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(X2) MULTIPLE CONSTRUCTION

Printed: 07/05/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES	ı
AND PLAN OF CORRECTION	Į

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

A. BUILDING

(X3) DATE SURVEY COMPLETED

495118 | B. WII

06/23/2016

NAME OF PROVIDER OR SUPPLIER

TRINITY MISSION HEALTH AND REHAB OF RO

STREET ADDRESS, CITY, STATE, ZIP CODE

300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY
OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 000 INITIAL COMMENTS

An unannounced Medicare/Medicaid standard survey and and complaint survey was conducted 6/21/16 through 6/23/16. Two complaints were investigated. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.

The census in this 180 certified bed facility was 141 at the time of the survey. The survey sample consisted of 22 current Resident reviews (Residents #1 through #21 & #28) and 6 closed record reviews (Residents #22 through #27).

F 155 483.10(b)(4) RIGHT TO REFUSE; FORMULATE SS=D ADVANCE DIRECTIVES

The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.

The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

This Requirement is not met as evidenced by:

F 000

Preparation and submission of this plan of correction by **Trinity Mission Health and Rehab of Rocky Mount, LLC,** does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws.

F 155

F-155

1. Resident #14 Durable Do Not Resuscitate (DDNR) was reviewed and completed on 06/22/16 by the physician.

Resident #15 Durable Do Not Resuscitate (DDNR) was reviewed and completed on 06/22/16 by the physician.

2. The Unit Managers will complete an audit of the current residents
Durable Do Not Resuscitate (DDNR) by 07/22/16 to ensure the Durable Do Not Resuscitate (DDNR) are completed as required.

5 8

(X6) DATE

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

July D. Coch

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

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program participation.

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CENIC	KS FOR WEDICARE	<u>,& IVIEDICAID SERV</u>	IUES			OMB NO.	<u>0938-0391</u>
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495118		B. WING	·	06/23	3/2016
NAME OF	PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, ST	ATE, ZIP CODE	***************************************	
TRINITY	MISSION HEALTH	AND REHAB OF RO	1	TCHER STR			
			ROCKY	' MOUNT, V	A 24151		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE T BE PRECEDED BY FULL I ENTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 155	Continued From page	age 1		F 155			
		rview and clinical rec			3. The Licensed Nurses will	be re-	
		omplete and accurat			educated by the Staff Develo	opment	İ
		(DDNR) for 2 of 28			Coordinator by 07/22/16 rel	ated to	
	in the sample surve	ey, Resident #14 and	#15.		ensuring the Durable Do No	•	
	The Findings Includ	led:			Resuscitate (DDNR) are con		
	-				required.	•	İ
	1. For Resident#	14 the facility staff fa	iled to		104011001		
	ensure a complete Resuscitate (DDNF	and accurate Durabl	e Do Not		4. The Unit Managers will	nomnlata	
	Mesuscitate (DDIAL	().			_	-	J
	Resident #14 was a	an 84 year old female	who was		an audit weekly for 4 weeks		***
	admitted on 6/2/15.	Admitting diagnose	S		monthly for 2 months to ens		
		not limited to: demen		•	Durable Do Not Resuscitate	-	
	osteoporosis, nyper	lipidemia and glauco	oma.	•	continue to be completed as	required.	
	The most current M	linimum Data Set (M	DS)	•	The Director of Nursing wil	l submit a	
	located in the clinicated	al record was an Ann	ual MDS		report to the Quality Assura	nce	
		Assessment Refere			Committee monthly for 3 m	onths.	
	Resident #14 had a	ne facility staff coded Cognitive Summary	Score of		The Director of Nursing wil	l be	
	3. The facility staff	also coded that Resi	dent #14		responsible for monitoring a		
	required limited (2/2	?) to total nursing car	e (4/2)			inia tonto	
	with Activities of Da	ily Living (ADL's).			up.		
	On June 22 2016 a	it 8:45 a.m. the surve					07/07/1
	reviewed Resident	#14's clinical record.	gui Review		Completion date:		07/23/1
	of the clinical record	l produced a Durable	Do Not				İ
	Resuscitate (DDNR). The DDNR was	dated	į		:	İ
	3/31/16. Review of	the DDNR sheet rev	ealed			NED	
	DDNR had not doci	not accurate/comple imented whether Re	ite. I Ne eldent	į	RECE	I V L	***************************************
		Incapable of making		:			
	informed decision a	bout providing, withh	olding or		JUL 1	A TAIA	
	withdrawing specific	medical treatment of	or course		VDH	OLC	
	of medical treatmen	t.			VUT!	A prom page.	

Reference: Code of Virginia § 512.1-2987.1. Durable Do Not Resuscitate Orders. A. A Durable

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CENTERS FOR MEDICARE	& MEDICAID SEKVICES			ONID NO. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495118	B. WING		06/23/2016	
NAME OF PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
TRINITY MISSION HEALTH	AND DELIAB OF DE SAN LI	ATCHER ST	CET		
ININH I MISSION REALIN				,	
	ROCI	(Y MOUNT, V	A 24151		
PREFIX (EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATOR' ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFIGIENCY)	OULD BE COMPLETION	
F 155 Continued From pa	age 2	F 155			
		1 100			
	Order may be issued by a				
	itient with whom he has a bona	1			
fide physician/patie	nt relationship as defined in				
the guidelines of the	e Board of Medicine, and only				
	the patient or, if the patient is	-			
	wise incapable of making an				
	egarding consent for such an				
	juest of and with the consent of				
the person authoriz	ed to consent on the patient's				
behalf.		+ 1			
On June 22, 2016 a	at 9:45 a.m. the surveyor				
	Practical Nurse (LPN #1) and	:		·	
	UM), who was an LPN, that				
	NR was incorrect/inaccurate.	:			
The surveyor review	wed the clinical record with	1			
LPN #1 and the UM	 The surveyor reviewed the 				
	N (#1) and the UM. The				
	ut that the physician/facility	1			
	nined whether Resident #14	1			
	capable of making an informed				
	iding, withholding or				
	c medical treatment or course				
of medical treatmer	nt.				
1					
On June 22, 2016 a	at 2:25 p.m. the survey team				
met with the Admin	istrator (Adm) and Director of				
	surveyor notified the				
	m (AT) that the facility staff	:			
	omplete and accurate DDNR	***************************************			
for Resident #14.		Official control of the second			
:		4 4 4		4	
No additional inforn	nation was provided prior to				
	s to why the facility staff failed	The state of the s		:	
	te and accurate DDNR for	4		:	
Resident #14.					
Nodiuciii mir.				<u> </u>	
0 F D1414	AE the feelite staff felled to			÷	
	15 the facility staff failed to			<u> </u>	
	and accurate Durable Do Not	1			
Resuscitate (DDNF	₹).			* :	

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If continuation sheet Page 3 of

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	AND HUMAN SERVIC & MEDICAID SERVIC	CES CES			FO	ed: 07/05/2016 RM APPROVED NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/IDENTIFICATION NUMB		1 .	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	495118		B. WING		06	3/23/2016	
NAME OF PROVIDER OR SUPPLIER TRINITY MISSION HEALTH		300 HAT	RESS, CITY, STA CHER STR MOUNT, VA	EET			
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F 155 Continued From pa	ige 3		F 155		<u> </u>		
originally admitted of 11/06/15. Admitting not limited to: parap	a 48 year old male who on 8/15/15 and readmi g diagnoses included, l blegia, diabetes mellitu cer, blind in one eye a nputation.	itted on but were is,					
located in the clinica Change MDS asses Reference Date (AF staff coded that Res Summary Score of coded that Resident	linimum Data Set (MDial record was a Signific ssment with an Assess RD) of 4/12/16. The fa sident #15 had a Cogn 14. The facility staff al t #15 required total nuities of Daily Living (Al	cant sment acility nitive ilso irsing					

On June 22, 2016 at 3 p.m. the surveyor reviewed Resident #15's clinical record. Review of the clinical record produced a Durable Do Not Resuscitate (DDNR). The DDNR was dated 3/01/16. Review of the DDNR sheet revealed that the DDNR was not accurate/complete. The DDNR had not documented whether Resident #15 was Capable or Incapable of making an informed decision about providing, withholding or withdrawing specific medical treatment or course of medical treatment.

