PRINTED: 12/13/2021 FORM APPROVED

OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		C
		495140	B. WING		12/02/2021
NAME OF PE	ROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CODE	
	L HEALTH AND REHAB			HALMERS COURT RYVILLE, VA 22611	
ROSE HIL				PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG	JEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PREC EDED BY FUL L LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DE COMPLETION ATE DATE
E 000	Initial Comments		E 000	The statements made on	this
		D		plan of correction are not	
	An unannounced En	nergency Preparedness d 11/29/2021 through		admission to and do not	
	12/02/2021. The faci	lity was in substantial		constitute an agreement	with
	compliance with 42 C	FR Part 483.73,		the alleged deficiencies h	
		g-Term Care Facilities.	F 000	To remain in compliance	
F 000	INITIAL COMMENTS			federal and state regulati	
	An unannounced Me	edicare/Medicaid standard		the center has taken or is	
	survey was conducted	d 11/29/2021 through		planning to take the action	
	12/02/2021. Nine co	mplaints (VA00050023-		forth in the following plan	
	substantiated with de	eficiencies, VA00053506 - 00052476 - substantiated		correction. The following	
	with deficiencies, VA	00053338 - unsubstantiated,		of correction constitutes	
	VA00051138 - unsub	stantiated, VA00050967 -		center's allegation of	
	unsubstantiated, VAI	00050063 - substantiated VA00050795 - substantiated		compliance. alleged	
	with no deficiencies,	VA00053738 -		deficiencies cited have be	en or
	unsubstantiated), we	re investigated during the		are to be corrected by th	
	survey. Corrections	are required for compliance 3 Federal Long Term Care		or dates indicated.	c data
	Requirements. The I	ife Safety Code		or dates indicated.	
	survey/report will foll	ow.			
	The census in this 1	20 certified bed facility was			
	94 at the time of the	survey. The survey sample			
		ent resident reviews and nine			
	closed record review Resident/Family Gro		F 565	F565	
1 565	CFR(s): 483.10(f)(5)	(i)-(iv)(6)(7)		4. The second line	
				1. The residents were	
	§483.10(f)(5) The re	sident has a right to organize		identified, inventory shee	
	and participate in re-	sident groups in the facility. provide a resident or family		reviewed, searches done	
	group, if one exists,	with private space; and take		missing items and replace	ments
	reasonable steps, w	ith the approval of the group,		for items purchased.	
	to make residents a	nd family members aware of			
	upcoming meetings	IN A UITIEIY IIIAHINEI.	F	TITLE	(X6) DATE

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

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

program participation.

Event ID: TH2611

Facility ID: VA0210

If continuation sheet Page 1 of 122

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CENTERS	FOR MEDICARE & I	MEDICAID SERVICES	T		- OCHOTOLICTION	(X3) DATE SURVEY
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILD		E CONSTRUCTION	COMPLETED
AND PLAN OF	CORRECTION	region 1 1 to the control of the con	A. BUILD	,,,,,,		С
		495140	B. WING	_		12/02/2021
NAME OF PR	OVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	
					110 CHALMERS COURT	
ROSE HILI	HEALTH AND REHAB				BERRYVILLE, VA 22611	(X5)
(X4) ID PREFIX TAG	JEACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)	E COMPLETION
		4	_	565	2. An audit of last six mont	hs of
F 565	Continued From page		r	500	resident council concerns	
	(II) Staff, visitors, or or resident group or fam	ther guests may attend ily group meetings only at			revealed no other issues. T	he
	the respective group's	s invitation.			laundry process for the ce	nter
	person who is approv	orovide a designated staff ed by the resident or family			was reviewed and modifie	d.
	group and the facility	and who is responsible for and responding to written			3. The Administrator will re	2-
	requests that result fr	om group meetings.			educate staff on the grieva	ince
(iv) The facility must consider the views of a		consider the views of a			process to include missing	
	resident or family gro	up and act promptly upon commendations of such			items process.	
	groups concerning is:	sues of resident care and life			4. Resident council minute	e will
	in the facility.					
	(A) The facility must be response and rational	be able to demonstrate their			be reviewed monthly by th	
	(B) This should not be	e construed to mean that the			Administrator to ensure an	ıy
	facility must impleme	nt as recommended every			grievance expressed was addressed. Results will be	
	request of the resider	nt or family group.				
	§483.10(f)(6) The res	ident has a right to			presented to QAPI month!	
	participate in family g				continued monitoring. Any noted trends will be addre	
	5402 40/8/7) The rea	ident has a right to have				sseu
	family member(s) or	other resident			immediately.	
	representative(s) me	et in the facility with the				
		epresentative(s) of other			5 Compliance Date: 01/04	/22
	residents in the facilit	y. Tis not met as evidenced				
	bv:					
	Based on staff interv	riew and facility document				
	review, it was determ	ined that the facility staff grievance expressed during				
	a resident council me	eeting for one of three				
	resident council mee	tings reviewed.				
	expressed regarding	d to ensure a concern laundry during the August I meeting was responded to				

Facility ID: VA0210

AND HUMAN SERVICES

PRINTED: 12/13/2021 FORM APPROVED

		D HUMAN SERVICES			OMB NO. 0938-0391
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
STATEMENT OF	F DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
					C
		495140	B. WING	REET ADDRESS, CITY, STATE, ZIP CODE	12/02/2021
NAME OF PE	ROVIDER OR SUPPLIER			CHALMERS COURT	
ROSE HIL	L HEALTH AND REHAB			RRYVILLE, VA 22611	
		THE NEW OF REPORT NOISE	ID	PROVIDER'S PLAN OF CORRECT	TION (X5)
(X4) ID PREFIX	VEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	OPRIATE COMPLETION DATE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	MONATOR A
			- 0		
F 565	Continued From page	e 2	F 565		
	The findings include:				
	A review of Resident	Council Minutes from			
	August 2021 revealed	d the following entry:			
	"Residents complained	ed that laundry isn't coming			
		getting the wrong clathing			
	items."				
	On 12/1/21 at 4:50 p.	m., ASM (administrative			
	staff member) #1, the	e interim administrator, ASM			
	#2, the director of nul	rsing, ASM #4, the regional erations, and ASM #5, the			
	regional vice preside	nt of operations, were			
	informed of these cor	ncerns. Evidence that the			
	concern regarding la	undry had been addressed			
	and resolved was red	questeu.			
	On 12/2/21 at 8:56 a.	.m., ASM #1 presented a			
	facility concern form.	This form stated: "7/13/21			
	Resident CouncilDe	ocumentation of Concern: 10 I that laundry isn't coming			
	back and they are ge	tting the wrong clothes			
	backDocumentation	n of Facility Follow-Up (blank			
	lines)Resolution of	Concern (blank lines)." ASM			
	#1 stated: "We had to	nis documented as a n form, but I can't find that it			
	was followed up."	Triomi, but round in a second			
		0011/-1			
	On 12/2/21 at 9:07 a	.m., OSM (other staπ cial services assistant, was			
	interviewed. She state	ted she has only been in her			
	position for five days	. She stated her			
	understanding of the	resident council process is			
	that when a concern	is expressed by the resident, nented on a formal concern			
	form. The form is giv	en to the staff person			

responsible for the area of concern. The staff member addresses the concern and documents

PRINTED: 12/13/2021 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES	_			(X3) DATE SURVEY
STATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUC	TION	COMPLETED
AND PLAN OF	CORRECTION	IDENTIFICATION NOMBEN.	A. BUILD	NG		C
		495140	B. WING			12/02/2021
	ROVIDER OR SUPPLIER	700170		STREET ADDR	RESS, CITY, STATE, ZIP CODE	
NAME OF PE	ROVIDER OR SUPPLIER			110 CHALME	RS COURT	
ROSE HIL	L HEALTH AND REHAB			BERRYVILL	.E, VA 22611	
(X4) ID PREFIX TAG	IFACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD LOSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
			_	565		
F 565	Continued From page		۲	565		
	their actions. The for	m then goes to the				
	administrator, who di	scusses the outcome with				
	leadership staff at the	e daily morning meeting . OSM #10 is responsible for				
	After this discussion,	n the concern log she keeps.				
	logging the concent	The concerning and				
	The staff member res	sponsible for attending the				
	August 2021 residen	t council meeting and				
	distributing the conce	erns was not available for				
	interview during the t	ime of the survey.				
	A review of the facility	y policy, "Concerns,"				
	revealed, in part: "Up	on identification of a patient				
	or representative cor	cern, staff completes the				
	Concern Form identi	fying the issue and forward				
	the form to the Admir	nistrator or designeeThe s and forwards the Concern				
	Administratorcopie	ate department head for				
	follow-up and resolut	ion during the morning				
	meetingThe assign	ed department head				
	investigates the iden	tified concern timely and				
	interviews staff and p	patients as appropriate to				
	identify root cause of	the issue or concern. Once				
	the root cause of the	aken to resolve the issue for				
	the identified party at	s well as potential systemic				
	changes to reduce ri	sk of recurrence or				
	occurrence for other	s. The assigned department				
	head contacts the ap	propriate party once				
	resolution has been	completed. Once resolved,				
	the concern form is t	updated with the resolution of				
	the concern and retu	rned to the Administrator."				
	No further information	n was provided prior to exit.				
F 580	Notify of Changes (In	njury/Decline/Room, etc.)	F	580	F580	
	CFR(s): 483.10(g)(1	4)(i)-(iv)(15)			4 5 11 11554 11 1	
					1. Resident #201 discha	-
	§483.10(g)(14) Notif	ication of Changes.			from the center on 05/	24/21.

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

PRINTED: 12/13/2021 FORM APPROVED OMB NO. 0938-0391

		MEDICAID SERVICES	(X2) MUI	TIPLE CON	NSTRUCTION	(X3) DATE SURVEY
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COMPLETED
,						C
		495140	B. WING			12/02/2021
NAME OF PR	OVIDER OR SUPPLIER			ı	ET ADDRESS, CITY, STATE, ZIP CODE	
BOSE HILL	HEALTH AND REHAB				HALMERS COURT RYVILLE, VA 22611	
KOSE HIE			125	DEM	PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG	/FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPLETION ATE DATE
F 580	Continued From page	2.4	F	580	2. No other residents had the	he
F 300		ediately inform the resident;			potential to be affected as	
	consult with the resid	ent's physician; and notify,			there was no other resident	
	consistent with his or	her authority, the resident			admitted on 5/22/21. New	
	representative(s) who	ving the resident which			admissions in the last 30 da	ys
	results in injury and h	as the potential for requiring			medications reviewed to en	
	physician intervention	n; ge in the resident's physical,			physician notification if	
	mental, or psychosoc	cial status (that is, a			medication was unavailable	. s
	deterioration in health	n, mental, or psychosocial				_
	status in either life-th clinical complications	reatening conditions or			3. The DON/designee will re	
	(C) A need to alter tre	eatment significantly (that is,			educate licensed nurses wit	
	a need to discontinue	e an existing form of erse consequences, or to			the center of the requirement	snc
	commence a new for	m of treatment); or			to notify the physician for	
	(D) A decision to tran	sfer or discharge the			medications that are not	
	resident from the fac	ility as specified in			available.	
	§483.15(c)(1)(ii). (ii) When making not	ification under paragraph (g)			4. A report will be generate	ed of
	(14)(i) of this section	the facility must ensure that			medications not given 5 tin	nes a
	all pertinent informati	on specified in §483.15(c)(2) ided upon request to the			week, report will be review	red .
	physician.				for notification of physiciar	
	(iii) The facility must	also promptly notify the			Results will be presents to	QAPI
	when there is-	dent representative, if any,			monthly for continued	
	(A) A change in room	or roommate assignment			monitoring. Any noted trer	
	as specified in §483.	10(e)(6); or			will be addressed immedia	tely.
	(B) A change in resid	lent rights under Federal or ons as specified in paragraph			5. Compliance Date 01/04/	/22
	(e)(10) of this section	0.			5. Compliance Date 01/04/	
	(iv) The facility must	record and periodically				
	update the address (phone number of the	mailing and email) and resident				
	representative(s).	· • = = · · · · · · · · · · · · · · · ·				
	§483.10(g)(15)					

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DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES			OMB NO. 0938-0391
		MEDICAID SERVICES	(X2) MULTIPLE CO	NISTRUCTION	(X3) DATE SURVEY
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
AND FLAN OF	CORRECTION		A. 60 LESI 10		С
		495140	B. WING		12/02/2021
NAME OF D	ROVIDER OR SUPPLIER		STRI	EET ADDRESS, CITY, STATE, ZIP CC	DDE
NAME OF PI	ROVIDER OR SUIT LIER		110	CHALMERS COURT	
ROSE HIL	L HEALTH AND REHAB		BEF	RRYVILLE, VA 22611	
0/4/10	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	CORRECTION (X5)
(X4) ID PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	HE APPROPRIATE DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	IAG	DEFICIENCY	
F 580	Continued From page	e 5	F 580		
		osite distinct part. A facility			
	that is a composite d	istinct part (as defined in			
	§483.5) must disclos	e in its admission agreement			
	its physical configura	ition, including the various			
	locations that compri	se the composite distinct			
	part, and must specif	fy the policies that apply to			
	under §483.15(c)(9).	en its different locations			
	This RECUIREMEN	T is not met as evidenced			
	by:				
	Based on clinical red	cord review, facility document			
	review and staff inter	view it was determined that			
	the facility staff failed	to notify the physician that a			
	resident's medication	ns were not available for			
		e of 46 residents in the			
	survey sample, Resid	gent # 201.			
	The facility staff failed	d to notify Resident # 201's			
	physician that the me	edications, metoprolol,			
	zestoretic, gabapenti	in, glimepiride, and ozempic			
	were not available fo				
	05/22/2021 and 05/2	3/2021.			
	The findings include:				
	Resident # 210 was	admitted to the facility with			
	diagnoses that include	ded but were not limited to:			
	breast cancer, pain,	diabetes mellitus [6] and			
	kidney disease, high	blood pressure.			
	Resident # 201's MI	OS (minimum data set), an			
	admission 5-day ass	essment with an ARD			
	(assessment referen	ce date) of 05/24/2021			
	coded Resident # 20	1 as scoring a 15 on the brief			
	interview for mental:	status (BIMS) of a score of 0			
		nitively intact for making daily			
	decisions.				

