STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/1/18 through 10/03/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/1/18 through 10/3/18. Corrections are required for compliance with CFR Part 483 Requirements for Federal Long Term Care facilities. The Life Safety Code survey/report will follow. The census in this 180 certified bed facility was 121 at the time of the survey. The sample consisted of 26 Resident reviews and 3 closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal	F 550		11/13/18

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

Electronically Signed | 10/25/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 1 access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to observe the resident's dignity for one of 29 residents (Resident #81). The findings included: The facility staff failed to ensure Resident #81's dignity was maintained. Physical therapy staff were observed to ambulate the resident down the halls and around the nurse's station with holes in the back of her jogging pants. The clinical record of Resident #81 was reviewed	F 550	F 000 Preparation and submission of this plan of correction by Rocky Mount Health and Rehab., LLC, does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2 10/1/18 through 10/3/18. Resident #81 was admitted to the facility 7/8/15 and readmitted 2/4/16 with diagnoses that included but not limited to epilepsy, cerebrovascular disease, hemiplegia, urinary incontinence, hypertension, unsteadiness on feet, muscle weakness, age-related osteoporosis, dry eye syndrome, chronic atrial fibrillation, low back pain, mood disorder, schizoaffective disorder, major depressive disorder, hyperlipidemia, gastro-esophageal reflux disease, and chronic obstructive pulmonary disease. Resident #81's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 8/14/18 assessed the resident with a BIMS (brief interview for mental status) as 15/15. The resident was assessed with no signs/symptoms of delirium, psychosis, or behaviors that affected others. Functional status for dressing was coded extensive assistance of one person required. The surveyor observed Resident #81 walking with the physical therapist #1 in the hall and around the nurse's station on 10/2/18 at 10:38 a.m. The surveyor observed two (2) holes in Resident #81's jogging pants on the left side. The holes were large enough to see the white undergarment Resident #81 was wearing. Physical therapist #1 stated "are these your holy pants?" The surveyor interviewed Resident #81 on 10/3/18 at 9:25 a.m. and asked the resident if the jogging pants with holes bothered her and she stated yes. Resident #81 stated she didn't get a shower last night (10/1/18) and was still wearing the same ones from the day before.	F 550	F 550 1. Resident # 81□s pants were discarded and replaced on 10/3/18. 2. Staff to complete 100% audit of all clothes for holes completed by 10/29/18. 3. SDC to in-service all staff by 10/29/18 on residents rights and dignity. SDC to In-service all nursing staff not to dress resident in tattered clothes, and if clothes are tattered take out of service and notify social services. Maintenance Director to in service laundry staff to take clothing in disrepair out of service and report items to Social Services. 4. Weekly audit x4, then monthly for 2 months of 5 resident□s clothing on each unit by unit manager to ensure no holes in clothes x4 then monthly, then reported to DON/ADON. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. Date of compliance 11/13/2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 3 The surveyor informed the administrative staff of the observation during the end of the day meeting on 10/2/18 beginning at 4:16 p.m. No further information was provided prior to the exit conference on 10/3/18.	F 550		
F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to accommodate residents needs and preferences for 5 of 29 residents (Residents #13, #67, #82, #91, and #111). The findings included: 1. For Resident #13, the facility failed to post menus or notify the Resident of what they would be receiving at meal times. The record review revealed that Resident #13 had been admitted to the facility 09/19/05. Diagnoses included, but were not limited to, anxiety disorder, schizophrenia, diabetes, and gastroesophageal reflux disease. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of	F 558	F 558 1. On 10/2/18, menus provided to resident #13, resident #67, resident #82, and resident 91. Menus posted in each resident□s room. 2. Audit of resident□s room for menus on 10/2/18 by unit managers. 3. Menus to be provided to residents in room monthly by the DSM or designee. DSM or designee to post Daily Menu with alternatives at each nurse□s station daily. The Administrator in serviced DSM on 10/8/18 regarding posting of daily menus at each nurse□s station, and placing menus in each resident□s room monthly at resident□s desired location. DSM or designee will pass out menu and meal tickets for each resident to the unit. Nursing staff to ask the residents preferences daily and write information on the meal tickets and give meal tickets to	11/13/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 4 07/06/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. Section G (functional status) was coded (4/2) to indicate the Resident was totally dependent on one person for bed mobility, locomotion on and off the unit, dressing, and eating. Transfers were coded (4/3) to indicate the Resident was totally dependent on two staff. The Resident's comprehensive care plan included the focus area potential for visual limitations and requires total assistance to and from group activities due to immobility. On 10/01/18 at 2:42 p.m., Resident #13 verbalized to the surveyor a concern regarding food menus. Resident #13 stated she did not know what she was having for lunch until she received her food tray. When asked if she wanted to know Resident #13 stated she did. The surveyor checked the Resident's room for a menu and was unable to locate one. During a walk-through of the facility, the surveyor was unable to find any posted menu(s). There was a menu display board posted behind the tray line in the dining room with the menu for that day posted. On 10/03/18 at 9:25 a.m., the surveyor interviewed the LDC (lead dietary cook), during this interview the LDC verbalized to the surveyor that the menu board in the dining room is updated at night when they leave. Alternates are written on the board after breakfast. The LDC stated they did not currently have a dietary manager and a manager from another facility was assisting them. LDC stated if we have issues, we go to the administrator.	F 558	dietary. 4. Unit mangers to do weekly audits x4, then monthly x2 of 5 resident□s room to ensure menu posting and posting of daily menu at nurse□s station. Audits to be reviewed with DON/ADON. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. Date of compliance 11/13/18. F 558 1. Briefs provided to resident #67 on 10/2/18. 2. 100% Audit by central supply clerk completed on 10/2/18 to ensure all residents that require briefs are available in room and in supply closet. 3. Central supply clerk in serviced by DON on 10/3/18 to ensure par level of briefs at all times, and to ensure briefs are available in resident□s room and supply closet; also in serviced on reporting low supplies of briefs to DON/Administrator. SDC to in service all staff by 10/29/18 to immediately notify their supervisor of any shortage of supplies. 4. Central supply clerk to do weekly audits x4, then monthly x2 of 5 resident□s rooms on each unit and supply closet to ensure briefs are available. Audits to be reviewed by DON/ADON. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 5 Due to Resident #13's immobility, they would not have been able to access this menu board in the dining room unless they had been assisted to the dining room by the facility staff. The administrative staff were notified of the issues regarding the dietary menus on 10/02/18 at 4:15 p.m. On 10/03/18 at 1:40 p.m., during a meeting with the DON (director of nursing), the DON verbalized to the surveyor that the previous dietary manager printed the menus, passed them out to the CNA's (certified nursing assistants) and they posted them. However, since we do not currently have a dietary manager that was not done. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #67, the facility staff failed to post menus or notify the Resident of what they would be receiving at meal times and failed to supply the Resident with briefs, which resulted in the Resident not being able to get out of the bed. The record review revealed that Resident #67 had been admitted to the facility 07/02/15. Diagnoses included, but were not limited to, diabetes, spastic hemiplegia, schizophrenia, congestive heart failure, bipolar disorder, depressive disorder, hypertension, asthma, and gastroesophageal reflux disease. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment	F 558	5. Date of compliance 11/13/18. F 558 1. Resident #111□s bed was replaced on 10/2/18 2. 100% Audit of residents□ room for proper working beds completed on 10/2/18 by Unit Managers. 3. Maintenance Director in serviced by Administrator on 10/3/18 to complete every 6 month audits of all electric beds per manufacturer guidelines and keep a log of audit. SDC to in service all staff by 10/29/18 on correct procedure to report inoperable beds using work order forms as soon as found and to notify supervisor. 4. Maintenance Director or designee do weekly audits x4, then monthly x2 of 15 residents□ room to ensure proper working beds. To be reviewed with DON/ADON. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. Date of compliance 11/13/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 6	F 558		

with an ARD (assessment reference date) of 08/17/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. Section G (functional status) was coded (4/2) to indicate the Resident was totally dependent on two staff for bed mobility, locomotion on and off the unit, dressing, toilet use, personal hygiene, and bathing. Transfers were coded (4/3) to indicate the Resident was totally dependent on two staff for this task. Section H (bladder and bowel) was coded to indicate the Resident was always incontinent in both of these areas.

The Resident's comprehensive care plan included the focus areas of alteration in comfort, alteration in elimination episodes of incontinence of bowel and bladder; maintain nutritional status, and self-care deficit.

On 10/01/18 at 12:09 p.m., during an interview with Resident #67, the Resident voiced to the surveyor that they had no choice of what they received at meals and the facility did not give them a menu. Resident #67 then stated that the facility had ran out of my briefs. When asked about not having briefs Resident #67 stated this prevented her from getting out of the bed.

On 10/01/18 at 3:03 p.m., during an interview with the central supply person, this employee verbalized to the surveyor that they had ordered bariatric briefs last week. However, the delivery company (name omitted) was partially on strike and she did not know why they did not get the briefs from somewhere else. When asked when they had ran out of briefs they stated maybe Wednesday.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 7	F 558		

The surveyor checked the Resident room for a menu and was unable to locate one. During a walk-through of the facility, the surveyor was unable to find any posted menu(s). There was a menu display board posted behind the tray line in the dining room with the menu for that day posted.

10/02/18 at 10:43 a.m., Resident #67 stated to the surveyor that they had finally brought a menu around and put in my room yesterday evening.

On 10/03/18 at 9:25 a.m., the surveyor interviewed the LDC (lead dietary cook), during this interview the LDC verbalized to the surveyor that the menu board in the dining room is updated at night when they leave. Alternates are written on the board after breakfast. The LDC stated they did not currently have a dietary manager and a manager from another facility was assisting them. LDC stated if we have issues, we go to the administrator.

Due to Resident #67's immobility, they would not have been able to access this menu board in the dining room unless they had been assisted to the dining room by the facility staff. Resident #67 ate her meals in her room.

The administrative staff were notified of the above issues on 10/02/18 at 4:15 p.m.

On 10/03/18 at 1:40 p.m., during a meeting with the DON (director of nursing), the DON verbalized to the surveyor that the previous dietary manager printed the menus, passed them out to the CNA's (certified nursing assistants) and they posted them. However, since we do not currently have a dietary manager that was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 8	F 558		

done.

No further information regarding this issue was provided to the survey team prior to the exit conference.

3. For Resident #82, the facility staff failed to post menus or notify the Resident of what they would be receiving at meal times.

The record review revealed that Resident #82 had been admitted to the facility 09/30/16. Diagnoses included, but was not limited to, cerebellar stroke syndrome, insomnia, hypertension, transient cerebral ischemic attack, prostatic dysplasia, and depressive disorder.

Section C (cognitive patterns) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 08/26/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. Section G (functional status) was coded (0/0) to indicate the Resident was independent in the areas of bed mobility, transfers, walk in room, and locomotion on and off the unit. Eating had been coded (0/1) to indicate the Resident was independent with setup help only.

The Resident's comprehensive care plan included the focus areas at risk for decline of nutritional status, self-care deficit, and alteration in visual function.

On 10/01/18 at 1:06 p.m., during an interview with Resident #82, the Resident verbalized to the surveyor that they no longer received menus. "...they use to give us menus. The food situation went downhill when this other company bought

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 9	F 558		

them out..."

A review of the Residents weights revealed that the Resident weighed 263 pounds on 09/12/18 and 258 pounds on 05/10/18.

On 10/03/18 at 9:25 a.m., the surveyor interviewed the LDC (lead dietary cook), during this interview the LDC verbalized to the surveyor that the menu board in the dining room is updated at night when they leave. Alternates are written on the board after breakfast. The LDC stated they did not currently have a dietary manager and a manager from another facility was assisting them. LDC stated if we have issues, we go to the administrator.

