STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495187	A. BUILDING _____ B. WING _____	C 09/20/2018

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HILLSVILLE HEALTH & REHAB CENTER	222 FULCHER STREET HILLSVILLE, VA 24343

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 09/18/18 through 09/20/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. Two complaints were investigated during the survey.	E 000	Preparation and submission of this plan of correction by Hillsville Rehabilitation and Healthcare Center LLC does not constitute an admission agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of defeciencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 09/18/18 through 09/20/18. Two complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 60 certified bed facility was 53 at the time of the survey. The final survey sample consisted of 14 current Resident reviews and 3 closed record reviews.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).	F 578	1. On 9/20/19 the DDNR was corrected for resident # 12 and #54. 2.An audit of all resident records was completed on 9/25/18 by the Unit Manager and ADON validating that all DDNRs were completed correctly. 3. The Staff Development aCoordinator has educated all clinical staff on the DDNR proccess. 4. The ADON or Unit Manager will audit all new residents to confirm that DDNRs are in place and completed thoroughly. This will be completed weekly x4 and then monthly x2. The results of the audits will be forwarded to the facility QAPI Committee for further review and recommendations. **Date of Compliance:11/4/18**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed Jenny M. Campbell ADM 10/24/18

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

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F 578	Continued From page 1 (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure accurate DDNR's (durable do not resuscitate) orders for 2 of 17 Residents, Residents #12 and #54. The findings included: 1. For Resident #12, the facility staff failed to ensure the Residents DDNR was complete. The Resident or the Resident's authorized representative had not signed the DDNR and section's 1 and 2 had been left blank.	F 578		

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F 578	Continued From page 2 The clinical record review revealed that Resident #12 had been admitted to the facility 03/29/18. Diagnoses included, but were not limited to, dementia, communication deficit, anemia, and weakness. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/06/18 included a BIMS (brief interview for mental status) summary score of 3 out of a possible 15 points. The Residents clinical record included a DDNR order form from the Virginia Department of Health. This form was dated 03/29/18 and read in part. Under section 1 "I further certify [must check 1 or 2]: 1. The patient is CAPABLE of making an informed decision... 2. The patient is INCAPABLE of making an informed decision..." Neither box had been checked. Section 2 read, "If you checked 2 above, check A, B, or C below..." All three boxes had been left blank. This form had not been signed by the Resident or the Residents authorized representative. The DON (director of nursing) and the vice president of operations were made aware of the above findings during a meeting with the survey team on 9/20/18 at 11:28 a.m.	F 578		

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F 578	Continued From page 3 No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #54, the facility staff failed to ensure the Residents DDNR was complete. Section 1 and 2 had been left blank. The clinical record review revealed that Resident #54 had been admitted to the facility 05/02/18. Diagnoses included, but were not limited to, malignant neoplasm, atrial fibrillation, hypertension, and constipation. Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 05/09/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. The Residents clinical record included a DDNR order form from the Virginia Department of Health. This form was dated 05/03/18 and read in part. Under section 1 "I further certify [must check 1 or 2]: 1. The patient is CAPABLE of making an informed decision.. 2. The patient is INCAPABLE of making an informed decision..." Neither box had been checked. Section 2 read, "If you checked 2 above, check A, B, or C below..." All three boxes had been left blank.	F 578		

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F 578	Continued From page 4 The DON (director of nursing) and the vice president of operations were made aware of the above findings during a meeting with the survey team on 9/20/18 at 11:28 a.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 578		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure an accurate MDS (minimum data set) assessment for 1 of 17 Residents, Resident #55. The findings included: For Resident #55, the MDS coordinator coded the Resident as being discharged to an acute hospital when in fact he had been discharged home. The record review revealed that Resident #55 had been admitted to the facility 04/05/18. Diagnoses included, but were not limited to, acute embolism and thrombosis femoral vein, bilateral, unspecified atrial flutter, stiffness in unspecified joint, and pain in unspecified joint. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 04/12/18 coded the Resident as 4 out of 15 in section C,	F 641	1. The MDS for #55 was corrected for resident #55 to indicate he was discharged home on 9/20/18. 2. The DON audited all discharges for the last 30 days to ensure each MDS was coded properly on 9/20/18. 3. The MDS Coordinator was educated by the Staff Development Coordinator on 9/20/18 on completing the MDS accurately. 4. The MDS Coordinator will conduct audits on all discharged residents weekly x4 and then monthly x2 for accurrate completion. The results of the audits will be forwarded to the facility QAPI Committee for further review and recommendation. **Date of Compliance: 11/4/18** DLC 10/26/18	

