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

PRINTED 08/25/2016 FORM APPROVED OMB NO 10938-0301

1		& MEDICAID SERVICES	~ 		OMB N	<u>0 0938-039</u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TPLE CONSTRUCTION NG	(X3) D	ATE SURVEY OMPLETED
		495015	B WING			C 9/44/2046
NAME OF	PROVIDER OR SUPPLIER		***************************************	STREET ADDRESS CITY	Y STATE ZIP CODE	8/11/2016
ROMAN	EAGLE REHABILITA	TION AND HEALTH CARE CENTE	R	2526 NORTH MAIN ST DANVILLE, VA 2454		
(X4) IO PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	FACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X) COMPLETION DATE
F 000	INITIAL COMMENT	"S	F 00	00		n de de de la companya
	conducted 8/9/16 th were investigated d are required for con Federal Long Term Safety Code survey. The census in this 3 298 at the time of th consisted of 27 curi	12 certified bed facility was e survey. The survey rent Resident reviews h #27) and 3 closed reviews gh #30)	F 22	5		
SS≃G	INVESTIGATE/REP ALLEGATIONS/IND	ORT	+ Z2	5		
	been found guitty of mistreating residents had a finding entered registry concerning a of residents or misap and report any know court of law against a indicate unfitness for	employ individuals who have abusing, neglecting, or by a court of law; or have dinto the State nurse aide abuse, neglect, mistreatment apropriation of their property, ledge it has of actions by a contemployee, which would service as a nurse aide or the State nurse aide registry es.				
	nvolving mistreatment neluding injuries of u misappropriation of re mmediately to the ad olother officials in ac	esident property are reported ministrator of the facility and cordance with State law rocedures (including to the			RECEIVED SEP 02 2016 VDH/OLC	

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

ministrator 9/11

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.

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

PRINTED 08/25/2016 FORM APPROVED OMB NO 0938-0361

CENII	ERS FOR MEDICAR	E & MEDICAID SERVICES			OMB NO 0938-0391
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER	1	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495015	8 WNG		C
Verenzioni	PROVIDER OR SUPPLIER	TION AND HEALTH CARE CENT	ER	STREET ADDRESS CITY STATE ZIP CODE 2526 NORTH MAIN STREET DANVILLE, VA 24540	08/11/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF ()	PROVIDER'S PLAN OF CORRE	DIRTER DAMPERSON
F 225	The results of all in to the administrator representative and with State law (inclicentification agency incident, and if the	ave evidence that all alleged bughly investigated, and must ential abuse while the progress.	F 2:	25	
	by Based on staff intereview, clinical reco of a complaint inves	IT is not met as evidenced rview, facility document rd review, and in the course tigation, the facility staff failed sidents was free from		Past noncompliance Inc plan o correction required	4
	free from abuse Resident #1 was adi 12/5/12 with diagnos dementia, hypertens	mitted to the facility on ses of neurogenic bladder, son, fractured femur, anxiety, ure, gastro-esophageal reflux			
• •	The current quarterly of 5/29/16 was review assessed with a loog The resident was assessed.	MDS with a reference date wed. The resident was initive score of "0" of 15" sessed requiring total ons for toileting, dressing,			Allega de la compansa de la delega de la compansa d

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

Event ID H03Z11

Facility ID VA0209

If continuation sheet Page 2 of 15



DEPARTMENT OF HEALTH AND HUMAN CED HOLE

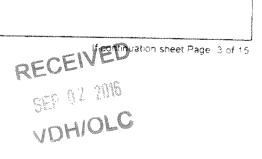
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OCIA	CINICIAI OF HEALI	H AND HUMAN SERVICES				PRINI	EU 08/25/201
CENI	ERS FOR MEDICAR	E & MEDICAID SERVICES				OMB:	RM APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVID IDENTIFE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	ž.		CONSTRUCTION	(X 3,	NO 0938-039 DATE SURVEY COMPLETED
-		495015	B WING			11. ***********************************	C
NAME OF	PROVIDER OR SUPPLIER						08/11/2016
			- Company		REET ADDRESS CITY STATE ZIP COL	Œ	
RUMAN	EAGLE REHABILITA	TION AND HEALTH CARE CENT	ER		6 NORTH MAIN STREET		
1X4/10	CHMMADV CT	ATEMENT OF DEFICIENCIES			NVILLE, VA 24540	_	
PREFIX 1AG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD RE	CAXS: COMPLETED NO. DATE
F 225	Continued From pa	age 2	r o	25		MMMM comparison and an action and action and action and action and action and action action and action acti	
		fers, bathing, and hygiene	F 2:	20			
	The resident was o	coded to resist care					
	care plan included was alert but delus being combative ar interventions included techniques when reprovide support and expressing negative. The director of nurs 8/10/16 at 1.45 p m DON stated a family with a video taken is "nannie cam" set up DON stated she vie	ing (DON) was interviewed on about the incident. The member had provided her in the resident's room from a by the family member. The wed the video and					
	assistant (CNA#1) II	ited the certified nursing nvolved. The police were					and district any of the party o
	notified, APS notified	d. DHP notified, and the					Meriterross
	Office of Licensure	and Certification notified					Venille projections.
	survey team. The su- enter Resident #1's approached the bed resident. CNA#1 pul- and roughly pulled o resident had on her i resident's gown off a arms and rubbed it in	ed by two members of the inveyors observed CNA#1 room on 3/15/16 CNA#1 and did not speak to the led the covers off the resident ff the blue booties the feet. She then pulled the nd roughly pulled it off her in the resident's face. The up in hands in a defensive					

manner. CNA#1 then stepped out of view and water could be heard running. The resident was left uncovered at this time. CNA#1 returned with a

turned her to her side and pushed on her, then

pan of water for bathing. She grabbed the resident's arm and jerked her up and roughly