Review of Resident #201's clinical record

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DEPART	MENT OF HEALTH AN	D HUMAN SERVICES			OMB NO. 0938-0391
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES		T. F. COMPTRUCTION	(X3) DATE SURVEY
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	COMPLETED
AND PLAN OF	CORRECTION	IDENTI IOATION NOMBER	A. BUILDIN	<u> </u>	c
		495140	B. WING _		12/02/2021
	ROVIDER OR SUPPLIER		- 1	STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PE	KONIDEK OK SUPPLIEK			110 CHALMERS COURT	
ROSE HIL	L HEALTH AND REHAB			BERRYVILLE, VA 22611	
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION (X5) COMPLETION
(X4) ID PREFIX	(FACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	PRIATE DATE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	IAO	DEFICIENCY)	
F 580	Continued From page	- 6	F 5	80	
1 000		s order dated 5/21/21,			
	signed by the physician	an on 5/24/21, which			
	documented in part: "	Metoprolol [1] ER [extended			
	releasel 25mg [millign	ams]. Give 1 [one] tablet by			
	mouth one time a day	for htn [hypertension - high			
	blood pressure]; Zest	oretic [2] 20-25 mg. Give 1			
	[one] tablet by mouth	one time a day for htn blood pressure]; Gabapentin			
	[Nypertension - night L	0 mg by mouth two times a			
	day for neuropathy; G	Blimepiride [4] Tablet. Give			
	2mg by mouth two tin	nes a day for DM [diabetes			
	mellitus]; Ozempic [5	(0.25 or 0.5 MG/DOSE)			
	Solution Pen-Injector	2 MG/1.5ML [milliliter].			
	Inject 0.5 mg subcuta	ineously [beneath the skin]			
	one time a day every	Sun [Sunday] for dm."			
	Review of the eMAR	[electronic medication			
	administration record	dated May 2021 for			
	Resident # 201 document	mented the physician's			
	orders as stated above	ve from 05/21/2021 through			
	05/24/2021. The eM	AR further documented the			
	code "3 [three] = Hold	d/See Nurse's Notes" for 021 and 05/23/2021 at 9:00			
	metoproloi on bizzizi	23/2021 at 9:00 a.m.;			
	zestoretic on 05/22/2	021 and 05/23/2021 at 9:00			
	a m.: gabapentin on	05/22/2021 at 9:00 a.m.;			
	alimepiride 5/22/2021	1 and 05/23/2021 at 9:00			
	a.m. and coded "7 [s	even] = See Nurse's Notes"			
	on 05/24/2021 at 9:0	0 a.m.			
	The puree's "Drogres	s Notes" dated 05/22/2021			
	and 05/23/2021 for F	Resident # 201 documented,			
	"Gabapentin Capsule	e. Give 300 mg by mouth			
	two times a day for n	europathy. Pharm			
	[pharmacy] sent wro	ng dose; Metoprolol			
	Succinate ER Tablet	Extended Release 24 Hour			
	25 MG. Give 1 table	t by mouth one time a day for			

htn. awaiting delivery; Glimepiride Tablet. Give 2 mg by mouth two times a day for DM. awaiting

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FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING С 12/02/2021 B. WING 495140 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 110 CHALMERS COURT BERRYVILLE, VA 22611 ROSE HILL HEALTH AND REHAB (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) TAG F 580 F 580 Continued From page 7 delivery." The nurse's "Progress Notes" dated 05/23/2021 "Ozempic (0.25 or 0.5 MG/DOSE) Solution Pen-injector 2 MG/1.5ML. Inject 0.5 mg subcutaneously one time a day every Sun [Sunday] for dm. awaiting delivery." Further review of Resident # 201's clinical record failed to reveal that the physician was notified that the above medications were not available or administered. On 12/01/2021 at 8:18 a.m., a request to interview the nurse who admitted resident # 201 was made to ASM [administrative staff member] # 1, interim administrator. ASM # 1 stated that the nurse was no longer employed by the facility. On 12/01/2021 at approximately 10:05 a.m., an interview was conducted with ASM # 2, director of nursing. When asked to describe the procedure to obtain medications for newly admitted residents that is followed by nursing, ASM # 2 stated, "Before they arrive, we get a report from the hospital or they arrive with a discharge summary with their medications. The admitting nurse calls the nurse practitioner [NP] or the physician to go over the resident's medications and make any necessary changes and then they give a verbal order for the medications. The order is then faxed to the pharmacy If there is a narcotic, the nurse gets a written order. If the resident is a late day admission the medications

arrive the next morning, if the admission is early in the day, the medications arrive by the end of the day." When asked about the procedure staff follow when a resident's medication are not

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CENTER	S FOR MEDICARE & I	MEDICAID SERVICES	_		OMB NO. 0930-0	٦
STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 ' '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A, BUILDI	NG	C	
		495140	B. WING		12/02/2021	
		490140	J. 1111.0	STREET ADDRESS, CITY, STATE, ZIP CODI		
NAME OF P	ROVIDER OR SUPPLIER			110 CHALMERS COURT		- 1
ROSE HIL	L HEALTH AND REHAB			BERRYVILLE, VA 22611		
		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COL	RRECTION (X5)	ION
(X4) ID PREFIX	/FACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI TAG	X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	3110000 00	
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	IAG	DEFICIENCY)		
				•		
F 580	Continued From page	8	F	580		
F 360		-drug box [prepared by the				
	pharmacy to provide	for initiating therapy prior to				
	the receipt of ordered	drug from the pharmacy]				
	and the house stock	of medications. If they				
	[medications] are not	in the STAT-drug box or in				
	the house stock, the	NP or physician, and let the				
	resident and/or respo	nsible party know." When				
	asked where it was d	ocumented that a				
	medication was not a	vailable and that the				
	pharmacy and NP/ph	ysician were notified, ASM # AR and or the nurse's				
	2 stated, "Un the elvir	er reviewing Resident #				
	201's eMAR dated M	ay 2021, nurse's progress				
	notes dated 05/21/20	21 through 05/24/2021, the				
	STAT-drug box list ar	nd the facility's house stock				
	list, ASM # 2 was ask	ted if the pharmacy, NP/				
	Physician was notifie	ove were not available and				
	administered. ASM #					
	The facility policies re	egarding medication				
	administration failed	to document specific				
	information regarding	physician notification for able for administration.				
	medications not avail	apic ioi administration.				
	On 12/01/2021 at app	proximately 4:10 p.m., ASM				
	fadministrative staff r	nember] # 1, the interim				
	administrator, ASM #	2, director of nursing, ASM				
	# 4, director of clinica	al operations and ASM # 5, nt of operations, were made				
	regional vice preside aware of the findings	in or operations, were muce				
			12			
	No further information	n was provided prior to exit.				
	Complaint deficiency					

References:

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	THAND HIMAN SERVICES			OMB NO. 0938-0391
DEPARTMENT OF H CENTERS FOR MED STATEMENT OF DEFICIENCI AND PLAN OF CORRECTION	EALTH AND HUMAN SERVICES DICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 12/02/2021
	495140	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR S			110 CHALMERS COURT BERRYVILLE, VA 22611	(X5)
	SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEDED BY FULL SULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICENCY)	D BE COMPLETION

F 580 Continued From page 9

[1] Used alone or in combination with other medications to treat high blood pressure. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682864.html.

[2] The combination of lisinopril and hydrochlorothiazide is used to treat high blood pressure. This information was obtained from the website:

https://medlineplus.gov/druginfo/meds/a601070.html.

[3] Used to help control certain types of seizures in people who have epilepsy. Gabapentin capsules, tablets, and oral solution are also used to relieve the pain of postherpetic neuralgia (PHN; the burning, stabbing pain or aches that may last for months or years after an attack of shingles). This information was obtained from the website:

https://medlineplus.gov/druginfo/meds/a694007.html.

- [4] Used along with diet and exercise, and sometimes with other medications, to treat type 2 diabetes (condition in which the body does not use insulin normally and, therefore, cannot control the amount of sugar in the blood). This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a696016.html.
- [5] Used along with a diet and exercise program to control blood sugar levels in adults with type 2 diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood) when other medications did not control the sugar levels well

F 580

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CENTERS	S FOR MEDICARE &	MEDICAID SERVICES	T	E CONSTRUCTION		(X3) DATE SURVEY
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		COMPLETED
AND PLAN OF	CORRECTION	IDEATH IONITOTI (TOTAL)	A, BUILDING		С	
		495140	B. WING		-	12/02/2021
NAME OF PE	OVIDER OR SUPPLIER			STREET ADDRESS, CITY,	STATE, ZIP CODE	
			1	110 CHALMERS COURT	•	
ROSE HILI	. HEALTH AND REHAB			BERRYVILLE, VA 226		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(FACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION NTE OATE
		10	F 58	n		
F 580	Continued From page		F 30			
	website:	ation was obtained from the ov/druginfo/meds/a618008.h				
	tml.	3				
[6] A chronic disease in which regulate the amount of sugar information was obtained from		of sugar in the blood. This ined from the website:				
	·	ov/medlineplus/ency/article/				
	001214.htm.	Naglact	F 60	oo F600		
	Free from Abuse and CFR(s): 483.12(a)(1)	Neglect				
SS=D	CFR(S). 403.12(a)(1)			1. Reside	nt #96 remains safe	e
	§483.12 Freedom fro	m Abuse, Neglect, and		and secu	re in the center wit	h
	Exploitation			no post t	rauma effects note	d.
	The resident has the	right to be free from abuse, ation of resident property,		2 Curron	t residents in the	
	and exploitation as d	efined in this subpart. This				h =
	includes but is not lin	nited to freedom from			ive the potential to	
	corporal punishment,	involuntary seclusion and ical restraint not required to			Randomly selected	1
	treat the resident's m	edical symptoms.			that are alert and	
					were interviewed t	_
	§483.12(a) The facilit	ty must-			e any potential issu	ies.
	8483 12(a)(1) Not us	e verbal, mental, sexual, or		No conce	rns identified.	
	physical abuse, corp	oral punishment, or		3. The Ad	ministrator/design	ee
	involuntary seclusion	i			ucate staff on the	
		is not met as evidenced			d Neglect policy.	
	by:	n, staff interview and facility		Abuse un	a riegicer policy.	
	document review it w	as determined that the				
	facility staff failed to e	ensure one of 46 residents in				
	the survey sample, (Resident #96), was free from				
	abuse.					
ļ	On 7/9/20, at 10:30 p	o.m. a facility CNA [certified empted to give Resident #96				

Facility ID: VA0210

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	S SOO MEDICARE A	MEDICAID SERVICES				OMB NO. 0938-0391
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CO	DNSTRUCTION	(X3) DATE SURVEY
	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN			COMPLETED
						С
		495140	B. WING			12/02/2021
NAME OF PE	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	
					CHALMERS COURT	
ROSE HIL	L HEALTH AND REHAB			BEF	RRYVILLE, VA 22611	
(X4) ID PREFIX TAG	FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) BE COMPLETION ATE DATE
				7.47		
F 600	Continued From page	⇒ 11	F 6	300	4. Random knowledge checks	i
, 555		nt declined stating they were			will be completed with	
	tired. The CNA proce	eeded with the bath,			associates in different	
	upsetting the residen	t. Resident #96 cursed at the			departments weekly for 1	
	CNA and the CNA su	bsequently cursed at s rude to the resident.			month to ensure residents ar	e
	Resident #95 and wa	s filde to the resident.			free from abuse. Results will	
	The findings include:				presented to QAPI monthly.	J.C
	-				•	
	Resident #96 was ad	mitted to the facility on			Any noted trends will be	
	1/6/18 with diagnosis	that included but were not brovascular accident'			addressed immediately.	
	(hemorrhage of block	age of the blood vessels of			5) Compliance Date: 01/04/2	2
	the brain leads to lac	k of oxygen to brain) (1),			3, 30mpa 22cc2, -1, -	_
	hemiplegia (paralysis	only affecting one side of				
	the body) (2) and vas	scular dementia (progressive ne, including memory				
	function and judgeme	ent due to impairment of				
	vasculature of the bra					
	The most recent MD3	S (minimum data set)				
	assessment, a quarte	erly and 5 day assessment,				
	with an ARD (assess	ment reference date) of				
	11/15/21, coded Res	ident #96 as scoring a 10 out rief interview for mental				
	status) score, indicat	ing the resident was				
	moderately cognitive	ly impaired. A review of the				
	MDS Section G-func	tional status coded Resident				
	#96 as requiring exte	ensive assistance for bed				
	mobility, transfer, loc	omotion, dressing, hygiene; g and supervision for eating.				
	Walking did not occu	r. A review of MDS Section				
	H- Bowel and Bladde	er coded Resident #96 as				
	always incontinent for	r bowel and for bladder.				
	A review of the comp	rehensive care plan dated				
	1/6/18 documented i	n part, "FOCUS: I have a				
	physical functioning	deficit related to: Mobility				
	impairment, Self-care	e impairment, history of CVA				

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CENTERS FOR	MEDICARE & MEDICAID	SERVICES

CENTERS F	OR MEDICARE &	MEDICAID SERVICES			(X3) DATE SURVEY	
STATEMENT OF DEFICIENCIES (X1)		(X1) PROVIDER/SUPPLIER/CLIA (X2) (X2)		(X2) MULTIPLE CONSTRUCTION		
AND PLAN OF CO		IDENTIFICATION NUMBER:	A. BUILDIN	IG	С	
		495140	B. WING		12/02/2021	
		493140		STREET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER						
				110 CHALMERS COURT		
ROSE HILL H	IEALTH AND REHAB			BERRYVILLE, VA 22611		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION TE DATE		

F 600 Continued From page 12 Encourage choices with care."

> A review of the FRI dated 7/10/20, documented in part, "CNA (certified nursing assistant) giving resident a bed bath at 10:30 PM. Resident stating he did not want bed bath at that time, as he was tired. Resident said he wanted to wait until tomorrow. CNA proceeded with bed bath and resident was upset. He began cursing at CNA. CNA allegedly cursed back at resident and was rude with him. After review of the incident to include statements and interview with Resident #96, it has been determined that this allegation has been substantiated due to poor customer service, verbal abuse and mistreatment of the resident, it has been determined that the employee will no longer be used as a traveler CNA in the facility."

> A review of the nursing progress note dated 7/10/20 at 1:44 PM, documented in part, "Alleged verbal altercation between resident and CNA (certified nursing assistant) during bed bath. Notification of NP (nurse practitioner), POA (power of attorney), DON (director of nursing), Administrator, and Berryville Police Department. All paperwork completed."

> A review of the nursing progress note dated 7/10/20 at 2:36 PM, documented in part, "Resident alert. Makes needs/wants known. No complaints voiced. No apparent complications or complaint post alleged verbal altercation. Temperature-97.2, Pules-65, Respirations-16, Blood pressure-103/69, oxygen saturation- 97% on room air."

A review of the nursing progress note dated 7/10/20 at 2:38 PM, documented in part, "Spoke F 600

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495140	B. WING			C 12/02/2021
NAME OF PR	OVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	
ROSE HILI	L HEALTH AND REHAB				0 CHALMERS COURT ERRYVILLE, VA 22611	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	E COMPLETION	
F 600	Continued From page with resident in regard altercation with CNA. of any emotion distrest Psych [psychiatry] to	ds to alleged verbal Resident exhibits no signs ss and states he is fine.	F	600		
	A review of the nursin 7/11/20 at 12:04 AM, post verbal altercation	ng progress note dated documented in part, "Status n. resident is amicable and resident shows no signs of				
	7/13/20 at 7:39 AM, o	to show no signs of any ne to alleged verbal				
	PM with Resident #90 remembered the incident assistant, Resident # he gave be a bed bate Resident #96 stated, evening and I wanted	dent with the nursing 96 stated, "You mean when th and I didn't want one." "Yes, it was late in the I to go to sleep. He argued I things to me. I don't think				
	PM with LPN (license asked if she rememb Resident #96 in July do not." When asked stated, "It can be ver neglect. It can be re-	aducted on 11/29/21 at 5:35 ad practical nurse) #3. When wered an incident with 2020, LPN #3 stated, "No, I d what abuse was, LPN #3 bal, physical, mental or sident to resident or staff to or see abuse, we report it				

immediately."