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F 641	Continued From page 5 cognitive patterns. This is an admission MDS. The Resident had been discharged home on 06/23/18. The Residents discharge MDS assessment with an ARD of 06/23/18 had been coded to indicate the Resident had been discharged to an acute hospital. The clinical record included a plan of care note dated 06/25/18 read "This Resident discharged home on 06/23/18 with daughter." On 09/20/18 at 8:49 a.m., the surveyor reviewed the discharge MDS with the MDS coordinator. After reviewing the MDS, the MDS coordinator stated she had marked acute hospital in error and she would get it fixed. The DON (director of nursing) was notified of the inaccurate MDS assessment on 09/20/18 at approximately 8:50 a.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 641		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health	F 645	1. A Level 1 PASSR was completed on Resident #11 and #20 on 9/28/18. 2. 100% audit has been conducted of all current residents to ensure that a Level 1 PASSR has been completed as of 9/28/18. 3. The SDC educated the Social Worker on completing and ensuring that every resident has been screened for a Level 1 PASSR upon admission on 9/19/18. 4. The Social Worker/designee will audit all new admissions weekly x4 then monthly x2 to ensure the medical record reflects a Level 1PASSR. The results of the audits will be forwarded to the facility QAPI Committee for further review and recommendations. **Date of Compliance: 11/4/18**	

JLC 10/26/18

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F 645	Continued From page 6 authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,	F 645		

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F 645	Continued From page 7 (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, the facility failed to ensure a level 1 PASRR (pre-admission screening and Resident review) was completed for two of 17 Residents, Resident #11 and #20. The findings included: 1. For Resident #11 the facility staff failed to ensure a level I PASRR was completed within 30 days of admission. Resident #11 was admitted to the facility on 06/11/12 and readmitted on 05/30/16. Diagnoses included but not limited to hypertension, dementia, anxiety, depression, psychotic disorder, chronic obstructive pulmonary disease, gastroesophageal reflux disease, constipation, insomnia and hypothyroidism.	F 645		

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F 645	Continued From page 8 The most recent MDS (minimum data set) with an ARD (assessment reference date) of 07/03/18 coded the Resident as 3 of 15 in section C, cognitive patterns. This is a quarterly MDS. Resident #11's clinical record was reviewed on 09/18/18. The surveyor could not locate a level I PASRR in the clinical record. The surveyor spoke with the previous social worker of the facility on 08/18/18 at approximately 1450. This social worker stated that, to her knowledge, only one Resident at the facility had a PASRR. Surveyor also spoke with the DON (director of nursing) on 09/18/18 at approximately 1500. DON stated that she did not know it was a state regulation for Residents to have a PASRR completed. The concern of the PASRR not being completed was discussed with the administrative team during a meeting on 09/191/18 at approximately 1530. The DON stated that the PASRR could not be located. No further information was provided prior to exit. 2. For Resident #20 the facility staff failed to obtain a level 1 PASRR (pre-admission screening and Resident review). Resident #20 was admitted to the facility on 05/15/15 and readmitted on 03/05/18. Diagnoses included but not limited to alcohol dependence with alcohol induced persisting dementia, atherosclerosis of aorta, long term use of anticoagulants, anxiety disorder, bipolar disorder, and dysphagia. The most recent MDS (minimum data set)	F 645		