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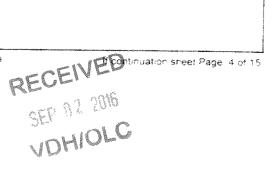
CENTI	ERS FOR MEDICAR	E & MEDICAID SERVICES					RM APPROVEC 10 0938-0391
STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			CONSTRUCTION	(X3) I	DATE SURVEY COMPLETED
	nokkoki mengapukan oku ungaka mengapukan kelulukan kelulukan kelulukan kelulukan kelulukan kelulukan kelulukan	495015	8 WING	***************************************	AND COLORS OF THE POST OF THE PLAN AND COLORS OF THE POST OF THE P		C 08/11/2016
NAME OF	PROVIDER OR SUPPLIER	₹		STI	REET ADDRESS CITY STATE ZIP CODE		
ROMA	NEAGLE REHABILITA	ATION AND HEALTH CARE CENT	ER		RONTH MAIN STREET NVILLE, VA 24540		
(X4) ID PREFIX TAG	(EACH DEFICIEN(FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	COMPLETION DATE
F 225	grabbed her hair a bed. The CNA spotential in the residuped off. At this parameter a family member en handled and spoke manner as she spotential in the incident. The DON provided as follows. The CNA was term examined and nour All residents cared and interviewed if promplaints. All staff were insertial interviewed in the complaints. Residents with Residents with Residents with Residents with Residents with requires care and himonitor care more considered and interviewed if promplaints. The DON and qualification on 8/10/16 and informed on 8/10/16 and informed on 8/10/16 and interviewed in the completion date.	and pulled her up and then and lifted the resident off the like to the resident and could be pe you do spit on me." CNA#1 and could be seen dent's face which she roughly oint a voice could be heard and intered the room. CNA#1 then a to the resident in gentle oke with the family member. If the facility investigation into the facility plan of correction anated and Resident #1 was injuries noted for by CNA#1 were assessed possible and none had any viced on "Caring for Residents and Dignity". If the facility plan of correction and the facility plan of correction.		25			
F 278	483.20(g) - (j) ASSE	SSMENT	F 27	8			Ter skaleningsget

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

SS=D ACCURACY/COORDINATION/CERTIFIED

Event ID H03Z11

Facility ID VA0209



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

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STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	T		INID INC	<u>7_0838-039</u>
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		LTIPLE CONSTRUCTION DING		TE SURVEY MPLETED
		495015	B WING	·	Albert	C
NAME OF	PROVIDER OR SUPPLIE	R	1	STREET ADDRESS CITY STATE ZIP CODE	80	//11/2016
		ATION AND HEALTH CARE CENTE	R	2526 NORTH MAIN STREET DANVILLE, VA 24540		
-X411D PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	The second of th) RE	XI COMPLETALN DATE
F 278	Continued From p	page 4	En	278 F 278	Address to the section of the sectio	
		must accurately reflect the	1 2	1 / O		
	resident's status.	and the state of t		Resident #1's MDS was modifi	ad ta	
						0/11/17
	A registered nurse	must conduct or coordinate		show that no Foley catheter is pre	sent.	8/11/16
	each assessment	with the appropriate				
	participation of he	alth professionals		The MDS of all residents with	-	
	A conjetered assess	. manual museum and a second of the second		catheters that have received an		
	assessment is con	must sign and certify that the		for removal will be audited to		
	assessment is con	ilpieted.		that no Foley catheter is present	when	
	Each individual wh	o completes a portion of the		the update of the MDS is due, or	r if a	
	assessment must	sign and certify the accuracy of		significant change occurs. This w	rill be	
	that portion of the	assessment.		completed by the MDS Assess	sment	
				Coordinator.		9/16/16
	Under Medicare ar	nd Medicaid, an individual who				
	willfully and knowir	ngly certifies a material and		Results of the audit will be revi	ewed	
	laise statement in	a resident assessment is		by the Quality Assurance Coord		
	Subject to a civil mi	oney penalty of not more than		and Director of Nursing	with	
	willfully and knowing	sessment; or an individual who agly causes another individual		appropriate action taken.	** 1011	9/16/16
	to certify a materia	l and false statement in a		appropriate action taken.		2/10/10
	resident assessme	int is subject to a civil money		The Director of Nursing will e	neuro	
	penalty of not more	than \$5,000 for each			nsure	
	assessment			compliance.		9/16/16
				O (1 100/ - 6 - 11 ; 1t-	1.	9/10/10
	Clinical disagreeme	ent does not constitute a		Quarterly, 10% of all residents		
	material and false s	statement		have had Foley catheters removed		5
				have their MDS audited to ensure		Manadian Republication Republi
	This REQUIREMEN	NT is not met as evidenced		the Foley catheter is not marked of		en e
	by	CO TO THE CAS ENGERCED		MDS that was completed after l	•	Percentage
	Based on staff inte	rview and clinical record		removal. This will be complete	•	
į	review, the facility s	taff failed to ensure a		the MDS Assessment Coordinator	•	9/23/16
(complete and accur	rate Minimum Data Set (MDS)				and the state of t
1	for 1 of 30 residents	s (Resident #1).		Audit results will be reviewed b	-	Add de la constantina
-	The findings include	.		Quality Assurance Coordinator an	d the	
	c mangs module	•		Director of Nursing with approp	oriate	grap a aced
-	The facility staff faile	ed to ensure the MDS was		action taken.		9/23/16