Reference: Code of Virginia § 512.1-2987.1. Durable Do Not Resuscitate Orders. A. A Durable Do Not Resuscitate Order may be issued by a physician for his patient with whom he has a bona fide physician/patient relationship as defined in the guidelines of the Board of Medicine, and only with the consent of the patient or, if the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order, upon the request of and with the consent of the person authorized to consent on the patient's

Printed: 07/05/2016

CENTERS FOR MEDICARE	& MEDICAID SERVICES		0	FORM APPROVED 0MB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 -	C COMETDUCTION	3) DATE SURVEY COMPLETED
	495118	B. WING		06/23/2016
NAME OF PROVIDER OR SUPPLIER TRINITY MISSION HEALTH	AND REHAB OF R(300 HA	RESS, CITY, ST TCHER STF / MOUNT, V	REET	
PREFIX (EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 155 Continued From p	age 4	F 155		
behalf.			F-156	
notified the Admini #15's DDNR was in surveyor reviewed surveyor pointed on staff had not determined the staff had not determined the surveyor pointed on the staff had not determined the surveyor withdrawing specific of medical treatment. On June 23, 2016 and met with the Administration facility staff failed to accurate DDNR for the surveyor without the facility and the facility and the facility and the facility and the facility and the facility and the facility and the surveyor reviews	at 11:10 a.m. the survey team Director of Nurses (DON) and nsultant (RNC).The surveyor strative Team (AT) that the o ensure a complete and r Resident #15. nation was provided prior to s to why the facility staff failed		 Posting/ documentation regathow to apply for Medicare/Mewas posted in the facility on 07 by the Administrator. The Administrator will comaudit on 07/12/16 to ensure recognized in the facility required. The Administrator will be reducated by the Regional Nurse Consultant by 07/12/16 related ensuring required post/documentations are poster facility as required. 	edicaid 7/01/16 plete an quired ty as e- se
Resident #15. F 156: 483.10(b)(5) - (10), SS=C: RIGHTS, RULES, 3 The facility must int and in writing in a launderstands of his regulations governing responsibilities duri	SERVICES, CHARGES form the resident both orally anguage that the resident or her rights and all rules and ng resident conduct and ng the stay in the facility. The	F 156	4. The Administrator will come an audit weekly for 4 weeks are monthly for 2 months to ensure required posting/documents control to be posted in the facility as real The Administrator will submit report to the Quality Assurance Committee monthly for 3 months.	nd re ontinue equired a
notice (if any) of the f §1919(e)(6) of the f made prior to or up resident's stay. Re	ovide the resident with the state developed under Act. Such notification must be on admission and during the ceipt of such information, and o it, must be acknowledged in		The Administrator will be resp for monitoring and follow up. Completion date:	

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Records and Viet Fage 5 of 26

Printed: 07/05/2016 FORM APPROVED MB NO 0938-0391

CENTERS FOR MEDICARE	& MEDICAID SERVICES	5			O. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE : COMPI	
	495118	B. WING		06/	23/2016
NAME OF PROVIDER OR SUPPLIER		REET ADDRESS, CITY, S	TATE, ZIP CODE		
TRINITY MISSION HEALTH		300 HATCHER ST			
		ROCKY MOUNT, \	/A 24151		
PRÉFIX (EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES FBE PRECEDED BY FULL REGUI INTIFYING INFORMATION)	ID LATORY PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 156 Continued From pa	age 5	F 156			
The facility must inf	orm each resident who is	3			
entitled to Medicaid	benefits, in writing, at the	e time.			
	nursing facility or, when teligible for Medicaid of the				
items and services	that are included in nursi	na na			
facility services und	er the State plan and for	'' ' 9			
which the resident n	may not be charged; thos	е			
other items and serv	vices that the facility offer	rs			
	esident may be charged, a ges for those services; an				
	it when changes are mad				
the items and service	ces specified in paragraph	hs			
(5)(i)(A) and (B) of t	his section.				
	orm each resident before				
at the time of admis	sion, and periodically dur	ring			
the resident's stay, of	of services available in th	e			
including any charge	es for those services, es for services not covere	ad			
under Medicare or b	by the facility's per diem ra	ate.			
The facility must furn	nish a written description	of			
legal rights which inc					
A description of the t	manner of protecting pera aph (c) of this section;	sonal			
rando, andor paragra	apri (c) or this socion,				
A description of the	requirements and proced	lures			
for establishing eligil	bility for Medicaid, includi	ing			
the right to request a	an assessment under sec	ction			
1924(c) which detering non-exempt resource	mines the extent of a cou	ıpie's			

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down to Medicaid eligibility levels.

institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy

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Printed: 07/05/2016 FORM APPROVED OMB NO. 0938-0391

CTATEMENT	Δr	DECIDIENTOIC
PINIEMENT	Ur	DEFICIENCIES
AND DLANO	E 0	ODDECTION

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:**

(X2) MULTIPLE CONSTRUCTION A. BUILDING COMPLETED

(X3) DATE SURVEY

495118

B. WING

06/23/2016

NAME OF PROVIDER OR SUPPLIER

TRINITY MISSION HEALTH AND REHAB OF RO

STREET ADDRESS, CITY, STATE, ZIP CODE

300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

F 156 Continued From page 6

groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits,

This Requirement is not met as evidenced by: Based on observation and staff interview it was determined that the facility staff failed to prominently display written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by Medicare and Medicaid benefits.

