STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	02/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Minimum Data Set 3.0 special focus survey was conducted 1/31/17 through 2/1/17. Corrections are required for compliance with the following Federal Long Term Care requirements. The census in this 120 certified bed facility was 101 at the time of the survey. The survey sample consisted of 12 current resident reviews (Resident #1 through Resident #12).	F 000	Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of corrections prepared and executed as a means to continuously improve quality of care and to comply with applicable state and federal regulations.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures.	F 272	F272 1. Resident #10 CAA was noted to not show specific date and location of the supporting assessment documentation in section V or in the CAA worksheet. 2. An audit of the CAAs completed in the last 90 days will be done, then 10% of CAAs will be audited for the next three months. 3. The Interdisciplinary Team will be re-educated to include the specific date, time, and location of the supporting assessment documentation for the CAA. 4. The Director of Nursing Services or designee will audit CAAs for location, date, and time for three months. Findings will be reported to QAPI. 5. February 28, 2017	

VDH/OLC
FEB 17 2017

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Keith Schuler, LNHA	ADMINISTRATOR	2/14/17

ıy deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ıer safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ɔgram participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	02/01/2017

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

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F 272	Continued From page 1	F 272		

(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the
care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct
observation and communication with the resident, as well as communication with licensed and
non-licensed direct care staff members on all shifts.

The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review it was determined that the facility staff failed to ensure complete and accurate Care Area Assessments (CAA's) for 1 of 12 Residents in the sample survey, Resident #10.

The Findings Included:

1. For Resident #10 the facility staff failed to ensure complete and accurate Care Area Assessments (CAA's) on an Admission Minimum Data Set (MDS) assessment with an Assessment Reference Date of 1/19/17.
Resident #10 was a 44 year old female who was originally admitted on 10/26/16 and readmitted on 1/12/17. Admitting diagnoses included, but were not limited to: extra dural and subdural abscess,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	02/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 2	F 272		

obesity, major depression, anxiety and mononeuropathy right lower leg.

The most current Minimum Data Set (MDS) located in the clinical record was an Admission MDS assessment with an Assessment Reference Date (ARD) of 1/19/17. The facility staff coded that Resident #10 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #10 required extensive assistance (3/3) with Activities of Daily Living (ADL's). In Section V. Care Area Assessment s (CAA's) Resident #10 "triggered" for ADL Functional Rehabilitation, Urinary Incontinence, Psychosocial Well Being, Mood State, Activities, Falls, Nutritional Status, Pressure Ulcer, Psychotropic Drug Use, Pain and Return to Community Referral. For the "triggered" areas of Psychosocial Well Being, Mood State, Activities and Return to Community Referral the facility staff documented "CAA WS (care area assessment work sheet) dated 1/19/2017." The facility staff had not documented the specific date and location of the supporting assessment documentation for the care plan decision making.

On January 31, 2017 at 3:15 p.m. the surveyor reviewed Resident #10's clinical record. Review of the clinical record produced the CAA worksheets. Review of the CAA worksheets documented the following for the "triggered" areas of Psychosocial Well Being, Mood State, Activities and Return to Community Referral, "CAA WS dated 1/19/2017." (sic) The facility staff had not documented the specific location and dated of the supporting assessment documentation for the care plan decision making.

On February 1, 2017 at 8:10 a.m. the surveyor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	02/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 3	F 272		

interviewed the Social Worker (SW). The surveyor notified the SW that Resident #10's CAA's were incomplete/inaccurate. The surveyor reviewed the Admission MDS assessment with the SW. The surveyor specifically pointed out that Section V. CAA's did not document the specific date and location of the supporting assessment documentation for Psychosocial Well Being, Mood State, Activities and Return to Community Referral. The surveyor pointed out that the facility staff had documented CAA WS dated 1/19/2017. The surveyor then reviewed the CAA worksheets for Psychosocial Well Being, Mood State, Activities and Return to Community Referral with the SW. The surveyor pointed out that the facility staff had documented CAA WS dated 1/19/2017. The surveyor notified the SW that the CAA's were incomplete and inaccurate. The surveyor notified the SW that the specific date and location of the supporting assessment documentation was not documented in Section V or in the CAA worksheets.