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

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STATEM	ENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CUA	/V2: N#1	1 Table 1	OMB NO	<u>0 0938-039</u>
ANDPLA	N OF CORRECTION	IDENTIFICATION NUMBER		ULTIPLE CONSTRUCTION	(X3) DA	ATE SURVEY
		observation of the state of the	A. BUILI	DING	50	MPLETED
		495015	2 33340	•	and the same of th	С
NAME C	F PROVIDER OR SUPPLIER		8 MNG		l n	3/11/2016
		•		STREET ADDRESS, CITY STATE ZIP CODE		2/1/2016
ROMA	N EAGLE REHABILITA	ATION AND HEALTH CARE CENTE	: D	2526 NORTH MAIN STREET		
			_ r,	DANVILLE, VA 24540		
(X4) (C	SUMMARY ST	ATEMENT OF DEFICIENCIES	10		***************************************	****
PREFI; TAG	X (EACH DEFICIENC REGULATORY OR	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF	A CONTRACT OF THE STATE OF THE	WUMBE	X5: COMPLETION DATE
F 27	8 Continued From page	ane 5		TI OA C P		
			F 2	The QA Coordinator wil	l ensure	
	accurate for Resid	ent#1.		compliance.		9/23/16
	Resident #1 was admitted to the facility on 12/5/12 with diagnoses of neurogenic bladder, dementia, hypertension, fractured femur, anxiety, congestive heart failure, gastro-esophageal reflux disease, and osteoporosis.			(See Attached Form) These systemic changes wi		
	The current quarter of 5/29/16 was reviassessed with a continuous assessed with a continuous assistance of 2 per bed mobility, transfer the resident was of the clinical record variation of 2 per contained a physicial catheter on 3/24/16. A staff nurse (LPN: 8/10/16 at 3:00 p.m. did not have a catheter of 2 per contained a physicial catheter of 3/24/16.	rly MDS with a reference date ewed. The resident was ognitive score of "0" of "15", ssessed requiring total sons for toileting, dressing, ers, bathing, and hygiene, oded to have a Foley catheter. was reviewed. The record an order to remove the Foley.		continued compliance w regulation.	ith the	9/23/16
F 280 SS=D	nurse were informed meeting with the sur p m. 483.20(d)(3) 483.10 PARTICIPATE PLAN The resident has the incompetent or other incapacitated under the meeting of the meetin	INING CARE-REVISE CP right, unless adjudged wise found to be the laws of the State, to g care and treatment or	F 28	F280 Resident #1's care plan was r show that no Foley cathe present. Voiding incontiner appropriate care plan inter was added.	eter was	8/11/16

FOLEY CATHETER MDS AUDIT

LIST OF RESIDENTS WITH FOLEY CATHETERS	REMOVAL DATE	MDS AFTER REMOVAL OF FOLEY MARKED		IF YES, ACTION TAKEN
		☐ YES	□ NO	
		☐ YES	□ NO	
		☐ YES	□ NO	
		☐ YES	□ NO	
		☐ YES	□ NO	
		☐ YES	□ NO	
		☐ YES	□ NO	
		☐ YES	□ NO	
		☐ YES	□ NO	
		☐ YES	□ NO	
		☐ YES	□ NO	
		□ YES	□ NO	
		☐ YES	□ NO	
		☐ YES	□ NO	
		☐ YES	□ NO	
		☐ YES	□ NO	
		☐ YES	□ NO	
		☐ YES	□ NO	
		☐ YES	□ NO	
		□ YES	□ NO	
		□ YES	□ NO	
		☐ YES	D NO	IVED
		☐ YES	□ NO	3 2016
COMPLETED BY:		REVIEWED BY:	(0)	HIOFC 55 5016