The Findings Included:

On June 21, 2016 at 3:30 p.m. this surveyor made an Initial tour of the facility. The surveyor observed that the front lobby had several documents posted regarding reporting abuse and F 156

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If continuation sheet Page 7 of 26 RECEIVED

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	DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	AND HUMAN SERV & MEDICAID SERV	/ICES			FORM	07/05/2016 APPROVED 0.0938-0391
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM			CONSTRUCTION	(X3) DATE S COMPLE	URVEY
		495118	<i>i</i>	B. WING		06/2	3/2016
	NAME OF PROVIDER OR SUPPLIER	AND DEMAR OF BU	i i	RESS, CITY, STA		•	
-	TRINITY MISSION HEALTH		ROCKY	CHER STRI MOUNT, VA	——·		
	PRÉFIX (EACH DEFICIENCY MUST TAG OR LSC IDE	ENTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
Management of the state of the	local Ombudsman. any posting/docume apply for Medicare/l refunds for previous Medicare/Medicaid. On June 22, 2016 a a walkthrough of the unable to locate any Medicare/Medicaid The surveyor observ Manager (UM) was surveyor informed th unable to locate the documentation rega use Medicare/Medica made a tour of the f locate the posting/pr regarding Medicare/ benefits. While wall the surveyor observ	for the State Agency This surveyor did no entation regarding ho Medicaid and how to s payments covered at 8:30 a.m. the survey y posting/documenta applications and ber eved that the facility L standing in the hallw he UM that the survey	eyor made yor was ation for nefits. Juit way. The eyor was for and and UM is unable to n ns and nt lobby r (Adm)	F 156			

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JUL 18 2016

VDH/OLC

On June 22, 2016 at 2:25 p.m. the survey team

written documentation regarding Medicare and Medicaid application and benefits had probably

the Adm that the UM and surveyor were unable to locate the written documentation regarding application of Medicare and Medicald benefits. The Adm walked through the front lobby with the UM and surveyor. The Adm was unable to locate the written documentation regarding Medicare and Medicaid application and benefits. The Adm stated that the front lobby had experienced some water damage earlier in the year and that the

been removed due to damage.

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

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		495118		B. WING		06/23/2016
1	PROVIDER OR SUPPLIER MISSION HEALTH	AND REHAB OF RO	300 HA1	RESS, CITY, STA CHER STR MOUNT, VA	EET	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL R NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
F 156	Continued From pa	age 8	<u> </u>	F 156		
	posting/documental application and ben	tion for Medicare/Med efits.	licaíd		F-167	
	exiting the facility as to prominently displ	nation was provided p s to why the facility sta ay information regard application and benef	aff failed ing		1. The notice/signage of the recent Survey Results was p 07/01/16 by the Administrat	osted on
		TO SURVEY RESU	LTS -	F 167	2. The Administrator will co	mplete an
SS=C	READILY ACCESS	IBLE			audit on 07/12/16 to ensure	^
	the most recent sur	ight to examine the reversely to examine the re	ducted		notice/signs are posted as re-	*
		surveyors and any plants with respect to the fact			3. The Administrator will be educated by the Regional Nu	•
	examination and mu	ake the results availabust post in a place rea ents and must post a	adily		Consultant on 07/12/16 relate ensuring notice/signs are postacility as required.	ted to
	Based on observation determined that the	s not met as evidence on and staff interview, facility staff failed to p e availability of the mo s.	, it was oost a		4. The Administrator will co audit weekly for 4 weeks an for 2 months to ensure notic continue to be posted in the required. The Administrator submit a report to the Qualit	d monthly es/signs facility as will
	The Findings Includ	ed:			Assurance Committee month	· 1
	entered the building wall mount that held The binder was labe	t 3:30 p.m. the survey and observed a small a white three ring bir eled Survey Results.	ll clear ider. The		months. The Administrator versions ible for monitoring a up.	
	surveyor results for the surveyor made an ir was unable to locate regarding where the	e binder an observed e 7/02/15 survey. The nitial tour of the facility e a notice or signage most recent survey r residents, families an	e / and esults		Completion date:	07/23/16

DEPARTMENT	OF HEALTH AND	NAMUH C	SERVICES
	MEDICARE & M		

STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIE	R/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SU	0830-038
= m =		A. BUILDING		COMPLET			
		495118		B. WING	17 - 17 - 18 - 18 - 18 - 18 - 18 - 18 -	06/23	/2016
NAME OF	PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, ST	TATE, ZIP CODE	L	
TRINIT	Y MISSION HEALTH	AND REHAB OF RO		TCHER STI			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIE		ID ID		· · · · · · · · · · · · · · · · · · ·	(Ve)
PRÉFIX TAG	(EACH DEFICIENCY MUST OR LSC IDE	T BE PRECEDED BY FULL I ENTIFYING INFORMATION)	REGULATORY	PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE :	(X5) COMPLETION DATE
F 167	Continued From pa	age 9		F 167			
	for viewing.				F 256		
	notified the Administ notifying residents, the most recent surnot be found. The stated she didn't kn asking about. The signage had to be partiallies and the pult the most recent surstated, "Oh I've nev notified the Adm that public should not have results were located." On June 22, 2016 a met with the Adm and The surveyor notified (AT) that the facility regarding were the	at 2:25 p.m. the surve and Director of Nurses and the Administrative staff had not posted results of the most re	e signage lic where ated could cation and or was Adm that ents, results of he Adm curveyor lies and survey by team s (DON). Team signage ecent		 The florescent light bulb we changed in the hallway near on 06/23/16 by the Maintena Assistant. An audit will be completed Maintenance Director on 07/ensure adequate and comfort lighting levels are maintained required. The Maintenance Department be re-educated by the Admin by 07/15/16 related to the requirements of maintaining and comfortable lighting level facility. 	d by the /15/16 to table d as ment will histrator adequate	
SS=D	No additional inform exiting the facility as to post a notice/sign	UATE & COMFORTA S ovide adequate and	orior to aff failed y of the families	F 256	4. The Maintenance Director complete audit weekly for 4 and monthly for 2 months to adequate and comfortable lig levels continue to be maintai required. The Administrator submit a report to the Quality Assurance Committee month months. The Maintenance Di and Administrator will be refor monitoring and follow-up	weeks ensure ghting ined as will y nly for 3 irector sponsible	
	Based on observation	s not met as evidenc on and staff interview facility staff failed to	it was		Date of compliance:		07/2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	495118	B. WING		06/23/2016		
NAME OF PROVIDER OR SUPPLIER TRINITY MISSION HEALTH AND REHAB OF RI ROCKY MOUNT, VA 24151						
PREFIX (EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES THE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION		
wings in the facility. the hallways on the 146. The Findings Included the Principal of the observed that a flor the skilled unit, near the skilled unit, near the skilled unit, near the skilled unit, near the skilled unit, near the skilled unit, near the skilled unit, near the surveyor unit. The surveyor light in the hallway, MD stated he would light. On June 23, 2016 a met with the Administration (DON) and (RNC). The surveyor Team (AT) that a flounit, located near received and earlier on surveyor made a to	fortable lighting levels on 1 of 6 The light was out on one of skilled unit, located near room	F 256	F-279 1. Resident #5 care plan was and updated to included Cogn Activities of Daily Living/Rehabilitation, fall, Nutritional, and Psychotropic use on 06/24/16 by the MDS Coordinator. 2. The MDS Coordinators with complete an audit of the currence and audit of the currence and the complete and the comprehensive care plans has developed on the identified to the comprehensive care plans has developed on the identified to the comprehensive care plans has developed on the identified to the comprehensive care plans has developed on the identified to the comprehensive care plans has developed on the identified to the comprehensive care developed for identified to the comprehensive care are developed for identified to the c	Il ent ensure ve been riggers.		
the facility staff faile comfortable lighting	d to provide adequate and on the skilled unit in the		on the Comprehensive assess	ements.		
hallway, near room F 279 483.20(d), 483.20(k	(1) DEVELOP	F 279	RECE	EIVED		
SS=D COMPRÉHENSIVE		:	Carrow (Service)	8 2016		
	he results of the assessment and revise the resident's nof care.		VDH	OLC		

