18 at 12:15			
		sed practical nurse) #5.			
	50	cess staff followed if there			
		ouse or neglect of a resident,			
	LPN #5 stated, "If it's	s a bruise, I would go to that			
	resident of course ar	nd assess of course. I would			

call the MD (medical doctor), the POA (power of attorney) and my DON (director of nursing)

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPL	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPL	SURVEY
495140 B. WING	; 4/2018
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	4/2010
ROSE HILL HEALTH AND REHAB 110 CHALMERS COURT BERRYVILLE, VA 22611	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 sent the patient to the BR [emergency room] where it showed he had fractured ribs. The facility sent the patient to shoth 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.	



director on 6/12/18 at 4:45 p.m. ASM #1 stated the FRI was the only thing he could find. ASM #1

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES_			OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495140	B. WING		C 06/14/2018
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
ROSE HIL	L HEALTH AND REHAB		1000	IO CHALMERS COURT ERRYVILLE, VA 22611	DW
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 646	March of 2018. ASM a stated, "I may have set stated, "I may have set on 6/13/18 at 8:45 a.m. not able to locate any resident's fractured rit investigation should have stated, yes. Review of the facility's Abuse" documented in "POLICY: VIII. Invest Investigation will be a manner: 1. a. Immediated incident to the individual shall be segregated from basis for and credibility ascertained, and the Anotified. 2. Investigation and/or director of Nursestatements from the vipossible witnesses into in the vicinity of the all also secure all physical of the investigation, a prepared. 4. Discipline Facility will refer any or resident abuse to the No further information MD/ID Significant Characteristics.	curred prior to his arrival in #2, the director of nursing een something, I'll look for it. m., ASM #2 stated she was investigation regarding the bes. When asked if an have been done, ASM #2 s policy titled, "Resident in part the following, igation of Abuse. B. ccomplished in the following ately upon report of an ual in charge, the suspect(s) for the allegation shall be abuse Coordinator shall be for. The Abuse Coordinator sing shall take written ictim, the suspect(s) and all cluding all other employees deged abuse. He/she shall all evident. Upon completion detailed report shall be ee: The Abuse Coordinator of or all incidents and reports of appropriate state agencies."	F 646	Preparation, submission and implement this plan of correction does not constitute admission of or agreement with the factoric conclusions set forth on the survey reproduced plan of corrections prepared and coas a means to continuously improve quarter that the factoric prepared and coas a means to continuously improve quarter that the factoric prepared and coas a means to continuously improve quarter that the factoric prepared and coas a means to continuously improve quarter that the factoric prepared and coas a means to continuously improve quarter that the factoric prepared and coas a means to continuously improve quarter that the factoric prepared and coas a means to continuously improve quarter that the factoric prepared and coas a means to continuously improve quarter that the factoric prepared and coas a means to continuously improve quarter that the factoric prepared and coas a means to continuously improve quarter that the factoric prepared and coas a means to continuously improve quarter that the factoric prepared and coas a means to continuously improve quarter that the factoric prepared and coas a means to continuously improve quarter that the factoric prepared and coas a means to continuously improve quarter that the factoric prepared and coas a means to continuously improve quarter that the factoric prepared and coas a means to continuously improve quarter that the factoric prepared and coas a means to continuously improve quarter that the factoric prepared and coas a means to continuously improve quarter that the factoric prepared and coas a means to continuously improve quarter that the factoric prepared and coas a means to continuously improve quarter that the factoric prepared and coas a means to continuously improve quarter that the factoric prepared and coas a means to continuously improve quarter that the factoric prepared and coas a means to continuously improve quarter that the factoric prepared and coas a means the factoric prepared and coas a means the factoric prepared and coas a means t	ite an its and ort. kecuted
SS=D		ing facility must notify the other interests or state intellectual		care and to comply with applicable stat federal regulations.	11.50

disability authority, as applicable, promptly after a significant change in the mental or physical

	MENT OF HEALTH AN				PRINTED: 06/26/2018 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495140	B. WING		C 06/14/2018
	ROVIDER OR SUPPLIER		11	REET ADDRESS, CITY, STATE, ZIP CODE 0 CHALMERS COURT ERRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 646	intellectual disability for This REQUIREMENT by: Based on staff intervificatility document reviet a complaint investigate the facility staff failed change in condition of residents in the survey. The facility staff failed Resident #3 refused of multiple occasions during the findings include: Resident #3 was adm and readmitted on 6/4 included but were not	t who has mental illness or or resident review. is not met as evidenced ew, clinical record review, ew, and during the course of ion, it was determined that to notify the physician of a f the resident for one of 12 y sample, Resident#3. to notify the physician or ordered medications on ring December 2017.	F 646	1. Resident #3 comprehensive care play updated on 6/4/2018 reflects that residerefuses medications as ordered. After 2 consecutive doses of vital medication a withheld or refused, the physician or Nobe notified per pharmacy policy and primanual. 2. Residents that reside in the facility of frequently refuse medications or have medication held due to not being inside parameters have the potential to be affective this deficient practice. 3. Nursing staff to be reeducated when notify physician/NP when resident refunctions utilizing pharmacy policy procedure manual. DON/designee will documented refusals on Medication administration record 3 days per week weeks.	ent often Pare P will rocedure that vital e ected by to uses vital and I audit

failure, high blood pressure, depression and arthritis.

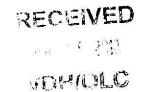
The most recent MDS, (minimum data set), a five day assessment, with an ARD (assessment reference date) of 6/4/18 coded the resident as having scored a 14 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was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

- 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

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CENTER	S FOR MEDICARE & I	MEDICAID SERVICES	#		OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A BUILDING	DNSTRUCTION	(X3) DATE SURVEY COMPLETED
		495140	B WING		C 06/14/2018
NAME OF PR	ROVIDER OR SUPPLIER	40 - 10	STRI	EET ADDRESS, CITY STATE, ZIP CODE	
ROSE HILI	L HEALTH AND REHAB		i	CHALMERS COURT RRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 646	treatments at times	6/4/18. Interventions. Ins as ordered." There was garding notifying the ent refused the medication. Iber 2017 physician's orders ex (1) Nebulization Solution ia nebulizer four times a day Iber 2017 (MAR) medication documented, "Xopenex 2 dose inhale orally via a day for cough/dyspnea." It is the resident refused the on at least 17 occasions. IMAR did not evidence the physician or nurse fied that the resident was ts. Iducted on 6/13/18 at 1:35 instrative staff member) #4, When asked if staff notified refused medications at the resident was the refuses her times." When asked when notified if a resident was ASM #4 stated, "If they're is in a row I like them to let	F 646		

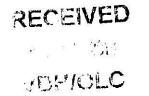


the morphine."