An interview was conducted on 11/30/21 at 2:37 PM with LPN #2, unit manager north wing. When

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		MEDICAID SEDVICES				OMB NO. 0938-0391
CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES			IPLE CONSTRUCTION		(X3) DATE SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDI	YG		С
					,	
		495140	B WING			12/02/2021
NAME OF B	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ITE, ZIP CODE	
NAME OF F	ROVIDER OR SOLIT EIER			110 CHALMERS COURT		
ROSE HIL	L HEALTH AND REHAB			BERRYVILLE, VA 22611		
					PLAN OF CORRECTION	(X5)
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID PREFI	/EACH CORREC	TIVE ACTION SHOULD B	COMPLETION
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFEREN	ICED TO THE APPROPRIA	ITE DATE
TAG	REGULATURE	Lac IDEIXIII TIIVO IIII GENERALIS		D	EFICIENCY)	
			_	200		
F 600	Continued From page		г	500		
	asked if she rememb	ered the incident with				
	Resident #96 and a C	NA, July 2020, LPN #2				
	stated, "Yes, the resid	dent did not want a bath at				
	that time and the CN	A proceeded to do the bath				
	even though the resid	dent said he did not want the				
	bath at that time, whi	ch was late evening, about				
	10:30 PM. We suspe	ended the CNA, who was a				
	traveler pending the	investigation and then				
	terminated him. I bel	ieve we did substantiate				
	verbal abuse."					
	VCIDAI ADAGO.					
	A request was made	for the final FRI including the				
	investigation on 11/3	0/21 at 8:15 AM. The final				
	EDI with investigation	was provided by the ASM				
	(administrative staff r	nember) #1 on 12/1/21 at				
	1:10 DM When ask	ed about the FRI, ASM #1				
	stated "It was not will	th the rest of the FRI's. It				
	stated, it was not will	der. This happened before I				
	was in a separate for was hired here. I've	been here 7 days "				
	was nired nere. The	been here i days.				
	0 40/4/21 at 5:00 P	M, ASM #1, the interim				
	Of 12/1/21 at 5.00 i	2, the director of nursing,				
	ACM #2 the director	of nursing, ASM #4, the				
	Moivi #o, the director	inical operations and ASM				
	regional director of ci	president of operations were				
	#5, the regional vice	president of operations work				
	informed of the finding	ıyə.				
	Ai	y's "Abuse and Neglect"				
	A textem of the lactilit	which documents in part, "It				
	policy dated 4/2020,	ure and dignity of each				
	is innerent in the nati	that he/she be afforded				
	resident at the facility	ncluding the right to be free				
	basic numan rights, i	not mistreatment and/or				
	from abuse, neglect	and mistreatment and/or				
	misappropriation of p	property. Acts of abuse				
	directed at residents	are strictly prohibited. Verbal				
	abuse means the us	e of oral, written or gestured				
	language that willfully	y includes disparaging and/or				
	derogatory terms to	residents or their families,				

Facility ID: VA0210

within their hearing distance, regardless of their

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CENTERS FOR MEDICARE & MEDICAID SERVICES			POTRUCTION	(X3) DATE SURVEY	
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CON	BIRUCTUN	COMPLETED
AND PLAN OF	CORRECTION	IDEATH IONION ROMOEN	A. BUILDING		С
		495140	B. WING		12/02/2021
NAME OF PE	ROVIDER OR SUPPLIER		STREE	ET ADDRESS, CITY, STATE, ZIP CODE	
				HALMERS COURT	
ROSE HIL	L HEALTH AND REHAB		BER	RYVILLE, VA 22611	
(X4) ID PREFIX TAG	/FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION TE DATE
F 600	Continued From page		F 600		
	age, ability to compre	hend or disability."\			
	No further information	n was provided prior to exit.			
	Non-Medical Reader Chapman, page 111. (2) Barron's Dictional Non-Medical Reader Chapman, page 264. (3) Barron's Dictional Non-Medical Reader Chapman, page 154. Develop/Implement A	ry of Medical Terms for the , 5th edition, Rothenberg and ry of Medical Terms for the , 5th edition, Rothenberg and Abuse/Neglect Policies	F 607	F607	
SS=D	CFR(s): 483.12(b)(1)	-(3)		1. Resident #7 remains safely	in
		licies and procedures that:		the community. No current sl related issues noted.	
	neglect, and exploita misappropriation of r	esident property,		2. Current residents in the center have the potential to be affected. Skin sweeps of currents	
	to investigate any su			residents in the center were completed on 12/8/2021. No	
	paragraph §483.95,	e training as required at		new issues noted.	2.
	This REQUIREMENty: by: Based on staff intenty and clinical record rethe facility staff failed	r is not met as evidenced view, facility document review view, it was determined that to implement the facility of 46 residents in the survey		3. The Administrator will re- educate clinical leadership or the policy of investigating bruises on unknown origin.	1
	The facility staff faile	d to implement the facility			

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONS	(X3)	(X3) DATE SURVEY COMPLETED	
	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	1 ' '	NG			
							С
		495140	B. WING				12/02/2021
NAME OF P	ROVIDER OR SUPPLIER			11.	ADDRESS, CITY, STATE, ZIP CODE		
					ALMERS COURT		
ROSE HIL	L HEALTH AND REHAB			BERRY	VILLE, VA 22611		
(X4) ID PREFIX TAG	FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED 8Y FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 607	Continued From page		F	607	4. Incidents/accidents th		
	abuse policy for inves	stigating and reporting an			involve bruising will be a		
	injury of unknown orig	gin when Resident #7			weekly for 1 month to er	rsure	
	sustained a bruise or	1 8/5/21.			that abuse policy was		
	The findings include:				implemented. Results w	ill be	
	•				presented to QAPI mont		
	The facility policy title	d, "Resident Abuse- Injuries			Any noted trends will be		
	of Unknown Origin" d Administrator, Directo	locumented, "4. The			addressed immediately.		
	designee must heair	a documented investigation			addressed infinediately.		
	for the cause of the in will include interviews involved (directly or in or volunteers which in the resident and may Obtain written statem 7. All injuries of unkni	njury. 5. The investigation is with the resident, all staff indirectly), any family, visitors may have had contact with the help with the investigation. In the investigation is as deemed necessary. Own origin must be reported encies per state specific			5. Compliance Date: 01/	04/22	
	were not limited to didementia. Resident a minimum data set as assessment reference the resident's cognition making as severely in Resident #7 as requitive or more staff with	7's diagnoses included but abetes, paralysis and #7's five day Medicare sessment with an e date of 11/11/21, coded we skills for daily decision mpaired. Section G coded ring extensive assistance of a bed mobility.					
	nurse's note dated 8/ (licensed practical nu "Situation: Resident of bruise that is starting	#7's clinical record revealed a /5/21 and signed by LPN urse) #1 that documented, observed with a dark purple to have faded green on her from elbow to the shoulder.					

Front and posterior (back) shoulder and axilla (armpit). Resident alert with some confusion

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DEPARTM	MENT OF HEALTH AN	D HUMAN SERVICES			OMB NO. 0938-0391
CENTERS	FOR MEDICARE & I	MEDICAID SERVICES	NOVE AND THE E	CONSTRUCTION	(X3) DATE SURVEY
STATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILDING _		COMPLETED
AND PLAN OF	CORRECTION	IDENTIFICATION TO THE PROPERTY OF THE PROPERTY	A, BUILDING_		С
		495140	B_ WING		12/02/2021
		400140	s	TREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PR	OVIDER OR SUPPLIER		1	10 CHALMERS COURT	
ROSE HILL	HEALTH AND REHAB		E	BERRYVILLE, VA 22611	
	OU WALL OV CT	ATEMENT OF DEFICIENCIES	-ID	PROVIDER'S PLAN OF CORRECTION	ON (X5) D.RE COMPLETION
(X4) ID PREFIX	JEACH DESIGIENC	V MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	
F 007	O 11 1 Fram 200	. 17	F 607		
F 607	Continued From page				
	Possible Properties of the Possible Properties o	oice her concerns very well.			
	discomfort Resting if	her room at this time with			
	call bell in reach				
	Background: CVA (ce	erebrovascular accident			
	[stroke]), falls,				
	Assessment: Head to Response: MD (med	ical dector) and RP			
	(response) with (medical control of the control of	ware. Will continue to			
	monitor."				
	"Describe the bruise: green faded. Location Size: whole upper and (posterior). Color: Defaded. Caregiver/Em LPN #1). Date report 1100 AM. Resident of confusion. Does the No. Does the reside in a W/C (wheelchair Notified- Yes. Direct YesBased on investigation of the bruise: nursing) or designed staff and document in Caregiver/Employee 8/5/21. Shift: 7-3. Raymonth when I remote the professional opin mistreatment occurrence and the professional opin mistreatment occurrence."	ark purple and some green aployee reporting: (name of ted: 8/5/21. Time reported: cognition: alert w/ (with) resident ambulate alone-nt wheel themselves around: - NoAdministrator or of Nursing Notified-stigation, determination of the (blank). DON (Director of to complete interviews of			

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CENTERS FOR MEDICARE &	MEDICAID SERVICES			WAY DATE BUDYEY		
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	С		
	495140	B. WING		12/02/2021		
	495140		OTATE ZIE CODE			
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
The state of the s			110 CHALMERS COURT			
ROSE HILL HEALTH AND REHAB			BERRYVILLE, VA 22611			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) E COMPLETION ATE DATE		

F 607 Continued From page 18

and thorough investigation. Also, a FRI (facility reported investigation) was not submitted to the SA (state agency) or any other agency.

On 12/1/21 at 8:04 a.m., an interview was conducted with LPN #1. LPN #1 stated she had been off of work for a month and returned on 8/5/21. LPN #1 stated that on 8/5/21 she noticed Resident #7 had purplish but greenish and yellowing bruising from her right shoulder to her right elbow. LPN #1 stated it looked like the bruising was fading. LPN #1 stated she completed the above nurse's note, completed an incident report and gave the report to the DON. LPN #1 stated the DON is responsible for investigating bruises.

On 12/1/21 at 1:48 p.m., an interview was conducted with ASM (administrative staff member) #3 (the DON). ASM #3 was not the DON on 8/5/21. ASM #3 stated the DON is responsible for investigating resident bruises. ASM #3 stated the investigation should consist of a complete head to toe assessment, speaking with the resident if he/she is alert and oriented, speaking to staff possibly the staff on the last several shifts, depending on the looks of the bruise, and possibly speaking with the resident's roommate. ASM #3 stated if the cause of the bruise is unknown then the bruise should be reported as an injury of unknown origin to the state agency and other required agencies. ASM #3 was shown the above bruise investigation form. ASM #3 stated she thought she remembered the former DON and LPN #1 talking about Resident #7's bruise. ASM #3 stated she thought the former DON thought the bruise was from a mechanical lift and that could be why the former DON did not submit a FRI. ASM #3 stated F 607

Facility ID: VA0210

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CENTER	S FOR MEDICARE & I	MEDICAID SERVICES					C. 0930-0031
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		STRUCTION		E SURVEY MPLETED
MIND LIMIT OF	G5.1(L511611		, a boile bit				С
		495140	B, WING			1	2/02/2021
NAME OF PE	ROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE, ZIP CODE		
					ALMERS COURT		
ROSE HIL	L HEALTH AND REHAB			BERR	YVILLE, VA 22611		0/5)
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
				607			
F 607	Continued From page		Γ.	307			
	the bruise investigation	she heard but by looking at on form, she did see where it					
	looked like an investig	gation was completed.					
	On 12/1/21 at 4:56 p.	m., ASM (administrative					
	staff member) #1 (the	interim administrator), ASM					
	#2 (the director of nul	rsing), ASM #4 (the regional erations) and ASM #5 (the					
	regional vice presider	nt of operations) were made					
	aware of the above of	oncern.					
		n was presented prior to exit.	_		FC00		
	Reporting of Alleged		F	609	F609		
SS=D	CFR(s): 483.12(c)(1)	(*)			1. Resident #7 remains sa	fely in	
	§483.12(c) In respons	483.12(c) In response to allegations of abuse, eglect, exploitation, or mistreatment, the facility			the community. No curre		
	neglect, exploitation, must:				related issues noted		
	8483 12(c)(1) Ensure	that all alleged violations			2. Residents in the cente	r that	
	involving abuse, negl	ect, exploitation or			have sustained a bruise v	vithin	
	mistreatment, includir	ng injuries of unknown			the last 30 days have the		
	source and misappro	priation of resident property, Itely, but not later than 2			potential to be affected.		
	hours after the allega	tion is made, if the events			residents were reviewed		
	that cause the allega	tion involve abuse or result in or not later than 24 hours if			issues with notification n		
	the events that cause	the allegation do not involve sult in serious bodily injury, to			3. Re-education of the re	sident	
	the administrator of the	ne facility and to other			abuse-injuries of unknov	n .	
	officials (including to	the State Survey Agency and			origin policy was comple		
	adult protective servi	ces where state law provides			current center leadership		
	for jurisdiction in long accordance with Stat procedures.	term care facilities) in e law through established			appropriate licensed state		
	\$483.12(c)(4) Report	the results of all administrator or his or her					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEIART	WEITI OF THE	ALEDICATE CERVICES				OWR	NO. 0938-0391
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	ROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION				OATE SURVEY
	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI			1	
							C 12/02/2021
		495140	B. WING		REET ADDRESS, CITY, STATE, ZIP CODE		12/02/2021
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, 21F CODE O CHALMERS COURT		
ROSE HILL HEALTH AND REHAB					ERRYVILLE, VA 22611		
KOOL IIIL					PROVIDER'S PLAN OF CORRECTIO	N	(X5)
(X4) ID PREFIX TAG	JEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	BE	COMPLETION DATE
F 600	O House d From page	20	F	609	4. Incidents/accidents will be	•	
F 609		ative and to other officials in	·	000	audited weekly for 1 month		
	accordance with Stat	e law, including to the State			ensure they were reported it		
	Survey Agency, withi	n 5 working days of the			appropriate. Results will be		
	incident, and if the al	eged violation is verified eaction must be taken.			presented to QAPI monthly.		
	This REQUIREMEN	is not met as evidenced			Any noted trends will be		
	bv:				corrected immediately.		
Based on staff interview, facility document review		view, facility document review			2011.001011		
i i	and clinical record review, it was determined that the facility staff failed to report an injury of unknown origin for one of 46 residents in the survey sample, Resident #7.				5. Compliance Date 01/04/2	2	
	on the right arm exte elbow that was found failed to report this in	d a bruise of unknown origin nding from the shoulder to for 85/21. The facility staff jury of unknown origin to the dother required agencies.					
	The findings include:						
	7/15/19. Resident # were not limited to di dementia. Resident minimum data set as assessment reference the resident's cogniti making as severely in	te date of 11/11/21, coded ve skills for daily decision mpaired. Section G coded iring extensive assistance of					
	nurse's note dated 8 (licensed practical numbers) "Situation: Resident bruise that is starting	#7's clinical record revealed a /5/21 and signed by LPN urse) #1 that documented, observed with a dark purple g to have faded green on her from elbow to the shoulder.					