On February 1, 2017 at 4:10 p.m. the survey team met with the Administrator (Adm), DON, ADON and MDS Coordinator. The surveyor notified the Administrative Team (AT) that Resident #10's CAA's were incomplete/inaccurate. The surveyor notified the AT that the facility staff had documented in Section V. CAA's Psychosocial Well Being, Mood State, Activities and Return to Community Referral "CAA WS dated 1/19/2017." The surveyor then informed the AT that the CAA worksheets documented "CAA WS dated 1/19/2017." The surveyor notified the AT that the facility staff had not documented the specific dated and location of the supporting assessment documentation for the care plan decision making.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	02/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 4 No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure complete and accurate CAA's for Resident #10.	F 272		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.	F 278	F278 1. Resident #11 MDS assessment was modified to reflect the treatment of the UTI reported on 2/2/17. 2. An audit of UTIs in the past 90 days will be conducted to ensure they are coded in the MDS assessments. 3. MDS personnel will be re-educated on UTI coding according to the RAI manual. 4. The ID team will review current UTIs in clinical start up to ensure they are coded correctly in the MDS. Findings will be reported to QAPI. 5. February 28, 2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	02/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 5	F 278		

(2) Clinical disagreement does not constitute a material and false statement.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review it was determined that the facility staff failed to ensure a complete and accurate Minimum Data Set (MDS) assessment for 1 of 12 Residents in the sample survey, Resident # 11.

The Findings Included:

Resident #11 was an 88 year old female who was originally admitted on 2/8/10 and readmitted on 1/5/17. Admitting diagnoses included, but were not limited to: hypothyroidism, dehydration, cataracts, anxiety, pyelonephritis, dementia, major depression and Alzheimer's.

The most current Minimum Data Set (MDS) assessment located in the clinical record was a 5 Day Medicare and Significant Change MDS assessment with an Assessment Reference Date (ARD) of 1/12/17. The facility staff coded that Resident #11 had a Cognitive Summary Score of 6. The facility staff also coded that Resident #11 required limited (2/2) to extensive (3/3) assistance with Activities of Daily Living (ADL's). In Section I. Active Diagnoses the facility staff did not code that Resident #11 had a Urinary Tract Infection within the past 30 days.

On February 1, 2017 at 2 p.m. the surveyor reviewed Resident #11's clinical record. Review of the clinical record produced a physician telephone order dated 12/30/16 that read ... "UA C&S STAT (urinalysis and culture and sensitivity stat)." (sic)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	02/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 6	F 278		

A physician telephone order dated 12/30/16 read ... "Levaquin Tablet 750 MG (LevoFLOXacin) Give 1 tablet by mouth one time a day for URI/UTI (upper respiratory infection/urinary tract infection) for 10 Days." (sic)

Continued review of the clinical record produced "Progress Notes" dated 12/31/16 that read in part ... "Resident noted to have elevated temperature of 99.3 ... Resident exhibiting increased confusion ... Resident reported chills and a headache ..." (sic) The progress notes also documented that Resident #11 was discharged to the local hospital on 12/31/16 and returned to the facility on 1/6/16 with a diagnoses of a UTI.

Further review of the clinical record produced the December 2016 Medication Administration Records (MAR's). Review of the MAR's documented that Resident #11 received the Levofloxacin as ordered by the physician on 12/30/16 and 12/31/16.

Continued review of the clinical record produced the results of the UA C&S dated 12/30/16. Resident #11's urine was brown, very cloudy, had 250/ul's of blood, had 500 HPF of white blood cells, had 10-15 red blood cells, and a few bacteria.