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

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		NO HOWAIN SERVICES			FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES	4 p.		OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE I	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495140	B. WING		C 06/14/2018
NAME OF P	ROVIDER OR SUPPLIER	100 100 100 100 100 100 100 100 100 100	I st	REET ADDRESS, CITY, STATE, ZIP CODE	00/14/2016
11, 11, 12, 13, 13, 13, 13, 13, 13, 13, 13, 13, 13			ANALYS STATES	CHALMERS COURT	
ROSE HIL	L HEALTH AND REHAB			ERRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 646	Continued From page	0.31	F 646		
F 040	of 1500		F 646		
		urse) #3, a nurse who had			
	staff followed when a	5. When asked the process			
		stated, "Well, if they're			
		st three attempts (to get			
		When asked what staff did if			
		d to refuse the medications,			
		uld document the refusal and			
		se practitioner and doctor			
		ow as well." When asked why			
		ed, LPN #3 stated, "If they			
	again to see if he wa	e days I'll talk to the doctor			
	(T)	asked if staff documented			
	5	is notified, LPN #3 stated,			
	9.17	3 was asked to review the			
		ses' notes for Resident #3.			
	When asked if there	was documentation that the			
	physician had been r	notified, LPN #3 stated, "No			
	ma'am. There's no no	ote."			
	421	.m. ASM #1, the executive			
	Pro-company and the second sec	e director of nursing and ASM			
	37 347	ctor of clinical services were			
	made aware of the fir	ndings.			
	Review of the facility	's document for physician			
	notification was the s	tate regulation for			
	notification, which do				
		ges. (i) A facility must			
	1.5 m	ne resident; consult with the			
		and if known, notify the			
		sentative or an interested			
	family when there is				
		y (i.e., a need to discontinue eatment due to adverse			
	-	commence a new form of			
	CONSEQUENCES, OF IO	COMMISSION A HEW WITH DE			



treatment); or..."

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES	<u> </u>		OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495140	B. WING		C 06/14/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS. CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611	1 33/1-12010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRECIENCY)	D BE COMPLETION
F 646	In Basic Nursing, Ess edition (Potter and Pewas a reference sour notification. Failure to condition appropriatel information to the phy provider are causes oway to avoid being lia follow standards of care, and to communi providers. The physic	ential for Practice, 6th erry, 2007, pages 56-59), be for physician's orders and ormonitor the patient's y and communicate that	F 64	6	
F 656 SS=E	or prevention of brond adolescents, and child older with reversible of This information was https://dailymed.nlm.rm?setid=1700a5b8-4410 Develop/Implement CCFR(s): 483.21(b)(1) §483.21(b) Comprehe §483.21(b)(1) The faci implement a comprehe care plan for each resersident rights set fort §483.10(c)(3), that indobjectives and timeframedical, nursing, and	indicated for the treatment shospasm in adults, dren 6 years of age and obstructive airway disease. obtained from: iih.gov/dailymed/drugInfo.cf 029-424a-bfed-15f6737dd2 comprehensive Care Plan ensive Care Plans iility must develop and ensive person-centered ident, consistent with the h at §483.10(c)(2) and	f 65	Preparation, submission and implement this plan of correction does not constadmission of or agreement with the factorial conclusions set forth on the survey reconclusions set forth on the survey reconclusions prepared and as a means to continuously improve a care and to comply with applicable safederal regulations.	itute an facts and eport. executed quality of

assessment. The comprehensive care plan must

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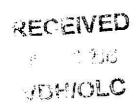
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
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		495140	B. WING			100	C 14/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET	TADDRESS, CITY, STATE, ZIP CODE	Transfer of the	
				110 CH	ALMERS COURT		
ROSE HIL	L HEALTH AND REHAB			BERR	YVILLE, VA 22611		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(XS) COMPLETION DATE
F 656	or maintain the reside physical, mental, and required under §483. (ii) Any services that under §483.24, §483 provided due to the runder §483.10, include treatment under §483. (iii) Any specialized sere abilitative services provide as a result of recommendations. If findings of the PASAI rationale in the reside (iv) In consultation with resident's representa (A) The resident's good desired outcomes. (B) The resident's prefuture discharge. Fact whether the resident' community was assellocal contact agencie entities, for this purpor (C) Discharge plans in plan, as appropriate, requirements set fort section. This REQUIREMENT by: Based on observation document review and was determined the factor of the property of the comprehensive of the section.	are to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required .25 or §483.40 but are not esident's exercise of rights ding the right to refuse 8.10(c)(6). ervices or specialized is the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. In the resident and the tive(s)-als for admission and efference and potential for edities must document is desire to return to the seed and any referrals to s and/or other appropriate	F	#8. ref of 2. por pra 3. up- car als res DC to 5 t ear and pla 4. mc Pe for Re 5.	Comprehensive care plan for rest, #9, and #10 updated on 6/15/20 lecting call light positioning and location in proximity to resident Residents that reside in the facilitential to be affected by this definition. Nursing staff will be re-educate dating and implementing the corresplans by DON/designee. C.N. to be re-educated on the location sident plan of care on the kiosk beneficially and the comprehensive imes per week for 4 weeks dependent of the comprehensions. Results of audits will be review onthly/ quarterly Quality Assurant formance Improvement (QAPI) in trend analysis and findings. Ecommendations implemented as Corrective action will be complete/2018.	I assurance I assu	

9 and 10.

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611	
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F 656	comprehensive care painting that it is within reach for Residual 1.b. The facility staff of comprehensive care part orders to administer of 2. The facility staff fair comprehensive care painting reach for Residual 3. The facility staff fair	failed to implement the plan to keep the care light dent #3. failed to implement the plan and the physician's exygen at eight liters/minute. Ided to implement the plan to keep the care light litert #8. Ided to implement the plan to keep the care light litert #8.	F 656		
	The findings include: 1. a. The facility staff comprehensive care particular within reach for Resident	plan to keep the care light dent #10. failed to implement the plan to keep the care light lent #3.			
	and readmitted on 6/4 included but were not difficulty swallowing, I failure, high blood prearthritis. The most recent MDS day assessment, with	itted to the facility on 1/8/15 I/18 with diagnoses that Ilimited to: diabetes, heart failure, respiratory essure, depression and Ilimited to: diabetes, heart failure, respiratory essure, depression and Ilimited to: diabetes, heart failure, respiratory essure, depression and Ilimited to: diabetes, heart failure, respiratory essure, depression and Ilimited to: diabetes, heart failure, respiratory			

interview for mental status) indicating the resident was cognitively intact to make daily decisions.



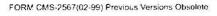
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NAME (SE D	ROVIDER OR SUPPLIER	495140	D. WING _	STREET ADDRESS SIDVESTATE TIP CORE	06/14/2018
IVAIVIL OF F	NOVIDER ON SUFFEIER			STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT	
ROSE HIL	L HEALTH AND REHAB			BERRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR	SHOULD BE COMPLETION
F 656	The resident was coo from staff for all activ	e 35 led as requiring assistance ities of daily living except for dent could perform after the	F 6	656	
	a.m., of Resident #3.	nade on 6/12/18 at 11:25 The resident was lying in . The call bell was lying on			
	a.m., of Resident #3.	nade on 6/13/18 at 10:25 The resident was lying in rith eyes closed. The call bell			
	initiated on 3/3/17 do physical functioning of	nt's comprehensive care plan cumented, "Focus. I have a deficit related to: Mobility impairment. Interventions.			
	p.m. with LPN (licens When asked why res #2 stated, to know the	ed if care plans were to be			
	p.m. with RN (registe nurse. When asked w plans, RN #3 stated, resident needed. Who	ducted on 6/13/18 at 4:27 red nurse) #3, the resident's /hy residents have care so staff knew what a en asked if the care plan :N #3 stated they should be.			
	THE PROPERTY AND ADDRESS OF THE PARTY AND ADDR	m. ASM (administrative staff			

director of nursing and ASM #3, the regional director of clinical services were made aware of