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F 645	Continued From page 9 assessment with an ARD (assessment reference date) of 07/12/18 coded the Resident as 15 out of 15 in section C, cognitive patterns. This is an annual MDS. Resident #20's clinical record was reviewed on 09/18/18. During this record review, the surveyor was unable to locate a level 1 PASRR. After the record review, the surveyor discussed the missing PASRR with SW (social worker) #1. During this interview, SW #1 stated that no PASRR had been completed for Resident #20. The concern of the missing PASRR was discussed with the administrative staff on 09/18/18 at approximately 3:46 p.m. On 09/19/18 at approximately 9:06 a.m., SW#2 confirmed that a PASRR had not been completed for this Resident. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 645		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the	F 657	1. An order was obtained for resident #17's spill proof cup. The Care Plan for #17 ws updated to reflect use of the spill proof cup on date 9/20/18. 2. An audit was completed on 9/28/18 indicating that each resident has an order for adaptive equipment, therapy agrees with the change in the plan of care. The Care Plan has been updated. 3. All staff were educated on 9/20/18 regarding the need to communicate through LPN/Unit Manager if a resident shows a need for adaptive equipment. A rehab screen will be initiated to determine if the need is substantiated. Once the plan of care is revised the care plan will be adjusted by staff. 4. The ADON or Unit Manager will audit all residents weekly x4 and then monthly x2 to ensure that all residents with adaptive equipment have been screened and their care plans revised accordingly. The results of the audits will be forwarded to the facility QAPI Committee for further review and recommendations. **Date of Compliance: 11/4/18**	

10/24/18

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F 657	Continued From page 10 resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to review and revise the comprehensive care plan for 2 of 17 Residents, Residents #17 and #54. The findings included. 1. For Resident #17, the facility staff failed to review and revise the Residents comprehensive care plan to include the Resident's sippy cup. The record review revealed that Resident #17 had been admitted to the facility 01/12/17. Diagnoses included, but were not limited to, Alzheimer's disease, bipolar disorder, hypertension, gastro-esophageal reflux disease, and diabetes. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of	F 657		

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F 657	Continued From page 11 04/09/28 had been coded 1/1/3 to indicate the Resident had problems with long and short term memory and was severely impaired in cognitive skills for daily decision making. The surveyor observed Resident #17 eating lunch on 09/18/18 at 12:45 p.m., during this observation the surveyor reviewed the Residents diet slip. This diet slip included the adaptive device "Sippy Cup." A review of the Residents nutritional CCP (comprehensive care plan) was completed and the surveyor was unable to locate any information regarding the sippy cup. A review of the Residents physician's orders was completed and again the surveyor was unable to locate any information regarding the sippy cup. In fact, the surveyor was unable to locate any information regarding the sippy cup in the Residents EHR (electronic health record) or the hard chart. On 09/20/18 at 8:36 a.m., the surveyor reviewed the Resident's CCP with the MDS coordinator. After reviewing the CCP, the MDS coordinator verbalized to the surveyor that she was unable to locate any information regarding the sippy cup. On 09/20/18 at 9:23 a.m., the surveyor interviewed the DON (director of nursing). The DON stated the sippy cup idea came from a CNA (certified nursing assistant) who saw the Resident struggling and spoke with the dietary personnel and no one else was made aware. The surveyor observed the sippy cup being used	F 657		

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F 657	Continued From page 12 at two of three meals. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #54, the facility staff failed to review and revise the Resident's CCP (comprehensive care plan) to include the Residents DDNR (durable do not resuscitate) order. The clinical record review revealed that Resident #54 had been admitted to the facility 05/02/18. Diagnoses included, but were not limited to, malignant neoplasm, atrial fibrillation, hypertension, and constipation. Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 05/09/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. The Residents clinical record included a DDNR. The Residents CCP did not include any information to indicate that the Resident had a DDNR in place. On 09/20/18 at 8:34 a.m., the MDS coordinator and the surveyor reviewed the Residents CCP. After reviewing the CCP, the MDS coordinator verbalized to the surveyor that this information was not included in the Residents CCP. The DON (director of nursing) and the vice president of operations were made aware of the	F 657		

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F 657	Continued From page 13 above findings during a meeting with the survey team on 9/20/18 at 11:28 a.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care In accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to follow physician orders in regards to diabetic management for 1 of 17 Residents, Resident 15. The findings included, The facility staff failed to administer the Residents insulin per the physicians order. The facility nursing staff held the Residents insulin two times in the month of August 2018. The record review revealed that Resident #15 had been admitted to the facility 06/24/13. Diagnoses included, but were not limited to, diabetes, cerebral infarction, Alzheimer's disease, dysphagia, and age related osteoporosis.	F 684	1. AMedication Error Report along with MD and RP notification was completed for two doses of insulin held for resident #15. Insulin was held on 9/8/18 and 9/17/18 at 2100. 2. An audit was conducted on all diabetics by the DON and ADON on 9/19/18 to ensure that all residents were having their blood sugars obtained and medications provided per Physicians orders. 3. All nurses were educated by the Staff Development Coordinator on 9/19/18 that all orders must be followed as written unless a physician or NP has provided a new order indicating a change. 4. The ADON or Unit Manager will audit all residents who are receiving treatment for diabetes to ensure that physician orders were followed weekly x4 and monthly x 2. The results of the audit will be forwarded to the facility QAPI Committee for further review and recommendations. **Date of Compliance: 11/4/18** 10/30/18	