Printed: 07/05/2016 FORM APPROVED DMB NO. 0938-0391

CENT	ERS FOR MEDICARE	& MEDICAID SERV	ICES			<u>OMB NO.</u>	0938-0391
	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495118		B. WING	PROCESSOR AND ADMINISTRATION ADMINISTRATION ADMINISTRATION AND ADMINISTRATION AND ADMINISTRATION ADMINISTRATION AND ADMINISTRATION ADMINISTRATION AND ADMINISTRATION AND ADMINISTRATION AND ADMINISTRATION AND ADMINISTRATION	06/23	3/2016
NAME O	PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
TRINIT	Y MISSION HEALTH	AND REHAB OF RO		TCHER STR MOUNT, V			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE I BE PRECEDED BY FULL I ENTIFYING INFORMATION)	S REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 27	9 Continued From page	age 11		F 279			
	The facility must de	velop a comprehens	ive care		4. The Assistant Director of	Nursing	Ì
	plan for each reside	ent that includes mea tables to meet a resi	surable		or Director of Nursing will complete		
	medical, nursing, a	nd mental and psych	osocial		audits weekly for 4 weeks a	-	
	needs that are iden	tified in the compreh	ensive		monthly for 2 months to ens		
	assessment.				comprehensive care plans co		
	The care plan must	describe the service	s that are		be developed for the identifi		
		ttain or maintain the			triggers on Comprehensive		
		physical, mental, and eing as required und			Assessments. The Director of	of Nursing	
	§483.25; and any s	ervices that would ot	e: herwise	will submit a report to the Qualit			İ
	be required under §	483.25 but are not p	rovided		Assurance Committee mont		
	8483.10 including t	s exercise of rights u he right to refuse tre	nder atment	months. The Director of Nursing be responsible for monitoring and			
	under §483.10(b)(4).	aunon				
		•			follow up.		
	Based on staff inter review, it was determ failed to develop a (is not met as evidence view and clinical recommend that the facility Comprehensive Care esidents in the samp	ord / staff · Plan		Completion date:		07/23/1
	The Findings Includ	ed:	-		•		
	a Comprehensive C care plan for Cognit Living/Rehabilitation Psychotropic Drug U on an Admission/5D	facility staff failed to fare Plan (CCP) to in ion, Activities of Daily I, Falls, Nutritional, ai Jse as triggered and lay Medicare Minimu Issessment Reference	clude a / nd identified : m Data				
	admitted on 8/17/15 included, but were n	73 year old female who will be a second of the second of the following of the following on the second on the second or the se	es wing:				

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DEPARTMENT	OF HEALTH AND H	UMAN SERVICES
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Printed: 07/05/2016 **FORM APPROVED**

CENTERS FUR MEDICARE	& MEDICAID SERVIC	JES			OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		(X2) MULTIPL A. BUILDING	E CONSTRUCTION ,	(X3) DATE SURVEY COMPLETED		
	495118		B. WING	· · · · · · · · · · · · · · · · · · ·	06/23/2016		
NAME OF PROVIDER OR SUPPLIER TRINITY MISSION HEALTH AND REHAB OF ROCKY MOUNT, VA 24151 STREET ADDRESS, CITY, STATE, ZIP CODE 300 HATCHER STREET ROCKY MOUNT, VA 24151							
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION			
F 279 Continued From page 1	age 12		E 270				

neuralgia and congestive heart failure.

The most current MDS located in the clinical record was a Quarterly MDS assessment with an ARD of 5/9/16. The facility staff coded that Resident #5 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #5 required total nursing care (4/2) to with Activities of Daily Living (ADL's). The facility staff also coded that Resident #5 was totally incontinent of bladder and bowels.

On June 22, 2016 at 1 p.m. the surveyor reviewed Resident #5's clinical record. Review of the clinical record produced an Admission/5 Day Medicare MDS assessment with an ARD of 8/24/15. The facility staff coded that Resident #5 had a Cognitive Summary Score of 13. The facility staff coded in Section C-Cognitive Patterns that Resident #5 was able to report the correct year, was able to identify the correct month within 5 days, and was able to identify the correct day of the week. The facility staff also coded that Resident #5 was able to recall the items sock, blue and bed with verbal cueing. In Section G-Functional Status the facility staff coded that Resident #5 required total nursing care (4/2) with ADL's. In Section K-Swallowing/Nutritional Status the facility staff coded that Resident #5 was 65 inches tall, weighed 139 pounds and received a therapeutic diet. In Section N-Medications the facility staff coded that Resident #5 received 7 days on an antianxiety medication. In Section V. Care Area Assessment Summary (CAA'S) Resident #5 "triggered" for Cognition, ADL/Rehab, Falls, Nutritional Status and Psychotropic Drug Use. The facility staff documented that a care plan would be developed to address Resident #5's triggered deficits.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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_	CENTERS FOR MEDICARE	& MEDICAID SERVIC	CES				. 0938-039
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		1	E CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		495118		B. WING		06/2	3/2016
	NAME OF PROVIDER OR SUPPLIER TRINITY MISSION HEALTH	AND REHAB OF RO	300 HAT	RESS, CITY, ST CHER STF MOUNT, V			
	PREFIX (EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL RI ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
Γ	F 279 Continued From pa	age 13		F 279			
	the CCP. Review of	of the clinical record proof the CCP failed to income the two failed to income the failure in th	clude a		F-309		
	Cognition, ADL/Rel and Psychotropic D On June 22, 2016 a notified the MDS Ni Nurse (RN #1), that Cognition, ADL's, Psychotropic Drug Medicare MDS with surveyor notified the staff documented the developed to addre	at 1:10 p.m. the survey urse, who was a Regis t Resident #5 "triggere Falls, Nutritional Statu Use on the Admission the ARD of 8/24/15. e MDS Nurse that the nat a care plan would be ss Resident #5 's trig	Status yor stered ed" for is and /5 Day The facility be gered		1. Resident #6's medication verified by the charge nurse Omeprazole Sodium 20.6r Synthroid 225 mcg was gife:00am by LPN #1 per physorders and the Nurse Practinotified 06/22/16. LPN #1 was reeducated on by the Director of Nursing Medication Administration Documentation.	se that ng and ven at ysician's citioner was 1 07/08/16	
	review of the CCP f that addressed Cog Status, and Psycho #5. The MDS Nurs unable to locate a c Resident #5 's trigg On June 22, 2016 a met with the Admini Nursing (DON). Th Administrative Team failed to develop a C Cognition, ADL, Fall Psychotropic Drug U	or notified the MDS Nuralled to produce a cargoition, ADL, Falls, Nuralled to produce a cargoition, ADL, Falls, Nuralled the CCP are plan that address gered areas. It 2:25 p.m. the survey strator (Adm) and Direct e surveyor notified the CCP for Resident #5 to Is, Nutritional Status Use as "triggered" on the edicare MDS with the	re plan tritional esident and was ed team ector of estaff o include		2. The Unit managers will an audit of the current resimedication records by 07/2 ensure medications are givedocumented as required. 3. The licensed nurses will educated by the Staff Deve Coordinator by 07/22/16 requirements of medication administration and documer requirements.	dents ² 22/16 to 22/16 to 22/16 to 24 25 26 27 27 27 27 27 27 27 27 27 27 27 27 27	•
	No additional inform	ARE/SERVICES FOR	ff failed	F 309	4. The Unit managers will audits weekly for 4 weeks monthly for 2 months to emedications continue to be documented as required. Director of Nursing will sureport to the Quality Assure	and nsure e given and The ubmit a	

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. Each resident must receive and the facility must

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Committee monthly for 3 months.