The administrative staff were notified of the issues regarding the dietary menus on 10/02/18 at 4:15 p.m.

On 10/03/18 at 1:40 p.m., during a meeting with the DON (director of nursing), the DON verbalized to the surveyor that the previous dietary manager printed the menus, passed them out to the CNA's (certified nursing assistants) and they posted them. However, since we do not currently have a dietary manager that was not done.

No further information regarding this issue was provided to the survey team prior to the exit conference.

4. For Resident #91, the facility failed to post menus or notify the Resident of what they would be receiving at meal times.

The record review revealed that Resident #91

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 10	F 558		

had been admitted to the facility 04/18/11. Diagnoses included, but were not limited to, multiple sclerosis, paraplegia, anemia, gastro-esophageal reflux disease, dysphagia, diabetes without complications, and depression.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with the ARD (assessment reference date) of 08/29/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. Section G (functional status) was coded (4/2) to indicate the Resident required total dependence of one person for bed mobility, locomotion on and off the unit, dressing, toilet use, and personal hygiene. Transfers were coded (4/3) for total dependence on two staff, and eating was coded (0/2) for independent with one-person assist.

The Resident's comprehensive care plan included the focus areas nutritional needs, potential for alteration in fluids balance related to poor intake, self-care deficit, impaired physical mobility, impaired functional mobility, alteration in visual function, and diabetes.

On 10/01/18 at 11:40 a.m., during an interview with Resident #91, Resident #91 verbalized to the surveyor that they use to have two choices in regards to their menus and now we just have one. Resident #91 also stated she did not have a menu in her room and she did not know what she was getting to eat until she got it.

On 10/02/18 at 8:24 a.m., Resident #91 stated not having a menu was still an issue and stated that even if the menus were posted I would not know what it was, as I do not go out onto the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 11	F 558		

halls. Resident #91 chose to eat her meals in her room.

On 10/02/18 at 1:13 p.m., the surveyor observed a menu hanging on a bulletin board in the Residents room. However, this bulletin board was not near her bed and the Resident was unable to see or access the menu.

On 10/03/18 at 9:25 a.m., the surveyor interviewed the LDC (lead dietary cook), during this interview the LDC verbalized to the surveyor that the menu board in the dining room is updated at night when they leave. Alternates are written on the board after breakfast. The LDC stated they did not currently have a dietary manager and a manager from another facility was assisting them. LDC stated if we have issues, we go to the administrator.

The administrative staff were notified of the issues regarding the dietary menus on 10/02/18 at 4:15 p.m.

On 10/03/18 at 1:40 p.m., during a meeting with the DON (director of nursing), the DON verbalized to the surveyor that the previous dietary manager printed the menus, passed them out to the CNA's (certified nursing assistants) and they posted them. However, since we do not currently have a dietary manager that was not done.

No further information regarding this issue was provided to the survey team prior to the exit conference.

5. The facility staff failed to ensure Resident #111's remote control to raise and lower the head of the bed was accessible and working.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 12	F 558		

The clinical record of Resident #111 was reviewed 10/1/18 through 10/3/18. Resident #111 was admitted to the facility 4/7/16 and readmitted 9/5/18 with diagnoses that included but not limited to cerebral palsy, diabetes mellitus, lack of coordination, abnormal posture, neuromuscular dysfunction of the bladder, sepsis, anxiety, glaucoma, major depressive disorder, muscle spasms, anemia, pain, iron deficiency anemia, hyperlipidemia, insomnia, hypertension, constipation, left elbow contractures, scoliosis, left stage IV trochanteric pressure ulcer and an unstageable pressure ulcer of sacral region.

Resident #111's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 9/18/18 assessed the resident with a BIMS (brief interview for mental status) as 15/15. The resident was without signs/symptoms of delirium, psychosis, and did not exhibit behaviors that affected others. Section G Functional Status was reviewed. Resident #111 required extensive assistance of one person for dressing, limited assistance of one person for eating and toilet use, extensive assistance of one person for personal hygiene, and was totally dependent on two plus persons for bathing. Resident #111 had limitations in range of motion on both upper and lower extremities.

Resident #111's current comprehensive care plan had the focus area that read "Impaired functional mobility r/t (related to) contractures, scoliosis, chronic pain, muscle weakness, DM (diabetes mellitus), cerebral palsy, muscle spasms, lack of coordination, abnormal posture, debility and hypoxia. Initiated 5/4/2017 and revision on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 13	F 558		

8/7/18. Interventions: Call light in reach. Encourage resident to call and request help as needed. Trapeze over bed for bed mobility. A second focus area was for alteration in visual function. Initiated 6/28/18 with revision on 8/7/18. Interventions: Keep call light in reach for resident and place residents hand on it so they know where it is. Instruct resident to notify staff if assistance is necessary. Provide environment that accommodates impaired vision. Orient resident to surroundings as often as needed.

The surveyor interviewed Resident #111 on 10/1/18 at 1:58 p.m. Resident #111 was observed in bed with his head resting on a pillow; the bed flat. Resident #111 stated for the past couple of months, the remote controls on his bed didn't work. During the interview, the surveyor observed the remote controls lying on the floor near the window-out of reach for the resident.

The surveyor interviewed certified nursing assistant (C.N.A.) #1 on 10/1/18 at 2:35 p.m. C.N.A. #1 stated the remote controls for his bed have not worked for weeks and she stated she had reported the issue to all three maintenance staff but the remote control still does not work. C.N.A. #1 stated if the remote control was placed near his abdomen between his legs, Resident #111 could raise and lower the head of the bed.

The surveyor interviewed the maintenance director on 10/1/18 at 3:18 p.m. The maintenance director checked the remote. He checked the wiring underneath the bed and stated it looked like there was a short in it. He raised the head of the bed and it kept going up. He was unable to stop the bed from rising and had to go to the left side and pull the electrical cord from the wall to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 14	F 558		

keep it from continuing to rise. He stated he would replace the bed. In the meantime, he stated the staff would transfer the resident to a stretcher. Resident complained of pain in the right knee while the maintenance director was raising the head of the bed. The surveyor asked the maintenance director for all the work orders for the bed.

The maintenance director returned to Resident #111's room with a hand crank to lower the head of the bed at 3:27 p.m. The maintenance director stated there were no work orders for the bed. Two certified nursing assistants transferred the resident using a Hoyer lift to a stretcher.

The surveyor informed the director of nursing of the above issue with the remote controls not working on Resident #111's bed and not within reach on 10/2/18 at 7:40 a.m. and requested all the work orders. The DON stated she thought the bed was a rental and was checked a couple of weeks ago and had no issues.

The surveyor informed the administrative staff of the concern with Resident #111's bed not working properly in the end of the day meeting on 10/2/18 beginning at 4:15 p.m. The surveyor requested the manufacturer's manual for Resident #111's bariatric bed.

The surveyor reviewed the manufacture's manual for the Joerns Camtec Series Bed Frames RC 1000 Bed on 10/3/18. The manual read in part, "Periodic Inspection and Maintenance The amount of maintenance required by the end will be dictated by its use. As a minimum, the unit should be periodically inspected every 6 months. 5. Check all electrical wiring for fraying, kinking

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 15 damage and/or deterioration." No further information was provided prior to the exit conference on 10/3/18.	F 558		
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). (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	F 578		11/13/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 16 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 1 of 29 Residents, Resident #98. The findings include: For Resident #98, the facility staff failed to ensure the Resident's DDNR was complete. Section's 1 and 2 had been left blank. The clinical record review revealed that Resident #98 had been admitted to the facility on 05/31/18 and readmitted on 08/21/18. Diagnoses included, but were not limited to, aphasia following cerebral infarction, dysphagia, encephalopathy, and muscle weakness. Section C (cognitive patterns) of the Resident's most recent MDS (minimum data set) assessment with an ARD (assessment reference date) of 08/28/18, the resident was coded as having short term and long-term memory problems. The Resident's clinical record included a DDNR order form from the Virginia Department of Health. This form was dated 08/21/18 and read in part:	F 578	F 578 1. Resident #98□s DNR was corrected on 10/2/18. 2. 100% Audit of all current resident□s DNR status to ensure proper completion by unit manger by 10/29/18. 3. SDC to in service all licensed staff to ensure proper completion of DNR sheets by MD. SDC to in-service all unit mangers to check all new code status changes, and all new admits for proper completion by 10/29/18. 4. Unit Managers to complete weekly audits x4, then monthly x2 of 5 residents per unit to ensure proper completion of DNR sheet and report to DON/ADON. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. Date of compliance 11/13/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 17 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 been signed by the Residents authorized representative. The administrator and the vice president of operations were made aware of the above findings on 10/02/18 at 9:00 a.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 578		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can	F 584		11/13/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 18 receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, and clinical record review the facility staff failed to maintain a clean, comfortable, homelike environment for 2 of 29 Residents, Residents #13 and #118. The findings included: 1. For Resident #13, the facility had placed tape on the Residents air conditioning/heater unit and	F 584	F 584 1. Resident #13□s tape was removed from air conditioner, and resident # 118, tape was removed from air conditioner and plexyglass removed from closet. 2. 100% Audit of resident□s room for tape on air conditioners and plexyglass on closets by 10/24/18 by Maintenance Director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 19 the wall next to the Resident's closet contained a piece of plexiglass with a large piece of torn foam attached to it. The record review revealed that Resident #13 had been admitted to the facility 09/19/05. Diagnoses included, but were not limited to, anxiety disorder, schizophrenia, diabetes, and gastroesophageal reflux disease. 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 15 out of a possible 15 points. On 10/01/18 at 2:36 p.m., during an interview with Resident #13, the surveyor observed plexiglass on the wall across from the Residents bed next to the closet. Part of the plexiglass was observed to have ripped/brown foam in place. When #13 was asked if this bothered her she stated it did. The surveyor was also able to observe tape on the heater/air conditioning unit and debris scattered underneath this unit. The surveyor requested the maintenance director to come to the room. When the maintenance director was asked about the plexiglass, he stated he was not sure why it was there but he would remove it. During a second observation on 10/02/18 at 1:17 p.m., the plexiglass had been removed from the wall and the tape had been removed from the air conditioner unit.	F 584	3. Maintenance Director in serviced by Administrator on 10/2/18 to ensure all air conditioners are operating without tape on air conditioning unit, and all un-necessary plexyglass is removed, and must have Administrators or DON□s approval to apply plexyglass. 4. Maintenance director or designee do weekly audits x4, then monthly x2 of 15 resident□s room to ensure no tape on air conditioner units or un-necessary plexyglass is present which is to be reviewed with DON/ADON. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. Date of compliance 11/13/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 20	F 584		

The administrative staff were notified of the above issues during a meeting with the survey team on 10/02/18 at 4:15 p.m.

No further information regarding this issue was provided to the survey team prior to the exit conference.

2. For Resident #118, the air conditioning/heater unit was observed to be secured with tape.

The record review revealed that Resident #118 had been admitted to the facility 02/17/17. Diagnoses included, but were not limited to, traumatic brain injury, dysphagia, insomnia, depressive disorder, and anxiety disorder.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 02/17/17 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.

This Resident was not interviewable.

On 10/01/18 at 12:32 p.m., the surveyor entered Resident #118's room. During this observation, the surveyor was able to observe tape on the air conditioner/heater unit in this room.

The administrative staff were notified of the above issue during a meeting with the survey team on 10/02/18 at 4:15 p.m.