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
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	ROVIDER OR SUPPLIER		1	TREET ADDRESS CITY, STATE, ZIP CODE 10 CHALMERS COURT ERRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 656	Continued From page the findings.	e 36	F 656		
	No further information	n was provided prior to exit.			
	Williams and Wilkins documented, "A writte communication tool a members that helps e careThe nursing ca information about the and goals. It contains achieving the goals e and is used to direct e revise and update the there are changes in with new orders" (1) Fundamentals of	en care plan serves as a mong health care team ensure continuity of re plan is a vital source of patient's problems, needs, is detailed instructions for stablished for the patient careexpect to review, is care plan regularly, when condition, treatments, and			
	(Potter and Perry, 20 reference for care plata written guideline for promoting continuity criteria to be used in care. The written carnursing care priorities professionals. The coordinates resource care. A correctly formeasy to continue care If the patient's status nursing diagnosis and	atials for Practice, 6th edition. 107, pages 119-127), was a suns. "A nursing care plan is recoordinating nursing care, of care and listing outcome the evaluation of nursing e plan communicates at to other health care are plan also identifies and sused to deliver nursing nulated care plan makes it from one nurse to another. has changed and the direlated interventions are expended.			

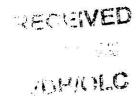


compromises the quality of nursing care."



Facility ID: VA0210

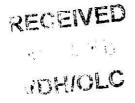
If continuation sheet Page 37 of 63



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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ROSE HIL	L HEALTH AND REHAB			20000	0 CHALMERS COURT ERRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ΊX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 656	Continued From page	e 37	F	656	1. Comprehensive care plan for resupdated 6/14/2018 reflecting order to	О
	1.b. The facility staff f			administer oxygen continuously at o	right	
	and the second s	plan and the physician's			liters/minute.	
	orders to administer oxygen at eight liters/minute.				2. Residents residing in the facility	~ .~ .
	An observation was n			have potential to be affected by this		
		The resident was lying in			3. Nursing staff will be re-educated	
		. The resident had a nasal			updating and implementing the com	prehensive
		prongs that deliver oxygen in			care plans by DON/designee. MDS	7 S
	the nose) on and the			coordinator/designee to audit compl		
	per minute via oxyger	n concentrator.			comprehensive care plans 5 times po	20022 2004 40
		- T			for 4 weeks depending on care plan	SUA COURT SERVICE SEQUENTIAL SECURITION OF
		nade on 6/13/18 at 10:25			to ensure facility develops and follo	
		The resident was lying in . The resident had a nasal			complete comprehensive care plans.	THE SECOND STORY
	A CONTRACTOR OF THE PROPERTY O	xygen was set at five and			4. Results of audits will be reviewe	d during
	one-half liters via oxy	The state of the s			monthly/quarterly Quality Assurance	e
	Annual Communication and A				Performance Improvement (QAPI)	Committee
	An observation was n	nade on 6/13/18 at 12:30			for trend analysis and review.	
		The resident was sitting up			Recommendations implemented as	ndicated.
	Y SERVICE TO THE PROPERTY OF T	ind talkative. The resident			5. Corrective action will be comple	ted by
	at six liters via oxyger	а оп and the oxygen was set n concentrator.			7/14/2018.	
	of Resident #3. The re	xygen was set at six liters				
	of Resident #3's oxyg nurse) #3, the resider the oxygen rate was s now it's on six liters."	nade on 6/13/18 at 4:27 p.m. gen with RN (registered ht's nurse. When asked what set at, RN #3 stated, "Right When asked what rate the				
		RN #3 stated, it should be I #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



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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
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		495140	B. WING		06/14/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E
ROSE HIL	L HEALTH AND REHAB			110 CHALMERS COURT	
SS SS WARRAN MAC			27300	BERRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		N SHOULD BE COMPLETION
F 656	Continued From page	e 38	F	656	
	follow a physician's of follow the order, we have residents had care pl the plan of care for the	rder, RN #3 stated, "We have to." When asked why ans, RN #3 stated, to know be residents. When asked if the followed, RN #3 stated it			
	Review of the care plan initiated on 6/4/18 documented, "Focus. Alteration in Respir Status Due to Chronic Obstructive Pulmo Disease. Interventions. Administer oxygeneeded per Physician order. Monitor oxygrate and response."	Alteration in Respiratory c Obstructive Pulmonary s. Administer oxygen as			
	documented, "O2 via	018 physician's orders NC (nasal cannula soft nose to deliver oxygen) @ ite) continuous.			
	via NC @ 8LPM cont	018 medication (MAR) documented, "O2 inuous." It was documented administered each day.			
	p.m. with LPN (ficens When asked why res #2 stated, to know the	ed if care plans were to be			
	member) #1, the exedirector of nursing an	m. ASM (administrative staff cutive director, ASM #2, the d ASM #3, the regional vices were made aware of			
	2. The facility staff fai	led to implement the			

comprehensive care plan to keep the care light

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1). PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED
39		495140	B. WING		C 06/14/2018
	ROVIDER OR SUPPLIER L HEALTH AND REHAB		11	TREET ADDRESS, CITY, STATE, ZIP CODE 10 CHALMERS COURT ERRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERICIENCY)	D BE COMPLETION
F 656	Continued From page within reach for Resident #8 was adm	ent #8.	F 656		
	limited to: irregular he depression, lung disea				
	with an ARD of 4/27/1 requiring assistance for daily living. The resident	i, a 30 day assessment, 8 coded the resident as rom staff for all activities of ent was coded as having rm memory problems and aired cognitively.			
	a.m. of Resident #8. T	nade on 6/12/18 at 11:15 The resident was lying in behind the head of the bed			
	of Resident #8. The re a washcloth on her for was tucked under the	nade on 6/12/18 at 6:10 p.m. esident was lying in bed with rehead. The call bell cord upper part of the pillow and ling over the head of the			
	Resident #8. The resident wheelchair on the right	nade on 6/13/18 at 10:17 of dent was sitting up in a it side of the bed. The call in the left side of the bed.			
	New environment, me Interventions. Call ligh	At risk for falls related to ds (medications).			

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

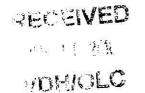
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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS REFERENCED TO THE API DEFICIENCY)	HOULD BE COMPLETION
F 656	When asked why res #2 stated, to know the residents. When asked followed, LPN #2 stated. On 6/13/18 at 5:10 p. member) #1, the exedirector of nursing and director of clinical sent the findings. 3. The facility staff fair comprehensive care within reach for Resident #9 was adm 10/7/17 with diagnose limited to: irregular he enlarged prostate and The most recent MDS with an ARD of 4/16/1 having scored a three indicting the resident cognitively. The resident cognitively. The resident cognitively. The resident for eating which the resident that the tray was prepared. An observation was rea.m. of Resident #9. bed with his back to the was clipped to the cut.	idents have care plans, LPN e plan of care for the ed if care plans were to be ded they were. m. ASM (administrative staff cutive director, ASM #2, the d ASM #3, the regional vices were made aware of led to implement the plan to keep the care light dent #9. hitted to the facility on es that included but were not eart beat, dementia, d communication deficit. 6, a quarterly assessment, 18 coded the resident, as e out of 15 on the BIMS was severely impaired ent was coded as requiring vities of daily living except esident could perform after d. made on 6/13/18 at 10:18 The resident was lying in the door. The call bell cord shion of a chair feet from the bed. The call	F 656		
	8 8	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