On February 1, 2017 at 2:35 p.m. the surveyor reviewed Resident #11's clinical record with the 2 MDS Nurses. The surveyor reviewed the nursing progress notes that documented symptoms of a UTI, reviewed the UA C&S results dated 12/30/16 that identified a UTI, reviewed the physician orders for diagnoses and treatment of a UTI and reviewed the December 2016 MAR's that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	02/01/2017

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

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F 278	Continued From page 7 documented treatment of a UTI. The surveyor then reviewed the 5 Day Medicare and Significant Change MDS assessment with the ARD of 1/12/17. The surveyor pointed out that the facility staff had not coded in Section I. Active Diagnoses that Resident #11 had a UTI in the past 30 days. The MDS Nurses stated that the MDS should have been coded to reflect a UTI in the past 30 days. On February 1, 2017 at 4:10 p.m. the survey team met with the Administrator (Adm), Director of Nursing (DON), Assistant Director of Nursing (ADON) and the MDS Coordinator. The surveyor informed the Administrative Team (AT) that Resident #11's 5 Day Medicare and Significant Change MDS assessment with the ARD of 1/12/17 was incorrect. The surveyor notified the AT that Resident #11 had a UTI in the look back period of 30 days and that the facility staff had not coded the UTI on the MDS. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate MDS assessment for Resident #11.	F 278		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 315	Continued From page 8 on the resident's comprehensive assessment. the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment. the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, resident interview and facility document review it was determined that the facility staff failed to ensure proper care and treatment of a resident with an indwelling Foley catheter for 1 of 12 Residents in the sample survey, Resident # 7. For Resident #7 the facility staff failed to keep the Foley catheter bag off of the floor, failed to anchor the indwelling Foley catheter to prevent	F 315	F 315 1. Resident #7 now has treatment orders for the Foley catheter. The Foley catheter bag has been removed from the floor. 2. An audit of current residents with indwelling catheters will be created to ensure necessary orders are in place and indwelling catheter bags are kept off the floor. 3. Current nursing staff members will be re-educated on the policy and procedure for residents with indwelling urinary catheters. 4. Indwelling urinary catheters orders will be monitored daily in clinical start up for three months. Residents with indwelling catheters will be checked daily during zone rounds to ensure proper placement and positioning of indwelling catheters. Findings will be reported to QAPI. 5. February 28, 2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	02/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 9	F 315		

excess tension on the urinary meatus and failed to ensure that the physician provided necessary orders for care and treatment of an indwelling Foley catheter to include a Foley catheter size and balloon size.

The Findings Included:

Resident #7 was a 72 year old female who was originally admitted on 5/11/15 and readmitted on 10/25/15. Admitting diagnoses included, but were not limited to: major depression, hypothyroidism, hypertension, chronic obstructive pulmonary disease and osteoarthritis.

The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 11/9/16. The facility staff coded that Resident #7 had a Cognitive Summary Score of 14. The facility staff also coded that Resident #7 required extensive (3/2) to total nursing care (4/3) with Activities of Daily Living (ADL's). In Section H. Bladder and Bowels the facility staff coded that Resident #7 had an indwelling Foley catheter.

On January 31, 2017 at 2:50 p.m. the surveyor observed Resident #7 lying in bed. The surveyor observed that Resident #7's urinary drainage bag was laying in the floor on the right hand side of the bed. The surveyor was exiting the room when a Licensed Practical Nurse (LPN #1) entered the room with Resident #7's medications. The surveyor pointed out that the Foley catheter bag was laying in the floor. LPN (#1) picked up the urinary drainage bag and hung it on the lower right hand side of the bed frame. The surveyor asked LPN (#1) if Resident #7's Foley was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	02/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 10	F 315		

anchored. LPN (#1) stated "No." LPN (#1) stated that Resident #7 did not have the Foley catheter anchored "because she stooled a lot." The surveyor did not understand what LPN (#1) meant. The surveyor asked LPN (#1) and Resident #7 if the risks benefits of the Foley not being anchored were explained to Resident #7. The surveyor informed Resident #7 that if the catheter was not secured it increased the potential for infection and increased the potential of the catheter being pulled out with the bulb inflated. Resident #7 spoke up and stated, "Not that I can remember." The surveyor asked to see if Resident #7's Foley was anchored. LPN (#7) pulled down the covers and exposed Resident #7's lower legs. The surveyor observed that the Foley catheter tubing was under Resident #7's right leg. The surveyor pointed out that Resident #7 was lying on the Foley catheter tubing to LPN (#1).