No further information regarding this issue was provided to the survey team prior to the exit conference.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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 minimum data set (MDS) assessment for 1 of 29 residents (Resident #99). The findings included: The facility staff failed to ensure the coding in Section J was accurate for Resident #99. The staff failed to code Resident #99's fall with injury that occurred 6/22/18. The clinical record of Resident #99 was reviewed 10/1/18 through 10/3/18. Resident #99 was admitted to the facility 3/6/18 with diagnoses that included but not limited to encephalopathy, Parkinson's disease, fracture of upper end of left humerus, muscle weakness, difficulty in walking, dysphagia, cognitive communication disorder, cerebral infarction, narcolepsy without cataplexy, hypotension, unspecified dementia without behavioral disturbances, hypertension, joint stiffness, and tachycardia. Resident #99's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 9/5/18 assessed the resident with a BIMS (brief interview for mental status) as 05/15. The resident was assessed without signs or symptoms of delirium, psychosis, or behaviors that affected others.	F 641	F 641 1. For resident #99, MDS modification completed 10/5/18 to include fall with injury completed by MDS staff. 2. 100% Audit of resident□s falls with injury coded on mds for last 3 months by MDS staff by 10/29/18. 3. MDS staff in serviced by DON on 10/3/18 to ensure accuracy of falls with injury on mds 4. MDS nurse to do weekly audits x4, then monthly x2 of completed MDS□ for accuracy of falls with injuries, then go over audit with DON/ADON. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. Date of compliance 11/13/18.	11/13/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 22	F 641		

Resident #99's current comprehensive care plan initiated 3/6/18 and revised 3/22/18 identified the focus area that read the resident was at risk for fall related injuries.

The surveyor reviewed the June 2018 progress notes. Progress note dated 6/22/18 at 7:39 a.m. read in part "Resident rolled off side of bed while c.n.a. (certified nursing assistant) was getting his w/c (wheelchair) and clothes for shower. rsd (resident) was observed laying in the floor on right side with laceration (0.5 inch) to right forehead. area cleansed with NS (normal saline), steri-strips applied and dry dressing put in place. neuro checks wnl (within normal limits). rom (range of motion) wnl. no s/s (signs/symptoms) further injury noted. bruising and minimal swelling starting to appear. rsd (resident) denies pain. rsd placed in w/c and brought to nurses station for increased safety. n/o (new order)-monitor steri-strips q (every) shift; dry dressing daily x 7 days. 10:37 a.m. Resident sent to ER (Emergency Room) per NP (nurse practitioner) orders. 6:40 p.m. Resident returned from the ER."

The surveyor reviewed Section J 1900 Falls on the quarterly MDS with an ARD of 9/5/18. The fall of 6/22/18 had not been coded on the MDS.

The surveyor interviewed the minimum data set (MDS) coordinator registered nurse #1 on 10/3/18 at 10:07 a.m. MDS RN #1 reviewed the 9/5/18 MDS and the 6/22/18 progress note and stated she missed it. She provided the surveyor with a copy of the MDS and stated she would do a correction.

The surveyor informed the director of nursing and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 23 the assistant director of nursing of the above concerns on 10/3/18 at 12:15 p.m. No further information was provided prior to the exit conference on 10/3/18.	F 641		
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 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 observation, resident interview, staff	F 657	F 657	11/13/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 24 interview, and clinical record review, the facility staff failed to review and revise the current comprehensive care plan for one of 29 residents (Resident #81). The findings included: The facility staff failed to review and revise the current comprehensive care plan for Resident #81 for the use of an over the toilet chair. The clinical record of Resident #81 was reviewed 10/1/18 through 10/3/18. Resident #81 was admitted to the facility 7/8/15 and readmitted 2/4/16 with diagnoses that included but not limited to epilepsy, cerebrovascular disease, hemiplegia, urinary incontinence, hypertension, unsteadiness on feet, muscle weakness, age-related osteoporosis, dry eye syndrome, chronic atrial fibrillation, low back pain, mood disorder, schizoaffective disorder, major depressive disorder, hyperlipidemia, gastro-esophageal reflux disease, and chronic obstructive pulmonary disease. Resident #81's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 8/14/18 assessed the resident with a BIMS (brief interview for mental status) as 15/15. The resident was assessed with no signs/symptoms of delirium, psychosis, or behaviors that affected others. Section G Functional status assessed Resident #81 to need limited assistance of one person for toileting. Resident #81 had limitation in range of motion on both upper and lower extremity on one side. Mobility devices included a walker and wheelchair. Section H Bladder and Bowel assessed Resident #81 to be continent of both.	F 657	1. Resident #81□s care plan updated to remove over toilet chair 10/2/18. 2. 100% Audit of all current resident□s care plans to be completed by MDS nurse/Unit Manager to ensure accuracy of care plans by 10/29/18. 3. DON/ADON in serviced unit managers/MDS nurses to ensure care plan matches resident□s equipment needs. 4. Unit Manager/MDS nurse to do weekly audits x4, then monthly x 2 months of completed MDS□ to ensure accuracy of resident□s equipment needs. Then to be reviewed with DON/ADON. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. Date of compliance 11/13/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 25 Resident #81's current comprehensive care plan identified that the resident was at risk for falls and accidents [hx (history) of CVA (cerebrovascular accident] left sided hemiplegia and dizziness at times) osteoporosis. Date initiated: 12/19/16 Revision on: 5/23/17. Interventions: 1/22/18 Over the toilet seat. The surveyor interviewed Resident #81 on 10/01/18 at 3:50 p.m. The resident was asked if she was able to toilet herself to and from the bathroom. The resident stated she used her walker to get in and out of the bathroom. The surveyor reviewed the care plan. The care plan intervention for falls was the use of the over the toilet chair. The resident stated she didn't have one and didn't need one. The surveyor checked Resident #81's bathroom. There was not an over the toilet chair in the bathroom. The surveyor informed the administrative staff of the above issue on 10/2/18 at 4:15 p.m. No further information was provided prior to the exit conference on 10/3/18.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, and facility document review, the facility	F 658	F 658	11/13/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 26 staff failed to follow standards of professional practice in regards to documentation of an assessment for 1 of 29 Residents, Resident #67. The findings included: The nursing staff failed to document in the clinical record the results of an assessment. The Resident was complaining of right side pain. The record review revealed that Resident #67 had been admitted to the facility 07/02/15. Diagnoses included, but were not limited to, diabetes, spastic hemiplegia, schizophrenia, congestive heart failure, bipolar disorder, depressive disorder, hypertension, asthma, and gastroesophageal reflux disease. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 08/17/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. Section G (functional status) was coded (4/2) to indicate the Resident was totally dependent on two staff for bed mobility, locomotion on and off the unit, dressing, toilet use, personal hygiene, and bathing. Transfers were coded (4/3) to indicate the Resident was totally dependent on two staff for this task. Section H (bladder and bowel) was coded to indicate the Resident was always incontinent in both of these areas. The Resident's comprehensive care plan included the focus areas of alteration in comfort/pain. Interventions included, but were not limited to, observe for signs and symptoms of pain and discomfort, administer medications as	F 658	1. Resident #67□s nursing assessment documented on 10/3/18. 2. Unit Managers to complete 100% Audit of current resident□s assessment documentation of pain by 10/29/18. 3. SDC to in service all licensed staff by 10/29/18 on proper change of condition assessments are being completed by using sbars (such as changing in pain). SDC to in service LPN #1 on proper assessment documentation in progress notes in timely manner. SDC to in service by 10/29/18 all Licensed Nursing Staff to ensure timely, accurate entries in the electronic health record. 4. Unit Manager to do weekly audits x4, then monthly x2 of 5 resident□s assessments to ensure proper documentation, then to be reviewed with DON/ADON. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. Date of compliance 11/13/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 27	F 658		

ordered, and notify MD if indicated.

On 10/01/18 at 12:13 p.m., the Resident verbalized to the surveyor that they were having pain in their side and they needed to be put on the list to see the physician.

On 10/02/18, LPN (licensed practical nurse) #1 checked the Resident in the presence of the surveyor when palpitating the Resident's right side the Resident grimaced as if in pain. LPN #1 stated she would put the Residents name down to be seen by the physician.

The surveyor reviewed the nursing notes on 10/03/18 and was unable to locate any documentation that referred to this incident.

On 10/03/18 at 8:25 a.m., during an interview with LPN #1, LPN #1 verbalized to the surveyor that physician saw the resident yesterday and he had made some changes in her insulin. When asked if she had documented anything yesterday LPN #1 replied, "I may not have." The EHR (electronic health record) was reviewed and no documentation was found. LPN #1 then stated, "When I went up there to speak with the nurse that makes rounds with the physician the physician was here." LPN #1 stated the physician had assessed the resident.

After this conversation LPN #1 then documented the following in the resident's EHR "Resident C/O (complained of) R (right) side pain around lunch and ask for pain pill. Pain (sic) was given but at this time states the pain has eased some but still hurts when moving or touching. Abd (abdomen) examined and noted to be tender but not rebounding. VSS (vital signs stable). Last BM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 28 (bowel movement) 10/1/2018. No signs of distress. Will notify physician at this time." On 10/03/18 at 9:50 a.m., after reading the above progress note the surveyor approached LPN #1. LPN #1 verbalized to the surveyor that she had not documented that note until this morning after the conversation with the surveyor. The facility provided the surveyor with their copy of a policy/procedure titled "NURSE PROGRESS NOTES." This policy/procedure read in part, "...A resident's progress shall be documented in the record as required...The nurse shall utilize the Progress Note to document resident progress...The note will be written legibly in black ink and shall include the following but not limited to...Resident specific information..." Reference provided by the facility "Lippincott Manual of Nursing Practice" 10th edition. "Nursing Assessment and Interventions. To provide effective pain management, nursing assessment, physical examination, and review of laboratory values are very important..." The administrative staff were notified of the above during a meeting with the survey team on 10/03/18 at 4:36 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 677		11/13/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 29 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to provide mouth care to one of 29 dependent residents (Resident #111). The findings included: The facility staff failed to provide mouth care to Resident #111. The clinical record of Resident #111 was reviewed 10/1/18 through 10/3/18. Resident #111 was admitted to the facility 4/7/16 and readmitted 9/5/18 with diagnoses that included but not limited to cerebral palsy, diabetes mellitus, lack of coordination, abnormal posture, neuromuscular dysfunction of the bladder, sepsis, anxiety, glaucoma, major depressive disorder, muscle spasms, anemia, pain, iron deficiency anemia, hyperlipidemia, insomnia, hypertension, constipation, left elbow contractures, scoliosis, left stage IV trochanteric pressure ulcer and an unstageable pressure ulcer of sacral region. Resident #111's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 9/18/18 assessed the resident with a BIMS (brief interview for mental status) as 15/15. The resident was without signs/symptoms of delirium, psychosis, and did not exhibit behaviors that affected others. Section G Functional Status was reviewed. Resident #111 required extensive assistance of one person for dressing, limited assistance of one person for eating and toilet use, extensive	F 677	F 677 1. Resident #111 received proper mouth care on 10/1/18 2. Unit Managers to complete 100% Audit of current residents mouth care by 10/29/18. 3. SDC to in service all nursing staff to provide proper oral care daily by 10/29/18. 4. Unit Manager to do weekly audits x4, then monthly x2 of 5 resident s mouth care to ensure proper oral care, then to be reviewed with DON/ADON. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. Date of compliance 11/13/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 30	F 677		

assistance of one person for personal hygiene, and was totally dependent on two plus persons for bathing. Resident #111 had limitations in range of motion on both upper and lower extremities.