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F 684	Continued From page 14 Section C (cognitive patterns) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/06/18 had been coded 1/1/3 to indicate the Resident had problems with long and short term memory and was severely impaired in cognitive skills for daily decision making. The Residents clinical record included a physicians order for 10 units of bassaglar insulin at bedtime for diabetes. A review of the Residents eMARs (electronic medication administration records) revealed that for the month of August 2018 LPN (licensed practical nurse) #1 held this insulin on 08/08 and again on 08/17. The clinical record included a nursing entry on 08/08 that read "Resident's BS (blood sugar) was 113. Insulin was held." and on 08/17 "Resident's BS was only 111. Did not give insulin because her BS drops during the night." The surveyor was unable to locate any information indicating the physician had been notified of the insulin being held. The Residents CCP (comprehensive care plan) included the focus area of diabetes. Interventions included, but were not limited to, administer my medications as ordered and report to physician/nurse practitioner as indicated. The nursing staff had documented the Residents BS on 08/09 and on 08/18 at 6:00 a.m. as 102. The DON (director of nursing) and vice president of operations were notified of the above during a meeting with the survey team on 09/19/18 at 3:39 p.m.	F 684		

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F 684	Continued From page 15 No further information regarding this issue was provided to the survey team prior to the exit conference.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(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. §483.25(e)(2)For a resident with urinary incontinence, based 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. §483.25(e)(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	F 690	1. Resdient #50's foley catheter drainage bag was removed from the floor and a leg strap was applied on 9/19/18. 2. An audit was completed on 9/24/18 by staff to ensure foley catheter tubing and bags are not lying on the floor or dragging the floor while resident is up in the wheelchair. A leg strapis also used to secure the positioning of the tubing. 3. All Clinical Staff were educated that catheter tubings should be anchored to resident's leg with a leg strap. The foley catheter tubing and urinary bag should not be touching or lying on the floor at any time. This education was completed on 9/19/18. 4. The ADON or Unit Manager will continue to audit all residents with foley catheters weekly x4 and monthly x2. The results of the audits will be forwarded to the facility QAPI Committee for further review and recommendations. **Date of Compliance: 11/4/18** DNC 10/26/18	

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F 690	Continued From page 16 restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to anchor and indwelling Foley catheter for 1 of 17 Residents, Resident #50. The findings included: For Resident #50 the facility staff failed to ensure Foley catheter tubing was anchored. Resident #50 was admitted to the facility on 07/10/18. Diagnoses included but not limited to anemia, neurogenic bladder, urinary tract infection, Alzheimer's disease, dementia, psychotic disorder, acute kidney disease and hypokalemia. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 07//18 coded the Resident as having both long and short term memory problems and severely impaired cognitive skills. This is an admission MDS. Resident #50's clinical record was reviewed on 09/18/18. It contained a physician's order summary which read in part, "Leg strap or other anchoring device to prevent pulling or dislodging foley cath every shift". Resident #50 was observed by the surveyor on 09/19/18 at approximately 0820, along with LPN #1. Resident was resting in bed. Foley catheter drainage bag was observed lying in the floor beside the Resident's bed. Resident voiced a complaint to LPN #1 of "I have a place on my leg"	F 690		