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

Printed: 07/05/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	495118		B. WING		06/2	3/2016
NAME OF PROVIDER OR SUPPLIER TRINITY MISSION HEALTH		300 HAT	RESS, CITY, ST CHER STE MOUNT, V			
PREFIX (EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REC ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE J DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
or maintain the hig mental, and psych	age 14 sary care and services to hest practicable physical osocial well-being, in the comprehensive asses	al,	F 309	The Director of Nursing responsible for monitoriup. Completion date:		07/23/16
Based on staff inte review, facility staff medications per phresidents in the sur Resident #6 was awith diagnoses include heart failure, asthmannual minimum diassessment with a 4/17/16, the reside interview for menta	is not met as evidenced review and clinical record failed to administer system order for 1 of 28 every sample (Resident # dmitted to the facility 5/1 uding hypertension, der ha, and depression. On that a set assessment (ME assessment reference dant scored 5/15 on the brill status and was assessivitum or psychosis.	d 3 46). 14/14 mentia, the OS) ate		F-333 1. Resident#5's physicianotified of the omission sliding scale insulin on the charge nurse. Resident #5 was re-asse Unit Manager on 06/22/change in condition not	s of the 06/22/16 by ssed by the 16 with no	
approximately 2 PN omeprazole sodium mcg due at 6 AM w administered on the record (MAR). The concern with the nu resident's medication	e medication administra surveyor discussed the trse responsible for the ons (LPN #1). LPN#1 s cations should have bee	tion		2. The Unit managers wan audit of the current remedication records by 0 ensure medication are a and documented as requiphysicians' orders.	esidents' 7/22/16 to dministered	
and director of nurs	eported to the administrating during a summary No additional information		E 222	3. The licensed nurses veducated by the Staff D Coordinator by 07/22/19 administering medication	evelopment 6 related to	*venite's

SS=D SIGNIFICANT MED ERRORS

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

Printed: 07/05/2016 FORM APPROVED

CENTERS FOR MI	DICARE	& MEDICAID SERV	ICES			OMB NO. 0938-0391
STATEMENT OF DEFICIE AND PLAN OF CORRECT		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU			CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495118		B. WING		06/23/2016
NAME OF PROVIDER OR TRINITY MISSION		AND REHAB OF RO	300 HA	RESS, CITY, STA TCHER STR MOUNT, V	EET	
(X4) ID \$ PREFIX (EACH DEFICE TAG	IENCY MUS	ATEMENT OF DEFICIENCI T BE PRECEDED BY FULL ENTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
F 333 Continue	d From p	age 15		F 333		
The facilit any signif	y must er icant med	isure that residents a lication errors.	are free of		documenting per physician's as required.	orders
Based on review, th Residents medicatio The findin The facilit Residents physician. Resident and had be included, included, included, included, included and included and included and included and included.	staff interest facility so (Resider n errors.) gs include y nursing sliding so errors are en readiout were i	is not met as evident view and clinical recutaff failed to ensure at #4) was free of signed. Staff failed to adminitual insulin as ordered insulin as ordered witted to the facility mitted 06/16/16. Diagnot limited to, diabete chronic pain, and universe with the second insulin as ordered to the facility mitted 06/16/16. Diagnot limited to, diabete chronic pain, and universe with the second insulin the second	ord 1 of 28 nificant ster the ed by the 11/13/15 gnoses		4. The Unit managers will contaudits weekly for 4 weeks and monthly for 2 months to ensure medication continue to be administered and documented physician's orders as required Director of Nursing will submareport to the Quality Assurance Committee monthly for 3 months Director of Nursing will responsible for monitoring and up.	d per d per d. The mit a ce onths. be
quarterly M with an AF 05/17/16 s 15 points.	MDS (min RD (asses scored the Indicating	e patterns) of the Resimum data set) asse sment reference dat Resident 15 out of a the Resident was a (active diagnoses)	ssment e) of a possible lert and		Completion date:	07/23/16
(06/17/16) included o meals) and novolog sl sugar of 1	POS (ph rders for d HS (bed iding scal 40-199 2 units, 300	cal record included a ysician order summa accuchecks AC (befo ltime/hour of sleep) a e insulin for a (BS) b units, 200-249 4 unit 0-349 8 units, and for ts.	ary) that ore and lood s.			

Printed: 07/05/2016

CENTERS	ENT OF HEALTH FOR MEDICARE	AND HUMAN SERV & MEDICAID SERVI	ICES ICES			FORM APPROVED OMB NO. 0938-039
STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIES IDENTIFICATION NUM			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495118		B. WING		06/23/2016
	VIDER OR SUPPLIER			RESS, CITY, ST	ATE, ZIP CODE	<u> </u>
TRINITY M	ISSION HEALTH	AND REHAB OF RO		TCHER STE MOUNT, V		
(X4) ID PREFIX (EA TAG	CH DEFICIENCY MUST	TATEMENT OF DEFICIENCIE T BE PRECEDED BY FULL F ENTIFYING INFORMATION)	S REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
F 333 C	ontinued From pa	age 16	······································	F 333		
A ac	review of the Res Iministration reco	sidents MAR (medical ord) for 06/2016 indical m. the Residents BS	ated that	. 555	F 502	
no the ac	o insulin was adm e Residents BS w Iministered, 06/19	inistered, 06/18 at 8:0 vas 138 2 units of insi 9 at 11:00 am the Res	00 p.m. ulin was sidents		1. Resident #4's physician w notified on 06/22/16 that the	January
p.i	m. it was 177 no i	ulin was administered insulin was administe 174 and no insulin wa	red and		HBA1C was not obtained wi new orders given.	in no
ac	ministered, 06/20	at 8:00 p.m. the Resulin was administered	sidents		Resident #13's physician was on 6/22/16 that the March CF	
11 wa	:00 a.m. the Resi as administered a	idents BS was 179 no ind at 8:00 p.m. the R ullin was administered	insulin tesidents		not obtained with no new ord given.	ers
su nu su rev su	rveyor interviewe rse) #1. LPN #1 r rveyor and identif viewing the MAR	roximately 10:55 a.m d LPN (licensed pracreviewed the MAR wit fied her initials for 06/LPN #1 verbalized to bought the Residents	tical th the 19. After the		2. The Unit managers will co an audit by 07/22/16 of the cr residents' medical record to e labs have been obtained as or	urrent ensure
Th we the wit	e administrator a	nd DON (director of r medication errors inv g scale insulin in a m n on 06/22/16 at	olving		3. The licensed nurses will be educated by the Staff Develo Coordinator by 07/22/16 to e labs are obtained as ordered.	pment
pro	further information ovided to the surventerence.	on regarding this issu ey team prior to the e	e was exit		4. The Unit managers will audits weekly for 4 weeks an monthly for 2 months to ensu	d
F 502 48	3.75(j)(1) ADMINI	STRATION		F 502	continue to be obtained as or	
The ser fac	vices to meet the	ovide or obtain laboral e needs of its resident e for the quality and ti	s. The		The Director of Nursing will report to the Quality Assuran Committee monthly for 3 mo	ce