Resident #111's current comprehensive care plan had the focus area that read "Self Care deficit with risk of constipation, incontinence as evidenced by (AEB): cerebral palsy, generalized muscle weakness, chronic pain, debility, scoliosis, htn (hypertension), DM (diabetes mellitus), contractures, muscle spasms, lack of coordination, abnormal posture, glaucoma, incontinence, depression, anxiety, insomnia, delusions, mood disorder with intermittent psychosis, hypoxia, chronic urticarial, costipation (sic). Initiated 5/4/17 and revised on 8/7/18. Interventions: Assist with oral care as needed."

The surveyor interviewed Resident #111 on 10/1/18 at 1:58 p.m. Resident #111 was observed in bed with his head resting on a pillow; the bed flat. During the interview, the surveyor asked the resident about his teeth. Resident #111 stated he had his own teeth but needed to see a dentist. When asked how often the staff brush his teeth, the resident stated, "It's been awhile."

Certified nursing assistant (C.N.A.) #1 was asked if the resident had a toothbrush and toothpaste in the nightstand drawer. C.N.A. #1 stated the resident did but she had not brushed his teeth today. C.N.A. #1 stated she would brush his teeth.

The surveyor informed the director of nursing (DON) of the above issue on 10/1/18 at 4:00 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 31 The DON was asked how often mouth care should be provided. The DON stated a couple of times a day. The surveyor requested the September 2018 and October 2018 activities of daily living forms. The surveyor reviewed the forms. The surveyor reviewed the September 2018 and October 2018 ADL forms. In September 2018 on both the 7-3 shift and 3-11 shift, the documentation for Resident #111's personal hygiene was "4/2-total dependence on 1 person." The 11-7 shift documentation was recorded as "8/8-activity did not occur." The October 2018 ADL form was reviewed. The 10/1/18 documentation recorded for personal hygiene was "8/8-activity did not occur." The surveyor informed the administrative staff of the concern with Resident #111's mouth care not done in the end of the day meeting on 10/2/18 beginning at 4:15 p.m. No further information was provided prior to the exit conference on 10/3/18.	F 677		
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	F 684		11/13/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 32 by: Based on staff interview and clinical record review, the facility staff failed to ensure the highest practicable well-being for 3 of 29 Residents, Resident #67, #81, and #99. The findings included: 1. For Resident #67, the facility staff failed to administer the Residents novolog insulin with meals. The nursing staff were documenting that this was being administered at 6:30 a.m., 11:30 a.m., and 4:30 p.m. The record review revealed that Resident #67 had been admitted to the facility 07/02/15. Diagnoses included, but were not limited to, diabetes, spastic hemiplegia, schizophrenia, congestive heart failure, bipolar disorder, depressive disorder, hypertension, asthma, and gastroesophageal reflux disease. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 08/17/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. The Resident's comprehensive care plan included the focus areas of maintain nutritional status, potential for uncontrolled blood sugars, and self-care deficit. Approaches included, but were not limited to, administer accuchecks as ordered and administer medications as ordered. The current POS (physician order sheet) included orders for novolog insulin 20 units to be administered with meals.	F 684	F 684 1. Resident #67□s order changed to give insulin with meals on 10/3/18. 2. Unit Managers to complete 100% Audit of current resident□s insulin orders to ensure insulin being given in correct time by 10/29/18. 3. SDC to in service all licensed staff to ensure proper administration of insulin according to orders By 10/29/18 4. Unit Manager to do weekly audits x4, then monthly x2 of 5 resident□s insulin orders to ensure proper administration of insulin according to orders, then to be reviewed with DON/ADON. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. Date of compliance 11/13/18. F 684 1. Resident #81□s ted stockings placed on resident 10/2/18. 2. Unit Managers to complete 100% Audit of current residents□ ted stockings to ensure following MD orders by 10/29/18 3. SDC to in service all nursing staff to ensure proper placement of ted stockings per MD orders. 4. Unit Manager to do weekly audits x4, then monthly x2 of 5 resident□s ted stockings to ensure proper placement per orders, then to be reviewed with DON/ADON. The results of the audits will be forwarded to the facility QAPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 33 A review of the resident's eMARs (electronic medication administration records) for 09/18 and 10/18 revealed that the facility nursing staff were administering this medication at 6:30 a.m., 11:30 a.m., and 4:30 p.m. On 10/02/18 at 11:28 a.m., during an interview with LPN (licensed practical nurse) #1, LPN #1 verbalized to the surveyor that Resident #67 received her lantus insulin at 8:00 a.m. and the novolog was given on third shift. The administrative staff were notified of the issue regarding the Residents insulin during a meeting with the survey team on 10/02/18 at 4:15 p.m. On 10/03/18 at 3:45 p.m., the following interviews were completed. Per the lead dietary cook, the trays went out to this unit at breakfast at 8:00 a.m., lunch 12:30-12:45 p.m., and supper 4:30-4:45 p.m. Per LPN #1 the breakfast trays were delivered to the hall at 8:45-9:00 a.m., lunch 12:45 p.m., and she did not know about supper. Per LPN #2 supper trays were delivered around "4:45 p.m. to 5-ish it varies." No further information regarding this issue was provided to the survey team prior to the exit conference. 2. The facility staff failed to follow the physician orders to apply TED (thromboembolic stockings) hose in the am (morning) for Resident #81. The clinical record of Resident #81 was reviewed	F 684	committee for further review and recommendations. 5. Date of compliance 11/13/18. F 684 1. Med error completed for incorrect administration of Cipro on resident # 99 2. Unit Managers to complete 100% audit of current resident□s antibiotic orders for the last 30 days to ensure proper administration of antibiotic per orders by 10/29/18 3. SDC to in service all licensed staff on appropriate order entry for correct number of doses by 10/29/18. 4. Unit Manager to do weekly audits x4, then monthly x2 of 5 residents□ ted stockings to ensure proper documentation of antibiotics per orders, then to be reviewed with DON/ADON. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. Date of compliance 11/13/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 34	F 684		

10/1/18 through 10/3/18. Resident #81 was admitted to the facility 7/8/15 and readmitted 2/4/16 with diagnoses that included but not limited to epilepsy, cerebrovascular disease, hemiplegia, urinary incontinence, hypertension, unsteadiness on feet, muscle weakness, age-related osteoporosis, dry eye syndrome, chronic atrial fibrillation, low back pain, mood disorder, schizoaffective disorder, major depressive disorder, hyperlipidemia, gastro-esophageal reflux disease, and chronic obstructive pulmonary disease.

Resident #81's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 8/14/18 assessed the resident with a BIMS (brief interview for mental status) as 15/15. The resident was assessed with no signs/symptoms of delirium, psychosis, or behaviors that affected others. Functional status for dressing was coded extensive assistance of one person required.

The 9/16/18 through 11/14/2018 physician orders were reviewed. The order dated 7/11/18 read, "TED hose knee high on in am and off in pm."

Resident #81's current comprehensive care plan initiated 5/23/17 and revised on 5/23/17 included the focus area of self-care deficits with risk of constipation and one intervention that read "7/11/18 TED Hose Knee High on in the a.m. (morning) and off in the p.m. (evening)."

The surveyor observed Resident #81 walking with the physical therapist #1 (PT #1) in the hall and around the nurse's station on 10/2/18 at 10:38 a.m. The surveyor asked Resident #81 if staff had put her TED hose on. She stated no. PT #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 35	F 684		

and the surveyor checked both legs. Resident #81 only had fuzzy socks on her feet/legs.

The surveyor informed the administrative staff of the observation during the end of the day meeting on 10/2/18 beginning at 4:16 p.m.

No further information was provided prior to the exit conference on 10/3/18.

3. The facility staff failed to follow the physician order for the administration of Cipro for Resident #99. The physician ordered Cipro 750 mg (milligrams) for 10 days or 20 doses. Resident #99 was administered three (3) extra doses of Cipro.

The clinical record of Resident #99 was reviewed 10/1/18 through 10/3/18. Resident #99 was admitted to the facility 3/6/18 with diagnoses that included but not limited to encephalopathy, Parkinson's disease, fracture of upper end of left humerus, muscle weakness, difficulty in walking, dysphagia, cognitive communication disorder, cerebral infarction, narcolepsy without cataplexy, hypotension, unspecified dementia without behavioral disturbances, hypertension, joint stiffness, and tachycardia.

Resident #99's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 9/5/18 assessed the resident with a BIMS (brief interview for mental status) as 05/15. The resident was assessed without signs or symptoms of delirium, psychosis, or behaviors that affected others.

A physician order dated 8/13/18 read "Ciprofloxacin 750 mg po (by mouth) bid (twice a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 36	F 684		

day) x 10 days for empiric tx (treatment) of probable pseudomonal wound infection. Acidophilus 1 capsule po q (every) day x 30 days."

The surveyor reviewed the August 2018 electronic medication administration records (eMARS). Cipro 750 mg had been administered twenty-three (23) times from 8/13/18 through 8/24/18. Resident #99 received three (3) extra doses of Cipro 750 mg.
The surveyor informed licensed practical nurse #2 of the above concern on 10/3/18 at 10:19 a.m. L.P.N. #2 reviewed the order and confirmed twenty three doses of Cipro were administered instead of 20 doses or 10 days as ordered by the physician.

The surveyor requested the pharmacy manifest for Resident #99's Cipro and a list of the contents of the stat box from the unit manager L.P.N. #1 on 10/3/18 at 11:00 a.m.

The pharmacy manifest was reviewed with the unit manager L.P.N. #1 on 10/3/18 at 12:03 p.m. The unit manager L.P.N. #1 stated the pharmacy sent twenty-two doses (22) of Cipro. He stated the pharmacy followed the order put in the computer by the nurse. L.P.N. #1 stated he did not know if one was removed from the stat box. The stat box contents were reviewed. There were six (6) Cipro 250 mg listed in the stat box contents.

The surveyor informed the director of nursing and the assistant director of nursing of the above concerns on 10/3/18 at 12:15 p.m.

No further information was provided prior to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 37 exit conference on 10/3/18.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to provide one of 29 residents (Resident #111) with pressure ulcer treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. The findings included: The facility staff failed to provide wound care consistent with professional standards of practice to prevent infection and to promote healing for Resident #111. The facility staff did not change gloves or perform hand hygiene after removing a soiled dressing from the resident's left hip and failed to cleanse the sacral wound from the center towards the outer part of the wound.	F 686	F686 1. Resident # 111 received proper wound cleansing and proper dressing change on 10/4/18. 2. Unit Managers to complete 100% Audit for residents requiring wound care for proper procedure 3. DON/ADON in serviced Wound Care Nurse by 10/29/18 on proper clean technique, including hand washing, wound cleansing, and dating dressing. SDC to in service all licensed staff by 10/29/18 on proper clean technique, including hand washing, wound cleansing, and dating dressing. SDC to in service all staff by 10/29/18 on hand washing. 4. DON/ADON or designee to observe	11/13/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 38 The clinical record of Resident #111 was reviewed 10/1/18 through 10/3/18. Resident #111 was admitted to the facility 4/7/16 and readmitted 9/5/18 with diagnoses that included but not limited to cerebral palsy, diabetes mellitus, lack of coordination, abnormal posture, neuromuscular dysfunction of the bladder, sepsis, anxiety, glaucoma, major depressive disorder, muscle spasms, anemia, pain, iron deficiency anemia, hyperlipidemia, insomnia, hypertension, constipation, left elbow contractures, scoliosis, left stage IV trochanteric pressure ulcer and an unstageable pressure ulcer of sacral region. Resident #111's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 9/18/18 assessed the resident with a BIMS (brief interview for mental status) as 15/15. The resident was without signs/symptoms of delirium, psychosis, and did not exhibit behaviors that affected others. Section G Functional Status was reviewed. Resident #111 required extensive assistance of one person for dressing, limited assistance of one person for eating and toilet use, extensive assistance of one person for personal hygiene, and was totally dependent on two plus persons for bathing. Resident #111 had limitations in range of motion on both upper and lower extremities. Section M Skin Conditions was reviewed. Resident #111 was assessed with one unstageable pressure ulcer measuring 10.0 cm (centimeters) width, x 6.0 centimeters (length) x 0.2 cm (depth) and one surgical wound). Resident #111's comprehensive care plan was reviewed. Resident #111 has a focused area that read, "The resident has infection of the surgical	F 686	and audit of 3 residents weekly x 4, then monthly x 2 to ensure proper technique for wound care and hand washing. Audits will be reviewed with DON/ADON. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. Date of compliance 11/13/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 39	F 686		

wound left hip. Interventions: 7/24/18 Treatment to left hip as ordered, air mattress, maintain universal precautions when providing resident care, monitor for s/s (signs/symptoms) of infection. Report to MD (medical doctor)/NP (nurse practitioner) as indicated. A second focus area read "I have an alteration in my skin integrity AEB (as evidenced by) pressure ulcer location (s): surgical wound to left hip, unstageable to buttocks. Interventions: float my heels as tolerated, low air loss mattress with 4 side rails, provide my treatment as ordered, observe response to treatment, if poor, no response, or deterioration notify MD/ARNP (Advanced Registered Nurse Practitioner), weekly skin assessment by nurse, refer to wound MD as needed for follow-up."