On January 31, 2017 at 4 p.m. the surveyor notified the Director of Nursing (DON) and Assistant Director of Nursing (ADON) that Resident #7's Foley catheter bag was laying in the floor and that the Foley catheter was not anchored. The surveyor requested the facility policy and procedure for care and treatment of residents with Foley catheters.

On January 31, 2017 at 4:25 p.m. the ADON hand delivered the facility policy and procedure titled, "Preventing Catheter Associated UTIs (CAUTI) (urinary tract infections/catheter associated urinary tract infections)." The policy and procedure read in part ... " ... 6. Maintain unobstructed urine flow. a. Keep the catheter and tubing free of kinks. b. Secure catheter after insertion to prevent movement. c. Keep drainage

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	02/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 11 bag below the level of the bladder at all times. Do not place the drainage bag on the floor." (sic) On February 1, 2017 at 8:10 a.m. the surveyor reviewed Resident #7's clinical record. Review of the clinical record produced physician orders. Physician orders included, but were not limited to: "Monitor foley cath (catheter) output QS (every shift). Foley cath care Q (every) shift)."(sic) The physician orders did not include orders for catheter care if the Foley became occluded or dislodged, how often to change the Foley catheter, or a catheter size and balloon size. On February 1, 2017 at 8:30 a.m. the surveyor reviewed the clinical record with the ADON. The surveyor reviewed the physician orders with the DON. The surveyor pointed out that the facility staff did not have physician orders for the Foley catheter size and balloon size, how often to change the Foley catheter, and how to treat if the Foley catheter became occluded or dislodged. On February 1, 2017 at 4:10 p.m. the survey team met with the Administrator (Adm), DON, ADON and MDS Coordinator. The surveyor notified the Administrative Team (AT) that Resident #7's Foley catheter bag was lying in the floor, the Foley catheter was not anchored and that the signed physician orders did not included specific orders for Foley catheter care and Foley catheter size and balloon size.	F 315		
F 329 SS=E	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	02/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 12	F 329	F 329	

used--

(1) In excessive dose (including duplicate drug therapy); or

(2) For excessive duration; or

(3) Without adequate monitoring; or

(4) Without adequate indications for its use; or

(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review it was determined that the facility staff failed to ensure that 6 of 12 Residents in the sample survey were free of unnecessary medications, Resident #7, Resident #8, Resident #9, Resident #10, Resident #11 and Resident #5.

The Findings Included:

1. For Resident #7 the facility staff failed to monitor for side effects, interventions, effectiveness and specific behaviors for the use of an antidepressant (Paxil and Remeron) and for an antianxiety (Xanax).

Resident #7 was a 72 year old female who was originally admitted on 5/11/15 and readmitted on 10/25/15. Admitting diagnoses included, but were not limited to: major depression, hypothyroidism, hypertension, chronic obstructive pulmonary

F 329

1. Resident #7, 8, 9, 10, 11, and 5 have been noted to have no documentation of potential side effects, or interventions, from psychotropic medications.
2. An audit of patients currently prescribed psychotropic medications will be created to ensure a monitoring tool for side effects is being utilized.
3. Current licensed nursing staff members will be re-educated on utilizing a monitoring tool after administering psychotropic medications.
4. The Director of Nursing Services will monitoring new psychotropic med orders to ensure monitoring tool is in place. Findings will be reported to QAPI.
5. February 28, 2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	02/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 13	F 329		

disease and osteoarthritis.

The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 11/9/16. The facility staff coded that Resident #7 had a Cognitive Summary Score of 14. The facility staff also coded that Resident #7 required extensive (3/2) to total nursing care (4/3) with Activities of Daily Living (ADL's). In Section N. Medications the facility staff coded that Resident #7 received 7 days of an antidepressant medication and 7 days of an antianxiety medication.