Front and posterior (back) shoulder and axilla

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-0391
			(X2) MUI	TIPLE CONSTR	(X3)	DATE SURVEY	
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A_BUILDI				COMPLETED
AND PLAN OF	CORRECTION	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	A, BOILD			- 1	С
		495140	B, WING			1	12/02/2021
		495140		STREET AL	DDRESS, CITY, STATE, ZIP CODI	E .	
NAME OF PR	ROVIDER OR SUPPLIER			ı	MERS COURT		
DOSE HILL	L HEALTH AND REHAB			1	ILLE, VA 22611		
KOSE IIIEI	E III CALLINIA			BERKIV		PRECTION	(YS)
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 609	episodes. Does not v No s/s (signs or symp discomfort. Resting in call bell in reach	ert with some confusion oice her concerns very well.	F	609			
	"Describe the bruise: green faded. Location Size: whole upper and	ical doctor) and RP ware. Will continue to dated 8/5/21 documented, Dark purple and some on: R arm, shoulder, axilla.					
124	faded. Caregiver/Em LPN #1). Date report 1100 AM. Resident of confusion. Does the No. Does the resider in a W/C (wheelchair Notified- Yes. Direct YesBased on investigate of the bruise: (nursing) or designee staff and document in Caregiver/Employee' 8/5/21. Shift: 7-3. Ramonth when I remote bruise." Supervisor I my professional opin	aployee reporting: (name of ted: 8/5/21. Time reported: cognition: alert w/ (with) resident ambulate alone- nt wheel themselves around of -NoAdministrator or of Nursing Notified- tigation, determination of the (blank). DON (Director of to complete interviews of esponses. Is Name: (LPN #1). Date: esponse: I have been off for oved her sheet I observed the Report. (An "X" beside) In ion, no abuse, neglect or					
	Required- (blank). D	ed. Further Investigation letails of investigation and Signature of DON: (blank). nvestigation failed to					

document a potential cause for the bruise.

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		ID HUMAN SERVICES			OMB NO. 0938-0391
		MEDICAID SERVICES	(VO) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		COMPLETED
		495140	B. WING		C 12/02/2021
	THE OF SUPPLIED	433140		REET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			CHALMERS COURT	
ROSE HIL	L HEALTH AND REHAB		ВЕ	RRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE COMPLETION
5 000		- 00	F 609	Ę.	
	Continued From page		F 009		
	A FRI (facility reporte	d investigation) regarding			
	Resident #7's bruise	of unknown origin was not state agency) or any other			
	required agency.	state agency) or any other			
	required agency.				
	On 12/1/21 at 8:04 a.	m., an interview was			
		#1. LPN #1 stated she had			
	been off of work for a	month and returned on			
	8/5/21. LPN #1 state Resident #7 had purp	d that on 8/5/21 she noticed			
	Resident #7 had purp	m her right shoulder to her			
	right elbow LPN #1	stated it looked like the			
	bruising was fading.	LPN #1 stated she			
	completed the above	nurse's note, completed an			
	incident report and ga	ave the report to the DON.			
	On 12/1/21 at 1:48 p.	m., an interview was			
	conducted with ASM	(administrative staff			
	member) #3 (the DO	N). ASM #3 was not the			
	DON on 8/5/21. ASN	#3 stated the DON is			
	responsible for invest	tigating resident bruises.			
	ASM #3 stated if the	cause of the bruise is			
	unknown then the bro	uise should be reported as			
	an injury of unknown	origin to the state agency gencies. ASM #3 was shown			
	the above bruise inve	estigation form. ASM #3			
	stated she thought sh	ne remembered the former			
	DON and LPN #1 tall	king about Resident #7's			
	bruise. ASM #3 state	ed she thought the former			
	DON thought the bru	ise was from a mechanical			
	lift and that could be	why the former DON did not			
	submit a FRI. Hower	ver, there was no			
	documented cause o	tne oruise.			
	On 12/1/21 at 4:56 p	.m., ASM (administrative			
	staff member) #1 (the	e interim administrator), ASM			

Facility ID: VA0210

#2 (the director of nursing), ASM #4 (the regional director of clinical operations) and ASM #5 (the

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CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				ONB NO. 0936-0391
STATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED
AND PLAN OF	CORRECTION	IDENTIFICATION NOMBER	A. BUILDIN	G		c
		495140	B. WING			12/02/2021
NAME OF PE	OVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE	
	DELIAR DELIAR				ALMERS COURT	
ROSE HILL HEALTH AND REHAB				BERRY	VILLE, VA 22611	(ME)
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E COMPLETION
			F 6	ina		
F 609	Continued From page		F C	105		
	aware of the above co	oncern.				
	The facility policy title of Unknown Origin" d unknown origin must appropriate agencies protocols"	d, "Resident Abuse- Injuries ocumented, "7. All injuries of be reported to the per state specific				
	No further information	was presented prior to exit.				
F 610	Investigate/Prevent/C	orrect Alleged Violation	F 6	10	F610	
SS=D	CFR(s): 483.12(c)(2)	-(4)			1. Resident #7 remains safel	v in
	8493 12(c) In respons	se to allegations of abuse,			the community. No current	
	neglect, exploitation, must:	or mistreatment, the facility			related issues noted	SKIII
	0.400.407.7707.11===	vidence that all alleged			2. Residents in the center th	at
	violations are thoroug	vidence that all alleged			have sustained a bruise with	nin
					the last 30 days have the	
	§483.12(c)(3) Prever	t further potential abuse,			potential to be affected. The	ese
	neglect, exploitation, investigation is in pro	or mistreatment while the			residents were reviewed an	
					issues with investigation no	
	§483.12(c)(4) Report	the results of all				
	investigations to the	administrator or his or her ative and to other officials in			Re-education of the	
	accordance with Stat	e law, including to the State			investigation requirements	
	Survey Agency, withi	n 5 working days of the			completed by center leader	ship
	incident, and if the al	leged violation is verified			and appropriate licensed sta	aff.
	appropriate corrective	e action must be taken. is not met as evidenced			a to sidente/posidonte will b	^
	bv:				4. Incidents/accidents will b	
	Based on staff interv	riew, facility document review			audited weekly for 1 month	
	the facility staff failed	view, it was determined that to investigate an injury of the of 46 residents in the dent #7.			ensure they were investigat	eu II

Facility ID: VA0210

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ALAD I DIN CI	0011112011011		, a boilean	3=		С
		495140	B. WING_		X	12/02/2021
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	
					110 CHALMERS COURT	
ROSE HIL	L HEALTH AND REHAB			Е	BERRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES (PROVIDER OF THE APPROPRIES OF THE APPROPR	BE COMPLETION
F 610	Continued From page		F (610		
	Resident #7 sustained	d a bruise of unknown origin			presented to QAPI monthly,	
	on the right arm exter	nding from the shoulder to			Any noted trends will be	
		investigation to determine			corrected immediately.	
	the cause of the bruis	e.			5. Compliance Date 01/04/2	2
	The findings include:					
	were not limited to did dementia. Resident # minimum data set ass assessment reference the resident's cognitive making as severely in Resident #7 as require two or more staff with Review of Resident # nurse's note dated 8/ (licensed practical nu "Situation: Resident obruise that is starting R. (right) upper arm fifter front and posterior (but (armpit). Resident aleepisodes. Does not wood No s/s (signs or symptotical bell in reach	's diagnoses included but abetes, paralysis and #7's five day Medicare sessment with an e date of 11/11/21, coded we skills for daily decision inpaired. Section G coded ing extensive assistance of bed mobility. 7's clinical record revealed a 5/21 and signed by LPN rese) #1 that documented, observed with a dark purple to have faded green on her rom elbow to the shoulder. Seck) shoulder and axilla ent with some confusion of the room at this time with the rebrovascular accident of toe (cal doctor) and RP				

A bruise investigation dated 8/5/21 documented,

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DEPART	MENT OF HEALTH AN	D HUMAN SERVICES				OMB NO. 0938-0391
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES		IBI E CON	STRUCTION	(X3) DATE SURVEY
	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A_BUILDI		STRUCTION	C
		495140	B. WING_		<u> </u>	12/02/2021
NAME OF PE	ROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE, ZIP CODE	
					HALMERS COURT	
ROSE HIL	L HEALTH AND REHAB			BERK	PROVIDER'S PLAN OF CORRECTION	N (X5)
(X4) ID PREFIX TAG	/FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PREC EDED BY FU LL LSC IDENTIFYING INFORMATION)	PREFIX TAG	x	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
				610		
F 610	Continued From page		г	510		
	"Describe the bruise:	Dark purple and some n: R arm, shoulder, axilla.				
	Size: whole upper arr	n & shoulder (front)				
	(posterior). Color: Da	ark purple and some green				
	faded. Caregiver/Em	ployee reporting: (name of				
	LPN #1). Date repor	ted: 8/5/21. Time reported: cognition: alert w/ (with)				
	confusion. Does the	resident ambulate alone-				
	No. Does the resider	nt wheel themselves around				
	in a W/C (wheelchair) - NoAdministrator				
	Notified- Yes. Directo	or of Nursing Notified- tigation, determination of the				
	cause of the bruise: (blank). DON (Director of				
	nursing) or designee	to complete interviews of				
	staff and document re	esponses.				
	Caregiver/Employee'	s Name: (LPN #1). Date:				
	8/5/21. Shift: 7-3. Ri	esponse: I have been off for oved her sheet I observed the				
	bruise." Supervisor f	Report. (An "X" beside) In				
	my professional opin	ion, no abuse, neglect or				
	mistreatment occurre	ed. Further Investigation				
	Required- (blank). D	etails of investigation and Signature of DON: (blank).				
	Date: (blank)."	signature of Botts. (olds)				
		investigation and nurses'				
	notes for August 202	1 failed to reveal a complete				
	and thorough investig	gation.				
	On 12/1/21 at 8:04 a	.m., an interview was				
	conducted with LPN	#1. LPN #1 stated she had				
	been off of work for a	a month and returned on ed that on 8/5/21 she noticed				
	8/5/21. LPN #1 state	plish but greenish and				
	vellowing bruising fro	om her right shoulder to her				
	right elbow. LPN #1	stated it looked like the				

bruising was fading. LPN #1 stated she completed the above nurse's note, completed an incident report and gave the report to the DON.

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OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 12/02/2021 B. WING 495140 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 110 CHALMERS COURT ROSE HILL HEALTH AND REHAB BERRYVILLE, VA 22611 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION ID SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 610 F 610 Continued From page 26 LPN #1 stated the DON is responsible for investigating bruises. On 12/1/21 at 1:48 p.m., an interview was conducted with ASM (administrative staff member) #3 (the DON). ASM #3 was not the DON on 8/5/21. ASM #3 stated the DON is responsible for investigating resident bruises. ASM #3 stated the investigation should consist of a complete head to toe assessment, speaking with the resident if he/she is alert and oriented, speaking to staff (possibly the staff on the last several shifts, depending on the looks of the bruise), and possibly speaking with the resident's roommate. ASM #3 was shown the above bruise investigation form. ASM #3 stated she thought she remembered the former DON and LPN #1 talking about Resident #7's bruise. ASM #3 stated she thought the former DON thought the bruise was from a mechanical lift. ASM #3 stated this is the information she heard but by looking at the bruise investigation form, she did see where it looked like an investigation was completed. On 12/1/21 at 4:56 p.m., ASM (administrative staff member) #1 (the interim administrator), ASM #2 (the director of nursing), ASM #4 (the regional director of clinical operations) and ASM #5 (the regional vice president of operations) were made aware of the above concern. The facility policy titled, "Resident Abuse- Injuries of Unknown Origin" documented, "4. The Administrator, Director of Nursing, or their designee, must begin a documented investigation

for the cause of the injury. 5. The investigation will include interviews with the resident, all staff involved (directly or indirectly), any family, visitors or volunteers which may have had contact with

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	VIENT OF REALITIAN					C	MB NO. 0938-0391
		MEDICAID SERVICES	(VO) 141 11 3	IDLE CON	STRUCTION	0	X3) DATE SURVEY
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ſ	COMPLETED
AND PLAN OF	CORRECTION	DEATH OWNER	A. BUILDI	NG	2		С
		405440	B. WING				12/02/2021
		495140	D. WII4G	STDEE	T ADDRESS, CITY, STATE, ZIP CODE		The state of the s
NAME OF PE	ROVIDER OR SUPPLIER				ALMERS COURT		
DOSE UII I	L HEALTH AND REHAB			•	RYVILLE, VA 22611		
KUSE HILI	L HEALITI AND RELIAD			BERN	PROVIDER'S PLAN OF CORRE	CTION	(X5)
(X4) ID PREFIX TAG	FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION
F 610	Obtain written statem necessary"	help with the investigation. ents as deemed	F	510			
F 622 SS=E	Transfer and Dischar CFR(s): 483.15(c)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	and discharge- requirements- ermit each resident to and not transfer or at from the facility unless- scharge is necessary for the d the resident's needs facility; scharge is appropriate 's health has improved ident no longer needs the the facility; viduals in the facility is ne clinical or behavioral ; ividuals in the facility would hered; failed, after reasonable and pay for (or to have paid edicaid) a stay at the facility. if the resident does not y paperwork for third party	F	622	1. Resident #91 is no lon the center. Residents #2: #49, and #26 remain safe the community and have had any transfers within 30 days. 2. Residents in the center have been transferred withe last 30 days have the potential to be affected. residents were reviewed issues with notification in 3. The DON/designee progreeducation of the documentation requirem licensed providers of the and provided an in-service the center's Transfer to the Hospital policy to license nurses in the center.	9, #13, ely in e not the last that ithin e These and noted. Divided ment to cente te on the	o O
	or (F) The facility cease						

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		D HUMAN SERVICES				(OMB NO. 0938-0391
		MEDICAID SERVICES	1	FIDI E CONS	TRUCTION		(X3) DATE SURVEY
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONS			COMPLETED
AND PLAN OF	CORRECTION	IDENTIFICATION OF THE PROPERTY	A. BUILD	NG			С
		495140	B. WING				12/02/2021
NAME OF PE	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE,	ZIP CODE	
MAINE	(OVIDER OT OT)			110 CH	ALMERS COURT		
ROSE HILL HEALTH AND REHAB				BERRY	(VILLE, VA 22611		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREF	x	(EACH CORRECTIVE	N OF CORRECTION ACTION SHOULD BE	(X5) COMPLETION DATE
PREFIX TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED DEFIC) TO THE APPROPRIA CIENCY)	it
F 622	Continued From page	28	F	622	4. Transfers wi	ll be audited	
1 022		ot transfer or discharge the			weekly for 1 m	onth to ensur	e
	resident while the app	eal is pending, pursuant to			there is corres		
	§ 431.230 of this chare exercises his or her ri	oter, when a resident ght to appeal a transfer or			physician note		
	discharge notice from	the facility pursuant to §			appropriate pa		
	431.220(a)(3) of this of	chapter, unless the failure to would endanger the health			provided to the		
	or safety of the reside	nt or other individuals in the			facility. Results		
facility. The facility must document the danger		ust document the danger	presented to QAPI monthly.				
	that failure to transfer	or discharge would pose.			Any noted trer	nds will be	
	§483.15(c)(2) Docum	entation.			corrected imm	ediately.	
	When the facility trans	sfers or discharges a			5. Compliance	Date 01/04/2	2
	resident under any of	the circumstances specified (A) through (F) of this			5. Compliance	Date 01/0-/2	-
	section the facility mu	ust ensure that the transfer					
	or discharge is docum	nented in the resident's					
	medical record and a	ppropriate information is					
	communicated to the						
	institution or provider.						
	• •	he resident's medical record					
	must include:	transfer per paragraph (c)(1)					
	(i) of this section.	transfer per paragraph (c)(1)					
	(I) Of this section.	agraph (c)(1)(i)(A) of this					
	section the specific r	esident need(s) that cannot					
	be met facility attems	ots to meet the resident					
	needs, and the service	e available at the receiving					
	facility to meet the ne	ed(s).					
	(ii) The documentatio	n required by paragraph (c)					
	(2)(i) of this section m	nust be made by-					
	(A) The resident's phy	ysician when transfer or					
	discharge is necessa	ry under paragraph (c) (1)					
	(A) or (B) of this secti	on; and					
	(B) A physician when	transfer or discharge is					
	necessary under para	agraph (c)(1)(i)(C) or (D) of					

Facility ID: VA0210

this section.