The October 2018 physician orders were reviewed. Resident #111 had orders for wound care to the sacrum that read to clean buttocks with normal saline (NS), pat dry, apply santyl and cover with a foam dressing qd (every day) and apply foam dressing to left hip surgical site, change Mon (Monday), Wed (Wednesday), Fri (Friday).

The surveyor observed wound care on 10/2/18 at 9:55 a.m. Resident #111 gave permission to watch wound care. The surveyor observed licensed practical nurse #3 do wound care to the surgical site on the left hip and to the unstageable pressure area on the sacrum. L.P.N. #3 stated the over the bed table had been cleaned with bleach wipes and allowed to air dry. L.P.N. #3 washed her hands and applied gloves as well as certified nursing assistant #1. L.P.N. #3 explained the procedure to the resident and checked the resident's pain level. L.P.N. #3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 40	F 686		

retuned to the treatment cart, removed the Santyl ointment from the cart, and put Santyl in a cup. Barrier placed on table and supplies placed on barrier. Supplies covered with a barrier. Privacy curtain pulled and blinds closed. Wedge removed. Resident #111 was turned to right side via draw sheet (soiled). Resident #111 had four (4) foam dressings on back. Three (3) are from surgical sites to left hip and the 4th was on the sacral area. Surgical site (upper one) had copius amounts of drainage and L.P.N. #3 removed the dressing L.P.N. #3 removed the sacral dressing. Area has copius amounts of drainage and with odor. Dark bloody looking drainage observed on gauze. L.P.N. #3 took gloves off and went back to cart to retrieve an additional foam dressing but did not wash her hands after removing soiled dressing, exiting room and entering treatment cart. L.P.N. #3 re-entered the room with gauze bandages and placed them on the barrier and then washed hands and applied gloves. L.P.N. #3 cleaned the sacral area with normal saline. L.P.N. #3 did not use a circular motion to clean the sacral wound. L.P.N. #3 started in the center of the wound in a circular motion then just started dabbing at area. L.P.N. #3 stated the sacral wound was unstageable. L.P.N. #3 removed gloves and washed hands. Applied new gloves and applied Santyl to the sacral wound with a q-tip and covered with foam dressing. Gloves off. Hands washed. New gloves applied. Surgical site cleaned with NS and foam dressing applied. Gloves changed. LPN #3 did not date or initial dressings when applied.

The surveyor discussed the wound care observation with L.P.N. #3 on 10/3/18 at 2:30 p.m. She stated she thought she had cleaned the wound appropriately. She stated she cleaned

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 41	F 686		

wounds from the center of the wound and then goes out in a "spoke like fashion." She also stated she was unaware that she had not washed her hands after removing the surgical dressing and the sacral dressing and going to the treatment cart to get supplies.

The surveyor requested the facility policy on hand washing, glove use and dressing changes from the corporate nurse on 10/3/18 at 3:00 p.m. The corporate nurse stated the facility was using competencies and provided the surveyor the competency for clean dressing application.

The surveyor reviewed the "Clean Dressing Application" on 10/3/18. The competency read in part "5. Cleanse wound with the solution ordered. Always clean the area from the center out or from the cleanest to least clean area."

The surveyor reviewed the information provided on 10/3/18. The facility policy titled "Hand Washing" read in part "Procedure 3. Perform hand hygiene: b. After removing gloves, d. After contact with body fluids or excretions, mucous membranes, non-intact skin and/or wound dressings, e. If moving from a contaminated body site to a clean body site during resident care, and g. Wash hands with either plain or antimicrobial soap and water or rub hands with an alcohol-based formulation before handling medication and preparing food."

The surveyor informed the administrative staff of the above concerns with wound care in the end of the survey meeting on 10/3/18 at 4:00 p.m.

No further information was provided prior to the exit conference on 10/3/18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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 restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility	F 690	F690	11/13/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 43 document review and clinical record review, the facility staff failed to provide appropriate treatment and services for the care of residents with a clinically justified indwelling catheter for three of 29 residents (Resident #86, Resident #111, and Resident #29). The findings included: 1. The facility staff failed to ensure Resident #86's indwelling Foley was not touching the floor. The clinical record of Resident #86 was reviewed 10/1/18 through 10/3/18. Resident #86 was admitted to the facility 3/14/16 with diagnoses that included but not limited to right lower leg amputation, paraplegia, muscle weakness, wasting and atrophy, lack of coordination, chronic pain, urine retention, nicotine dependence, major depressive disorder, anxiety disorder, gastro-esophageal reflux disease, constipation, hypokalemia, bronchitis, and urinary tract infection. Resident #86's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 8/29/18 assessed the resident with a BIMS (brief interview for mental status) as 14/15. Section H Bladder and Bowel was marked for indwelling catheter. During the initial tour of the facility on 10/1/18 around 11:30 a.m., the surveyor observed Resident #86 sitting in a wheelchair and watching television. Resident #86's indwelling Foley catheter drainage bag and tubing were observed lying on the floor. The surveyor informed the unit manager licensed	F 690	1. Resident #29 received new orders to change to size of Catheter to 20 FR 30 ml balloon on 10/1/18. Resident #111 foley catheter bag was placed below the bladder 10/1/18. Resident #86 foley catheter bag was removed from floor and placed below bladder on 10/1/18. 2. 100% audit to ensure correct size catheters, leg straps are in place, and proper placement of patients with catheters completed on 10/1/18 by Unit Managers. 3. SDC to in service nursing staff by 10/29/18 to ensure correct size on catheter changes, leg straps are utilized, and foley catheter bags are placed below the bladder and off the floor. 4. DON/ADON or designee to observe and audit catheter size, placement of catheter, and leg straps in place on 3 residents weekly x 4, then monthly x 2 to ensure size of catheter matches Physician order, leg straps in place, and to ensure proper placement of catheter bag. Audits will be reviewed with DON/ADON. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. Date of compliance 11/13/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 44	F 690		

practical nurse #1 on 10/1/18 at 11:35 a.m. of the Foley drainage bag and tubing on the floor. The unit manager L.P.N. #1 stated Foleys are supposed to be off the floor. L.P.N. #1 donned gloves and positioned the Foley to the side of the bed. L.P.N. #1 removed the gloves and washed hands. L.P.N. #1 stated keeping the Foley bags and tubing off the floor was a challenge when a resident was in a low bed.

The surveyor requested the facility policy on urinary catheter care from the director of nursing on 10/1/18 at 4:45 p.m.

The surveyor reviewed the facility policy titled "Catheter Care Urinary Male-Female--Personal Care" on 10/2/18.

The surveyor informed the administrative staff of the above issue with the placement of Resident #86's Foley drainage bag and tubing in the end of the day meeting on 10/2/18 beginning at 4:15 p.m. When the DON was asked if the Foley bag should be touching the floor, the DON stated no.

No further information was provided prior to the exit conference on 10/3/18.

2. The facility staff failed to ensure Resident #111's indwelling Foley was properly positioned with the Foley drainage bag lower than the bladder.

The clinical record of Resident #111 was reviewed 10/1/18 through 10/3/18. Resident #111 was admitted to the facility 4/7/16 and readmitted 9/5/18 with diagnoses that included but not limited to cerebral palsy, diabetes mellitus, lack of coordination, abnormal posture, neuromuscular

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 45	F 690		

dysfunction of the bladder, sepsis, anxiety, glaucoma, major depressive disorder, muscle spasms, anemia, pain, iron deficiency anemia, hyperlipidemia, insomnia, hypertension, constipation, left elbow contractures, scoliosis, left stage IV trochanteric pressure ulcer and an unstageable pressure ulcer of sacral region.

Resident #111's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 9/18/18 assessed the resident with a BIMS (brief interview for mental status) as 15/15. The resident was without signs/symptoms of delirium, psychosis, and did not exhibit behaviors that affected others. Section H Bladder and Bowel was coded for the presence of an indwelling catheter.

Resident #111's current comprehensive care plan had the focus area that read "The resident has an indwelling catheter: neurogenic bladder. Surgical wound left hip, unstageable buttocks. Date initiated 9/10/18 Revision on 9/27/18. Interventions: Position catheter bag and tubing below the level of the bladder and away from the door."

The surveyor interviewed Resident #111 on 10/1/18 at 1:58 p.m. During the interview, the surveyor observed Resident #111's Foley catheter drainage bag at the foot of the bed. The Foley catheter bag was noted to be higher than the bladder and clear yellow urine was observed in the tubing. Resident #111 was positioned so his legs were higher than his mid-section. Certified nursing assistant #1 was asked about the catheter bag in the bed and higher than the bladder. C.N.A. #1 stated she didn't know why the catheter bag was put there. C.N.A. #1 stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 46	F 690		

she would fix the bag. The indwelling Foley catheter was anchored.

Resident #111's September 2018 physician orders were to change the Foley catheter 16 Fr (French), 30 cc (cubic centimeter) bulb and Foley bag as needed when leaking, blocked or dislodged.

The surveyor informed the director of nursing of the above concern on 10/2/18 at 7:38 a.m. and requested the facility policy on catheter care. The DON was asked where the Foley should be placed. The DON stated the Foley bag should be lower than the bladder.

The surveyor reviewed the facility policy provided for Foley catheter care on 10/2/18. The policy titled "Catheter Care Urinary Male-Female Personal Care." The policy read under Procedure "19. Check drainage tubing and bag to insure that the catheter is draining properly."

The surveyor informed the administrative staff of the above concern during the end of the day meeting on 10/2/18 at 4:15 p.m.

No further information was provided prior to the exit conference on 10/3/18.
3. The findings included:

The facility staff failed to ensure that Resident # 29 had the correct size Foley catheter per physician's orders, and failed to ensure that the Foley catheter was secured.

Resident # 29 was a 66-year-old-male who was admitted to the facility on 2/10/17. Diagnoses included but were not limited to: neuromuscular

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 47	F 690		

dysfunction of the bladder, major depressive disorder, anxiety disorder, and hypertension.