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F 690	Continued From page 17 and indicated groin area. LPN #1 checked Resident and stated "That's your catheter". Surveyor observed that Resident's Foley catheter tubing was not anchored and was positioned in skin fold in Resident's groin area. Surveyor asked LPN #1 if Foley catheter should be anchored, and LPN #1 stated that it should, and stated that she would obtain a leg strap for Resident. The concern of the Foley catheter not being anchored was discussed with the administrative team during a meeting on 09/191/18 at approximately 1530. The surveyor requested a policy on catheter care at this time. The DON provided the surveyor with said policy entitled "Catheter Care: Male/Female" on 09/19/18 at approximately 0745. This policy read in part "18. Secure catheter utilizing a leg band". No further information was provided prior to exit.	F 690		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761	1. DON consulted the pharmacy on 9/19/18 regarding resident #14. The medication was placed in the tote for return and a new card was delivered with a corrected label on 9/19/18. The new card was in the facility for resident #14 before it was due again. 2. The DON looked at each medication card for all active residents to ensure that the label was correct on 9/19/18. 3. SDC educated the staff that medications should not be accepted by the nurse if the label has been checked and not correct. This education was completed on 9/19/18. 4. The ADON or Unit Manager will conduct an audit of all medication cards to ensure the label is correct weekly x4 and then monthly x2. The results of the audits will be forwarded to the facility QAPI Committee for further review and recommendations. **Date of Compliance 11/4/18**	

QMC 10/26/18

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F 761	Continued From page 18 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and during a medication pass and pour observation, the facility staff failed to ensure medication was labeled correctly for 1 of 17 Residents, Resident #14, and failed to dispose of expired medications. The findings included: 1. For Resident #14 the facility staff failed to ensure the medication, Lasix, was labeled correctly. Resident #14 was admitted to the facility on 01/11/17. Diagnoses included but not limited to anemia, hypertension, diabetes mellitus, hyperlipidemia, Alzheimer's disease, anxiety, depression, psychotic disorder, chronic kidney disease, dysphagia, and gastroesophageal reflux disease. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 07/09/18 coded the Resident as 12 of 15 in section C, cognitive patterns. This is quarterly MDS. Surveyor observed LPN (licensed practical nurse)	F 761	1. On 9/19/18 the insulin was discarded by the floor nurse and replaced by the pharmacy to ensure that residents were not receiving expired insulin. There were no abnormal blood sugars during this time. 2. An audit was completed by the DON on 9/19/18 of all insulin pens and vials to ensure they were dated and not expired. 3. All nurses were educated on 9/19/18 by the SDC regarding the need to date each insulin pen and vial when opened. Each nurse was provided with documentation indicating when each type of insulin should be discarded after opening. 4. The ADON or Unit Manager will conduct an audit of all insulin pens and vials to ensure they are dated when opened and discarded once expired weekly x4 and monthly x2. The results of the audits will be forwarded to the facility QAPI Committee for further review and recommendations. **Date of Compliance:11/4/18** jwc 10/26/18	

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F 761	Continued From page 19 #2 during a medication pass and pour on 09/19/18 at approximately 0800. One of the mediations observed being administered was Lasix 20 mg, 1 tablet. The medication card was labeled as "Furosemide (generic for Lasix) 20 mg tablet, Give 1 tablet by mouth one time a day and give 2 tablets by mouth one time a day for 3 days". The surveyor reconciled the Resident's medications with the clinical record on 09/19/18. The clinical record contained a physician's order summary which read in part "Lasix tablet 20 mg (furosemide) give 1 tablet mouth one time a day for fluid retention". The eMAR (electronic medication administration record) included an entry which read in part "Furosemide tablet 20 mg give 1 tablet by mouth one time a day for edema-start date-03/24/18". The surveyor spoke with LPN #2 on 09/19/18 at approximately 0915 regarding the label on the Lasix. LPN #2 stated that the current order was for one tablet one time a day. LPN #2 also stated the order for 2 tablets one time a day for three days was an old one time order, which have "fell off". LPN #2 also stated that she did not know why the medication card was still labeled this way. The concern of the mislabeled medication card was discussed with the administrative team during a meeting on 09/191/8 at approximately 1530. On 09/2018 at approximately 0800, the DON (director of nursing) provided the surveyor with a copy of a corrected label. No further information was provided prior to exit.	F 761		