(iii) Information provided to the receiving provider

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CENTERS FOR MEDICARE & I	MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	FIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		7 33.23		С
	495140	B. WING		12/02/2021
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
SOCIAL DEALTH AND DEUAD			110 CHALMERS COURT	
ROSE HILL HEALTH AND REHAB			BERRYVILLE, VA 22611	
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	LD BE COMPLETION
contact information (C) Advance Directive (D) All special instruct ongoing care, as appr (E) Comprehensive ca (F) All other necessal copy of the resident's consistent with §483.2 any other documentat a safe and effective to This REQUIREMENT by: Based on staff intervi review, and clinical re determined that the fa physician documentat and/or failed to provid documentation to the to the hospital for five survey sample; Resid #13. 1. The facility staff fai physician wrote a note Resident #91's hospit that all required docur the receiving facility. 2. The facility staff fai physician wrote a note Resident #49's hospit 9/1/21, and that all receiving	um of the following: on of the practitioner re of the resident. Intative information including se information ions or precautions for opriate. Interplan goals; ry information, including a discharge summary, 21(c)(2) as applicable, and ion, as applicable, to ensure ansition of care. Is not met as evidenced wew, facility document cord review, it was incility staff failed to evidence ion of the rationale for the all required receiving facility for transfer of 46 residents in the tents #91, #49, #26, #29 and led to evidence the the regarding the reason for all transfer on 10/26/21, and mentation was provided to	F	522	

3. The facility staff failed to evidence that all

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		ID HUMAN SERVICES			OMB NO. 0938-0391
CENTER	S FOR MEDICARE &	MEDICAID SERVICES	1	NOTELIOTION	(X3) DATE SURVEY
STATEMENT OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	DNSTRUCTION	COMPLETED
			2 14/110		C 12/02/2021
		495140	B. WING	EET ADDRESS, CITY, STATE, ZIP CODE	12/02/2021
NAME OF PE	ROVIDER OR SUPPLIER			CHALMERS COURT	
DOCE IIII	L HEALTH AND REHAB			RRYVILLE, VA 22611	
RUSE HIL	L HEACTT AND REINS				N (X5)
(X4) ID PREFIX TAG	JEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
			,		
F 622	Continued From page	e 30	F 622		
	required documentati	on was provided to the			
	receiving facility when	n Resident #26 was			
	transferred to the hos	spital on 9/15/21 and			
	11/4/21.				
	The findings include:				
	to a Hospital" docume Emergency Transfer	and obtain an order to			
	4. Print two copies o	ract Facility Transfer Form. f the residents chart via			
	EMS and one for the 5. Place printed conf	ord system). A. one copy for hospital. tent into 2 transfer			
	envelopes.	or responsible party of the			
	nending transfer, and	the reasons for the move.			
	Obtain information	n necessary for telephone			
	report. A. Vital signs	. B. Medical history - Include			
	allergies. C. Resider	nt's status: i. Reason for			
	admission. II. Proble	ms and goals identified and eason for transfer. D. Name			
	and number of signif	icant other. E. DNR [do not			
	resuscitate] status.	F. Precautions			
	(respiratory/contact).				
	8. Identify equipmen	it and belongings sent with			
	resident on Inventory	of Personal Effects.			
	9. Send a copy of B	ed Hold Policy and form with the resident.			
	10 Following ambul	ance pick-up of the resident,			
	the primary nurse is	to contact the ER Nurse			

receiving the resident by telephone, and give report. Include above information in addition to

Facility ID: VA0210

		D HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/13/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ - \	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
ANDIBATO	oo, ii.eo ii.e		A. BOILD!		С
		495140	B, WING		12/02/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ROSE HIL	L HEALTH AND REHAB			110 CHALMERS COURT BERRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	COACC DEFENCED TO THE ADDROPS	BE COMPLETION
F 622	number for follow up. 11. Notify DON of the 12. Report on 24-hou 13. Write discharge Notification of family. Areas noted per #7 al resident's belongings (Section on non-emer Please note: Notifica from the facility must Coordinate with local communication freque monthly. 1. Resident #91 was 5/21/21 with the diagr COVID-19, stroke, hig kidney disease, end s	e resident's transfer. or report. note. Include; A. B. Reason for transfer. C. bove. D. Status of	F	622	

A review of the clinical record revealed a nurse's note dated 10/26/21 at 2:47 PM that documented, "Pt (patient) went out for dialysis @ (at) 9am and came back at 2:15pm very weak. Pt was assessed by MD (medical doctor) new order to send Pt to ER (emergency room) for confusion post dialysis."

(Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 11/13/21. Resident #91 was coded as cognitively impaired in ability to make daily life decisions.

A nurse's note dated 10/26/21 at 9:22 PM documented, "Resident return from (hospital) with no discharge paper work, Spoke with charge nurse ad she stated she would fax (fax number)."

Further review of the clinical record failed to

Facility ID: VA0210

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		D HUMAN SERVICES					NO. 0938-0391
		MEDICAID SERVICES		_			ATE SURVEY
STATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION		OMPLETED
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG_			c
						1 .	
		495140	B. WING		70.005		12/02/2021
NAME OF PR	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
	LUCALTU AND DEMAR				10 CHALMERS COURT		
ROSE HIL	L HEALTH AND REHAB			В	ERRYVILLE, VA 22611	_	
(X4) ID PREFIX TAG	FACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERIOR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	Continued From page	32	F 6	522			
	evidence that the phy						
	documenting the ratio	nale for Resident #91's					
	hospital transfer, the	specific resident need(s)					
	that could not be met	facility attempts to meet the					
	resident needs, and the	he service available at the					
	receiving facility to me	eet the residents need(s).					
	There was no evidence	ce in the clinical record					
	regarding any transfe	r documents or paperwork					
	completed prior to tra	nsfer and what					
	documentation, if any						
	hospital for this transf	er.					
	On 12/2/2021 at 8:30	a.m., an interview was					
	conducted with LPN (licensed practical nurse) #1.					
	When asked about th	e process for hospital					
	transfers, LPN #1 sta	ted that they sent a face					
	sheet, physician orde	r summary, current labs					
	[laboratory tests], bed	hold notice, notice of					
	transfer and SBAR (s	endation) to the hospital					
	with residents I PN 2	#1 stated they also call a full					
	verbal report to the er	mergency room. LPN #1					
	stated they contact th	e responsible party to notify					
	of the discharge and	send a written discharge					
	notification in the pap	erwork to the hospital. LPN					
	#1 stated that they we	ere supposed to keep a copy					
	of these documents a	and place it in the front of the this information was sent.					
	CHAIL TO EAIGE ICE THE	tano mornidado nos sono					
	On 12/1/21 at approx	imately 5:00 PM at the end					
	of day meeting with A	SM (Administrative Staff					
	Member) #1 (the Adn	ninistrator), ASM #2 (the					
	Director of Nursing),	ASM #4 (the Regional					
	Director of Clinical), a	and ASM #5 (the Regional					
	Vice President of Ope	erations) were made aware					

of the findings.

On 12/2/21 at 8:05 AM, ASM #1 stated that the

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		ID HUMAN SERVICES			OMB NO. 0938-0391
	attitude to the same of the sa	MEDICAID SERVICES	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
STATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER	A. BUILDING		COMPLETED
AND PLAN OF	CORRECTION		A. BOILDING		С
		495140	B. WING		12/02/2021
NAME OF DE	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PE	COVIDER OR SOLIT LIER		110	CHALMERS COURT	
ROSE HIL	L HEALTH AND REHAB		BEF	RRYVILLE, VA 22611	
244117	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT	TON (X5) COMPLETION
(X4) ID PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	120	DEFICIENCY)	
			= E		
F 622	Continued From page	e 33	F 622		
1 022	facility did not have a				
	hospital transfer for R	Resident #91.			
		n was provided by the end of			
	the survey.				
	2. Resident #49 was	admitted to the facility on			
	5/27/21 with the diag	noses of but not limited to			
	congestive heart failu	ire, chronic obstructive dementia, chronic kidney			
	disease morbid obes	sity, high blood pressure,			
	atrial fibrillation, brea	st and skin cancer, and			
	sleep apnea. The mo	ost recent MDS (Minimum			
	Data Set) was a sign	ificant change assessment			
	with an ARD (Assess	ment Reference Date) of			
	10/26/21. Resident #	#49 was coded as cognitively make daily life decisions.			
	impaired in ability to	make daily inc decisions.			
	A review of the clinical	al record revealed a nurse's			
	note dated 8/19/21 a	t 9:35 PM that documented,			
	"Change of shift @ (a	at) 3:15 pm, pt (patient) was			
	unable to verbally ex	press herself, temp			
	(temperature) was 10	00.9, BP (blood pressure) sat (saturation) 89% on 3lpm			
	90/52, OZ (oxygen) s	e via nasal cannula) O2,			
	BLE's (bilateral lower	r extremities) extremely			
	swollen and RLE (rig	ht lower extremity) grayish			
	white, LLE (left lower	extremity) purplish from the			
	knee down which is r	new. Daughter notified.			
	Administrator notified	as well as DON (Director of			
	Nursing). Resident is	DNR (Do Not Resuscitate). ransfer to (hospital) with			
	order from NP (nurse	e practitioner.)"			
	A nurse's note dated	8/23/21 at 10:25 PM			

documented in part, "Resident arrived via

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		LIBRIGAID OF DIMOFC			OI.	VID 140. 0000 0001
STATEMENT	OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(×	3) DATE SURVEY COMPLETED C 12/02/2021
1		495140	B, WING			12/02/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611		
(X4) ID PREFIX TAG	FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	ARREST SECTION OF TO THE AR	HOULD BE	(X5) COMPLETION DATE
F 622	Continued From page happy to be back per get in the bed"	e 34 her words. Total assist to	F	622		

meet the residents need(s).

There was no evidence in the clinical record regarding any transfer documents or paperwork completed prior to the 8/19/21, hospital transfer and what documentation, if any, was provided to the hospital for this transfer.

Further review of the clinical record failed to evidence that the physician wrote a note documenting the rationale for the transfer, the specific resident need(s) that could not be met, facility attempts to meet the resident needs, and the service available at the receiving facility to

A nurse's note dated 9/1/21 at 2:40 PM documented, "STAT (immediate) labs [laboratory tests] ordered obtained and sent to lab, cxr (chest x-ray) done, Called (x-ray company) to set up echocardiogram, they will call back to schedule. If pt has hypoxia, pulse ox less than 92% on O2 (oxygen) @ (at) 2 liter/min (liters per minute) or if has dyspnea or increase AMS (altered mental status) transport to ER (emergency room) per MD (medical doctor)."

A physician's progress note dated 9/4/21 at 6:59 PM documented, "....The patient had been hospitalized for acute CHF (congestive heart failure) exacerbation and lymphedema. She was evaluated by (Hospice Company) but was recommended to come back to our facility for rehab [rehabilitation], and then the family plan is to admit her to hospice...."

There was no evidence in the clinical record regarding any transfer documents or paperwork

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				PRINTED: 12/13/2021 FORM APPROVED OMB NO. 0938-0391
		MEDICAID SERVICES	(Y2) MULTI	PLE CONSTRUCTION		(X3) DATE SURVEY
STATEMENT OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN			COMPLETED
AND FLAN OF	CONNECTION	100-100-000				C
		495140	B. WING_			12/02/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	
NAME OF P	ROVIDER OR SOLI CIER		1	110 CHALMERS COURT		
ROSE HIL	L HEALTH AND REHAB			BERRYVILLE, VA 2261		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CCTIVE ACTION SHOULD B CNCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION ATE DATE
				7.		
E 633	Continued From page	a 35	F 6	22		
F 022		e 9/1/2021, hospital transfer				
	completed prior to the	tion, if any, was provided to				
	the hospital for this tr	ansfer.				
	On 12/2/2021 at 8:30	a.m., an interview was				
	conducted with LPN	(licensed practical nurse) #1. ne process for hospital				
	transfers I PN #1 sta	ated that they sent a face				
	sheet, physician orde	er summary, current labs,				
	and bed hold notice,	notice of transfer and SBAR				
	(situation, backgroun	id, assessment,				
	recommendation) to	the hospital with residents. also call a full verbal report to				
	LPN #1 stated triey a	. LPN #1 stated they contact				
	the responsible party	to notify of the discharge				
1	and send a written di	ischarge notification in the				
	paperwork to the hos	spital. LPN #1 stated that				
	they were supposed	to keep a copy of these				
	documents and place evidence that this inf	e it in the front of the chart to				
	evidence that this in	Offiation was some				
	On 12/1/21 at approx	ximately 5:00 PM at the end				
	of day meeting with	ASM (Administrative Staff				
	Member) #1 (the Adi	ministrator), ASM #2 (the				
1	Director of Nursing),	ASM #4 (the Regional				
1	Director of Clinical),	and ASM #5 (the Regional				
1		perations) were made aware				
	of the findings.					
	On 12/2/21 at 8:05 A	AM, ASM #1 stated that the				
1	facility did not have a	anything regarding the				
	hospital transfer for	Resident #49.				

the survey.

No further information was provided by the end of

		ID HUMAN SERVICES			OMB NO. 0938-039
TOTAL CARGOTT OF THE		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
AND PLAN OF CO	RECTION IDENTIFICATION NUMBER: A.		A. BUILDIN	A. BUILDING	
		495140	B, WING		12/02/2021
NAME OF PROVIDER OR SUPPLIER ROSE HILL HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	SE COMPLETION

F 622 Continued From page 36

4/5/21 with the diagnoses of but not limited to stroke, respiratory failure, diabetes, COVID-19, morbid obesity, chronic kidney disease, congestive heart failure, high blood pressure, and alcohol abuse. In addition, Resident #26 was readmitted to the facility on 9/14/21 status post a scheduled surgery of the carotid artery. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 9/24/21. Resident #26 was coded as being cognitively intact in ability to make daily life decisions.

A nurse's note dated 9/15/21 at 10:26 PM documented, "Resident had c/o (complained of) involuntary movement of the right arm. Upon evaluation, residents VS (vital signs) were stable with no s/s (signs or symptoms) of any neurological deficit. Resident was very anxious. NP (nurse practitioner) was contacted c (with) VS and instructed staff to monitor patient....Approximately an hour and a half later, resident was still complaining of involuntary movement. Resident appeared to be feeling better and her anxiety level had decreased. Resident insisted that something was wrong. Nurse contacted NP for further orders. Orders to send resident to ER. 911 called, resident left center at 8:05pm."

Resident #26 was readmitted to the facility from the hospital on 9/22/21.

A physician's progress note dated 9/26/21 at 6:04 AM documented, "....The patient has returned from (hospital) following a probable CVA (stroke) as a untoward event following her left carotid stenosis repair with stent placement....She will continue f/u (follow up) with vascular surgery...."