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If continuation sheet Page 17 of 26

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DEPARTME	NT OF HEALTH	AND HUMAN	SERVICES
CENTERS F	OR MEDICARE	& MEDICAID	SERVICES

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIES IDENTIFICATION NUM		1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495118		B. WING		06/23	3/2016
	PROVIDER OR SUPPLIER / MISSION HEALTH	AND REHAB OF RO	300 HAT	RESS, CITY, STA TCHER STR MOUNT, V	EET		
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F 502	Continued From page			F 502			
	This Requirement	is not met as evidend	ced by:		The Director of Nursing wi	ill be	
		rview and clinical rece staff failed to obtain a			responsible for monitoring		,
	ordered lab test for	2 of 28 residents, Re	esidents		up.		
	#4, 13.				-1 .		
	The findings include	ed.			Completion date:		07/23/16
	The facility staff fail ordered lab test HB	ed to obtain the phys A1C.	ician				thin the state of
	test that provides in individual's average	C (hemoglobin A1c) is formation about an elevel of blood glucos over the past 3 mont	se, also				
	and had been readr included, but were r	dmitted to the facility mitted 06/16/16. Diagnot limited to, diabete chronic pain, and uri	inoses is,				
	quarterly MDS (minimith an ARD (asses 05/17/16 scored the 15 points. Indicating	e patterns) of the Resimum data set) assessment reference date Resident 15 out of a the Resident was all (active diagnoses) in	ssment e) of a possible ert and				
	(06/17/16) POS (ph	cal record included a ysiclan order summa a HBA1C every 3 mo	ry) that				THE STATE OF THE S
	unable to locate the in January. The surv	ecord review the surv results for a HBA1C veyor asked the unit i ical nurse) #2 about t	obtained manager				THE COLUMN TWO IS NOT THE COLUMN TWO IS NOT

DEPARTM	NT OF HEALTH AND HUMAN SERV	ICES
CENTERS	OR MEDICARE & MEDICAID SERV	IČĒŠ

Printed: 07/05/2016

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STATEME AND PLAN	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	:R/CLIA MBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE S	SURVEY
		495118	·	B. WING		06/	23/2016
1	PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA			
IKINI	Y MISSION HEALTH	AND REHAB OF RO	1	TCHER STR Y MOUNT, VA			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST OR LSC IDE	TATEMENT OF DEFICIENCIE T BE PRECEDED BY FULL F ENTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENCY	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 502	2 Continued From page 2	age 18		F 502			
	verbalized to the su- January had not bee The administrator a	and DON (director of	1C in				
	were notified of the survey team on 06/2 p.m.	above in a meeting v 22/16 at approximate	with the ely 2:20				
	test was provided to exit conference. 2. For Resident #1	ion regarding the mis o the survey team pri 13 the facility staff fail ordered CBC in Marcl	ior to the				
	admitted on 2/28/12 included, but were n psychotic disorder w	an 87 year old female 2. Admitting diagnose not limited to the followith with hallucinations, gland and diabetes mellitus.	es owing: laucoma.			,	
	record was a Quarte ARD of 3/21/16. The Resident #13 had a solution. 3. The facility staff a was independent (0/	IDS located in the clirerly MDS assessment facility staff coded Cognitive Summary also coded that Resid/0) to requiring total retivities of Daily Living	nt with an that Score of dent #13 nursing				
	reviewed Resident # of the clinical record orders dated 5/10/16 included, but were no	t 9:50 a.m. the survey #13's clinical record. I produced signed phy 6. Signed physician of not limited to: " CBC I sses) 401.9." (sic) Ti	Review hysician orders EVERY				

Continued review of the clinical record failed to produce the results of the CBC for March 2016.

DEPARTMENT OF HEALTI CENTERS FOR MEDICAR	HAND HUMAN SËRV E & MEDICAID SERV	ICES			Printed: 07/05/ FORM APPRO OMB NO. 0938-0	VΕ
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	R/CLIA MBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495118		B. WING		06/23/2016	
NAME OF PROVIDER OR SUPPLIER			ESS, CITY, STA	ATE, ZIP CODE		
TRINITY MISSION HEALTI	HAND REHAB OF RO		CHER STR MOUNT, V			
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F 502 Continued From p	page 19		F 502			h-14-1-1
notified the Corpo that Resident #13	at 10:45 a.m. the sur rate Compliance Nurs had physicians order	e (CCN) to obtain		F-504		
CCN that review of produce the result and CCN reviewed surveyor pointed of CBC to be obtained CCN was unable to physician ordered	016. The surveyor no of the clinical record fa s of the CBC. The sud the clinical record. Tout the specific order for in March of every ye o locate the results of CBC for March 2016.	lled to rveyor The or the ear. The the		1. Resident #12's physician of notified by the Charge Nurse HgbA1C on 05/03/16, PT/IN 05/03/16, and a Phenobarbita Primidone on 05/05/16 were without physician orders. No orders noted.	that an IR on al and drawn	
approached the susurveyor that the factorial CBC.	at 11:10 a.m. the CCt urveyor and informed t acility staff had not ob	he tained the		2. The Unit Managers will can audit of the current reside medical records by 07/22/16 physician orders are obtained	nts' to ensure	
met with the Admir Nursing (DON). T Administrative Tea failed to obtain a p 2016 for Resident No additional infor	mation was provided p	rector of ne staff in March		drawing labs. 3. The licensed nurses will be educated by the Staff Develor Coordinator by 07/22/16 to trequirements of obtaining ph	pe re- opment he	
exiting the facility a physician ordered l	is to why the failed to lab, CBC, for Residen	obtain a t #13.		orders prior to drawing labs.		
F 504 483.75(j)(2)(i) LAB SS=E ORDERED BY PH	SVCS ONLY WHEN YSICIAN		F 504	4. The Unit Managers will co audits weekly for 4 weeks ar	-	
The facility must pr services only when physician.	rovide or obtain labora ordered by the attend	itory ding		monthly for 2 months to ensiphysician's orders continue to obtained prior to drawing lab	to be	

This Requirement is not met as evidenced by:

review, the facility staff failed to obtain a physician

order for laboratory testing performed for 1 of 28

Based on staff interview and clinical record

Director of Nursing will submit a

Committee monthly for 3 months.