On February 1, 2017 at 8:10 a.m. the surveyor reviewed Resident #7's clinical record. Review of the clinical record produced physician orders. Physician orders included, but were not limited to: "Remeron Tablet 15 MG (Mirtazapine) Give 1 tablet by mouth at bedtime for Depression, Paroxetine HCl Tablet 40 MG Give 1 tablet by mouth one time a day for Depression, Xanax Tablet 0.25 MG (ALPRAZolam) Give 0.25 tablet by mouth two times a day for anxiety 1 tab (tablet) at lunch and 1 tab at HS (bedtime)." (sic)

Continued review of the clinical record produced the January and February 2017 Medication Administration Records (MAR's). Review of the MAR's documented that the facility were administering the Paxil, Remeron and Xanax as ordered by the physician.
Further review of the clinical record produced the Comprehensive Care Plan (CCP). The CCP identified the following "Focus, Goal and Interventions." "Focus I sometimes have behaviors which included Crying; non-compliance with diuretic administering orders non-compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	02/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 14	F 329		

with orders for daily weights, and non-compliance with taking medications ... Goal My behavior will stop with staff intervention Interventions Attempt interventions before my behaviors begin. Goal Potential for drug related complications associated with psychotropic medications related to: Anti-Depressant medication, AntiAnxiety Goal Will be free of psychotropic drug related complications. Interventions ... Monitor for side effects and report to physician: Anti-anxiety/Hypnotic medications, drowsiness, morning, hang over, ataxia, dry mouth, constipation, blurred vision, urinary retention, headache, vertigo, nausea, hypotension, tachycardia, weakness, sedation, lethargy, confusion, memory loss and dependence. Monitor for side effects and report to physician: Antidepressant-Sedation. drowsiness, dry mouth, blurred vision, urinary retention, tachycardia, muscle tremor, agitation, headache, skin rash, photo sensitivity and excess weight gain." (sic)

Continued review of the clinical record failed to produce documentation of monitoring for specific behaviors of depression and antianxiety, effectiveness of the antidepressant and antianxiety medications, interventions and side effects of the antidepressant and antianxiety medications.

On February 1, 2017 at 4:10 p.m. the survey team met with the Administrator (Adm), DON, ADON and MDS Coordinator. The surveyor notified the Administrative Team (AT) that Resident #7 was receiving Paxil, Remeron and Xanax. The surveyor notified the AT that specific behaviors of depression and antianxiety, effectiveness of the antidepressant and antianxiety medications, interventions and side

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	02/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 15	F 329		

effects of the antidepressant and antianxiety medications could not be located in the clinical record.

No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure that Resident #7 was free of unnecessary medications.

2. For Resident #8 the facility staff failed to monitor for side effects, interventions, effectiveness and specific behaviors for the use of an antidepressant (Zoloft) and a hypnotic (Temazepam).

Resident #8 was a 77 year old male who was originally admitted on 3/16/15 and readmitted on 6/10/16. Admitting diagnoses included, but were not limited to: pneumonia, gout, diabetes mellitus, major depression, penile implant, chronic kidney disease, stage IV, urinary tract infection and sepsis.

The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date 9ARD of 10/24/16. The facility staff coded that Resident # had a Cognitive Summary Score of 9. The facility staff also coded that Resident #8 required extensive (3/3) to total nursing care (4/3) with Activities of Daily Living (ADL's). In Section N. Medications the facility staff coded that Resident #8 received 7 days of an antidepressant and 7 days of a hypnotic.

On February 1, 2017 at 1 p.m. the surveyor reviewed Resident #8's clinical record. Review of the clinical record produced physician orders. Physician orders included, but were not limited to:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	02/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 16	F 329		

"Sertraline HCL (Zoloft) 100 MG give 1 tablet by mouth one time a day for depression, Temazepam Capsules 15 MG give 15 mg by mouth at bedtime Insomnia (Hospice will cover)." (sic)

Continued review of the clinical record produced the January and February 2017 Medication Administration Records (MAR's). The MAR's documented that the facility staff were administering the Zoloft and Temazepam as ordered by the physician.