FORM: FOLEY CATHETER MDS AUDIT

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

PRINTED 08/25/2016 FORM APPROVED OMB NO 0938-0391

CENTE	TO FUR MEDICARE	: a MEDICAID SERVICES	Manager and Artifered to a constitution of the state of t		OMB NC	0938-0391
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	LTIPLE CONSTRUCTION DING	(X3) DA	TE SURVEY MPLETED
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NAME OF	PROVIDER OR SUPPLIER		***************************************	STREET ADDRESS CITY STATE ZIP CO	DE L	111/2010
ROMAN	EAGLE REHABILITAT	TION AND HEALTH CARE CENT	ĒR	2526 NORTH MAIN STREET DANVILLE, VA 24540		
X4 IO PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		HOULD BE	XS: COMPLETION OATE
F 280	within 7 days after to comprehensive ass interdisciplinary tear physician, a register for the resident, and	are plan must be developed the completion of the essment; prepared by an m, that includes the attending red nurse with responsibility other appropriate staff in	Fź	A one-time 100% audit of of all residents whose Fole has been removed will be by the MDS Assessment C to ensure that measures related to measures related to the total measures of the total sand measures related to the total sand measures related to the total sand measures.	ey catheter conducted Coordinator ated to the scontinued,	
	and, to the extent pr the resident, the res legal representative	nined by the resident's needs, racticable, the participation of ident's family or the resident's and periodically reviewed im of qualified persons after		bladder status are present. Results of this audit will be by the QA Coordinator and appropriate action taken.		9/16/16
				The DON will ensure compl	iance.	9/16/16
	by. Based on staff inter review, the facility st	T is not met as evidenced view and clinical record aff failed to review and revise care plan for 1 of 30 residents		Quarterly, an audit of 10 residents whose Foley removed during the quarter conducted to ensure that Folemeasures are not present of plan and measures related bladder status are present.	has been er will be ey catheter in the care	9/23/16
	The facility staff faile comprehensive care	d to review and revise the plan for Resident #1 to b longer had a Foley catheter		The QA Coordinator and review the results of the appropriate action taken.		9/23/16
	12/5/12 with diagnos dementia, hypertensi	nitted to the facility on es of neurogenic bladder, on fractured femur, anxiety, ire, gastro-esophageal reflux prosis		The QA Coordinator with compliance. (See Attached Form) These systemic changes with the control of the control	vill ensure	9/23/16
		MDS with a reference date ved. The resident was		continued compliance vegulation.	with the	9/23/16

FOLEY CATHETER CARE PLAN AUDIT

LIST OF RESIDENTS WITH FOLEY CATHETERS REMOVED	RELATED	ON CARE PLAN O TO FOLEY HETER	IF YES, ACTION TAKEN
	☐ YES	□ NO	
	☐ YES	□ NO	
	☐ YES	□ NO	
	☐ YES	□ NO	
	□ YES	□ NO	
	☐ YES	□ NO	
	☐ YES	□ NO	
	☐ YES	□ NO	
	☐ YES	□ NO	
	☐ YES	□ NO	
	☐ YES	□ NO	
	☐ YES	□ NO	
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	☐ YES	□ NO	
	□ YES	□ NO	
	☐ YES	□ NO	
	☐ YES	□ NO	
	□ YES	□ NO	
	□ YES	□ NO	
	□ YES	□ NO	
	□ YES	□ NO	ENED
	☐ YES	□ NO	RECEI
	□ YES	□ NO	SERVILLE
COMPLETED BY:		REVIEWED BY:	RECEIVED SEP 07 2016 VDHIOLG

FORM: FOLEY CATHETER CARE PLAN AUDIT

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

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STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CL/A	1		OMB NO 0938-039
AND PLAI	NOF CORRECTION	IDENTIFICATION NUMBER	A BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
NAMES		495015	B WING		00/44/0040
		ATION AND HEALTH CARE CENT	ER	STREET ADDRESS CITY STATE, ZIP CO 2526 NORTH MAIN STREET DANVILLE, VA. 24540	08/11/2016 CDE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIT TAG	PROVIDER'S PLAN OF COR	SHOULD BE COMPLETION
F 280	The resident was a assistance of 2 pe bed mobility, trans. The resident was of the clinical record contained a physic catheter on 3/24/16. The comprehensive care plan contained had bowel incontinute urinary retention interventions include monitor catheter tule. Foley catheter q 30	ognitive score of "0" of "15". assessed requiring total rsons for toileting, dressing, fers, bathing, and hygiene. coded to have a Foley catheter was reviewed. The record ian order to remove the Foley	F 2	80	
	A staff nurse (LPN 8/10/16 at 3.00 p.m did not have a cathe	#2) was interviewed on LPN#2 stated the resident eter and was doing well at this heter and voiding adequate			
F 285 SS=D	plan had not been re the survey team on.	ing and Quality assurance d of the finding that the care evised during a meeting with 8/10/16 at 4:00 p.m e) PASRR REQUIREMENTS	F 28:	5 F285	The second secon
	pre-admission scree	inate assessments with the ning and resident review cald in part 483, subpart C to practicable to avoid ad effort.		A PASRR Level 2 screening requested and the screening come to Roman Eagle and the Level 2 on Resident #22	g team will d complete