report to the Quality Assurance

The Director of Nursing will be

Printed: 07/05/2016 FORM APPROVED 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		
		495118		B. WING		06/2	3/2016
NAME OF F	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	STATE, ZIP CODE		
TRINITY	MISSION HEALTH	AND REHAB OF RO		TCHER ST MOUNT,	REET VA 24151		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL I NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 504	Continued From pa	age 20		F 504			
	residents (Resident	#12).			responsible for monitoring a	nd follow	
	The findings include	e:			up.		
	want c 1514) cc				•		
		formed laboratory (la rders for Resident #1			Completion date:		07/23/
	4/16/15 with diagno disorder, attention of traumatic stress dis	dmitted to the facility uses of psychosis, dis deficit disorder, bipolicorder, depression, and fibromyalgia.	ssociative ar, post				AND ADMINISTRATION OF THE PARTY
	with a reference da resident with a cogr resident was asses	e Minimum Data Set te of 3/17/16 assess nitive score of "15" of sed as independent ing except requiring son for bathing.	ed the "15". The with				We will be a second of the sec
	contained lab result averages blood glud PT/INR (measures 5/3/16, and two drug	was reviewed. The rest for a HgbA1C (mecose levels) dated 5/anticoagulant levels g level lab tests for primidone dated 5/5/	easures 3/16, a) dated				
::	for these lab tests. was asked about the	contain the physician The unit manager (Li e orders on 6/22/16 nable to find any phy sts.	PN#1) at 11:05				
	regional nurse cons	director of nursing, and ultant were informed eeting with the surve	of the				
	483.75(k)(2)(i) RAD SVCS ONLY WHEN		ΓIC	F 510			

TUZ111

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

RECEIVED 21 of 26

DEPARTMENT OF HEA	ALTH AND HUMAN SERV	/ICES /ICES			Printed: 07/05/201 FORM APPROVEI OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	ER/CLIA IMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495118	3	B. WING		06/23/2016	
	LTH AND REHAB OF R	300 HAT ROCKY	ESS, CITY, STA CHER STR MOUNT, VA	EET		
PREFIX (EACH DEFICIENCY	RY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	REGULATORY:	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION	
other diagnost the attending p This Requirem Based on staff	ist provide or obtain radio ic services only when ord	ced by:	F 510	F-510 1. Resident #20's physician vnotified that a 2 view x-ray vordered on 06/08/16 and only	/as	
ordered radiole the survey san Resident #20 v 6/8/16 with dia encephalopath cardiopulmona amputation. C assessment (N date 4/4/16, the brief interview was assessed	orgy exam for 1 of 28 residence (Resident #20). was readmitted to the facting gnoses including hypertay, diabetes mellitus, and above the nation of the minimum data set (MDS) with assessment representations of the mental status. The reas being without signs of the residents of	dents in ility on ension, e knee ference on the esident delirium,		view x ray was obtained with orders given. Resident #20 was re-assessed Unit Manager on 07/15/16 w change in condition noted. 2. The Unit Managers will coan audit by 07/22/16 of the cresidents' medical record to cradiology and other diagnost services are provided per phyorders.	no new I by the ith no omplete urrent ensure ic	
surveyor noted a CXR (chest) (cardiopulmons pneumonia. R record dated 6 (anterio-poster documentation changed or that only one vi	record review on 6/23/16 a physician order dated (-ray) 2 views wheezing ary disease) r/o (rule out) adiology results on the cli/8/16 were for chest - 1 vor)). The record contains to indicate that the order the physician had been ew had been obtained.	6/8/16 for COPD inical riew (AP ed no had been notified		 3. The licensed nurses will be educated by the Staff Develor Coordinator by 07/22/16 related ensuring radiology and other diagnostic services are proving physician orders 4. The Unit Managers will contain the contained of the	pment ted to ded per	
the chest X-ray	iscussed the process for with the resident's nurse	on		audits weekly for 4 weeks an monthly for 2 months to ensu	d	

6/23/16. The nurse stated that the nurse taking

the order called the radiology provider and read the order to the person taking the order. The

the nurse's station. The nurse attached the

provider then faxed the order for the technician to

radiology and other diagnostic

services continue to be provided per

physician's orders. The Director of

Nursing will submit a report to the

DEPARTMENT	OF HEALTH A	ND HUMAN	SERVICES
CENTERS FOR	MEDICARE 8	MEDICAID	SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495118	B. WING		06/23/2016
	PROVIDER OR SUPPLIER MISSION HEALTH	AND REHAB OF RO 300 HA	PRESS. CITY, STATEMENT, N		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 510	Continued From pa		F 510		
	to check prior to ob that there is a triple technician performs The unit manager, of	director of nursing, and		Quality Assurance Committee monthly for 3 months. The of Nursing will be responsible monitoring and follow up.	Director
	administrator were a summary meeting	notified of the concern during			
	483.75(I)(1) RES	ETE/ACCURATE/ACCESSIB	F 514	Completion date:	07/23/16
	resident in accordar professional standar complete; accurately accessible; and system of the clinical record information to identification of the clinical resident's assessment services provided; the preadmission screen and progress notes.	rds and practices that are y documented; readily tematically organized. nust contain sufficient fy the resident; a record of the ents; the plan of care and ne results of any ning conducted by the State;		F-514 1. Resident #17's physician a dialysis center were notified Unit Manager on 06/23/16 rethe missing and incomplete docommunication sheets with norders noted. Resident #17 was re-assessed licensed nurse on 06/23/16 with change in condition noted.	by the clated to lialysis to new I by the
	Based on observation record review it was failed to keep complete.	on, staff interview and clinical determined the facility staff ete, accurate clinical records (Residents #17, 14).		Resident #14's physician was on 06/23/16 by the Charge N an order clarification related Comprehensive Metabolic Probtained.	urse and to the
	•		4		
	3/10/10. His diagnos (end-stage-renal disc	admitted to the facility on ses included ESRD ease.) The resident's clinical I on 6/23/16 at 9:00 AM.		2. The Unit managers will co an audit by 07/22/16 of the c residents' medical record to dialysis communication shee	urrent ensure ts are
	Resident #17's MDS	(minimum data set)		completed and monthly POS current physician's orders wi	

Printed: 07/05/2016

	RIMENT OF HEALTH RS FOR MEDICARE					FORM APPR OMB NO. 0938	
	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495118		B. WING		06/23/2016	5
1	PROVIDER OR SUPPLIER			RESS, CITY, ST	ATE, ZIP CODE		
TRINIT	Y MISSION HEALTH	AND REHAB OF R		TCHER STR			
				MOUNT, V	A 24151		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI BE PRECEDED BY FULL NTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMP	(5) LETION LTE
F 51	4 Continued From page 4			F 514		· · · · · · · · · · · · · · · · · · ·	
	cognitively unimpair	3/31/16 coded the re ed. He was coded v	vith ESRD		clarifications are completed required.	as	
	updated 5/9/16, indistage renal disease "as ordered." Resident #17's physicated 6/7/16 include the resident to dialy and Fridays. The clinical record occumunication she staff to fill out the daresident going out. To conveyed to the offwere to complete the send it back. This were	et with a section for ate and vital signs properties information was site dialysis facility well section of the formation as to occur for each a week as schedule eviewed for March 20016. The inspector from munication sheets for 16, 6/17/16, 6/13/16/16, 5/20/16,5/11/16/16, 3/9/16. Incompleted in the section of the sectio	of end as dialysis ed and taff to get ednesdays facility ior to the where staff m and dialysis ed. 016 observed or the 6, 6, 6, ete sheets		3. The licensed nurses will be educated by the Staff Develor Coordinator by 07/22/16 related ensuring dialysis communicated sheets are complete and more are current per physician's owith clarification orders obtained. 4. The Unit Managers will contain a weekly for 4 weeks at monthly for 2 months to ensure dialysis communication combe completed and clarification continue to be obtained as real The Director of Nursing will report to the Quality Assurant Committee monthly for 3 memory of the Director of Nursing will responsible for monitoring a up.	opment ated to ation othly POS orders ained as omplete ad oure tinue to on orders equired. I submit a ace onths. I be	
	6/6/16.	uroro oboro di dale di F	781 14		Completion date:		07/23/1
	These observations 9:30 AM, She said s	ometimes the dialys	is clinic		RECEI	VED	Ì
	did not send the info staff) were supposed documentation comp	back at all and they to call the clinic an	(nursina		JUL 18	2016	11224
	The administrator was on 6/23/16 at 10:00 a provided.	as informed of these	e findings fo was		VDH/C	LC	Action to the second se