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CENTER	RS FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	}	495140	B. WING		C 06/14/2018
	ROVIDER OR SUPPLIER L HEALTH AND REHAB		111	REET ADDRESS, CITY, STATE, ZIP CODE D CHALMERS COURT ERRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 656	Continued From page observed at 10:18 a.r		F 656		
	with CNA #3, the resi where the call bell wa	nade on 6/13/8 at 12:44 p.m. dent's aide. When asked is, CNA #3 picked the call nd clipped it to the resident's			
	documented, "Focus. History of falls, unstea	an initiated on 11/8/17 At risk for falls related to: adiness. Interventions. Call s available in easy reach or			
	p.m. with LPN (licens When asked why resi #2 stated, to know the	ed if care plans were to be			
	member) #1, the exec director of nursing an	m. ASM (administrative staff cutive director, ASM #2, the d ASM #3, the regional vices were made aware of			
	No further information	was provided prior to exit.			
	4. The facility staff fai comprehensive care within reach for Resid	olan to keep the care light			
	5/31/13 with diagnose limited to: dementia, o	mitted to the facility on es that included but were not diabetes, stroke with igh blood pressure and			



heart failure.

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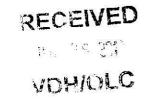
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KUSE NIL	L HEALTH AND REHAE			BERR	YVILLE, VA 22611		
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F 656	Continued From pag	ne 42	F	656			
	100 CT	S, a quarterly assessment,					
		/18 coded the resident as					
		d short-term memory					
	problems and was m						
		dent was coded as requiring f for all activities of daily					
	living.	nor all activities of daily					
	3						
		made on 6/13/18 at 8:15 a.m.					
		e resident was lying in bed					
		nis head. The call bell was nind the beside table out of					
	reach of the resident						
	No. 1970 - No. 1970 - No. 1970 - No. 1970	made on 6/13/18 at 10:20					
). The resident was lying in					
		ver his head. The call bell ir behind the beside table out					
	of reach of the reside						
		made on 6/13/18 at 12:15					
	p.m. of Resident #10 lunch.). The resident was being fed					
		made on 6/13/18 at 12:40					
	[4] ROSES CHUPAN THIRDAN "MANAGEMENT DISTRACTOR THE THIRD "A 1910 MAT".) with LPN #4, the resident's					
		where the resident's care bell the call bell up off the floor					
	and clipped it to the	Contract terms on III					
	and onppod it to the	icolasino boa.					
		lan initiated on 12/26/14					
		. At risk for falls related to					
		related to hx (history) of CVA					
	([cerebral vascular a	s) and dementia with					
		vareness. Interventions. Call					

bedside."

light and water available and in easy reach at

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CENTER	3 TON WEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495140	B WING		C 06/14/2018
	ROVIDER OR SUPPLIER L HEALTH AND REHAB		110	REET ADDRESS, CITY, STATE, ZIP CODE CHALMERS COURT RRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 656	p.m. with LPN (licens When asked why resi #2 stated, to know the	ducted on 6/13/18 at 2:25 ed practical nurse) #2. dents have care plans, LPN e plan of care for the ed if care plans were to be	F 656		
	member) #1, the executive director of nursing an	m. ASM (administrative staff cutive director, ASM #2, the d ASM #3, the regional vices were made aware of			
F 678 SS=G	No further information Cardio-Pulmonary Re CFR(s): 483.24(a)(3)	was provided prior to exit. suscitation (CPR)	F 678		
	such emergency care emergency medical prelated physician order advance directives. This REQUIREMENT by: Based on staff intervireview, clinical record investigation, the facil CPR (cardiopulmonar resident who was a further than the cardiopulmonar resident was a further than the cardi	R, to a resident requiring prior to the arrival of ersonnel and subject to ers and the resident's is not met as evidenced ew, facility document review and complaint ity staff failed to provide		Past noncompliance: no plan of correction required.	
	(cardiopulmonary resi				



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		ND HOWAN SERVICES			FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	15 %	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495140	B. WING		C
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	06/14/2018
				110 CHALMERS COURT	
ROSE HIL	L HEALTH AND REHAB			BERRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 678	Continued From page	9 44	F 678		3.000
	The findings include:				
	limited to: heart failure	es that included but were not			
	quarterly assessment reference date of 3/8/ having 15 out of 15 or mental status indication cognitively intact to make the companion of the co	18 coded the resident as n the brief interview for ng the resident was ake daily decisions. The			
	12/30/14 documented Full code (administer	Interventions CPR will be			
	resuscitate)/CPR Stat 10/20/15 evidenced d	ocumentation that the PR to be initiated in the case			
		de. Order Date: ord documented no advance n order prohibiting basic life			
	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

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0	
STATEMENT OF DEFICIENCIES (X1) PROVI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTAL BUILDI		STRUCTION	(X3) DATE SURVEY COMPLETED	5001
		495140	B. WING			C 06/14/2018	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		STREE	T ADDRESS, CITY, STATE, ZIP CODE	1 00/14/2010	-
ROSE HIL	L HEALTH AND REHAB		9		ALMERS COURT YVILLE, VA 22611		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROFICIENCY)	ULD BE COMPLET	HON
F 678	Continued From page	e 4 5	F	678			
	Emergency Medical	Services (EMS) was called.					
	director. ASM #1 bro which included the pl "The nurse called the who was home sick. family: she did not te suspended because procedure. I let the D	requested from ASM member) #1, the executive ught in the investigation, an of correction and stated, e DON (director of nursing) The DON said to call the Il them to do CPR. Both were they didn't follow policy and DON go but let the nurse she was following what the					
	events, surrounding I 5/30/18 was reviewed indicated RN (registed initiate and perform C 5/30/18. Their investigations	y's investigation of the Resident #1's death on d. The investigation ered nurse) #1 failed to CPR for Resident #1 on tigation included in part, the tion of events documented					
	assistant) #1 that the with Resident #1; RN #1 entered the roacross the bed with extremities, blue nail to auscultate heart or initiate CRP (sic) and RN #1 notified LPN (the supervisor and the	0 a.m. on 5/30/18: by CNA (certified nursing ere was something wrong com found resident lying eyes fixed with cold beds and RN #1 was unable or breath sounds; did not diresident was full code; licensed practical nurse) #1,					

protocol:

LPN #1 left room to verify code status;

LPN #1 called director of nursing (DON) to verify

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES					NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A. BUILDII		ISTRUCTION	(X3) I	DATE SURVEY COMPLETED
		495140	B. WING _				C 06/14/2018
	RÖVIDER OR SUPPLIER L HEALTH AND REHAB		20	110 Cł	ET ADDRESS, CITY, STATE, ZIP CODE HALMERS COURT RYVILLE, VA 22611		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	Χ	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 678	stated that he (Reside unresponsive and coorsigns this morning; DON stated to call far An interview statement (certified nursing assipp.m. CNA #1, stated to The lab (laboratory) swrong with him (Resident #1) was dehis mouth and couldned to get the vital sign mouth and said (rhave passed away and stated, "I was running sign machine and the me. I asked the nurse resuscitate) or a full response." CNA #1 stated he did to straighten the reside "Yes." An interview was contained and the was contained and the reside "Yes."	I #1) informed her at t #1) had expired. She also ent #1) was found of to the touch without vital mily and pronounce death. Int was obtain from CNA stant) #1 on 6/12/18 at 2:25 that around 5:40 to 5:50 a.m. taff said something was dent #1). I went over and a something was wrong he ad cold. I put my hand over "t feel any breath and I ran achine (automatic machine pressure, pulse, gen saturation). When I ran the enurse (RN [registered tham of Resident #1) might and she said 'What?' CNA #1 down the hall with the vital nurse, she was right behind of the was a DNR (do not	F €	578			
		sne had seen the resident 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,