Further review of the clinical record failed to produce documentation of monitoring for specific behaviors related to the antidepressant drug use and the hypnotic (Zoloft and Temazepam), interventions, side effects of the antidepressant and hypnotic drug use and effectiveness of the antidepressant and hypnotic.

Continued review of the clinical record produced the Comprehensive Care Plan (CCP). The CCP identified the following "Focus, Goal and Interventions." "Focus Potential for drug related complications associated with psychotropic medications related to: Anti-Depressant medication, AntiAnxiety medication, and hypnotic use. Goal Will be free of psychotropic drug related complications. Interventions ... Monitor for side effects and report to physician: Anti-anxiety/Hypnotic medications, drowsiness, morning, hang over, ataxia, dry mouth, constipation, blurred vision, urinary retention, headache, vertigo, nausea, hypotension, tachycardia, weakness, sedation, lethargy, confusion, memory loss and dependence. Monitor for side effects and report to physician: Antidepressant-Sedation, drowsiness, dry mouth,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	02/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 17	F 329		

blurred vision, urinary retention, tachycardia, muscle tremor, agitation, headache, skin rash, photo sensitivity and excess weight gain. Monitor for side effects and report to physician: Antipsychotic medications-sedation, drowsiness, dry mouth, constipation, blurred vision, EPS, weight gain, edema, postural hypotension, sweating, loss of appetite, urinary retention." (sic)

On February 1, 2017 at 1:30 p.m. the surveyor notified the MDS Nurse that review of the clinical record failed to produce monitoring for the use of the Zoloft and Temazepam. The surveyor and MDS Nurse reviewed Resident #8's clinical record. The MDS Nurse was unable to find monitoring for the use of the Zoloft and Temazepam to include specific behaviors, interventions, side effects and effectiveness.

On February 1, 2017 at 4:10 p.m. the survey team met with the Administrator (Adm), DON, ADON and MDS Coordinator. The surveyor notified the Administrative Team (AT) that Resident #8 was receiving Zoloft and Temazepam. The surveyor notified the AT that specific behaviors of depression and insomnia, effectiveness of the antidepressant and hypnotic medications, interventions and side effects of the antidepressant and hypnotic medications could not be located in the clinical record.

No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure that Resident #8 was free of unnecessary medications.

3. For Resident #9 the facility staff failed to monitor for the use of an antidepressant, Zoloft.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	02/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 18	F 329		

Resident #9 was a 76 year old male who was admitted on 9/18/13. Admitting diagnoses included, but were not limited to: major depression, Alzheimer's, gout seizures, diabetes mellitus, hypertension, chronic obstructive pulmonary disease, atrial fibrillation, retention of urine and anxiety disorder.

The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 12/14/16. The facility staff coded that Resident #9 required extensive (3/2) to total nursing care (4/2) with Activities of Daily Living (ADL's). In Section N. Medications the facility staff coded that Resident #9 received 7 days of an antidepressant.

On February 1, 2017 at 9:15 a.m. the surveyor reviewed Resident #9's clinical record. Review of the clinical record produced physician orders. Physician orders included, but were not limited to: "Zoloft Tablet 100 MG Give 100 mg by mouth at bedtime for depression." (sic)

Continued review of the clinical record produced the January and February 2017 Medication Administration Records (MAR's). Review of the MAR's documented that the facility staff were administering the Zoloft as order by the physician.

Further review of the clinical record failed to produce monitoring of the antidepressant drug use, Zoloft, to include specific behaviors, interventions, side effects and effectiveness.