DEPAR' CENTE	TMENT OF HEALTH	AND HUMAN SERV & MEDICAID SERV	ICES			FORM	: 07/05/2016 MAPPROVED D. 0938-0391
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	R/CLIA	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE S	URVEY
	WWW.	495118		B. WING		06/2	23/2016
	PROVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE		
TRINITY	MISSION HEALTH	AND REHAB OF RO		CHER STR			
			ROCKY	MOUNT, W	A 24151		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI BE PRECEDED BY FULL NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 514	Continued From pa	age 24		F 514			
	ensure a complete a	14 the facility staff fa and accurate Physic	iled to ian Order				
	Sheets (POS's).						
	Resident #14 was a	ın 84 year old female	who was				
	admitted on 6/2/15.	Admitting diagnose	s				
		not limited to: demer					
	osteoporosis, hyper	lipidemia and glauco	ma.				
	The most current M	inimum Data Set (M	DS)				
	located in the clinical	al record was an Ann	ual MDS				
	assessment with an	Assessment Refere	nce Date				
	(ARD) of 6/9/16. Th	ne facility staff coded	that				
	Resident #14 had a 3. The facility staff a	Cognitive Summary	Score of				
	required limited (2/2	also coded that Resi ') to total nursing car	uent#14 e (4/2)				
	with Activities of Dai	ly Living (ADL's).	O (-11/2)				
	On June 22, 2016 a	t 8:45 a.m. the surve	yor				
	reviewed Resident # of the clinical record	r 14 S Clinical record.	Review				
	Order Sheets (POS'	s). Review of the si	rnysician aned				
	POS's revealed the	following order: "Co	OMP				
	(Comprehensive Me	tabolic Profile) (CMI	P) Q				
	(EVERY) 6 MONTH						Í
	(January, April, July, originated on 9/8/15.	October)." (sic) 11	ne order				
	the COMP (CMP) ev	erv 6 months, but th	i opialii ien				
	stated to draw the C	OMP (CMP) quarter	lv. The				. [
	order was not clearly	defined as to when	to obtain	•			
	the COMP (CMP).						
	Continued review of	the clinical record of	nduced				
	the results of a COM	IP (CMP) every quar	ter				1
	(October, January, A	pril and July).					1

On June 22, 2016 at 9:45 a.m. the surveyor notified a Licensed Practical Nurse (LPN #1) and the Unit Manager (UM), who was an LPN, that

			and the		
DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			Printed: 07/05/2016 FORM APPROVED 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	
	495118 B. WING			06/23/2016	
NAME OF PROVIDER OR SUPPLIER		RESS, CITY, ST	ATE, ZIP CODE		
TRINITY MISSION HEALTH	l	CHER STR MOUNT, V			
PRÉFIX (EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ULD BE COMPLETION	
F 514 Continued From pa	age 25	F 514			
	S's were incorrect. The	. = . ,			
surveyor reviewed t	the signed POS's with LPN				
(#1) and the UM. T	he surveyor pointed out that				
	(CMP) was not clear. The				
surveyor pomieu ou lab to be obtained e	ut that the order read for the every 6 months, however, the				
order also directed t	for the facility staff to obtain				
the COMP (CMP) e	very quarter. The surveyor				
	an, April and July COMP				
(CMP) results with L	LPN (#1) and UM. The				
to obtain the COMP	PN (#1) and UM that the order (CMP) was not clear.				
	at 2:25 p.m. the survey team				
Met with the Adminis	strator (Adm) and Director of surveyor notified the				
Administrative Team	(AT) that the facility staff				
	omplete and accurate POS's				
for Resident #14. Th	he surveyor notified the AT				
that the physician or (CMP) was not clear	rder for obtaining a CMP r.				
exiting the facility as	nation was provided prior to s to why the facility staff failed				
to ensure complete a Resident #14.	and accurate POS's for				

PRINTED: 07/05/2016

State of \	Virginia					FORI	M APPROVE
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	:R/CLIA MBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE COMP	SURVEY
	,	495118		B. WING		06/	23/2016
NAME OF P	PROVIDER OR SUPPLIER			DRESS, CITY, STA	ATE, ZIP CODE		
TRINITY	MISSION HEALTH AN	ID REHAB OF ROCKY	300 HATC ROCKY M	HER STREET MOUNT, VA 241			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
F 000	Initial Comments	, , , , , , , , , , , , , , , , , , , ,		F 000			
	survey and and con 6/21/16 through 6/2 investigated. Correct compliance with 42 Term Care requirem Regulations for the The Life Safety Cool. The census in this 1 141 at the time of the consisted of 22 curr (Residents #1 through 6/21/2007).	Medicare/Medicaid stamplaint survey was co 23/16. Two complaint octions are required for 2 CFR Part 483 Feder ments and Virginia Rusticensure of Nursing de survey/report will for 180 certified bed facil he survey. The survey rent Resident reviews ugh #21 & #28) and 6 sidents #22 through #	onducted ats were or ral Long ules and g Facilities. follow. fility was ey sample s o closed				
F 001.	Non Compliance			F 001			
	The facility was out following state licens	of compliance with the sure requirements:	ne				
	The facility was not following Virginia Ru Licensure of Nursing 12 VAC 5-371-150.	Resident Rights. (A,B.1,B.3,C,D): Cros	he s for the				
	12 VAC 5-371-150. I 12 VAC 5-371-150 (F-167.	Resident Rights. (B.3): Cross reference	e to		-	CEIVED	į
	12 VAC 5-371-370. (12 VAC 5-371-370 (reference to F-256.	Quality of Life. (A, B,C,D,E,G,H,I): Ci	ross	,		L 18 2016 DH/OLC	
	care planning.	Resident assessmen					

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

Calministrator 1-15-16
6Q9211 If continuation sheet 1 of 2

PRINTED: 07/05/2016

State of	Virginia						MAPPROVE	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495118		B. WING		06/3	3/2016	
NAME OF PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE			00/20/2010	
TRINITY	MISSION HEALTH AN	D REHAB OF ROCKY	300 HATO ROCKY N	CHER STREET				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
	Continued From Pa	ige 1		F 001				
	12 VAC 5-371-220. 12 VAC 5-371-220 to F-309.	Quality of Care. (A THRU G) Cross re	eference					
	12 VAC 5-371-220. 12 VAC 5-371-220 (Quality of Care. (B) Cross reference	to F- 333.					
	12 VAC 5-371-310. 12 VAC 5-371-310 (504.	Administration. (A) Cross reference t	to F-502,					
	12 VAC 5-371-360. 12 VAC 5-371-360 (F-514	Clinical Records A,E,f,j) Cross Refere	ence to				į	
						RECEIVED)	
						JUL 18 2016		

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VDH/OLC