F 622

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OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT		495140	B. WING	NG	1	C 12/02/2021
ROSE HILL HEALTH AND REHAB BERRYVILLE, VA 22611				110 CHALMERS COURT	DE	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	(FACH DEFICIENC	MUST BE PRECEDED BY FULL	PREFIX	((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE

F 622 Continued From page 37

F 622

Review of the clinical record failed to evidence any transfer documents or paperwork completed prior to the 9/15/21, hospital transfer and what documentation, if any, was provided to the hospital for this transfer.

A physician's progress note dated 11/3/21 at 8:19 AM documented, "....She is continuing to have intermittent GI (gastrointestinal) bleeding from both internal and external hemorrhoids, which frequently requires transfer to the ER [emergency room] / admission. She has had banding of hemorrhoids, and is planning for further surgical procedures...."

A nurse's note dated 11/4/21 at 11:45 AM documented, "Resident sent to ER for rectal bleeding."

A nurse's note dated 11/5/21 at 5:08 AM documented, "Resident returned from hospital. Report given from EMT (emergency medical technician)....They kept an eye on bleeding which did not continue so resident was discharged. If problems with hemorrhoids again resident is to schedule apt (appointment) with primary care doctor."

Review of the clinical record failed to evidence any transfer documents or paperwork completed prior to the 11/04/21, hospital transfer and what documentation, if any, was provided to the hospital for this transfer.

On 12/2/2021 at 8:30 a.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked about the process for hospital transfers, LPN #1 stated that they sent a face

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DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				0	MB NO. 0938-0391
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES			averiorio)		(3) DATE SURVEY
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN		STRUCTION	100	COMPLETED
		495140	B. WING				12/02/2021
NAME OF PE	ROVIDER OR SUPPLIER				TADDRESS, CITY, STATE, ZIP CODE	Ε	
					IALMERS COURT		
ROSE HIL	L HEALTH AND REHAB			BERR	YVILLE, VA 22611		
(X4) ID PREFIX TAG	IFACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION E DATE
F 622	Continued From page	a 38	F6	322			
1 022		r summary, current labs,					
	and bed hold notice.	notice of transfer and SBAR					
	(situation, background	d, assessment,					
	recommendation) to t	the hospital with residents.					
	LPN #1 stated they a	Iso call a full verbal report to					
	the emergency room.	LPN #1 stated they contact to notify of the discharge					
	the responsible party	scharge notification in the					
	nanerwork to the hos	pital. LPN #1 stated that					
	they were supposed	to keep a copy of these					
	documents and place	it in the front of the chart to					
	evidence that this info	ormation was sent.					
	O - 40/4/04 at approv	imately 5:00 PM at the end					
	of day meeting with A	ASM (Administrative Staff					
	Member) #1 (the Adn	ninistrator), ASM #2 (the					
	Director of Nursing),	ASM #4 (the Regional					
	Director of Clinical), a	and ASM #5 (the Regional					
		erations) were made aware					
	of the findings.						
	On 12/2/21 at 8:05 A	M, ASM #1 stated that the					
	facility did not have a	nything regarding the					
	hospital transfer for F	Resident #26.					
	No further information	n was provided by the end of					
	the survey.						
	4. Resident #29 was	admitted to the facility with					
	diagnoses that include	led but were not limited to					
	sepsis (1) and gastro	stomy (2). Resident #29's					
	most recent MDS, a	quarterly assessment with an					
	ARD of 9/3/2021, cod	ded Resident #29 as being for making daily decisions.					
	moderately impalled	to making assi, accounts					
	The progress notes f	or Resident #29 documented					

- "10/23/2021 21:30 (9:30 p.m.) Late Entry: Note Text: While doing rounds, I noticed brown and clear drainage from resident's G-tube

Facility ID: VA0210

in part,

FORM APPROVED OMB NO. 0938-0391

PRINTED: 12/13/2021

STATEMENT OF C	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495140	B. WING		12/02/2021
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F 622 Continued From page 39

(gastrostomy tube). Tube seem to be leaking from somewhere. Resident's gown and bed was soaked. Per aid [Name of staff member], this was happening all day. Resident seem to be in more pain than usual, and more uncomfortable than usual. Feeding was stopped. Tube flushed well, and meds were given through tube in attempt to provide a little comfort. Called [Name of staff member], NP (nurse practitioner) for guidance. [Name of NP] told me to call the family and ask if they wanted me to send resident to the hospital because she would not be able to look at the tube until Monday. Spoke with family member and made the decision to go ahead and sent resident to the hospital."

- "11/17/2021 17:15 (5:15 p.m.) Note Text: Resident arrived at facility @ 1530 via (at 3:30 p.m. by) transport. Residents orders have been NP notified. Resident is now DNR (do not resuscitate) vitals were taken and resident is in [Room number]. Kangaroo pump (feeding tube pump) set up. Resident currently resting with no complications or s/s (signs/symptoms) of pain or discomfort."

The clinical record failed to evidence documentation of information provided to the hospital on 10/23/2021 for Resident #29's transfer.

On 11/30/2021 at approximately 4:30 p.m., a request was made by written list to ASM (administrative staff member) #1, the interim administrator for evidence of the documents provided to the receiving facility for the transfer of Resident #29 on 10/23/2021.

On 12/1/2021 at approximately 5:00 p.m., ASM

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F 622	Continued From page	e 40	F	622			
	#4, the regional direct	tor of clinical operations					
	stated that they did no	ot have any documents to					
	provide for Resident	‡ 29.					
	On 12/2/2021 at 8:30	a.m., an interview was					
	conducted with LPN (licensed practical nurse) #1.					
	When asked about th	e process for hospital					
	transfers, LPN #1 sta	ted that they sent a face r summary, cuπent labs,					
	and bed hold notice,	notice of transfer and SBAR					
	(situation, background	d, assessment,					
	recommendation) to t	he hospital with residents.					
	LPN #1 stated that th	ey also call a full verbal ncy room. LPN #1 stated					
	they contact the resor	onsible party to notify of the					
	discharge and send a	written discharge					
	notification in the pap	erwork to the hospital. LPN					
	#1 stated that they we	ere supposed to keep a copy					
	of these documents a	and place it in the front of the this information was sent.					
	CHAIL TO EAIGELICE THE	I this mornauon was some					
	On 12/1/2021 at appr	oximately 5:30 p.m., a					
	request was made to	ASM (administrative staff					
		acility policy for transfers and					
	discharges.						
	On 12/1/2021 at appr	oximately 5:10 p.m., ASM					
	#1, the interim admin	istrator, ASM #2, the director					
	of nursing, ASM #4, t	he regional director of d ASM #5, the regional vice					
	clinical operations an	ns were made aware of the					
	findings.						
	No further information	n was provided prior to exit.					
	References:						

1. Sepsis: An illness in which the body has a

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F 622 Continued From page 41

other germs. The symptoms of sepsis are not caused by the germs themselves. Instead, chemicals the body releases cause the response. This information was obtained from the website: https://medlineplus.gov/ency/article/000666.htm

- 2. Gastrostomy (G-Tube): A gastrostomy feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach. This information was obtained from the website: https://medlineplus.gov/ency/article/002937.htm.
- 5. Resident #13 was admitted to the facility with diagnoses that included but were not limited to cellulitis (1) and dementia (2). Resident #13's most recent MDS, a significant change assessment with an ARD (assessment reference date) of 9/7/2021, coded Resident #13 as scoring a 3 on the BIMS- brief interview for mental status, 3- being severely impaired for making daily decisions.

The progress notes for Resident #13 documented in part, that Resident #13 was transferred to the hospital on 8/19/21 at approximately 20:55 (8:55 p.m.) after staff found the resident on the floor with 2x2cm (centimeters) of bleeding to the scalp and complaints of head pain and was readmitted to the facility on 8/24/21.

Further review of the clinical record failed to evidence documentation of the information provided to the receiving hospital on 8/19/2021 for Resident #13.

On 11/30/2021 at approximately 4:30 p.m., a request was made by written list to ASM

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F 622	administrator for evide provided to the receive on 8/19/2021 for Resident 44, the regional direct stated that they did not provide for Resident 45 On 12/2/2021 at 8:30 conducted with LPN (When asked about the transfers, LPN #1 states sheet, physician order and bed hold notice, to (situation, background recommendation) to the LPN #1 stated they at the emergency room, the responsible party and send a written dispaperwork to the host they were supposed to documents and place evidence that this information of nursing, ASM #4, to clinical operations and president of operation findings.	nember) #1, the interimence of the documents ring facility for the transfer ident #13. eximately 5:00 p.m., ASM tor of clinical operations of the any documents to #13. a.m., an interview was licensed practical nurse) #1. e process for hospital ted that they sent a face or summary, current labs, notice of transfer and SBAR d, assessment, the hospital with residents. Iso call a full verbal report to LPN #1 stated they contact to notify of the discharge scharge notification in the pital. LPN #1 stated that to keep a copy of these it in the front of the chart to	F	622		

References:

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		D HUMAN SERVICES				FORM APPROVED OMB NO. 0938-0391
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F 623	(dermis) and the tissumuscle can be affected obtained from the we https://medlineplus.go. 2. Dementia: A loss of with certain diseases. language, judgment, information was obtain https://medlineplus.go. Notice Requirements CFR(s): 483.15(c)(3)-8483.15(c)(3) Notice Before a facility transpresident, the facility most of the reasons for the manguage and manner facility must send a compresentative of the Long-Term Care Ombound (ii) Record the reason discharge in the residence of the rea	middle layer of the skin les below. Sometimes, led. This information was besite: by/ency/article/000855.htm. of brain function that occurs It affects memory, thinking, and behavior. This ned from the website: by/ency/article/000739.htm. Before Transfer/Discharge (6)(8) before transfer. fers or discharges a nust- and the resident's ne transfer or discharge and ove in writing and in a r they understand. The bopy of the notice to a Office of the State budsman. Its for the transfer or lent's medical record in ligraph (c)(2) of this section; lice the items described in lis section.		622	F623 1. Resident #91 and #100 are no longer in the center. Resident's #49, #26, #29, and #13 remains safely in the cent and have not had a transfer within the last 30 days. 2. Residents in the center that have been transferred within the last 30 days have the potential to be affected. These residents were reviewed for notification to the Ombudsma and written notification to the Resident Representative and residents.	e n
	(i) Except as specifie	d in paragraphs (c)(4)(ii) and the notice of transfer or			issues with notification noted.	iu

Facility ID: VA0210

discharge required under this section must be made by the facility at least 30 days before the

(ii) Notice must be made as soon as practicable

resident is transferred or discharged.

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DEPARTMENT OF REALTH			OMB NO. 0938-039
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED C
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110 CHALMERS COURT BERRYVILLE, VA 22611

PREFIX TAG

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

PREFIX TAG

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

(X5) COMPLETION DATE

F 623 Continued From page 44

before transfer or discharge when-

- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
- (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of
- (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is
- required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:

- (i) The reason for transfer or discharge;
- (ii) The effective date of transfer or discharge;
- (iii) The location to which the resident is transferred or discharged;
- (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
- (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
- (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with

- F 623
- The DON/designee provided re-education to the Social Services team regarding the notification to the Ombudsman and written notification being sent to the Resident representative.
- 4. Transfers will be audited weekly for 1 month to ensure there is notification to the Ombudsman and written notification to the Resident representative. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately.
- 5. Compliance Date 01/04/22

FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 623 Continued From page 45

developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally III Individuals Act.

§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(1).

This REQUIREMENT is not met as evidenced by:

Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to evidence that written notification of a hospital transfer was provided to the Ombudsman and/or Resident Representative upon a hospital transfer for six of 46 residents in the survey sample; Residents #91, #49, #26, #29, #13 and #100.

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F 623 Continued From page 46

The facility staff failed to evidence that written notification was provided to the resident representative and Ombudsman for Resident #91's hospital transfer on 10/26/21, Resident #49's hospital transfers on 8/19/21 and 9/1/21, Resident #26's hospital transfer on 9/15/21 and 11/4/21, Resident #29's hospital transfer on 10/23/2021, Resident #13's hospital transfer on 8/19/21, and Resident #100's hospital transfer on 11/1/2021.

The findings include:

A review of the facility policy, "Transfer a Resident to a Hospital" documented in part, "....6. Notify the family or responsible party of the pending transfer, and the reasons for the move....13. Write discharge note. Include: A. Notification of family. B. Reason for transfer. C. Areas noted per #7 above. D. Status of resident's belongings....Please note: Notification of Involuntary Transfers from the facility must be sent to the Ombudsman. Coordinate with local Ombudsman to determine communication frequency. Must be at least monthly."

1. Resident #91 was admitted to the facility on 5/21/21 with the diagnoses of but not limited to COVID-19, stroke, high blood pressure, chronic kidney disease, end stage renal disease and congestive heart failure. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 11/13/21. Resident #91 was coded as being cognitively impaired in ability to make daily life decisions.

F 623

Facility ID: VA0210

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CENTERS FOR MEDICARE & I	MEDICAID SERVICES	_		(X3) DATE SURVEY
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A review of the clinical record revealed a nurse's note dated 10/26/21 at 2:47 PM that documented, "Pt (patient) went out for dialysis @ (at) 9am and came back at 2:15pm very weak. Pt was assessed by MD (medical doctor) new order to send Pt to ER (emergency room) for confusion post dialysis."

Further review of the clinical record failed to evidence written notification regarding Resident #91's hospital transfer to the resident's representative and Ombudsman.

On 12/2/2021 at 8:25 a.m., an interview was conducted with OSM (other staff member) #8, director of social services. OSM #8 stated it was the responsibility of the facility to follow up with the resident or responsible party within 24 hours to see if they wanted to hold the bed. OSM #8 stated that they were unsure of the process because they were new to the facility and would have to check on this. OSM #8 stated they notified the ombudsman of discharges by fax weekly but had not sent any since they had started working at the facility.

On 12/1/21 at approximately 5:00 PM at the end of day meeting with ASM Administrative Staff Member) #1 (the Interim Administrator), #2 (the Director of Nursing), #4 (the Regional Director of Clinical), and #5 (the Regional Vice President of Operations) were made aware of the findings.

On 12/2/21 at 8:05 AM, ASM #1 stated that the facility did not have anything regarding the hospital transfer for Resident #91.

No further information was provided by the end of the survey.

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F 623	Continued From page	e 48	F	523	
	5/27/21 with the diagrongestive heart failur pulmonary disease, disease, morbid obes atrial fibrillation, breas sleep apnea. The morbid bata Set) was a significant with an ARD (Assess 10/26/21. Resident # impaired in ability to resident A review of the clinical	admitted to the facility on noses of but not limited to re, chronic obstructive lementia, chronic kidney sity, high blood pressure, and skin cancer, and ost recent MDS (Minimum ficant change assessment ment Reference Date) of 49 was coded as cognitively make daily life decisions.			
	note dated 8/19/21 at "Change of shift @ (a unable to verbally exp (temperature) was 10	: 9:35 PM that documented, at) 3:15 pm, pt (patient) was			

order from NP (nurse practitioner.)" Further review of the clinical record failed to evidence written notification regarding Resident #49's hospital transfer to the resident's representative and Ombudsman.

nc (3 liters per minute via nasal cannula) O2, BLE's (bilateral lower extremities) extremely swollen and RLE (right lower extremity) grayish white, LLE (left lower extremity) purplish from the knee down which is new. Daughter notified. Administrator notified as well as DON (Director of Nursing). Resident is DNR (Do Not Resuscitate). All in agreement to transfer to (hospital) with

A nurse's note dated 9/1/21 at 2:40 PM documented, "STAT (immediate) labs ordered obtained and sent to lab, cxr (chest x-ray) done, Called (x-ray company) to set up echocardiogram, they will call back to schedule.