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-039
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495140	B. WING		C 06/14/2018
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>	1	STREET ADDRESS, CITY, STATE, ZIP CO	
ROSE HIL	L HEALTH AND REHAB			110 CHALMERS COURT BERRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE COMPLETION HE APPROPRIATE DATE
F 678			F	678	
	machine and I could	ulled, he had a CPAP hear it running but when we			
		ng the CPAP was on the asked if she had put the			
		t, RN #1 stated the resident y. When asked if she had			
		ident, RN #1 stated she had			
		at occurred next, RN #1			
		my med (medication) pass. so the lab lady was there			
) was going to have blood			
		n (CNA #1) came running up			
		ere's something wrong with			
		en the lab lady said there g with (Resident #1)." When			
	to any and the second of the s	next, RN #1 stated she went			
		om and determined the			
		ead and had been "dead for			
		1 stated she ran to get her irned to the room. She was			
	The state of the s	t or lung sounds and instead			
	Make a state attraction and season at the season attraction are a season and a	called the supervisor. When			
	asked if she knew ho				
		s, RN #1 stated she could			
		en asked why she did not #1 didn't have an answer.			
	REPORT OF AN EXPERIENCE PROGRAMMENT OF STREET AND AN EXPENSE OF AN EXPENSE AND AN EXPENSE OF AN EXPENSE OF AN	a mistake. I didn't know the			
		d if she had been educated			
	on the CPR policy at	the time of the incident, RN			
	manual "Manual annual and an "Manual and Malanda Salahar Salahar	n asked if a nurse needed a			
	policy to initiate CPR no.	on a full code RN #1 stated			
	An interview was con	ducted 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

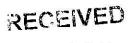
PRINTED: 06/26/2018 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495140	B. WING		C 06/14/2018
	ROVIDER OR SUPPLIER		110	REET ADDRESS, CITY STATE, ZIP CODE CHALMERS COURT RRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLETION
F 678	CNA#1) had the vital he didn't have any BI LPN #1 stated she che determined the reside stated we weren't sur was cold and blue so nursing for guidance normally occur if a re #1 stated, "Normally a code (that a reside #1) would have initial grabbed the crash care	e 48 sign machine in there and color (blood pressure), pulse, necked the code status and ent was a full code. LPN #1 re what to do if the resident of she called the director of When asked what would sident was found dead, LPN somebody would have called int needed CPR), she (RN ted CPR. I would have art and then it would have king back on it, it was poor	F 678		
	a.m. documented, "Ulying horizontally acrebreath sounds. Could or breath sounds. P (a.m.) NP (nurse pracemergency contacts Review of the nurses failed to reveal any diresident was cold or A telephone interview at 11:30 a.m. with Rhursing (DON) on 5/3 occurred the morning got the phone call are was home very sick.	s notes dated 5/30/18 at 5:50 depon entering room, resident coss bed without pulse or d not auscultate heart sounds fronounced at 0550 am ctitioner) on call notified and called and messages left." or notes and clinical record ocumented evidence that the blue. w was conducted on 6/14/18 N #2, the facility director of 8/18. When asked what g of 5/30/18, RN #2 stated, "I bound 5:40 that morning. I (LPN #1) told me that assed. That his arms were			
	asked me what time	n gone for some time. She she would use for time of neck the heart sounds and			

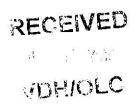
asked if there was an RN in the building. She said yes (RN #1) was here. I told her to call the family.

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	VIEW OF THE METHY				CURNIA PROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
		495140	B. WING		C 06/14/2018
NAME OF PR	ROVIDER OR SUPPLIER	And Andrews	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
			110 0	CHALMERS COURT	3
ROSE HIL	L HEALTH AND REHAB		BER	RYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 678	recall telling them to would be what would stated that staff would EMS (emergency me The nurse practitions facility on 5/30/18, for was not available for Review of the facility "Cardiopulmonary Redocumented, "POLIC Resuscitation (CPR) ventilation and circul arrives and the resid support systems; he on his/her own; and/1. Cardiopulmonary residents except those appropriate document resuscitation is performed in CPR. 3. A certified in CPR and needed."	g about code status. I don't call 911." When asked if that if normally occur, RN #2 d do CPR until relieved by edical services). er, who was covering the er another nurse practitioner, interview during the survey. 's policy titled, esuscitation (CPR)"	F 678		
	1. Statements obtain completed. (Completed. Audit of current in (Completed 5/30/18)	g interventions. ed and investigation ted 5/30/18) -house resident code status.			



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4. Reeducation (sic) for current staff of policy and

certification.

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DESCRIPTION OF THE PROPERTY OF		AD HOWAIN SERVICES			FORM APPROVED
CENTERS FOR	MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFIC AND PLAN OF CORRE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED
		495140	B. WING	<u>5</u>	C 06/14/2018
NAME OF PROVIDER	OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	Total Banket Carlotte
ROSE HILL HEAL	TH AND REHAB		STATE OF THE STATE	HALMERS COURT RYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
proce 5. AD admir [assis 5/30/* action 6. Aud during assur meeti On 6/ to the code reque On 6/ receiv reside Revie had re Revie docur It was attend had b the pl #2 sta morni and a recall An inf p.m. v do if t	HOC (when neastrator, medicatant director of 8 for review ar for incident. (Codits of any codes the monthly a cance and performs. 12/18 at approximate facility a list of and expires sted from ASM 12/18 at 11:10 red. The list documented to the inservice of the facility and commented to the inservice of the facility and I educated of an of correction at ed. "I know, I and I educated of the inservice of the facility and I educated of the inservice of the inservice of the facility and I educated of the inservice of the facility and I educated of the inservice of the facility and I educated of the inservice of the facility and I educated of the inservice of the facility and I educated of the inservice of the facility and I educated of the inservice of the facility and I educated of the inservice of the facility and I educated of the inservice of the facility and I educated of the inservice of the facility and I educated of the inservice of the facility and I educated of the inservice of the facility and I educated of the facility and I educat	de blue process. cessary) meeting with al director and adon nursing] (sic) held on d discussion of corrective completed 5/30/18) blues to be evaluated and quarterly QAPI (quality rmance improvement) dimately 10:45 a.m., entrance all residents who were a full d in the facility was #1, the executive director. a.m., a list of residents was cumented two additional ull codes and had expired. s documented the residents	F 678		

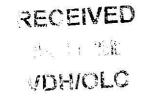
FORM CMS-2567(02-99) Previous Versions Obsolete

immediately start CPR." When asked what staff did if the resident felt cold and was blue, LPN #2