PRINTED 08/25/2016

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FURM APPROVE 0MB NO: 0938-039
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	LTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS CITY STATE ZIP CODE	***************************************
ROMAN		TION AND HEALTH CARE CENT	ER	2526 NORTH MAIN STREET DANVILLE, VA 24540	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE COMPLETION
	January 1, 1989, an (i) Mental illness as (i) of this section, un authority has detern independent physical performed by a pers State mental health (A) That, because condition of the individual services, whether this specialized services (ii) Mental retardation (b) If the individual services, whether this specialized services (iii) Mental retardation (c) (iii) of this section retardation or develothas determined prior (b) That, because condition of the individual services, whether the specialized services (ii) An individual is continued in the individual illness defined at §48 (ii) An individual is contented in §483.102(b)	ist not admit, on or after y new residents with a defined in paragraph (m)(2) aless the State mental health mined, based on an all and mental evaluation ion or entity other than the authority, prior to admission; to of the physical and mental ridual, the individual requires provided by a nursing facility, all requires such level of the individual requires for mental retardation on, as defined in paragraph ion, unless the State mental individual requires to admission—of the physical and mental idual, the individual requires provided by a nursing facility; all requires such level of the individual requires provided by a nursing facility; all requires such level of the individual requires for mental retardation section:	F 2	A one-time 100% audit of results of his audit will be conducted by the Services Director to ensure the PASRRs are present on the electromedical record. Results of this audit will be reverby the QA Coordinator and As Administrator with appropriate taken. Prior to admission of a resident the diagnosis of mentally chall (intellectually disabled), Admission Coordinator will that the facility has the correct Pascreening. This will be verified Assistant Administrator. The Assistant Administrator ensure compliance.	entally sabled) Social correct ctronic 9/16/16 viewed sistant action 9/16/16 at with lenged the ensure ASRR by the 8/15/16



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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	3.	PLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS CITY STATE, ZIP CODE	
ROMAN		TION AND HEALTH CARE CENTI	ER	2526 NORTH MAIN STREET DANVILLE, VA 24540	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION;	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DAE COMPLETION
	by: Based on staff inter review the facility sta and accurate PASR and Resident review (Resident # 22) The findings include For Resident # 22 th an accurate PASSR. Resident #22 was ac	IT is not met as evidenced View and clinical record aff failed to ensure a complete R (preadmission screening ii) for 1 of 30 Residents. d: le facility staff failed to ensure	F 28	the diagnosis of mentally chall (intellectually disabled), elec medical record will be audited by Social Services Director to ensure the appropriate PASSR screening present. The Quality Assured	enged tronic by the re that ing is arrance sistant results faction 9/23/16
	intellectual disabilitie	s, depression, ux disorder, hypothyroidism		(See Attached Form)	9/23/10
; ; §	an ARD (assessmen coded the Resident a cognitive patterns, Si	S (minimum data set) with t reference date) of 08/05/16 as 15 out of 15 in section C, ection A, subsection A1510 'ASRR Conditions, coded the rual Disability"		These systemic changes will e continued compliance with regulation.	ensure the 9/23/16
(08/11/16. It contained 06/12/06. Section A3 diagnosis of mental re	al record was reviewed on f a level 1 PASRR dated "Does the individual have a etardation (MR) which was e 18" was checked as "no"			Property (no. of the least of the state of t
r t	nursing) on 08/11/16 ; egarding Resident #2	with the DON (director of at approximately 1030 22's PASRR, DON stated as only "mild ID" she did not RR.			

The concern of the incorrect PASRR was

PASSR SCREENING AUDIT

RESIDENT WITH DIAGNOSIS OF MENTALLY CHALLENGED (INTELLECTUALLY DISABLED)	1	CREENING RECT	IF NO, ACTION TAKEN
	☐ YES	□ NO	
	□ YES	□ NO	
	□ YES	□ NO	
	□ YES	□ NO	
	□ YES	□ NO	
	☐ YES	□ NO	
	□ YES	□ NO	
	☐ YES	□ NO	
	□ YES	□ NO	
	☐ YES	□ NO	
	□ YES	□ NO	
	□ YES	□ NO	
	☐ YES	□ NO	
	☐ YES	□ NO	
COMPLETED BY:		REVIEWED BY	:

FORM: PASSR SCREENING AUDIT

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

PRINTED 08/25/2016 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING B WING	OMB NO 0938-03 (X3) DATE SURVEY COMPLETED C
NAME OF PROMINER OR CURRILER	-
NAME OF PROMOTER OF CHARLES	
STORET ADDOCCO OUT.	08/11/2016
ROMAN EAGLE REHABILITATION AND HEALTH CARE CENTER STREET ADDRESS, CITY STATE, ZIP CODE 2526 NORTH MAIN STREET	
DANVILLE, VA 24540	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH DEFICIENCY MUST BE PREFEDED BY \$1.11)	ITION X1
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPLICATION OF CROSS-	HEDDE Course
F 285 Continued From page 10 F 285	
discussed during a meeting with the administrative staff on 08/11/16 at approximately 1235.	
No further information was provided prior to exit F 441 483 65 INFECTION CONTROL, PREVENT F 441 SS=D SPREAD, LINENS	
The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection	orn with
(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections LPN #1 has been inservious appropriate infection techniques when performing care.	control
in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections (b) Preventing Spread of Infection A one-time 100% audit conducted by the Staff Deve Coordinator of residents resure appropriate infection	lopment eceiving nurse to control
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident measures are followed. (See Policy Attached)	9/16/16
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	essment
hand washing is indicated by accepted professional practice The DON will ensure compliant	9/16/16

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

Event ID: H03Z11

Facility ID VA0209

If continuation sheet Page 11 of 15



DRESSINGS - CLEAN

POLICY STATEMENT

It is the policy of this facility to perform dressings as ordered by physician.