Facility ID: VA0210

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	VIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611	
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If pt has hypoxia, pulse ox less than 92% on O2 (oxygen) @ (at) 2 liter/min (liters per minute) or if has dyspnea or increase AMS (altered mental status) transport to ER (emergency room) per MD (medical doctor)."

A physician's progress note dated 9/4/21 at 6:59 PM documented, "....The patient had been hospitalized for acute CHF (congestive heart failure) exacerbation and lymphedema. She was evaluated by (Hospice Company) but was recommended to come back to our facility for rehab [rehabilitation], and then the family plan is to admit her to hospice...."

Further review of the clinical record failed to evidence written notification regarding Resident #49's hospital transfer to the resident's representative and Ombudsman.

On 12/2/2021 at 8:25 a.m., an interview was conducted with OSM (other staff member) #8, director of social services. OSM #8 stated it was the responsibility of the facility to follow up with the resident or responsible party within 24 hours to see if they wanted to hold the bed. OSM #8 stated they were unsure of the process because they were new to the facility and would have to check on this. OSM #8 stated that they notified the ombudsman of discharges by fax weekly but had not sent any since they had started working at the facility.

On 12/1/21 at approximately 5:00 PM at the end of day meeting with ASM Administrative Staff Member) #1 (the Interim Administrator), #2 (the Director of Nursing), #4 (the Regional Director of Clinical), and #5 (the Regional Vice President of

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Operations) were made aware of the findings.

On 12/2/21 at 8:05 AM, ASM #1 stated that the facility did not have anything regarding the hospital transfer for Resident #49.

No further information was provided by the end of the survey.

3. Resident #26 was admitted to the facility on 4/5/21 with the diagnoses of but not limited to stroke, respiratory failure, diabetes, COVID-19, morbid obesity, chronic kidney disease, congestive heart failure, high blood pressure, and alcohol abuse. Resident #26 was readmitted on 9/14/21 status post a scheduled surgery of the carotid artery. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 9/24/21. Resident #26 was coded as being cognitively intact in ability to make daily life decisions.

A nurse's note dated 9/15/21 at 10:26 PM documented, "Resident had c/o (complained of) involuntary movement of the right arm. Upon evaluation, residents VS (vital signs) were stable with no s/s (signs or symptoms) of any neurological deficit. Resident was very anxious. NP (nurse practitioner) was contacted c (with) VS and instructed staff to monitor patient....Approximately an hour and a half later, resident was still complaining of involuntary movement. Resident appeared to be feeling better and her anxiety level had decreased. Resident insisted that something was wrong. Nurse contacted NP for further orders. Orders to send resident to ER. 911 called, resident left center at 8:05pm."

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12/02/2021

CENTERS FOR MEDICARE &			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED C

B. WING

NAME OF PROVIDER OR SUPPLIER

ROSE HILL HEALTH AND REHAB

STREET ADDRESS, CITY, STATE, ZIP CODE

110 CHALMERS COURT

BERRYVILLE, VA 22611

(X4) ID PREFIX TAG

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

495140

ID PREFIX TAG

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

(X5) COMPLETION

F 623 Continued From page 51

Resident #26 was readmitted to the nursing facility on 9/22/21.

A physician's progress note dated 9/26/21 at 6:04 AM documented, "....The patient has returned from (hospital) following a probable CVA (cerebrovascular accident) as a untoward event following her left carotid stenosis repair with stent placement....She will continue f/u (follow up) with vascular surgery...."

There was no evidence in the clinical record of written notification to the resident's representative and Ombudsman regarding Resident #26's hospital transfer.

A physician's progress note dated 11/3/21 at 8:19 AM documented, "....She is continuing to have intermittent GI (gastrointestinal) bleeding from both internal and external hemorrhoids, which frequently requires transfer to the ER / admission. She has had banding of hemorrhoids, and is planning for further surgical procedures...."

A nurse's note dated 11/4/21 at 11:45 AM documented, "Resident sent to ER for rectal bleeding."

There was no evidence in the clinical record written notification to the resident's representative and Ombudsman regarding Resident #26's hospital transfer.

On 12/2/2021 at 8:25 a.m., an interview was conducted with OSM (other staff member) #8, director of social services. OSM #8 stated it was the responsibility of the facility to follow up with

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F 623	Continued From page	e 52	∍F 6	23			
	the resident or respon	nsible party within 24 hours					
	to see if they wanted	to hold the bed. OSM #8					
	stated they were unsi	ure of the process because facility and would have to					
	check on this OSM	#8 stated that they notified					
	the ombudsman of di	scharges by fax weekly but					
	had not sent any sind	e they had started working					
	at the facility.						
	of day meeting with A Member) #1 (the Inte Director of Nursing), Clinical), and #5 (the	imately 5:00 PM at the end ISM Administrative Staff rim Administrator), #2 (the #4 (the Regional Director of Regional Vice President of de aware of the findings.					
	On 12/2/21 at 8:05 Ai facility did not have a hospital transfer for F	M, ASM #1 stated that the nything regarding the Resident #26.					
	the survey. 4. Resident #29 was diagnoses that includ sepsis (1) and gastro most recent MDS, a ARD of 9/3/2021, cod	n was provided by the end of admitted to the facility with led but were not limited to istomy (2). Resident #29's quarterly assessment with an ded Resident #29 as being for making daily decisions.					
	The progress notes fin part the following:	or Resident #29 documented					
	Text: While doing rou clear drainage from r	(9:30 p.m.) Late Entry: Note inds, I noticed brown and esident's G-tube Fube seem to be leaking					

from somewhere. Resident's gown and bed was soaked. Per aid [Name of staff member], this was happening all day. Resident seem to be in more

		ID HUMAN SERVICES					B NO. 0938-0391
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		495140	J.Wille	F	STREET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PI	ROVIDER OR SUPPLIER				110 CHALMERS COURT		
ROSE HIL	L HEALTH AND REHAB				BERRYVILLE, VA 22611		
				_	PROVIDER'S PLAN OF CORRECT	TION	(X5)
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F 623	Continued From page		۲.	623	3		
	pain than usual, and	more uncomfortable than					
	usual. Feeding was s	topped. Tube flushed well,					
	and meds were given	through tube in attempt to t. Called [Name of staff					
	memberl. NP (nurse)	practitioner) for guidance.					
}	[Name of NP] told me	to call the family and ask if					
	they wanted me to se	end resident to the hospital					
	because she would n	ot be able to look at the tube					
	until Monday. Spoke	with family member and					
	to the hospital."	go ahead and sent resident					
	to the nospital.						
	Further review of the	clinical record failed to					
	evidence documentat	tion of written notification					
	provided to the respo	nsible party or the					
		ransfer on 10/23/2021 for					
	Resident #29.						
1	On 11/30/2021 at app	proximately 4:30 p.m., a					
	request was made by	written list to ASM					
	(administrative staff r	nember) #1, the interim					
	administrator for evid	ence of written notification					
	provided to the respo	nsible party and the					
		ransfer on 10/23/2021 for					
	Resident #29.						
	On 12/1/2021 at app	roximately 1:38 p.m., ASM					
	#1 stated that they di	d not have evidence of					
	ombudsman notificat	ion of the transfer on					
	10/23/2021 for Resid	ent #29.					
	On 42/4/2021 at 4:25	p.m., ASM #1 provided via					
	email a copy of the p	roaress note dated					
	10/23/2021 documer	nting verbal notification of the					
	responsible party of t	the transfer on 10/23/2021.					

Event ID: TH2611

On 12/1/2021 at approximately 5:00 p.m., a request was made for evidence of written notification of the responsible party for the

PRINTED: 12/13/2021 FORM APPROVED 8-0391

DEPARTMENT OF HEALTH			OMB NO. 0938-0
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	495140	B. WING	12/02/2021

NAME OF PROVIDER OR SUPPLIER

ROSE HILL HEALTH AND REHAB

STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT

BERRYVILLE, VA 22611

(X4) ID PRFFIX TAG

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

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

(X5) COMPLETION DATE

F 623 Continued From page 54

transfer on 10/23/2021 for Resident #29. ASM #4, the regional director of clinical operations stated that they did not have any additional documents to provide for Resident #29.

On 12/2/2021 at 8:25 a.m., an interview was conducted with OSM (other staff member) #8, director of social services. OSM #8 stated that it was the responsibility of the facility to follow up with the resident or responsible party within 24 hours to see if they wanted to hold the bed. OSM #8 stated that they were unsure of the process because they were new to the facility and would have to check on this. OSM #8 stated that they notified the ombudsman of discharges by fax weekly but had not sent any since they had started working at the facility.

On 12/2/2021 at 8:30 a.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked about the process for hospital transfers, LPN #1 stated that they sent a face sheet, physician order summary, current labs, and bed hold notice, notice of transfer and SBAR (situation, background, assessment, recommendation) to the hospital with residents. LPN #1 stated they also call a full verbal report to the emergency room. LPN #1 stated they contact the responsible party to notify of the discharge and send a written discharge notification in the paperwork to the hospital. LPN #1 stated that they were supposed to keep a copy of these documents and place it in the front of the chart to evidence that this information was sent.

On 12/1/2021 at approximately 5:10 p.m., ASM #1, the interim administrator, ASM #2, the director of nursing, ASM #4, the regional director of

PRINTED: 12/13/2021 FORM APPROVED

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F 623	Continued From page	e 55	F	323		
		d ASM #5, the regional vice				
	president of operation findings.	ns were made aware of the				
	No further information					
	References:					
	severe, inflammatory other germs. The syn caused by the germs chemicals the body re This information was	in which the body has a response to bacteria or mptoms of sepsis are not themselves. Instead, eleases cause the response. obtained from the website: gov/ency/article/000666.htm				
	<nπps: mediinepius.<="" td=""><td>gov/ency/article/000000.htm</td><td></td><td></td><td></td><td></td></nπps:>	gov/ency/article/000000.htm				
	tube insertion is the p through the skin and directly into the stome obtained from the we	ube): A gastrostomy feeding blacement of a feeding tube the stomach wall. It goes ach. This information was bsite: ov/ency/article/002937.htm.				
	diagnoses that include cellulitis (1) and demonst recent MDS, as assessment with an A Resident #13 as score	ARD of 9/7/2021, coded ring a 3 on the BIMS- brief status, 3- being severely				
	in part, that Resident hospital on 8/19/21 a	or Resident #13 documented #13 was transferred to the t approximately 20:55 (8:55 I the resident on the floor			a	

with 2x2cm (centimeters) of bleeding to the scalp and complaints of head pain and was readmitted

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	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION
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1 023		ere unsure of the process				
	because they were no	ew to the facility and would				
	have to check on this	. OSM #8 stated that they				
	notified the ombudsm	an of discharges by fax				
		ent any since they had				
	started working at the	racinty.				
	On 12/2/2021 at 8:30	a.m., an interview was				
	conducted with LPN (licensed practical nurse) #1.				
	When asked about th	e process for hospital				
	transfers, LPN #1 stat	ted that they sent a face				
	sheet, physician orde	r summary, current labs, notice of transfer and SBAR				
	(situation, background					
		he hospital with residents.				
	LPN #1 stated they al	so call a full verbal report to				
	the emergency room.	LPN #1 stated they contact				
	the responsible party	to notify of the discharge scharge notification in the				
	and send a written dis	pital. LPN #1 stated that				
	they were supposed t	o keep a copy of these				
	documents and place	it in the front of the chart to				
	evidence that this info	rmation was sent.				
	0 40/4/0004 -1	avimataly 5:10 p.m. ACM				
	Un 12/1/2021 at appr	oximately 5:10 p.m., ASM istrator, ASM #2, the director				
	of nursing, ASM #4. tl	he regional director of				
	clinical operations and	d ASM #5, the regional vice				
	president of operation	is were made aware of the				
	findings.					
	No further information	was provided prior to exit.				
	References:					
	1. Cellulitis: A commo	on skin infection caused by				

bacteria. It affects the middle layer of the skin (dermis) and the tissues below. Sometimes,

		ID HUMAN SERVICES				ON	MB NO. 0938-0391
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			LOTE LOTE AND ADDRESS OF THE PARTY OF THE PA		3) DATE SURVEY
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	W4.4-4-3-0-0-0					_	
F 623	Continued From page	e 56	F	623			
	to the facility on 8/24/	21.					
		1. Its suidense					
	The clinical record fail documentation of write	led to evidence					
	documentation of Will	the ombudsman for the					
	transfer on 8/19/2021	for Resident #13.					
	tiansici on or rozacz.						
	On 11/30/2021 at app	proximately 4:30 p.m., a					
	request was made by	written list to ASM					
	(administrative staff n	nember) #1, the interim					
	administrator for evid	ence of the written to the responsible party and					
	notification provided the embudemen for the	ne transfer on 8/19/2021 for					
	Resident #13.	te transfer on or foreser to					
	(Coldone ii To-						
	On 12/1/2021 at appr	oximately 1:38 p.m., ASM					
	#1 stated that they di	d not have evidence of					
	ombudsman notificat	ion of the transfer on					
	8/19/2021.						
	On 12/1/2021 at 4:25	p.m., ASM #1 provided via					
	email a copy of the p	rogress note dated					
	8/19/2021 documenti	ng verbal notification of the					
1	responsible party of t	he transfer on 8/19/2021.					
	On 12/1/2021 at appr	roximately 5:00 p.m., a					
l	request was made fo	r written notification to the					
	responsible party of t ASM #4, the regional	he transfer on 8/19/2021.					
	operations stated that	t they did not have any					
	additional documents	ation to provide for Resident					
	#13.	,					

Event ID: TH2611

On 12/2/2021 at 8:25 a.m., an interview was conducted with OSM (other staff member) #8, director of social services. OSM #8 stated that it was the responsibility of the facility to follow up with the resident or responsible party within 24 hours to see if they wanted to hold the bed. OSM

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FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
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F 623 Continued From page 58

obtained from the website: https://medlineplus.gov/ency/article/000855.htm.

- 2. Dementia: A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.
- 6. Resident #100 was admitted to the facility with diagnoses that included but were not limited to Parkinson's disease (1) and dysphagia (2). Resident #100's most recent MDS, a quarterly assessment with an ARD of 9/10/2021, coded Resident #100 as scoring a 14 on the BIMS- brief interview for mental status, 14- being cognitively intact for making daily decisions.

The progress notes for Resident #100 documented in part, "11/12/2021 19:19 (7:19 p.m.) Note Text: Resident sent out per [Name of nurse practitioner] to [Name of hospital] for evaluation and treatment. Skin-has buttocks open area. [Names of emergency contacts] both were made aware."

The clinical record failed to evidence documentation of written notification provided to the resident/responsible party for the transfer on 11/1/2021 for Resident #100.

On 12/02/2021 at approximately 8:00 a.m., a request was made by written list to ASM (administrative staff member) #1, the interim administrator for evidence of written notification of the responsible party and the ombudsman for the facility initiated transfer on 11/1/2021.