Event ID: 1BPH11

Facility ID: VA0210

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	25927 15921	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495140	B. WING	25144294	C 06/14/2018
NAME OF PF	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	
ROSE HILI	L HEALTH AND REHAB			110 CHALMERS COURT BERRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE COMPLETION
F 678	Continued From page	e 51	F	678	
	stated, "Exactly the s start CPR."	ame thing. We immediately			
	a.m. with LPN #3. Who if they found without respirations, LPN #3 you're at the cart (me into their record it say DNR." When asked was found to be cold "Start a code blue." I code. Someone starts	stated, "Look at the chart. If edication cart) you can go ys if they're a full code or what staff did if the resident and blue, LPN #3 stated, LPN #3 stated, "They're a full s it (CPR) and we continue IT (emergency medical			
	No further information	n was provided prior to exit.			
	COMPLAINT DEFICI	ENCY			
	edition, 2005; Patricia Perry; Mosby, Inc; Paresuscitation. Cardia an absence of pulse a determines that a clie cardiopulmonary resu initiated. CPR is a ba artificial respiration at massage The purpo oxygenated blood to permanent tissue dar		F	695	
	•	ry care, including nd tracheal suctioning. ure that a resident who			

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CEMIEKOL	OR MEDICARE O	VIVIEDICAID SERVICES	-22	21 24/24	OMB NO. 0938-0391
STATEMENT OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495140	B. WING _		C 06/14/2018
NAME OF PROV	/IDER OR SUPPLIER		ľ	STREET ADDRESS, CITY, STATE, ZIP CODE	N 50E
ROSE HILL H	IEALTH AND REHAI	В		110 CHALMERS COURT BERRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOW CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
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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.

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CENTERS FOR MEDICARE & MEDICAID SERVI		MEDICAID SERVICES			OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE A BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495140	B WING		C 06/14/2018
NAME OF PI	ROVIDER OR SUPPLIER		30-30	TREET ADDRESS, CITY, STATE, ZIP CODE	
ROSE HIL	L HEALTH AND REHAB		98022	ERRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COMPLETION
F 695	a.m. of Resident #3. bed with eyes closed cannula (soft plastic puthe nose) on and the per minute via oxyger. An observation was ma.m. of Resident #3. bed with eyes closed cannula on and the orone-half liters via oxyger. An observation was mp.m. of Resident #3. in bed, awake, alert a had the nasal cannula at six liters via oxyger. An observation was mof Resident #3. The mof Residen	nade on 6/12/18 at 11:25 The resident was lying in The resident had a nasal prongs that deliver oxygen in oxygen was set at six liters in concentrator. nade on 6/13/18 at 10:25 The resident was lying in The resident was lying in The resident had a nasal axygen was set at five and gen concentrator. nade on 6/13/18 at 12:30 The resident was sitting up and talkative. The resident as on and the oxygen was set in concentrator. nade on 6/13/18 at 2:35 p.m. esident was interviewed at a concentrator. nade on 6/13/18 at 2:35 p.m. esident was interviewed at the had the nasal cannula on set at six liters via oxygen an initiated on 6/4/18 Alteration in Respiratory of Obstructive Pulmonary is. Administer oxygen as in order. Monitor oxygen flow 018 physician's orders NC (nasal cannula soft nose to deliver oxygen) @	F 695		

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

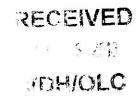
Review of the June 2018 medication

administration record (MAR) documented, "O2

Event ID: 1BPH11

Facility ID: VA0210

If continuation sheet Page 54 of 63



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PRINTED: 06/26/2018

		ID HUMAN SERVICES			FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES	100		OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495140	B WING		C 06/14/2018
NAME OF P	ROVIDER OR SUPPLIER	00 D T 10 D	22.00	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/14/2010
D005.1111	LUCALTH AND DELIAD			110 CHALMERS COURT	
ROSE HIL	L HEALTH AND REHAB			BERRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE COMPLETION
F 695	Continued From page via NC @ 8LPM cont	e 54 inuous." It was documented	F	695	
	that the oxygen was	administered each day.			
	p.m. with RN #3. Whethe resident, RN #3 sthe first time." When Resident #3 that day, her Tylenol." When a #3's physician ordere written here but I beliasked how she would rate, RN #3 stated, "Lasked to look at the oto have it on eight lite it yet."	en asked when staff assess stated, "Whenever we go in asked if she had seen, RN #3 stated, "Yes. I gave sked oxygen rate Resident ed, RN #3 stated, "It isn't eve its two liters?" When it know the resident's oxygen Look at the order." When order, RN #3 stated, "She's ers continuous. I didn't look at			
	of Resident #3's oxyg nurse) #3, the resider the rate the oxygen w "Right now it's on six oxygen to eight liters the physician's orders #3 stated, "No" Wher	made on 6/13/18 at 4:27 p.m. gen with RN (registered int's nurse. When asked what was set at, RN #3 stated, liters." RN #3 adjusted the at that time. When asked if s were being followed, RN in asked when staff would not inder, RN #3 stated, "We have to."			
	member) #1, the executive director of nursing an	m. ASM (administrative staff cutive director, ASM #2, the id ASM #3, the regional vices were made aware of			
	a.m. with LPN #3. Wh	ducted on 6/14/18 at 10:05 nen asked when were LPN #3 stated, "I normally			

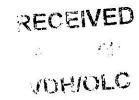


assess my resident's right after report." When asked what process staff follow to assess a

Event ID, 18PH11

Facility ID VA0210

If continuation sheet Page 55 of 63



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	O COD MEDICADE A				FURM APPROVEL
CENTER	RS FOR MEDICARE &	MEDICAID SERVICES	1 1 10000	V - V W	OMB NO. 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		105110	B MINO		С
		495140	B WING		06/14/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE.	
ROSE HII	L HEALTH AND REHAB			110 CHALMERS COURT	
NOOL IND	e nenennamo ((=)			BERRYVILLE, VA 22611	
(X4) ID PREΓIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 695	Continued From pag	e 55	F 695		
			F 093	!	
		LPN #3 stated, "When I			
		t their breathing and see if nd are alert and oriented."			
		aff did if a resident had			
		ed, "When I go in and check			
	to the management of the party of the state	blood pressure, pulse,			
	AND SECTION OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY.	perature) I check that the			
	The state of the s	and the rate is correct."			
	2004-2000 Page 100-00-00-00-00-00-00-00-00-00-00-00-00-	important to give the oxygen			
		stated, "Yes. You want to			
	make sure they are g	261 Later (1975) 10 10 10 10 10 10 10 10 10 10 10 10 10			
	10 D	ng." When asked if oxygen			
	was considered a me "Yes."	edication, LPN #3 stated,			
		's policy titled, "OXYGEN			
		documented, "A patient will			
		ypoxemia (low oxygen level)			
	an increase in metab	ntor or cardiac emergency or			
		Verify the doctor's order for			
	oxygen therapy.	verify the doctor's order for			
	No further information	n was provided prior to exit.			
		nentals of Nursing, Perry and			
		age 1122, Oxygen should be			
		has dangerous side effects,			
		r oxygen toxicity. As with			
		or concentration of oxygen			
		sly monitored. The nurse			
		k the physician's orders to			
		s receiving the prescribed			
	oxygen concentration				
	medication administration."	ation also pertain to oxygen			