Continued review of the clinical record produced the Comprehensive Care Plan (CCP). Review of the CCP identified the following "Focus, Gola and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	02/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 19	F 329		

Interventions." "Focus Potential for drug related complications associated with psychotropic medications related to: Anti-Depressant medication. Goal Will be free of psychotropic drug related complications. Interventions ... Monitor for side effects and report to physician: Antidepressant-Sedation drowsiness, dry mouth, blurred vision, urinary retention, tachycardia, muscle tremor, agitation, headache, skin rash, photo sensitivity and excess weight gain." (sic)

On February 1, 2017 at 10:10 a.m. the surveyor notified the Director of Nursing (DON) that Resident #9 was receiving Zoloft and that monitoring for the use of the antidepressant was not located in the clinical record. The surveyor notified the DON that specific behaviors of depression, side effects of the antidepressant, effectiveness of the antidepressant and interventions need to be documented. The surveyor and Don reviewed the clinical record. The DON was unable to locate documentation of the monitoring of the use of the antidepressant drug use, Zoloft.

On February 1, 2017 at 4:10 p.m. the survey team met with the Administrator (Adm), DON, ADON and MDS Coordinator. The surveyor notified the Administrative Team (AT) that Resident #9 was receiving Zoloft. The surveyor notified the AT that specific behaviors of depression, effectiveness of the antidepressant medication, interventions and side effects of the antidepressant medication could not be located in the clinical record.

No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure that Resident #9 was free of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	02/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 20	F 329		

unnecessary medications.

4. For Resident #10 the facility staff failed to monitor for the use of an antidepressant, Cymbalta, and an antianxiety, Ativan.

Resident #10 was a 44 year old female who was originally admitted on 10/26/16 and readmitted on 1/12/17. Admitting diagnoses included, but were not limited to: extra dural and subdural abscess, obesity, major depression, anxiety and mononeuropathy right lower leg.

The most current Minimum Data Set (MDS) located in the clinical record was an Admission MDS assessment with an Assessment Reference Date (ARD) of 1/19/17. The facility staff coded that Resident #10 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #10 required extensive assistance (3/3) with Activities of Daily Living (ADL's). In Section N. Medications the facility staff coded that Resident #10 received 7 days of an antidepressant and 7 days of an antianxiety medication.

On January 31, 2017 at 3:15 p.m. the surveyor reviewed Resident #10's clinical record. Review of the clinical record produced physician orders. Physician orders included, but were not limited to: "Lorazepam Tablet (Ativan) 1 MG Give 1 tablet by mouth every 6 hours as needed for anxiety related to GENERALIZED ANXIETY DISORDER, DULoxetine HCl (Cymbalta) Capsule Delayed Release Particles 30 MG Give 1 capsule by mouth two times a day related to DEPRESSIVE DISORDER, SINGLE EPISODE, UNSPECIFIED." (sic)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	02/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 21	F 329		

Continued review of the clinical record produced the January 2017 Medication Administration Records (MAR's). Review of the MAR's documented that the facility staff were administering the Cymbalta twice a day as ordered by the physician. The MAR's also documented that Resident #10 received the Ativan twice on 1/26/17, once on 1/27/17, once on 1/28/17, once on 1/29/17 and once on 1/30/17.

Further review of the clinical record failed to produce documentation of monitoring for the Ativan and Cymbalta drug use to include specific behaviors, side effects of the medications, effectiveness of the medication uses and interventions.

On February 1, 2017 at 8:05 a.m. the surveyor notified the Assistant Director of Nursing (ADON) that Resident #10 was receiving Ativan and Cymbalta. The surveyor notified the ADON that specific behaviors, effectiveness, interventions and side effects for the use of the Ativan and Cymbalta could not be located in the clinical record. The surveyor reviewed the clinical record with the ADON. The ADON stated that the facility did not monitor for the use of antidepressants and antianxiety medications. The ADON stated that the facility staff only monitored for psychotropic drug use.

On February 1, 2017 at 4:10 p.m. the survey team met with the Administrator (Adm), DON, ADON and MDS Coordinator. The surveyor notified the Administrative Team (AT) that Resident #10 was receiving Cymbalta and Ativan. The surveyor notified the AT that specific behaviors of depression and anxiety,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	02/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 22	F 329		

effectiveness of the antidepressant and antianxiety medications, interventions and side effects of the antidepressant and antianxiety medications could not be located in the clinical record.

No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure that Resident #10 was free of unnecessary medications.