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F 761	Continued From page 20 2. For the medication cart on 200 hallway, the facility staff failed to dispose of expired insulin. The surveyor checked the medication cart on the 200 hallway on 09/19/18 at approximately 0850. It contained a Novolog insulin pen labeled with an "opened on" sticker dated 08/18/18. This sticker also read "discard after 28 days". The surveyor asked LPN (licensed practical nurse) #1 to look at the pen. LPN #1 stated that the insulin needed to be discarded, and proceeded to do so. The surveyor requested and was provided with a copy of "Insulin Storage Recommendations" which read in part, "Novolog cartridge or pen unopened, refrigerated until expiration date, opened 28 days". The concern of the expired insulin was discussed with the administrative team during a meeting on 09/19/18 at approximately 1530. No further information was provided prior to exit.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable	F 812	1. The Dietary Manager removed the outdated food promptly on 9/19/18. 2.The Dietary Manager checked the remaining foods on 9/19/18 to ensure that each was dated and discarded accordingly. 3. The Dietary Manager educated all dietary staff on food storage on 9/19/18. 4. The Dietary Manager will audit the refrigerators to ensure foods are dated and discarded when appropriate weekly x4 and then monthly x2. The result of the audit will be forwarded to the facility QAPI Committee for further review and recommendations. **Date of Compliance: 11/4/18**	

JK 10/26/18

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F 812	Continued From page 21 safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility failed to discard food by the use by date and failed to obtain sanitization solution measurements. Findings included: The facility failed to discard outdated cooked chicken and opened thickened juice in the kitchen refrigerator and failed to obtain sanitization solution measurements. On 09/18/18 beginning at approximately 9:05 a.m., during initial tour of the facility, the surveyor toured the dietary department with dietary employee #1 (cook). During this observation, the surveyor observed a carton of thickened juice dated 08/15/18 in the facility refrigerator. Dietary employee #1 stated that needs to be thrown out. A second facility refrigerator contained a container of cooked chicken with a use by date of 09/16/18. Dietary employee #1 stated that needs to be thrown out as well. On 09/18/18 at approximately 10:15a.m., the surveyor reentered the dietary department to observe the dishwasher run through a wash and rinse cycle. During this wash and rinse cycle	F 812	1. The Dietary Manager confirmed with Echo Lab that the sanitation system was working properly. It was determined the wrong litmus paper and solution were used for testing. All meals were served with paper products until determined on 9/19/18. 2. The Dietary Manager checked t hesanitation system using the correct litmus paper and solution to determine that the system was functioning properly. Meals were resumed as scheduled using dishware on 9/20/18. 3. The Dietary Manager educated all dietary staff on 9/19/18 to check the sanitation system with the correct litmus paper and solution. The result is to be recorded on the log provided. 4. The Dietary Manager will audit the log to ensure the sanitation system is checked and recorded. This will be conducted weekly x 4 and then monthly x 2. The results of the audits will be forwarded to the facility QAPI Committee for further review and recommendations. **Date of Compliance: 11/4/18**	

QUE 10/26/18

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F 812	Continued From page 22 employee #2 (dietary manager) was present. The wash cycle temperature read 130 degrees, min is 120 degrees for wash and rinse per manufacturers guidelines posted on the wall next to dishwasher. Employee #2 stated that the dishwasher used a sanitation solution to ensure sanitization of dishes. Employee #3 (dishwasher) then stated a test strip to check the sanitation solution had not been used this morning. At the request of the surveyor employee #3 used a test strip to check the sanitization solution. This test strip indicated the solution was under 50 PPM. Per the manufactured guidelines posted on the dishwasher, a minimum of 50 PPM is adequate. Surveyor observed the dish machine log posted on the wall directly in front of dishwasher, the sanitation concentrate PPM column was blank for the entire month of September. On 09/18/18 at approximately 10:25 a.m., the surveyor asked employee #2 to test the sanitization solution in the three-compartment sink. The water temperature in the wash compartment measured at 108.8 degrees. Per the manufacturer's instructions, 75-90 degrees is recommended for this sanitizer. The test trip revealed the sanitizing solution was below 50 PPM. After this observation, employee #2 stated they would be using paper products until the sanitization issue was resolved. On 09/18/18 at approximately 10:37 a.m., the surveyor notified the DON (director of nursing) of the issue with the sanitization process in the dietary department. On 09/18/18 at approximately 10:45 a.m., the DON informed the surveyor that a vendor had been contacted regarding the sanitization issues	F 812		