F 761 Label/Store Drugs and Biologicals

SS=D CFR(s): 483.45(g)(h)(1)(2)

F 761

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OM	IB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495140	B. WING			C 06/14/2018
NAME OF P	ROVIDER OR SUPPLIER		70.	STREET ADDRESS, CITY, STATE, ZIP CI	ODE	
ROSE HIL	L HEALTH AND REHAB			110 CHALMERS COURT BERRYVILLE, VA 22611		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 761	§483.45(g) Labeling of Drugs and biologicals	of Drugs and Biologicals used in the facility must be with currently accepted s, and include the y and cautionary	F	Preparation, submission and of this plan of correction do admission of or agreement conclusions set forth on the Our plan of corrections pre as a means to continuously care and to comply with ap federal regulations.	oes not constitu with the facts a survey report, pared and exec improve qualit	ite an and uted y of
	§483.45(h)(1) In according to the facility of the Comprehensive December 2 of the Control Act of 1976 at abuse, except when the package drug distributy quantity stored is minimal to the Comprehensive December 2 of the Control Act of 1976 at abuse, except when the package drug distributy quantity stored is minimal to the comprehensive December 2 of the Control Act of 1976 at abuse, except when the package drug distribution of the control act of th	dility must provide separately affixed compartments for drugs listed in Schedule II of trug Abuse Prevention and other drugs subject to the facility uses single unit tion systems in which the simal and a missing dose can is not met as evidenced on, staff interview and facility letermined the facility staff tions in a safe manner for edication carts, the North		1. The deficient practice of medications has been correstaff nurses regarding the insecuring medications for readulting and correcting unlearts when visualized. 2. No residents have been in been affected by this deficied. 3. Nurses will be reeducated of medications to maintain safety by DON/designee. A keepers will occur 5 times proceeds and then ongoing with visualization if cart is noted any time to ensure facility it of residents and ensuring mestored appropriately. 4. Results of audits will be monthly/quarterly Quality and Performance Improvement for trend analysis and reviee Recommendations implements. Corrective action will be 7/14/2018.	cted by reeduca inportance of sident safety. locked medicat identified that hent practice, ed on proper stocompliance and Auditing by Carper week for 4 th repeat it to be unlocked is maintaining sidedications are brought to the Assurance (QAPI) Commw.	ion nave orage d re d at safety
	The facility staff failed medication on 6/13/18			1/14/2016.		

The findings include:

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	S EOD MEDICARE 8				7	DMB NO. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(V2) NOTE TO	DI E GOUCTEURTION	Ĭ	Andrew as allowed by Advisoria allow	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED
		495140	B WING	35		C 06/14/2018
NAME OF P	ROVIDER OR SUPPLIER	Mile in the second		STREET ADDRESS, CITY, STAT	TE, ZIP CODE	
DOOF IIII				110 CHALMERS COURT		
RUSE HIL	L HEALTH AND REHAB			BERRYVILLE, VA 22611		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION FIVE ACTION SHOULD BE CED TO THE APPROPRIAT EFICIENCY)	
F 761	Continued From page On 6/13/18 at 4:10 p.	m., the north unit -	F 70	61		
		observed. The cart was in				
	to a contract of the contract	gainst the wall outside a				
		cart was unlocked. There ents in the hall at the time.				
	RN (registered nurse	AND THE PROPERTY OF THE PROPER				
		11 p.m., took a plastic cup off				
		to the resident's room. The				
		e cart at that time. The				
		not in the nurse's line of was in the resident's room.				
		of the resident's room 30				
	seconds later and pu	shed the cart down the hall.				
		lications out of the cart and				
		into a resident's room. The cart. The nurse was in the				
		pproximately 1 and 1/2				
	20 20 200 2000 00 2000 00	time, the medication cart				
		s line of sight. There were no				
		s observed in the area				
	during that time.					
	An interview was con	ducted on 6/13/18 at 4:25				
		en asked about the process				
		y leave the medication cart				
		ated, "We are not supposed				
		When asked if she had left				
		nlocked, RN #3 stated she y the carts are to be locked,				
	RN #3 stated, "It's un					
		m. ASM (administrative staff				
		cutive director, ASM #2, the display d				
		vices were made aware of				
	the findings.					

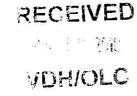
FORM CMS-2567(02-99) Previous Versions Obsolete

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

Event ID: 1BPH11

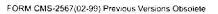
Facility ID: VA0210

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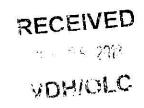
CENTERS FOR MEDICARE & MEDICAID SERVICES		MEDICAID SERVICES		W 112	OMB NO. 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495140	B. WING		C 06/14/2018	
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ROSE HIL	L HEALTH AND REHAB			10 CHALMERS COURT ERRYVILLE, VA 22611		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 761	following manufacture recommendations, to to support safe effect medication supply shilcensed nursing persor staff members law medications. PROCE pharmacy dispenses that meet state and feincluding requirement practices established Pharmacopeia (USP) in these containers at environment. This manufacture is a supplement of the secondariance of the supplement of the secondariance of the supplement of the secondariance of the supplement of the s	ogicals are stored properly, er's or provider pharmacy maintain their integrity and ive drug administration. The all only be accessible only to connel, pharmacy personnel, fully authorized to administer DURES. 1. The provider medication in containers ederal labeling requirements, its of good manufacturing by the United States. Medications are to remain and stored in a controlled ay include such containers medication room, medication	F 761			
	Infection Prevention 8 CFR(s): 483.80(a)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	ntrol blish and maintain an and control program asafe, sanitary and ment and to help prevent the asmission of communicable as. prevention and control blish an infection prevention (IPCP) that must include, at a ring elements:	F 880	Preparation, submission and implement of this plan of correction does not con admission of or agreement with the fa conclusions set forth on the survey report of the plan of corrections prepared and the as a means to continuously improve quare and to comply with applicable staffederal regulations.	stitute an ets and port. executed uality of	
		g, and controlling infections				