EQUIPMENT:

- 1. Appropriate dressings
- 2. Clean gloves
- 3. Prescribed cleaning solution
- 4. Container for soiled dressings

Procedure

- 1. Explain procedure to resident and bring equipment to bedside. Screen resident.
- 2. Assist resident to required position and expose area to be dressed.
- 3. Wash hands thoroughly.
- 4. Clean work surface with antiseptic.
- 5. Wash hands with antiseptic.
- 6. Open dressings and needed supplies.
- 7. Put on clean gloves. Remove soiled dressings and discard in container.
- 8. Place barrier beneath wound if likelihood of touching linen.
- 9. Wash hands with antiseptic. Put on clean gloves.
- 10. Cleanse wound with prescribed solution (if ordered).
- 11. Change barrier beneath wound if soiled.
- 12. Apply dressings. Secure with tape if necessary.
- 13. Remove gloves and dispose in container.
- 14. Tie and discard bag containing soiled dressings.
- 15. Wash hands.
- 16. Take soiled dressing to dirty utility room.
- 17. Wash hands thoroughly.
- 18. Chart procedure in clinical nursing record, condition of wound and surrounding area, character and amount of drainage. Include pertinent observations.

Policies - Dressings Clean

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

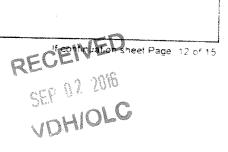
PRINTED: 08/25/2016 FORM APPROVED

STATEM	ENT OF DEFICIENCIES	(X1) PROVIDENCE OF THE PROVIDE			OMB N	O 0938-039
AND PLA	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		TIPLE CONSTRUCTION DING	(X3) D	ATE SURVEY OMPLETED
		495015	8 WING		*	С
NAME (OF PROVIDER OR SUPPLIER			STREET ADDRESS CITY STATE ZIP CO	0	8/11/2016
ROMA	N EAGLE REHABILITA	TION AND HEALTH CARE CENT	rER	2526 NORTH MAIN STREET DANVILLE, VA 24540)DE	
(X4) 10	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID.	PROVIDERS PLAN OF CORE		
PREFI TAG	REGULATORY OR I	Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	PREF! TAG	X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULDE	XS COMPLETION DATE
F 44	(c) Linens Personnel must ha transport linens so infection This REQUIREMENT by, Based on observat document review, a facility staff failed to and procedure during residents (Resident) The findings include The facility staff faile policy and procedure Resident #6.	as to prevent the spread of as to prevent the spread of NT is not met as evidenced ion, staff interview, facility and clinical record review, the follow infection control policy by wound care for 1 of 30 #6).		41 Quarterly, The Staff De Coordinator will audit the nurse performing wound ca of residents receiving wo Results of audit will be rethe QA Coordinator and I Nursing with appropriate act. The QA Coordinator we compliance. (See Attached Form) These systemic changes we consider the compliance of the coordinator we compliance.	evelopment e treatment are to 10% ound care. eviewed by Director of tion taken.	
	2/23/16 and re-admidiagnoses of pressure Alzheimer's disease, anxiety, transient isochronic pain, and gardisease. The current significant (MDS) with a referent the resident with a contract the resident was assistance of 1 persodressing, eating, toiled A staff nurse (LPN#1 wound care for Resident was assistance of Resident was assistance of 1 persodressing, eating, toiled A staff nurse (LPN#1 wound care for Resident was assistance of 1 persodressing, eating, toiled A staff nurse (LPN#1 wound care for Resident was assistance of 1 persodressing, eating, toiled A staff nurse (LPN#1 wound care for Resident was assistance of 1 persodressing, eating, toiled A staff nurse (LPN#1 wound care for Resident was assistance of 1 persodressing, eating, toiled A staff nurse (LPN#1 wound care for Resident was assistance of 1 persodressing).	mitted to the facility on ted on 7/21/16 with re ulcer, hypertension, delusional disorder, anemia, hemic attack, osteomyelitus, stro-esophageal reflux nt change Minimum Data Set ce date of 7/28/16 assessed ognitive score of "8" of "15", sessed requiring total on for bed mobility, transfers, eting, bathing, and hygiene. I) was observed performing lent #6 on 8/10/16 at 10.35 upplies into the room in				

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

Event ID H03Z11

Facility ID: VA0209



WOUND CARE AUDIT

RESIDENTS RECEIVING WOUND CARE	WOUND CARE FOLLOWING A INFECTION CO MEASURES (a policy)	ONTROL	IF NO, ACTION TAKEN
	☐ YES WOUND CARE BY:	□ NO E PROVIDED	
	☐ YES WOUND CARE BY:		
	☐ YES WOUND CARE BY:		
	☐ YES WOUND CARE BY:		
	☐ YES WOUND CARE BY:		
	☐ YES WOUND CARE BY:		
	☐ YES WOUND CARE BY:		
	☐ YES WOUND CARE BY:	□ NO PROVIDED	
	☐ YES WOUND CARE BY:		
	☐ YES WOUND CARE BY:		
COMPLETED BY:		REVIEWED BY:	