The clinical record for Resident # 29 was reviewed on 10/1/18 at 2:30 pm. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 7/15/18. Section C assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 29 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicated that Resident # 15 was cognitively intact. Section H assesses bowel and bladder. In Section H0100, the facility staff documented that Resident # 29 had an indwelling catheter.

The current plan of care for Resident # 29 was reviewed and revised on 9/20/18. The facility staff documented a focus area for Resident # 29 as, "Alteration in elimination AEB (as evidenced by) indwelling Foley catheter r/t (related to) urinary retention, hx (history) neurogenic bladder." Interventions included but were not limited to: :Provide catheter care Q (every) shift and PRN (as needed)."

The physician signed the current orders for Resident # 29 on 8/23/18. Orders included but were not limited to: "Change Foley Q month using 22FR (French) 30 cc (cubic centimeter) balloon every night shift every month(s) starting on the 10th for 1 day(s) related to retention of urine."

On 10/01/18 at 01:07 pm, Resident # 29 showed the surveyor his catheter. The surveyor observed that Resident # 29 had a 20 FR catheter with 30 ml (milliliter) bulb inserted into the bladder. The surveyor observed that the catheter was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 48 anchored. The surveyor asked Resident # 29 if he had declined to have the leg strap. Resident #29 stated, "I thought I had one on there." On 10/01/18 at 2:41 pm, RN # 1 (registered nurse) went in to Resident # 29"s room with the surveyor to look at Resident # 29's Foley catheter. RN # 1 observed the Foley catheter and stated that Resident # 29 had a #20 Fr with 30 ml bulb inserted into the bladder. The surveyor asked RN # 1 why Resident # 29's Foley catheter was not anchored. RN # 1 asked Resident # 29 if he refused to have his catheter anchored. Resident # 29 replied, "I thought it was." On 10/01/18 at 2:46 pm, the surveyor reviewed the physician's orders along with RN # 1. After reviewing the orders, RN # 1 agreed that Resident # 29 had in the incorrect size Foley catheter. According to the facility policy for "Catheter Care Urinary Male-Female," the procedure contained documentation that included but was not limited to: ...18. Secure catheter using a leg band." On 10/2/18 at 5:00 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 10/3/18.	F 690		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent	F 698		11/13/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 49 with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to coordinate care with dialysis center for 1 of 29 Residents, Resident #103. The findings include: For Resident #103 the facility staff failed to coordinate care with dialysis center. Resident #103 was admitted to the facility on 03/10/10 and readmitted on 09/01/18. Diagnoses included but not limited to end stage renal disease, depression, chronic obstructive pulmonary disease, peripheral vascular disease, diabetes mellitus, hypothyroidism, hypertension and polyneuropathy. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 09/08/18 coded the Resident as 15 of 15 in section C, cognitive patterns. Resident #103's CCP (comprehensive care plan) was reviewed and contained a focus area for "End stage renal disease, has fluid retention". Interventions included but were not limited to, dialysis as ordered, and monitor for fluid overload. SOB (shortness of breath, increased BP (blood pressure), swelling of the hands or feet s/s (signs and symptoms) of CHF (congestive heart failure) report to MD (medical doctor). Resident #103's clinical record was reviewed on	F 698	F698 1. Documentation for resident #103 was obtained from Dialysis Center for 9/12/18, 9/14/18, 9/17/18, 9/24/18, 9/26/18, 9/28/18, and 10/1/18. Documentation was placed in Communication Book . 2. No other Dialysis resident in the facility at this time. 3. SDC to in service all licensed staff to call Dialysis Center if no communication sheet received from Dialysis Center when resident returns and to document this information. Unit Manager on unit in serviced by DON on 10/2/18 to ensure that communication sheet is completed and send to dialysis and that the communication sheet is return with communication from dialysis.. 4. Unit Manager to perform weekly audits x4, then monthly x2 of residents Communication Book to ensure documentation obtained from dialysis center, then to be reviewed with DON/ADON. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. Date of compliance 11/3/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 50	F 698		

10/03/18. The surveyor could not locate any communications between the facility and the dialysis center regarding the status of Resident prior to or after dialysis treatments for the following dates: 09/12/18, 09/14/18, 09/17/18, 09/24/18, 09/26/18, 09/28/18 and 10/1/18.

The surveyor spoke to the unit manager on 10/02/18 at 8:47 a.m. in regards to Resident #103. The unit manager was asked about dialysis communication documentation and voiced it was probably in medical records.

On 10/02/18 at 12:34 p.m. The unit manager reported to surveyor he contacted dialysis center and weights were faxed to the facility, he voiced sometimes the resident refuses to give the staff the sheet, but there is no documentation of this. The facility could not provide surveyor with the dialysis communication sheets in question.

The surveyor reviewed the facility agreement with the dialysis center on 10/02/18. This agreement read in part under section 1.3, "Provider shall make available to facility copies of all such documentation at the time the resident is transported from the clinic back to facility " and under section 3.3 " Facility will maintain individual Resident clinical records in accordance with state and federal law. Facility will make portions of the individual Resident clinical record available to provider ...and other information necessary to ensure that the Resident experiences a continuum of care while receiving dialysis services from provider."

The concern of the facility not coordinating care with dialysis center was discussed with the administrative team during a meeting on 10/02/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 51 at approximately 4:15p.m. No further information was provided prior to exit.	F 698		
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention	F 732		11/13/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 52 requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to complete the daily staffing summary posting/sheet. The findings included: The facility had not updated the staffing summary sheet to include the clinical staffing hours for 10/1/18 and 10/2/18 for the second and third shifts. A review of the staffing summary sheet on 10/3/18 at approximately 8:00 a.m. revealed that the facility had not updated the staffing summary for 10/1/18 and 10/2/18 to include the clinical staff's hours for the second and third shifts. The administrator was notified of the same on 10/3/18 at 11:00 am. No further information regarding this issue was provided to the survey team prior to the exit conference on 10/3/18.	F 732	F732 1. Completed Daily Staffing Sheet of all three shifts placed in front lobby on 10/3/18. 2. New staffing sheet implemented to include posting of Clinical staffing hours for all three shifts opposed to one shift. 3. DON in-serviced staffing coordinator on 10/3/18 on completion of new staffing sheets. 4. Administrator or designee to observe and audit completion of Staffing Sheets weekly x 4, then monthly x 2 to ensure completion of staffing sheets. Audit to be reviewed with DON/ADON. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. Date of compliance 11/13/18.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:	F 758		11/13/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 53 (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 54 prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure one of 29 residents (Resident #81) was free of an unnecessary medication. The facility staff failed to ensure the physician assessed the resident for the continued use of the medication Hydroxyzine (Vistaril), failed to limit the use of the medication Hydroxyzine (Vistaril) to 14 days in July 2018, and failed to identify targeted behaviors for the use of the medication Hydroxyzine (Vistaril), the side effects, or documentation of non-pharmacological interventions. The findings included: The facility staff failed to ensure Resident #81 was free of an unnecessary medication Hydroxyzine (Vistaril). The Physician's Desk Reference (PDR) at www.pdr.net identified Hydroxyzine (Vistaril) in the class of anxiolytics, non-benzodiazepines, first generation (sedating) antihistamines, and other antiemetics and antinauseants. The clinical record of Resident #81 was reviewed 10/1/18 through 10/3/18. Resident #81 was admitted to the facility 7/8/15 and readmitted 2/4/16 with diagnoses that included but not limited to epilepsy, cerebrovascular disease, hemiplegia, urinary incontinence, hypertension, unsteadiness on feet, muscle weakness, age-related osteoporosis, dry eye syndrome, chronic atrial fibrillation, low back pain, mood disorder, schizoaffective disorder, major depressive	F 758	F758 1. Resident #81 received new orders to include non-pharmacological interventions and to establish parameters in medication delivery. 2. 100% audit to be completed by unit manager of all current residents receiving prn psychoactive meds to ensure proper number of days of administration by 10/29/18. 100% audit of all current care plans for non-pharmacological interventions and behavior warranted for all prn psychoactive meds by 10/29/18. 3. SDC to in service all licensed Nursing staff by 10/29/18 to utilize non-pharmacological interventions prior to administration of prn psychoactive meds and to document behaviors prior to administration of prn anti psychoactive meds to ensure all prn psychoactive meds only have a 14 day limit. DON or designee to in-service MDS coordinators on Care Planning non-pharmacological interventions, behaviors and side effects. 4. DON/ADON or designee to audit prn psychoactive med orders for number of days to be administered, non-pharmacological interventions, and behavior monitoring on residents receiving prn psychoactive meds weekly x4, then monthly x 2 to ensures residents are not receiving prn psychoactive meds unnecessarily. DON/ADON or designee to audit Care Plans for non-pharmacological	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 55 disorder, hyperlipidemia, gastro-esophageal reflux disease, and chronic obstructive pulmonary disease. Resident #81's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 8/14/18 assessed the resident with a BIMS (brief interview for mental status) as 15/15. The resident was assessed with no signs/symptoms of delirium, psychosis, or behaviors that affected others. Section G Functional status assessed Resident #81 to need limited assistance of one person for toileting. Section H Bladder and Bowel assessed Resident #81 to be continent of both. The current comprehensive care plan of Resident #81 identified the focus area that read "Bipolar, depression, and anxiety Date initiated: 5/23/17 Revision Date: 5/23/17. Interventions: Administer medications as ordered. Observe for tolerance/effectiveness and possible adverse side effects. Report to MD/ARNP (medical doctor)/ (advance registered nurse practitioner) as indicated. See psychotropic care plan for medication prescribed. Attempt to refocus behavior to something positive. Encourage and involve resident in activities as energy outlet and promote wakefulness during daytime hours. Encourage resident to verbalize feelings in an appropriate manner. Explain all procedures prior to start. If resident is angry, allow to stay in room. Involve resident in decision-making. Maintain a calm, unhurried approach. Provide reassurance and TLC (tender loving care). Notify MD/ARNP if changes or worsening of mood is observed. Provide quiet, darkened room with minimal, stimulation to promote sleep. Psych (psychological) eval (evaluation) and follow-up as	F 758	interventions, behavior and side effects monitoring. weekly x 4, then monthly x 2 to ensure non-pharmacological interventions and behaviors are documented. Audits will be reviewed with DON/ADON. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. Date of compliance 11/13/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 56	F 758		

needed. Reinforce positive statements. Speak in a calm voice."

(a) During the clinical record review, the consultation report by the contracting pharmacy read "Resident #81 has a prn order for an anxiolytic, which has been in place for greater than 14 days without a stop date: Hydroxyzine HCL (hydrochloride) 50 mg q6h (hour) prn anxiety. Recommendation: Please discontinue prn Hydroxyzine HCL. If the medication cannot be discontinued at this time, current regulations require that the prescriber document the indication for use, the intended duration of therapy, and the rationale for the extended time-period. Physician's Response: Continue dosing-limit to 2 weeks 5/17/18." The surveyor was unable to locate a physician assessment on 5/17/18. The physician and/or NP (nurse practitioner) assessed the resident on 5/8/18 and 5/10/18 prior to the pharmacist recommendation. A psychiatric evaluation was completed on 6/7/18-after the pharmacist evaluation.