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Facility ID. VA0210

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EXAMENTATION OF CORRECTION A SULDING BERRYVILLE, VA 22611 D PREMIDERS HAND FOORSECTION EACHOR HOUSE CORRECTION FRACE CONTINUED FOR A COLD EXEMPTIVE ME APPROXIMATION. FRACE CONTINUED A SULDING FOR A COLD SUBJECT OF A COLD	CENTER.	S FOR MEDICARE & I	MEDICAID SERVICES			OME	NO. 0938-0391
NAME OF PROVIDER OR SUPPLICE ROSE HILL HEALTH AND REHAB STREET ADDRESS, CITY, STATE, ZIP CODE							
Table Summary Statement or Depotencies Depotency			495140	B. WING			100 100
BERRYVILLE, VA 22611	NAME OF PE	ROVIDER OR SUPPLIER	3 5 63		STREET ADDRESS, CITY, STATE, ZIP CODE		
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 before they can of surveillance to: (ii) 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: (ii) 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 infection should be the least restrictive possible for the resident under the circumstances under which the facility must prohibit employees with a communicable disease; and (vi)The hand hygiene procedures to be followed	ROSE HIL	L HEALTH AND REHAB					
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 proceedures 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 diseases 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: (iv) The circumstances. (v) The circumstances under which the facility must probibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact with residents or thei	<u> </u>						
contamination reflected by CNA placing a roll of trash bags onto resident's bed and them replacing 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 will transmit the disease; and (vi)The hand hygiene procedures to be followed	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS REFERENCED TO THE AF	HOULD BE	COMPLET ON
by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the	F 880	and communicable di staff, volunteers, visito providing services unarrangement based u conducted according accepted national sta \$483.80(a)(2) Written procedures for the probut are not limited to: (i) A system of surveil possible communicable infections before they persons in the facility; (ii) When and to whom communicable diseast reported; (iii) Standard and trant to be followed to prev (iv) When and how iso resident; including but (A) The type and dura depending upon the ininvolved, and (B) A requirement that least restrictive possibility circumstances. (v) The circumstances must prohibit employed disease or infected sk contact with residents contact will transmit the (vi) The hand hygiene by staff involved in dires \$483.80(a)(4) A systematical experience of the staff involved in dires \$483.80(a)(4) A systematical experience.	seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following indards; standards, policies, and ogram, which must include, lance designed to identify ble diseases or can spread to other m possible incidents of se or infections should be assission-based precautions ent spread of infections; lation should be used for a triot limited to: attion of the isolation, infectious agent or organism to the isolation should be the ole for the resident under the sunder which the facility ses with a communicable in lesions from direct or their food, if direct in disease; and procedures to be followed ect resident contact.	F 886	contamination reflected by CN of trash bags onto resident's be replacing them into her pocket care. 2. Residents that reside in the require any assistance with act living are at risk of deficient in cross contamination. 3. Nursing Assistants will recordered and how to avoid cross contamination con and how to avoid cross contamination use items by DON/desig designee to audit Nursing assis ADL care to residents 3 times weeks. This is to ensure that dehas been corrected. 4. Results of audits will be bromonthly/ quarterly Quality Assistants of auditing will be implemented a corrective action will be confident will be confident and the confident will be implemented a corrective action will be confident will be confident.	A placing a ed and then after provide facility that ivities of danfection contained for the practice minating nee. DON/stants provide per week for efficient practice fought to surance API/Comminum Further as recomment of the provided by decorrection.	ling ily trol/ ation is ling r 4 ctice ttee

corrective actions taken by the facility.

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		MEDICAID SERVICES			OMB NO. 0938-0391
	All:	MEDICAID SERVICES	(V2) MULTIPLE CO	NOTELICATION	(X3) DATE SURVEY
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CO		COMPLETED
		495140	B WING		C 06/14/2018
NAME OF PE	ROVIDER OR SUPPLIER	in the state of th	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	1 00/14/2010
ROSE HILL HEALTH AND REHAB			7/00/200-0 bid 000/200-00/000	CHALMERS COURT	
			BER	RYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 880	Continued From page 60		F 880		
	§483.80(e) Linens.				
	The state of the s	die, store, process, and			
		s to prevent the spread of			
	§483.80(f) Annual rev	view.			
		uct an annual review of its			
	-	ir program, as necessary.			
		f is not met as evidenced			
	by:				
		on, staff interview, facility d clinical record review, it			
		acility staff failed to maintain			
		tices for one of 12 residents			
	in the survey sample				
		d to keep a roll of plastic e residents off Resident #3's			
	The findings include:				
		mitted to the facility on 1/8/15 4/18 with diagnoses that t limited to: diabetes,			
		heart failure, respiratory essure, depression and			
	day assessment, with reference date) of 6/4 having scored a 14 or interview for mental s	S, minimum data set, a five an ARD (assessment 4/18 coded the resident as ut of 15 on the BIMS (brief status) indicating the resident to make daily decisions.			

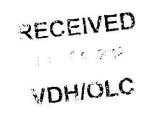


An observation of incontinence care was made on 6/13/18 at 2:10 p.m., with CNA (certified

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		MEDICAID SERVICES			OMB NO. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A BUILDING		COMPLETED
					С
		495140	B. WING		06/14/2018
NAME OF P	ROVIDER OR SUPPLIER		STF	EET ADDRESS, CITY STATE, ZIP CODE	- No. 1966 - 1966 - 1966 - 1966 - 1966 - 1966 - 1966 - 1966 - 1966 - 1966 - 1966 - 1966 - 1966 - 1966 - 1966 -
ROSE HIL	L HEALTH AND REHAB		00/40/40	CHALMERS COURT	
			BE	RRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 880	100 To 10	and CNA #6 both CNAs	F 880		
		. CNA #6 pulled two plastic			
	and the same of th	gs she had in her pocket.			
		of bags on the resident's bed. ed brief in one bag and the			
		the other bag. CNA #6 tied			
		up the roll of plastic bags with			
		I put it back into her pocket.			8
	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,				
		hy, CNA #5 stated, "its			
	cross-contamination.				
	An interview was cor	ducted on 6/13/18 at 2:25			
	p.m. with CNA #6. W				
		when obtaining supplies,			
		re supposed to take the			
		hands, put on new gloves d to do." When asked what			
		they put supplies on a			
		#6 stated, "It's contaminated.			
		n asked if she had put the			
	plastic bags back into	her pocket, CNA #6 stated,			
		she had used those bags			
		, CNA #6 stated, "Yes."			
	When asked what the "Cross contamination	at meant, CNA #6 stated,			
	Cross contamination	1.			
	AND ALL DESCRIPTIONS OF STREET STREET,	ducted on 6/13/18 at 3:10			
	p.m. with ASM (admi	nistrative staff member) #2,			

the director of nursing. When asked about the process staff follows if they needed additional

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER:SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED
		495140	B WING		C 06/14/2018
NAME OF PROVIDER OR SUPPLIER ROSE HILL HEALTH AND REHAB				STREET ADDRESS CITY, STATE, ZIP CO 110 CHALMERS COURT BERRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		ON SHOULD BE COMPLETION HE APPROPRIATE DATE
F 880	supposed to take the hands, put on new gl need to do." When as considered if they we ASM #2 stated, "It's ownat staff should do bags on a resident's them." ASM #2 was rat that time. On 6/13/18 at 5:10 p. director, ASM #2, the the regional director ownade aware of the fin Review of the facility' Precautions" docume Precautions will apply care in all facilities represumed infection s are designed to redumicroorganism from the unrecognized source facilities. PROCEDUI Equipment, a. Reusa used for the care of a been cleaned and processing to the care of a been cleaned and processing the supplement of the care of a been cleaned and processing the supplement of the care of a been cleaned and processing the supplement of the care of a been cleaned and processing the supplement of the care of a been cleaned and processing the supplement of the care of a been cleaned and processing the supplement of the care of a been cleaned and processing the supplement of the care of a been cleaned and processing the supplement of the care of a been cleaned and processing the supplement of the care of a been cleaned and processing the supplement of the care of a been cleaned and processing the supplement of the care of a been cleaned and processing the constant of the care of the	ASM #2 stated, "They're ir gloves off, wash their oves and then do what they sked what supplies were are laid on the resident's bed, dirty, soiled." When asked if they lay a roll of plastic bed, ASM #2 stated, "Trash made aware of the findings. The ASM #1, executive a director of nursing, ASM #3, of clinical services were notings. The spolicy titled, "Standard and the spolicy titled, "Standard and the statesStandard Precautions of the trisk of transmission of both recognized and spolicy of the statesStandard and spolicy infection in health care	F	880	

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

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