FORM: WOUND CARE AUDIT

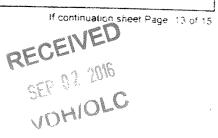
PRINTED 08/25/2016

	TENS FOR WEDICAR	E & MEDICAID SERVICES			FURM APPROVE
AND PLA	SENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE CONSTRUCTION	MB NO 0938-039
		IDENTIFICATION NUMBER			(X3) DATE SURVEY COMPLETED
				- Control of the Cont	
NAME	OF PROVIDER OR SUPPLIER	495015	5 WING		C
	OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY STATE ZIP CODE	08/11/2016
ROMA	AN EAGLE REHABILITA	TION AND HEALTH CARE CENT	FD	2526 NORTH MAIN STREET	
				DANVILLE, VA 24540	
(X4) (I PREFI TAG	IX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF:) TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	5 DE 20.00
F 44	o o minaca month pe	ige 12 I placed the baggies on the	F 4	4^	
	resident's bed I PN	I#1 then prepared a clean			
	barrier on the beds	ide table, washed her hands.			
	placed the clean ite	ms on the barrier from the			
	paggies and placed	the baggies on the hedeide			
	table. LPN#1 wash	ed her hands and donned			
	gioves and removed	d the old dressing from the			
	old packing from the	ea LPN#1 then removed the wound and proceeded to			
	clean the wound by	flushing with normal saline			
	and patting the wou	nd dry. LPN#1 then placed			
	the new packing in t	he wound and covered the			
	wound with the new	dressing LPN#1 failed to			
	dressing and placing	een removing the old			
	LPN#1 then cleaned	the new clean dressing. Ther supplies and placed			
	them back into the p	plastic baggies and carried the			
	paggies back to the	Wound supply cart in the half			
	LPN#1 was informed	of the findings and stated			lichtengen,
	sne usually did chan	ge gloves after removing the			· · · · · · · · · · · · · · · · · · ·
	old dressing.				
	The director of nursing	ng was asked for the facility			
	policy and procedure	s for wound care. The policy			**************************************
	stated for nandwashi	ing that hands should he			Mahary various
	washed "before and	after handling items			der für seine sein
	potentially contamina	ited with any resident's			Service case
	for a clean dressing a	secretions". The procedure was to "remove soiled			**
	dressings and discar	d in container, wash hands			
	with antiseptic, and p	ut on clean gloves, then			
	cleanse the wound ar	nd apply the clean dressing".		F514 Resident #8's physician orde clarified to state that a nasal cant face mask may be used to adm	Personal
		~		F514	Minimum to the
	director wars info	g and quality assurance			**************************************
	meeting with the cur-	d of the finding during a ey team on 8/10/16 at 4:00			i i
	p.m.	ey team on 6/10/16 at 4:00		clarified to state that a nasal cannu	į.
F 514	483 75(I)(1) RES		F 514	face mask may be used to admin	1
	***		F 014	oxygen at 2-4 liters prn.	8/10/16