(b) The clinical record contained a physician order dated 7/26/18 that read "Hydroxyzine 25 mg po q 8 hours prn anxiety x 45 days (long-term intermittent use)." The order exceeded the two-week use of the medication. Resident #81 received the medication 5 times in July without indications for use. Resident #81 received the medication 15 (fifteen) times in August 2018 without any indications for use. The August 2018 behavior monitoring sheets identified the behaviors to monitor. 0. None. 1. Afraid. 2. Agitated. 3. Angry. 4. Anxious 5. Mood Change 6. Noisy 7. Restless 8. Withdrawn/depressed 9. Crying 10. Combative 11. Blank. All the assessments from 8/1/18 through 8/31/18 had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 57 0-none. There were no observations of the resident with any of these documented behaviors yet the resident received Hydroxyzine 25 mg 15 times in August 2018. The September 2018 medication administration record was reviewed. Resident #81 received Hydroxyzine 25 mg twelve times during the month. All behaviors were indicated by a zero(0). None occurred. There were no interventions documented prior to the use of the medication. The surveyor reviewed the September 2018 progress notes. The notes did not identify any non-pharmacological interventions prior to the requested medication or any specific targeted behaviors. (c). The surveyor reviewed the current comprehensive care plan. The focus area for bipolar disorder, depression, and anxiety did not identify any targeted behaviors for the use of the prn Hydroxyzine. The surveyor was unable to locate monitoring of the side effects of Hydroxyzine. The surveyor informed the director of nursing (DON) of the concern with the use of Hydroxyzine on 10/3/18 at 12:30 p.m. The DON stated she had spoken with the psych NP about writing orders for psychiatric medications. No further information was provided prior to the exit conference on 10/3/18.	F 758		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant	F 760		11/13/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 58 medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to ensure 1 of 29 residents in the survey sample was free from a significant medication error (Resident #7). The findings included: The facility staff failed to administer Resident #7's blood pressure medication as ordered by the physician. Resident #7 was readmitted to the facility on 6/25/18 with the following diagnoses of, but not limited to high blood pressure, septicemia, diabetes, arthritis and depression. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/2/18, the resident was coded as being independent in dressing and personal hygiene and only requiring physical assistance of 1 staff member for bathing. Resident #7 was also coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. During the medication observation on 10/2/18 at 8:33 am, the surveyor observed LPN (licensed practical nurse) #1 administering Clonidine 0.1 mg (milligram) 1 tablet by mouth to Resident #7. The surveyor performed a review of Resident #7's clinical record. During this review, the surveyor noted the following physician order: Clonidine 0.2 mg by mouth three times a day for hypertension (high blood pressure). The surveyor notified the administrative team on	F 760	F760 1. Physician, Responsible Party, and Pharmacy notified on 10/3/18 of resident #7 receiving Clonidine 0.1 mg instead of Clonidine 0.2 mg without adverse effects. Medication Error complete on 10/25/18. 2. DON or designee to complete audit of all Charge Nurse medication administration per Physician orders to residents by 11/3/18. 3. Licensed Staff in serviced by DON or designee by 10/29/18 related to the requirements of providing medications per Physician orders and the five rights of medication administration. 4. DON or designee will complete audit of four(4) med passes weekly x 4, then monthly x 2 to ensure medications continue to be administered per Physicians orders. Audits will be reviewed with DON/ADON. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. Date of Compliance 11/13/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 59 10/2/18 at 4:14 pm of the above documented findings. No further information was provided to the surveyor prior to the exit conference on 10/3/18.	F 760		
F 761 SS=E	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. §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 observation, staff interview and facility document review, the facility staff failed to safely store and label medications on 3 of 3 nursing	F 761	F761 1. All opened and undated medications	11/13/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 60 units in the facility (Units North, East and West). The findings included: 1. The surveyor observed the following in the medication storage refrigerator on the East Unit on 10/1/18 at 2:06 pm: " (1) Multiuse vial of Tuberculin Purified Protein Derivative, Dilated Aplisol TU/0.1 ml 1 ml (10 tests) was noted to be opened but did not have the opened date documented on the box or vial of medication. On the side of the medication box, the instructions read in part, " ...Once entered, vial should be discarded after 30 days." " (1) Ketorolac Tromethhami 0.4% drops (Eye Drops) ml was noted to be opened but did not have the opened date documented on the box or vial of medication. " (1) Prednisolone Acet 1% Drops ml (Eye Drops) was noted to be opened but did not have the opened date documented on the box or vial of medication. " Ocuflox Opth 0.3% drops ml (Eye Drops) was noted to be opened but did not have the opened date documented on the box or vial of medication. The surveyor asked the unit manager for the East unit what the procedure was after a multi use vial of medication was opened and she replied, "You need to date it with the opened date on the vial or on the box." 2. The surveyor observed the following in the North Unit medication storage refrigerator on 10/1/18 at 2:47 PM: " (1) Latanoprost Ophthalmic 0.005% was	F 761	were removed from carts and medication rooms. All loose pills on medication carts were removed and disposed of properly 10/1/18. 2. 100% audit of each medication room and carts for opened, outdated medications, and loose pills was complete on 10/1/18. 3. DON or designee to complete in service licensed nursing staff of proper storage of medications on medication carts, open medications and discard medications by 10/29/18. 4. DON or designee to audit medication carts and medication rooms weekly x4, then monthly x2 for proper storage, and labeling of medications. Audits to be reviewed by DON. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. Date of compliance 11/13/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 61	F 761		

noted to be opened but did not have the opened date documented on the vail or box of medication.
The surveyor asked the staff development coordinator what was the procedure after you opened a multi use vial of medication and she stated, "You need to write on the box or vial the date it was opened."
The surveyor observed the following on the medication cart on the North Unit on 10/1/18 at 3:13 pm:
Found the following in the top left hand drawer of the medication cart that was not enclosed in a medication card:
" (1) small blue pill
" (1) small peach pill
" (1) Ketorolac Trometh 0.4% drops ml
Dispensed date from the pharmacy label 11/13/17
" (1) Ciprofloxacin HCL 0.3% drops ml
Dispensed date from the pharmacy label 11/13/17

3. The surveyor observed the following on the West Unit medication cart 1 on 10/1/18 at 3:44 pm:

Found the following in the top left hand drawer of the medication cart that was not enclosed in a medication card:
" (1) large white pill
" (1) medium sized white pill
" (1) peach colored pill med. sized
" (1) 1/2 small pink pill

The surveyor observed the following in the medication cart 2 on the West unit on 10/1/18 at 4:00 pm:

Found the following in the top left hand drawer of the medication cart that was not enclosed in a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 62 medication card: " (2) large white pills " (3) oblong yellow pills " (1) yellow medium. sized pill " (1) 1/2 pink pill " (2) white med. sized capsule " (1) yellow medium sized capsule The surveyor received the requested copy of the facility's policy titled "5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles" which read in part " ...16. Facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or biologicals in accordance with Pharmacy return/destruction guidelines and other Applicable Law ..." On 10/2/18 at 4:14 pm, the surveyor notified the administrative team of the above documented findings. No further information was provided to the surveyor prior to the exit conference on 10/3/18.	F 761		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by:	F 770		11/13/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 770	Continued From page 63 Based on staff interview and clinical record review, the facility staff failed to obtain a laboratory test for one of 29 residents (Resident #64). The findings included: The facility staff failed to obtain a PT/INR (prothrombin time) (international normalized ratio) ordered 10/1/18 for Resident #64. The prothrombin time (PT) is a test used to help diagnose bleeding or clotting disorders. The international normalized ratio (INR) is a calculation based on results of a PT that is used to monitor treatment with the blood-thinning medication warfarin (Coumadin®). The clinical record of Resident #64 was reviewed 10/1/18 through 10/3/18. Resident #64 was admitted to the facility 4/30/14 and readmitted 8/4/18 with diagnoses that included but not limited to paroxysmal atrial fibrillation, hypertension, asthma, depression, mental retardation, seizure disorder, type 2 diabetes mellitus, hyperlipidemia, chronic lower extremity ulceration, gastroesophageal reflux disease, testicular cancer s/p (status post) orchiectomy, edema, lymphedema of leg, chronic respiratory failure, iron deficiency anemia, bipolar disorder, cough, encephalopathy, right hip pain, venous insufficiency, obesity, major depressive disorder, schizoaffective disorder, and unspecified mood disorder. Resident #64's significant change in status assessment with an assessment reference date (ARD) of 8/10/18 assessed the resident with a BIMS (brief interview for mental status) as 15/15.	F 770	F770 1. Order for PT/INR obtained on resident #64 on 10/2/18. Labs were collected and received. 2. 100% Audit of PT/INRs obtained for the last 30days. 3. DON or designee to complete in service of licensed staff on placing PT/INRs ordered on lab log for collection by 10/29/18. 4. Unit manager to audit lab log weekly x 4, then monthly x 2. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. Compliance date 11/3/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 770	Continued From page 64 Resident #64 did not have any signs/symptoms of delirium, psychosis, or behaviors that affected others. Resident #64's current comprehensive care plan identified the focus area that read "Resident is at risk for bleeding/bruising abnormal labs r/t (related to) medications Coumadin Date initiated: 9/20/18 Revision on 9/20/18. Interventions: Monitor labs per orders and notify MD (medical doctor) of abnormalities." The physician order dated 9/26/18 read in part "PT/INR on Monday 10/1/18." The surveyor reviewed the laboratory section of the clinical record but was unable to locate the results of the ordered laboratory test. The surveyor informed the unit manager licensed practical nurse #1 of the concern on 10/3/18 at 7:56 a.m. L.P.N. #3 stated, "You won't find it. It was done last night (10/2/18)." The surveyor informed the administrative staff of the above concern during the end of the day meeting on 10/3/18 at 4:00 p.m. No further information was provided prior to the exit conference on 10/3/18.	F 770		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of	F 773		11/13/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 773	Continued From page 65 practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff obtained laboratory tests without obtaining a physician order for 2 of 29 residents (Resident #64 and Resident #81). The findings included: 1. The facility staff failed to obtain an order for a PT/INR (prothrombin time) (international normalized ratio) obtained 9/11/18 for Resident #64. The prothrombin time (PT) is a test used to help diagnose bleeding or clotting disorders. The international normalized ratio (INR) is a calculation based on results of a PT that is used to monitor treatment with the blood-thinning medication warfarin (Coumadin®). The clinical record of Resident #64 was reviewed 10/1/18 through 10/3/18. Resident #64 was admitted to the facility 4/30/14 and readmitted 8/4/18 with diagnoses that included but not limited to paroxysmal atrial fibrillation, hypertension, asthma, depression, mental retardation, seizure disorder, type 2 diabetes mellitus, hyperlipidemia, chronic lower extremity ulceration, gastroesophageal reflux disease, testicular cancer s/p (status post) orchiectomy, edema,	F 773	F 773 1. On 10/3/18, Medical Director notified of PT/INR obtained without an order on resident #64 with new order received to get pt/inr on 9/11/18. On 10/3/18, Medical Director notified of a urinalysis obtained without an order on resident #81 with new orders received to get ua reflex 9/13/18. 2. Unit Managers to complete 100% Audit of current residents labs for past 30 days to ensure labs obtained per orders. 3. SDC to in service all nursing staff to ensure to obtain an order prior to drawing resident s' labs by 10/29/18. 4. Unit Manager to do weekly audits x4, then monthly x2 of 5 residents labs each unit to ensure all labs were obtained after physician orders, then to be reviewed withDON/ADON. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. Date of compliance 11/13/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 773	Continued From page 66	F 773		

lymphedema of leg, chronic respiratory failure, iron deficiency anemia, bipolar disorder, cough, encephalopathy, right hip pain, venous insufficiency, obesity, major depressive disorder, schizoaffective disorder, and unspecified mood disorder.

Resident #64's significant change in status assessment with an assessment reference date (ARD) of 8/10/18 assessed the resident with a BIMS (brief interview for mental status) as 15/15. Resident #64 did not have any signs/symptoms of delirium, psychosis, or behaviors that affected others.