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F 812	Continued From page 23 and they were on the way to the facility. On 9/18/18 at approximately 4:11p.m., vendor #1 reported to this surveyor that the sanitizing solution was adequate in the dishwasher and three-compartment sink. He stated the facility was not using the correct test strips. A recheck of the dishwasher and three-compartment sink revealed that the sanitizing solution PPM was adequate and now measured between 200-400 PPM. On 09/19/18 9:44 a.m., the surveyor interviewed employee #3 regarding the dishwasher sanitizing solution testing. Employee #3 verbalized she was not shown how to test sanitizing solution and they were not doing it. On 09/19/18 at approximately 11:45 a.m., the surveyor requested from the DON the policy and procedure regarding use by dates on food items and manufacturer guidelines on the dishwasher. The facility policy/procedure titled "Storage of Refrigerated Foods" read in part under section # 14 "Food that has been prepared in-house can be stored for a maximum of three days at 41 degrees or lower. Foods which are not potentially hazardous may be stored 7 days. (The date opened or made counts as the first day). Leftover food must be used within 3 days or discarded. Monitor daily expiration dates or "use by" dates and discard all outdated items immediately ..." The facility document titled "Food Storage Guidelines-Reference" revealed that fruit beverages can be refrigerated up to 3 weeks unopened, and Chicken 1-2 days refrigerated.	F 812		

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HILLSVILLE HEALTH & REHAB CENTER	222 FULCHER STREET HILLSVILLE, VA 24343

(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 812	Continued From page 24 No further information regarding these issues were given to the survey team prior to the exit conference.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be	F 880	1. Resident #50's foley catheter drainage bag was removed from the floor on 9/18/18. 2. An audit was completed on 9/24/18 by the ADON to ensure that all foley catheter tubings and urinary bags were not touching or lying on the floor. 3. SDC educated all clinical staff that foley catheter tubing and drainage bags should not touch or lie in the floor on 9/19/18. 4. The ADON or Unit Manager will conduct an audit of all foley catheters and observe whether they are placed free from the floor. This will be done weekly x 4 and then monthly x2. The results of the audits will be forwarded to the facility QAPI Committee for further review and recommendations. **Date of Compliance: 11/4/18** ave 10/26/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 25 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to provide an effective infection control program for 1 of 17 Residents, Resident #50. The findings included:	F 880		

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F 880	Continued From page 26 For Resident #50 the facility staff failed to ensure the Foley catheter drainage tubing and bag did not touch/rest on the floor. Resident #50 was admitted to the facility on 07/10/18. Diagnoses included but not limited to anemia, neurogenic bladder, urinary tract infection, Alzheimer's disease, dementia, psychotic disorder, acute kidney disease and hypokalemia. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 07//18 coded the Resident as having both long and short term memory problems and severely impaired cognitive skills. This is an admission MDS. Surveyor observed Resident #50 on 09/18/18 at approximately 0935. Resident was seated in wheelchair in her bedroom. Surveyor observed Foley catheter drainage bag attached to bottom of wheelchair. The drainage tubing was observed lying on the floor under the wheelchair. The surveyor observed Resident #50 again on 09/18/18 at approximately 0940. Resident was propelling self up the hallway in wheelchair. The surveyor observed Foley catheter drainage tubing dragging along the floor, under Resident's wheelchair. The surveyor observed Resident #50 in the activity room on 09/18/18 at approximately 1100. Resident was seated in wheelchair, with Foley drainage bag attached to bottom of wheelchair. The Foley drainage tubing was resting on a rug on the floor. The surveyor observed Resident #50 on 09/18/18 at approximately 1345. Resident was outside on the sidewalk with a staff member. Resident's Foley catheter drainage tubing was observed dragging	F 880		

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F 880	Continued From page 27 along the sidewalk, under wheelchair. The surveyor observed Resident #50 on 09/19/18 at approximately 0820. Resident was resting in her bed. Surveyor observed Resident's Foley catheter drainage bag resting on the floor, beside the bed. Surveyor observed Resident on 09/19/18 at approximately 1130. Resident was up in wheelchair, Foley catheter drainage bag was observed touching the floor, under Resident's wheelchair. Surveyor observed Resident again on 09/19/18 at approximately 1400. Resident was propelling self in hallway. Resident's Foley catheter drainage bag was rubbing along the floor under the wheelchair. The surveyor spoke with the infection control nurse on 09/19/18 at approximately 1610. Infection control nurse stated that the Resident's Foley drainage tubing or bag should be in the floor. The surveyor reviewed the facility infection control policy and could not locate anything specific to catheter usage. The concern of the Foley catheter drainage bag/tubing being in the floor was discussed with the administrative team during a meeting on 09/19/18 at approximately 1530. No further information was provided prior to exit.	F 880		