5. For Resident #11 the facility staff failed to monitor for the use of an antidepressant, Lexapro.

Resident #11 was an 88 year old female who was originally admitted on 2/8/10 and readmitted on 1/5/17. Admitting diagnoses included, but were not limited to: hypothyroidism, dehydration, cataracts, anxiety, pyelonephritis, dementia, major depression and Alzheimer's.

The most current Minimum Data Set (MDS) assessment located in the clinical record was a 5 Day Medicare and Significant Change MDS assessment with an Assessment Reference Date (ARD) of 1/12/17. The facility staff coded that Resident #11 had a Cognitive Summary Score of 6. The facility staff also coded that Resident #11 required limited (2/2) to extensive (3/3) assistance with Activities of Daily Living (ADL's). In Section N. Medications the facility staff coded that Resident #11 received 7 days of an antidepressant.

On February 1, 2017 at 2 p.m. the surveyor reviewed Resident #11's clinical record. Review of the clinical record produced physician orders. Physician orders included, but were not limited to:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	02/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 23	F 329		

"Lexapro Tablet (Escitalopram Oxalate) Give 15 mg by mouth one time a day related to MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, UNSPECIFIED."(sic)

Continued review of the clinical record produced the January and February 2017 Medication Administration Records (MAR's). Review of the MAR's documented that the facility staff were administering the Lexapro as ordered by the physician.

Further review of the clinical record failed to produce documentation of monitoring for the Lexapro drug use to include specific behaviors, side effects of the medications, effectiveness of the medication uses and interventions.

Continued review of the clinical record produced the Comprehensive Care Plan (CCP). The CCP identified the following "Focus, Goals and Interventions," "Focus Potential for drug related complications associated with psychotropic medications related to: Anti-Depressant medication. Goal Will be free of psychotropic drug related complications. Interventions ... Monitor for side effects and report to physician: Antidepressant-Sedation drowsiness, dry mouth, blurred vision, urinary retention, tachycardia, muscle tremor, agitation, headache, skin rash, photo sensitivity and excess weight gain." (sic)

On February 1, 2017 at 2:35 p.m. the surveyor notified two MDS Nurses that review of the clinical record failed to produce monitoring for the use of the Lexapro. The surveyor and MDS Nurse reviewed Resident 10's clinical record. The MDS Nurses were unable to find monitoring for the use of the Lexapro to include specific

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	02/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 24	F 329		

behaviors, interventions, side effects and effectiveness.

On February 1, 2017 at 4:10 p.m. the survey team met with the Administrator (Adm), Director of Nursing (DON), Assistant Director of Nursing (ADON) and the MDS Coordinator. The surveyor informed the Administrative Team (AT) that Resident #10 was receiving Lexapro. The surveyor notified the AT that specific behaviors of depression, effectiveness of the antidepressant medication, interventions and side effects of the antidepressant medication could not be located in the clinical record.

No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure that Resident #10 was free from unnecessary medications.

6. For Resident #5, facility staff failed to monitor the resident for effectiveness of antipsychotic medications.

Resident #5 was admitted to the facility on 10/24/15 with diagnoses including dementia with behavior, depression, hypertension, and cerebrovascular disease. On the minimum data set (MDS) assessment with assessment reference date 1/4/2017, the resident scored 9/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting others.

Clinical record review revealed an physician orders for the antipsychotic medication Risperdal. The first order was for Risperdal .25 (milligram) 2 times per day for bipolar disorder written 12/29/2016 and the second order for Risperdal .5 mg 2 times per day for r/o (rule out) bipolar

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	02/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 25	F 329		

disorder written 1/20/2017.

The medication administration record documented the resident received the medication two times per day every day during January 2017. A nursing order for behavior monitoring was entered in the record starting 1/20/2017. The specific behaviors for which the resident was being treated were not documented. The first behavior monitoring entry was entered on 1/31/2017 (indicating no behaviors noted) after the surveyors entered the facility on 1/31/17.

The surveyors discussed the concerns with monitoring with the assistant director of nursing on 2/1/2017.