Resident #64's current comprehensive care plan identified the focus area that read "Resident is at risk for bleeding/bruising abnormal labs r/t (related to) medications Coumadin Date initiated: 9/20/18 Revision on 9/20/18. Interventions: Monitor labs per orders and notify MD (medical doctor) of abnormalities."

The laboratory section of the clinical record was reviewed on 10/3/18. The results of a PT/INR obtained 9/11/18 were found in the record. The surveyor was unable to find the physician order for the PT/INR obtained 9/11/18. The surveyor informed the unit manager licensed practical nurse #1 on 10/3/18 at 8:13 a.m. L.P.N. #3 stated the resident had a colonoscopy that day and the order may have originated from the endoscopy office. The unit manager L.P.N. #1 called the endoscopy office and the office stated an order could not be found in his clinical record for the PT/INR obtained 9/11/18.

The surveyor informed the administrative staff of the above concern during the end of the day

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 773	Continued From page 67	F 773		

meeting on 10/3/18 at 4:00 p.m.

No further information was provided prior to the exit conference on 10/3/18.

2. The facility staff failed to obtain an order for the urinalysis obtained on 9/13/18 for Resident #81.

The clinical record of Resident #81 was reviewed 10/1/18 through 10/3/18. Resident #81 was admitted to the facility 7/8/15 and readmitted 2/4/16 with diagnoses that included but not limited to epilepsy, cerebrovascular disease, hemiplegia, urinary incontinence, hypertension, unsteadiness on feet, muscle weakness, age-related osteoporosis, dry eye syndrome, chronic atrial fibrillation, low back pain, mood disorder, schizoaffective disorder, major depressive disorder, hyperlipidemia, gastro-esophageal reflux disease, and chronic obstructive pulmonary disease.

Resident #81's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 8/14/18 assessed the resident with a BIMS (brief interview for mental status) as 15/15. The resident was assessed with no signs/symptoms of delirium, psychosis, or behaviors that affected others. Section G Functional status assessed Resident #81 to need limited assistance of one person for toileting. Section H Bladder and Bowel assessed Resident #81 to be continent of both.

The surveyor interviewed Resident #81 on 10/1/18 at 4:09 p.m. She stated she had a recent urinary tract infection and was told she had a bad "urethra." The resident stated she had blood

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 773	Continued From page 68 coming from her urethra. The surveyor reviewed the laboratory section of the clinical record and found the results of a urinalysis obtained on 9/13/18; however, the surveyor was unable to locate a physician order for that lab test. The surveyor informed the unit manager licensed practical nurse #1 on 10/1/18 at 4:30 p.m. The unit manager informed the surveyor 10/2/18 at 8:00 a.m. that an order for the urinalysis could not be found. The surveyor informed the administrative staff of the above concern in the end of the day meeting on 10/2/18 beginning at 4:15 p.m. No further information was provided prior to the exit conference on 10/3/18.	F 773		
F 880 SS=E	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	F 880		11/13/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 69	F 880		

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 70 §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 staff interview and facility document review, the facility staff failed to ensure an effective infection control program. The findings included: On 10/3/18 at 11:15 am, the surveyor requested the infection control line list (tracking form for facility infections) from July 2017 through July, 2018 from the staff development coordinator (SDC). When the infection control line listing was provided to the surveyor by the SDC, the form was found to be incomplete. The infection control line listing form did not provide the information if the infection was community acquired or facility acquired. The corporate nurse and corporate employee #2 attended this meeting along with the SDC. The Corporate employee #2 stated, "When our corporation took over in this facility September 1, we reviewed these lists and there were areas that we felt did not meet our criteria. We asked that our form be implemented starting with the month of August of this year. So going forward, we will be meeting this regulation."	F 880	F880 1. New infection control form implemented to accurately record community acquired vs facility acquired infections 9/1/18. 2. Starting September 2018 going forward, new logs show community vs facility acquired infections 3. DON to in service SDC to ensure to use new infection control form which includes community and facility acquired infection boxes by 10/29/18. 4. SDC to do weekly audits x4, then monthly x2 of all infections to ensure documentation of community vs facility acquired infections, then to be reviewed with DON/ADON. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. Date of compliance 11/13/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 71 No further information was provided to the surveyor prior to the exit conference on 10/3/18.	F 880		
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to ensure an effective Antibiotic Stewardship Program. The findings included: The staff development coordinator, corporate nurse and corporate employee #2 met with the surveyor on 10/3/18 at 11:15 am. The surveyor reviewed the antibiotic stewardship program from July 2017 to July 2018. During this review, the surveyor noted the following: " For the month of July 2017, there were 21 reports of infections and 100% of these were treated with antibiotics. " For the month of August 2017, there were 16 reports of infections and 100% of these were treated with antibiotics.	F 881	F881 1. New antibiotic stewardship program was implemented on 9/1/18. DON will review antibiotic stewardship program with medical director by 10/24/18 2. 100% audit of all residents receiving antibiotic last 30 days to ensure correct antibiotic stewardship being implemented. 3. DON to in service SDC to use and implement new antibiotic stewardship program by 10/24/18. 4. SDC to do weekly audits x4, then monthly x2 of all infections to ensure antibiotic stewardship program being implemented, then to be reviewed with DON/ADON. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. Date of compliance 11/13/18	11/13/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 881	Continued From page 72 " For the month of September 2017, there were 14 reports of infections with 100% of these were treated with antibiotics. " For the month of October 2017, there were 13 reports of infections with 100% of these were treated with antibiotics. " For the month of November 2017, there were 8 reports of infections with 100% of these were treated with antibiotics. " For the month of December 2017, there were 21 reports of infections with all of them except for 1 was treated with antibiotics. " For the month of January 2018, there were 17 reports of infections and 100% of them were treated with antibiotics. " For the month of February 2018, there were 16 reports of infections and 8 of these were treated with antibiotics. " For the month of March 2018, there were 18 reports of infections and 10 of these were treated with antibiotics. " For the month of April 2018, there were 27 reports of infections and 20 of these were treated with antibiotics. " For the month of May 2018, there were 26 reports of infections and 23 of these were treated with antibiotics. " For the month of June 2018, there were 16 reports of infections with 100% of these were treated with antibiotics.	F 881		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 881	Continued From page 73 " For the month of July 2018, there were 30 reports of infections with 27 of these were treated with antibiotics. The corporate employee #2 stated, "We found after we obtained this facility that we needed to do further education with all staff and physicians to move forward in the antibiotic stewardship program." No further information was provided to the surveyor prior to the exit conference on 10/3/18.	F 881		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, the facility staff failed to ensure patient care equipment was in safe operating condition for one of 29 residents (Resident #111). The findings included: The facility staff failed to ensure Resident #111's remote control to raise and lower the head of the bed was accessible and working. The clinical record of Resident #111 was reviewed 10/1/18 through 10/3/18. Resident #111 was admitted to the facility 4/7/16 and readmitted 9/5/18 with diagnoses that included but not limited to cerebral palsy, diabetes mellitus, lack of coordination, abnormal posture, neuromuscular	F 908	F 908 1. Resident #111□s bed was replaced on 10/2/18. 2. 100% Audit of resident□s room for proper working beds completed on 10/2/18 by unit managers. 3. Maintenance Director in serviced by Administrator on 10/3/18 to complete every 6 month audits of all electric beds per manufacturer guidelines and keep a log of audit. All staff to be in serviced by SDC by 10/29/18 on correct procedure to report inoperable beds using work order forms as soon as found and to notify supervisor. 4. Maintenance Director or designee do weekly audits x4, then monthly x2 of 15	11/13/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 908	Continued From page 74 dysfunction of the bladder, sepsis, anxiety, glaucoma, major depressive disorder, muscle spasms, anemia, pain, iron deficiency anemia, hyperlipidemia, insomnia, hypertension, constipation, left elbow contractures, scoliosis, left stage IV trochanteric pressure ulcer and an unstageable pressure ulcer of sacral region. Resident #111's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 9/18/18 assessed the resident with a BIMS (brief interview for mental status) as 15/15. The resident was without signs/symptoms of delirium, psychosis, and did not exhibit behaviors that affected others. Section G Functional Status was reviewed. Resident #111 required extensive assistance of one person for dressing, limited assistance of one person for eating and toilet use, extensive assistance of one person for personal hygiene, and was totally dependent on two plus persons for bathing. Resident #111 had limitations in range of motion on both upper and lower extremities. Resident #111's current comprehensive care plan had the focus area that read "Impaired functional mobility r/t (related to) contractures, scoliosis, chronic pain, muscle weakness, DM (diabetes mellitus), cerebral palsy, muscle spasms, lack of coordination, abnormal posture, debility and hypoxia. Initiated 5/4/2017 and revision on 8/7/18. Interventions: Call light in reach. Encourage resident to call and request help as needed. Trapeze over bed for bed mobility. A second focus area was for alteration in visual function. Initiated 6/28/18 with revision on 8/7/18. Interventions: Keep call light in reach for resident and place residents hand on it so they know	F 908	residents room to ensure proper working beds. To be reviewed with DON/ADON. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. Date of compliance 11/3/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 908	Continued From page 75	F 908		

where it is. Instruct resident to notify staff if assistance is necessary. Provide environment that accommodates impaired vision. Orient resident to surroundings as often as needed.

The surveyor interviewed Resident #111 on 10/1/18 at 1:58 p.m. Resident #111 was observed in bed with his head resting on a pillow; the bed flat. Resident #111 stated for the past couple of months, the remote controls on his bed didn't work. During the interview, the surveyor observed the remote controls lying on the floor near the window-out of reach for the resident.

The surveyor interviewed certified nursing assistant #1 on 10/1/18 at 2:35 p.m. C.N.A. #1 stated the remote controls for his bed have not worked for weeks and she stated she had reported the issue to all three maintenance staff but the remote control still does not work. C.N.A. #1 stated if the remote control was placed near his abdomen between his legs, Resident #111 could raise and lower the head of the bed.

The surveyor interviewed the maintenance director on 10/1/18 at 3:18 p.m. The maintenance director checked the remote. He checked the wiring underneath the bed and stated it looked like there was a short in it. He raised the head of the bed and it kept going up. He was unable to stop the bed from rising and had to go to the left side and pull the electrical cord from the wall to keep it from continuing to rise. He stated he would replace the bed. In the meantime, he stated the staff would transfer the resident to a stretcher. Resident complained of pain in the right knee while the maintenance director was raising the head of the bed. The surveyor asked the maintenance director for all the work orders

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 908	Continued From page 76	F 908		

for the bed.

The maintenance director returned to Resident #111's room with a hand crank to lower the head of the bed at 3:27 p.m. The maintenance director stated there were no work orders for the bed. Two certified nursing assistants transferred the resident using a Hoyer lift to a stretcher.

The surveyor informed the director of nursing of the above issue with the remote controls not working on Resident #111's bed and not within reach on 10/2/18 at 7:40 a.m. and requested all the work orders. The DON stated she thought the bed was a rental and was checked a couple of weeks ago and had no issues.

The surveyor informed the administrative staff of the concern with Resident #111's bed not working properly in the end of the day meeting on 10/2/18 beginning at 4:15 p.m. The surveyor requested the manufacturer's manual for Resident #111's bariatric bed.

The surveyor reviewed the manufacture's manual for the Joerns Camtec Series Bed Frames RC 1000 Bed on 10/3/18. The manual read in part, "Periodic Inspection and Maintenance The amount of maintenance required by the end will be dictated by its use. As a minimum, the unit should be periodically inspected every 6 months. 5. Check all electrical wiring for fraying, kinking damage and/or deterioration."

No further information was provided prior to the exit conference on 10/3/18.