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

Event ID H03Z11

Facility ID VA0209



PRINTED 08/25/2016

CENTERS FOR ME		MEDICAID SERVICES			FOR	MAPPROVE
STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION	DES ((1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MU	LTIPLE CONSTRUCTION		O 0938-039
	- Percoverence of the second o	DENTIFICATION NUMBER		DING		OMPLETED
		495015	B WING		terimore va	С
NAME OF PROVIDER OR S	SUPPLIER		I G ANIAG		0	8/11/2016
ROMAN FACIF PEU	ADII ITATIC	AN ASS LINE		STREET ADDRESS CITY STATE ZIP CODE 2526 NORTH MAIN STREET		
TOWN LAGEE REM	ABILITATIC	ON AND HEALTH CARE CENTE	R	DANVILLE, VA 24540		
(X4) ID SUM PREFIX (EACH D	MARY STATE	MENT OF DEFICIENCIES	<u>_</u>			
TAG REGULAT	ORY OR LSC	UST BE PRECEDED BY FULL IDENTIFYING INFORMATION:	PREFI TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	11 h oc	EX ^E COMPLETION DATE
F 514 Continued F	From page	- 13				
SS=D RECORDS	-COMPLE	TE/ACCURATE/ACCESSIB	F 5	71 one time 10070 addit of an re		
LE		. E. NOOONATE/ACCESSIB		with physician orders for oxyg		
				be conducted by nursing superv		
The facility i	must main	tain clinical records on each		ensure that the order states		
resident in a	accordance	with accepted professional es that are complete:		cannula or face mask unless c		
accurately d	locumente	d, readily accessible; and		indicated. The nursing super		
systematica	lly organiz	ed.		will check residents with oxy		
	-			ensure oxygen is being admir by the ordered method.	istered	9/16/16
The clinical i	record mu	st contain sufficient		by the ordered method.		9/10/10
resident's as	o identify i	the resident; a record of the s; the plan of care and		Results of this audit will be re	viewed	
services pro	vided: the	results of any		by the QA Coordinator and DO		
pr eadmiss ioi	n screenin	g conducted by the State		appropriate action taken.		9/16/16
and progress	s notes.	• • • • • • • • • • • • • • • • • • • •		appropriate action taken.		27.107.10
				Each shift, the medication nur	se will	
This REQUIP	REMENT	is not met as evidenced		check the administration of oxy	gen on	
by:				residents on the unit where th	ey are	
Based on ob	oservation,	staff interview and clinical		working, to ensure oxygen is	being	
record review	v. the facili	ty staff failed to maintain a		administered according to	the	
residents (Re	sident #8	clinical record for 1 of 30		physician's order. This is	then	
,,,,	,0.00,,0			documented on the MAR.		8/12/16
The findings	included.			TI DON III		0/1////
Resident #8 :	was admitt	ed to the facility on		The DON will ensure compliance	e.	9/16/16
7/18/14 with t	the following	ng diagnoses of but not		Quarterly, the electronic reco	rda of	**Au_rija in common
limited to den	nentia, ane	emia, high blood pressure		10% of all residents receiving of		n. i) — i i i i i i i i i i i i i i i i i
high choleste	rol and os	teoporosis. The quarterly		will be audited to ensure the		
wiDO (Minimu	IM Data Se	et, an assessment Assessment Reference			oxygen	
Date) of 4/22/	16 coded	Resident #8 as having a		administration matches the met		TO LEAVE A STATE OF THE STATE O
BIMS (Brief In	iterview fo	r Mental Status) score of		administration of oxygen	(nasal	**************************************
3 out of a pos	sible score	of 15. The resident was		cannula/face mask) on the re		**Elizable confiden
also coded as	requiring	total dependence from 1		This audit will be conducted		otibianous
bathing.	ioi oressir	ng, personal hygiene and		nursing supervisors.	, ,,,,,	9/23/16

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

Event ID: H03Z11

Facility ID VA0209

9/23/16

RECENTACHTINUation sheet Page 14 of 15

SEE 97. 2016

SEE 97. 2016

OXYGEN METHOD AUDIT

RESIDENTS RECEIVING OXYGEN PHYSICIAN ORDERED METHOD NASAL CANNULA/FACE MASK	METHOD	AN ORDERED ON RESIDENT, CORRECTLY	IF NO, ACTION TAKEN		
	☐ YES	□ NO			
	☐ YES	□ NO			
	☐ YES	□ NO			
	☐ YES	□ NO			
	☐ YES	□ NO			
	□ YES	□ NO			
	☐ YES	□ NO			
!	□ YES	□ NO			
	□ YES	□ NO			
	☐ YES	□ NO			
	☐ YES	□ NO			
	☐ YES	□ NO			
COMPLETED BY:		REVIEWED BY:	RECEIVED		
ORM: OXYGEN METHOD AUDIT			RECEIVED SEP 02 2016 VOHIOLO		

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

PRINTED: 08/25/2016 FORM APPROVED OMB NO. 0938-0391

			- Stage - Commission - Commissi		NIR NO 0838-038
STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	B .	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495015	B WING_	nantra jähänyssä työ mullikulustiinistää siinnantan ona "saikkaisikkistä kiristäänistä siinnäkiyn kaikista toi	C
	VIDER OR SUPPLIER GLE REHABILITAT	TON AND HEALTH CARE CENT		STREET ADDRESS CITY STATE ZIP CODE 2526 NORTH MAIN STREET DANVILLE, VA 24540	08/11/2016
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION
The by The Rephymin An 8/1 bein bein At in sur-	the surveyor on the resident is MA ecord) for August, ysician order. If the control via (by) face observation was 0/16 at 8.10 among fed by a CNA de resident had oxing administered (fired of the above veyor. The DON cand had to use	ge 14 of Resident #8 was reviewed 8/9/16 at approximately 3pm R (Medication Administration 2016 reflected the following Dxygen 2-4 L/M (liters per e mask d/t (due to) hypoxia "made by the surveyor on The resident was observed (Certified Nursing Assistant) year at 2 liters per minute by nasal cannula. For of nursing (DON) was observation made by the stated "I believe he was facial mask but they should not to nasal cannula when he	F 51	Results of this audit will be revelop the QA Coordinator and DON appropriate action taken. The QA Coordinator will ecompliance. (See Attached Form) These systemic changes will econtinued compliance with regulation.	9/23/16 ensure 9/23/16 ensure
ass doc No	urance nurse we umented findings further informatio	of nursing and quality re notified of the above n was provided to the exit conference on 8/11/16		Submission of this plan correction is made in compl with federal mandates and doe constitute an admission by nursing facility that deficie exist, were correctly cited require correction. Allegation of Compliance: This plan of correction with stated correction dates constitute nursing facility's allegatic compliance with the listed fe and state licensure requirement	tiance es not the encies d or 9/23/16 n the itutes on of ederal