TH AND HUMAN SERVICES

PRINTED: 12/13/2021 FORM APPROVED

		D HUMAN SERVICES			¥	OMB NO. 0938-0391
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NAMEOFF	COVIDEN ON COLL FIELD			110 CHALMERS COUR	Т	
ROSE HIL	L HEALTH AND REHAB			BERRYVILLE, VA 22		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	(EACH COR	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIA DEFICIENCY)	E COMPLETION TE DATE
	Continued From page On 12/2/2021 at apport 11 stated that they did written notification of transfer on 11/1/2021 ombudsman notification of 12/2/2021 at 8:30 conducted with LPN (When asked about the transfers, LPN #1 states they have and bed hold notice, resituation, background recommendation) to the LPN #1 stated they all the emergency room. The responsible party and send a written dispaperwork to the hospithey were supposed to documents and place evidence that this information of 12/2/2021 at apport 12/2/2021 at apport 14. The interim admining regional director of cli aware of the findings. No further information References: 1. Parkinson's diseat disorder. This information website:	e 59 oximately 9:57 a.m., ASM of not have evidence of the responsible party for the and provided evidence of on faxed on 12/2/2021. a.m., an interview was discensed practical nurse) #1. e process for hospital ted that they sent a face resummary, current labs, notice of transfer and SBAR of, assessment, the hospital with residents. So call a full verbal report to LPN #1 stated they contact to notify of the discharge scharge notification in the poital. LPN #1 stated that to keep a copy of these it in the front of the chart to ormation was sent. Oximately 10:09 a.m., ASM strator and ASM #4, the nical operations were made in was provided prior to exit.		523		
	https://www.nlm.nih.g	ov/medlineplus/parkinsonsdi				

2. Dysphagia: A swallowing disorder. This

sease.html.

PRINTED: 12/13/2021 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391
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		495140	B. WING			12/02/2021
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1 020	information was obtai					
		ov/medlineplus/swallowingdi				
		olicy Before/Upon Trnsfr (2)	F	525	F625	
00 L	0.11(0). 100.10(0)(1),	(-)			1. Resident #49, #26 and #68	
	§483.15(d) Notice of	bed-hold policy and return-			remain safely in the center and	i
	0400 45/ 11/41 11-4:	Lafara Arrantes Refere o			have not had a transfer within	
		before transfer. Before a ers a resident to a hospital or			the last 30 days.	
	the resident goes on t				,	
	nursing facility must p	rovide written information to			2. Residents in the center that	
	the resident or residen	nt representative that			have been transferred within	
	specifies-	state bed-hold policy, if			the last 30 days have the	
		resident is permitted to			potential to be affected. These	
	return and resume res				residents were reviewed and n	0
	facility;				issues with being provided bed	
		ayment policy in the state			hold policy identified.	
	plan, under § 447.40 (iii) The nursing facility				nota poney recrimes.	
		ch must be consistent with			3. The DON/designee provided	
	paragraph (e)(1) of the				re-education to the Social	
	resident to return; and				Services and Business Office	
	(iv) The information sp of this section.	pecified in paragraph (e)(1)			associates regarding the	
	of this section.				Transfer to Hospital policy	
	§483.15(d)(2) Bed-ho	ld notice upon transfer. At			related to bed holds.	
	the time of transfer of	a resident for			related to bed holds.	
	•	apeutic leave, a nursing			4. Transfers will be audited	
	facility must provide to resident representativ				weekly for 1 month to ensure	
	specifies the duration				there is of the bed hold policy.	
	described in paragrap					
		is not met as evidenced			Results will be presented to	
	by:	E 11th d			QAPI monthly. Any noted	
	Based on staff intervi	ew, racility document			trends will be corrected	

review, and clinical record review, it was

immediately.

		MEDICAID SERVICES			01	MB NO. 0938-0391	
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING		(X	(X3) DATE SURVEY COMPLETED C	
		495140	B. WING			12/02/2021	
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CO 110 CHALMERS COURT BERRYVILLE, VA 22611	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 625	Continued From page determined that the fa that a written bed hol	e 61 acility staff failed to evidence d notice was provided to the	F	625 5. Compliance Date: 03	1/04/22		

resident and/or resident representative prior to and or at the time of transfer to the hospital for three of 46 residents in the survey sample; Residents #49, #26 and #68.

The facility staff failed to evidence that a written bed hold notice was provided to the resident and or resident representative for the hospital transfers of Resident #49 on 8/19/21 and 9/1/21, Resident #26 on 9/2/2021 and Resident #68 on 10/27/21.

The findings include:

A review of the facility policy, "Transfer a Resident to a Hospital" documented, "Emergency Transfer....9. Send a copy of Bed Hold Policy and Involuntary Transfer form with the resident."

1. Resident #49 was admitted to the facility on 5/27/21 with the diagnoses of but not limited to congestive heart failure, chronic obstructive pulmonary disease, dementia, chronic kidney disease, morbid obesity, high blood pressure, atrial fibrillation, breast and skin cancer, and sleep apnea. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 10/26/21. The resident was coded as cognitively impaired in ability to make daily life decisions.

A review of the clinical record revealed a nurse's note dated 8/19/21 at 9:35 PM that documented, "Change of shift @ (at) 3:15 pm, pt (patient) was unable to verbally express herself, temp (temperature) was 100.9, BP (blood pressure) 90/52, O2 (oxygen) sat (saturation) 89% on 3lpm

	MENT OF HEALTH AN					Of	MB NO. 0938-0391
	S FOR MEDICARE & I		(V2) MULT	IPLE CONSTR	HICTION		3) DATE SURVEY
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII		0011011		COMPLETED
AND FEAT OF	OOMEONEM		7, 50,25				С
		495140	B. WING				12/02/2021
NAME OF D	ROVIDER OR SUPPLIER			STREET AD	DDRESS, CITY, STATE, ZIP CODE		
NAME OF PI	ROVIDER OR SUFFLIEN			110 CHAL	MERS COURT		
ROSE HIL	L HEALTH AND REHAB			BERRYV	ILLE, VA 22611		
	CUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORF	RECTION	(X5) COMPLETION
(X4) ID PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI:	X	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF	HOULD BE	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		
			_				
		20	E (625			
F 625	Continued From page		Г	023			
	nc (3 liters per minute	e via nasal cannula) O2,					
	BLE's (bilateral lower	extremities) extremely nt lower extremity) grayish					
	white I I E (left lower	extremity) purplish from the					
	knee down which is n	ew. Daughter notified.					
	Administrator notified	as well as DON (Director of					
	Nursing). Resident is	DNR (Do Not Resuscitate).					
	All in agreement to tra	ansfer to (hospital) with					
	order from NP (nurse	practitioner.)"					
	Further review of the	clinical record failed to					
	evidence that a writte	n bed hold notice was #49 and or the resident					
	representative prior to	and or at the time of					
	transfer to the hospita	al on 8/19/21.					
	A nurse's note dated	9/1/21 at 2:40 PM					
	documented, "STAT (immediate) labs [laboratory					
	tests] ordered obtained	ed and sent to lab, cxr (chest					
	x-ray) done, Called (x	c-ray company) to set up					
	echocardiogram, they	will call back to schedule. se ox less than 92% on O2					
	(ovegon) @ (at) 2 lite	r/min (liters per minute) or if					
	has dyspnes or incre	ase AMS (altered mental					
	status) transport to E	R (emergency room) per MD					
	(medical doctor)."						
	•						
	A physician's progres	s note dated 9/4/21 at 6:59					
	PM documented, "	the patient had been					
	nospitalized for acute	CHF (congestive heart and lymphedema. She was					
	evaluated by (Hospic	e Company) but was					
	recommended to com	ne back to our facility for					
	rehab [rehabilitation].	and then the family plan is					
	to admit her to hospic	ce"					

hospital transfer.

There was no evidence in the clinical record that a written bed hold notice was provided with this

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DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES			3	FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391
STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	-	С
			B WING			12/02/2021
		495140	B WIING _	STREET ADDRESS, CITY.	STATE ZIP CODE	12/02/2021
NAME OF PE	ROVIDER OR SUPPLIER			110 CHALMERS COURT		
ROSE HIL	L HEALTH AND REHAB			BERRYVILLE, VA 226		
NOOL III					R'S PLAN OF CORRECTION	(X5)
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORE	RECTIVE ACTION SHOULD BE	E COMPLETION
PREFIX TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFER	RENCED TO THE APPROPRIA DEFICIENCY)	ATE DATE
					DEI IGIEITO I ,	
F 625	Continued From page	e 63	F6	25		
	On 12/2/2021 at 9:10	a.m., an interview was				
	conducted with OSM	(other staff member) #10,				
	social services assist	ant. OSM #10 stated that				
	the bed hold policy w	as given to residents or n admission to review and				
	responsible parties of	d that a copy of this was				
	kent in the residents	chart. OSM #10 stated that				
	when a resident went	to a hospital a bed hold				
	form was completed a	and sent along with the			18	
	resident transfer shee	et. OSM #10 stated that a				
	copy of the form was	kept in a binder in the social				
	services office and a	follow up phone call the next				
	day to see if a bed no	old is requested. OSM #10 new to the facility and had				
	stated that they were	hold as of today but their				
	process was to keep	a copy of any letters sent				
	out and a binder with	the bed hold notices in				
	them. OSM #10 state	ed that there was an existing				
	binder for the bed hol	ld notices but there was a				
	gap in them when the	ere was a change in social				
	workers.					
	0 40/4/04 -4	inately 5:00 PM at the end				
	on 12/1/21 at approx	imately 5:00 PM at the end SM Administrative Staff				
	Momber #1 (the Inte	rim Administrator), #2 (the				
	Director of Nursing).	#4 (the Regional Director of				
	Clinical), and #5 (the	Regional Vice President of				
	Operations) were ma	de aware of the findings.				
	On 12/2/21 at 8:05 Al	M, ASM #1 stated that the				
	facility did not have a	nything regarding the				
	hospital transfer for R	Resident #49.				
	81 E	n was provided by the end of				
		i was provided by the end of				
	the survey.					

2. Resident #26 was admitted to the facility on

		D HUMAN SERVICES				(OMB NO. 0938-0391
		MEDICAID SERVICES	(V2) MIII	TIDL	E CONSTRUCTION		(X3) DATE SURVEY
STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI			- 1	COMPLETED
AND PLAN OF	CONNECTION		A. BOILDI			1	С
		495140	B. WING				12/02/2021
NAME OF PE	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF THE				۱ ۱	110 CHALMERS COURT		
ROSE HIL	L HEALTH AND REHAB			F	BERRYVILLE, VA 22611		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	I D PREFI TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION TE DATE
F 625	Continued From page 4/5/21 with the diagnostroke, respiratory fai morbid obesity, chron congestive heart failualcohol abuse. Reside 9/14/21 status post a carotid artery. The modulation of the resident was a quaran ARD (Assessment Resident was code intact in ability to make resident was coded a areas of activities of the company of the	pe 64 poses of but not limited to lure, diabetes, COVID-19, sic kidney disease, re, high blood pressure, and ent #26 was readmitted on scheduled surgery of the post recent MDS (Minimum terly assessment with an eference Date) of 9/24/21. The dealed as being cognitively the daily life decisions. The set being independent for all draily living. 19/15/21 at 10:26 PM ent had c/o (complained of) at of the right arm. Upon VS (vital signs) were stable symptoms) of any desident was very anxious. The religious of the properties of the p		625	DEFICIENCY)		
	facility on 9/22/21.	admitted to the nursing					
	A physician's progres	s note dated 9/26/21 at 6:04					

AM documented, "....The patient has returned from (hospital) following a probable CVA (stroke) as a untoward event following her left carotid stenosis repair with stent placement....She will

S FOR MEDICARE & MEDICAID SERVICES

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	:R/SUPPLIER/CLIA CATION NUMBER:	` '		(X3) DATE SURVEY COMPLETED
	SUPPLIER/CLIA (X2) MUL		(X2) MULTIPLE CONSTRUCTION A. BUILDING	
	495140	B. WING		12/02/2021
PPLIER ID REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611	
I DEFICIENCY MUST BE PRE	CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	OULD BE COMPLE
	UMMARY STATEMENT OF DI		UMMARY STATEMENT OF DEFICIENCIES ID 1 DEFICIENCY MUST BE PRECEDED BY FULL PREFIX	ID REHAB UMMARY STATEMENT OF DEFICIENCIES UMMARY STATEMENT OF DEFICIENCIES UMMARY STATEMENT OF DEFICIENCIES UMMARY STATEMENT OF DEFICIENCY UMMARY STATEME

F 625 Continued From page 65

continue f/u (follow up) with vascular surgery...."

There was no evidence in the clinical record that a written bed hold notice was provided to the resident and or resident representative for this hospital transfer.

On 12/2/2021 at 9:10 a.m., an interview was conducted with OSM #10, social services assistant. OSM #10 stated that the bed hold policy was given to residents or responsible parties on admission to review and sign. OSM #10 stated that a copy of this was kept in the residents chart. OSM #10 stated that when a resident went to a hospital a bed hold form was completed and sent along with the resident transfer sheet. OSM #10 stated that a copy of the form was kept in a binder in the social services office and a follow up phone call the next day to see if a bed hold is requested. OSM #10 stated that they were new to the facility and had not completed a bed hold as of today but their process was to keep a copy of any letters sent out and a binder with the bed hold notices in them. OSM #10 stated that there was an existing binder for the bed hold notices but there was a gap in them when there was a change in social workers.

On 12/1/21 at approximately 5:00 PM at the end of day meeting with ASM Administrative Staff Member) #1 (the Interim Administrator), #2 (the Director of Nursing), #4 (the Regional Director of Clinical), and #5 (the Regional Vice President of Operations) were made aware of the findings.

On 12/2/21 at 8:05 AM, ASM #1 stated that the facility did not have anything regarding the hospital transfer for Resident #26.

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	MENT OF HEALTH AN					OMB NO. 0938-0391
		MEDICAID SERVICES	040) 1411	TID! E (CONCEDUCTION	(X3) DATE SURVEY
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILD		CONSTRUCTION	COMPLETED
		495140	B. WING			C 12/02/2021
	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUFFLIER			111	D CHALMERS COURT	
ROSE HIL	L HEALTH AND REHAB			BE	ERRYVILLE, VA 22611	
(X4) lD PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SE COMPLETION
F 625	Continued From page	e 66	F	625		
' 525	Commission Fig.					
	No further information	n was provided by the end of				
	the survey.					
	3. Resident #68 was	admitted to the facility on				
	7/11/19. Resident #6	8's diagnoses included but				
	were not limited to: 0	liabetes mellitus (inability of				
	insulin to function nor	rmally in the body) (1),				
	sepsis (life threatenin	ng organ dysfunction caused				
	by deregulated respo	nse to infection) (2) and I, random contraction of the				
l	upper portion of the					
	Resident #68's most	recent MDS (minimum data				
	set) assessment, a q	uarterly and five day				
	assessment, with an	assessment reference date				
	of 11/6/21, coded the	resident as scoring 14 out				
	of 15 on the BIMS (bi	rief interview for mental				
1	status) score, indicati cognitively intact.	ing the resident was				
	cognitively intact.					
	A review of the comp	rehensive care plan revised				
	9/27/21, documented	in part, "FOCUS: Alteration				
		el and bladder incontinence,				
	constipation history o	f urinary tract infections. I				
	will be free of urinary	tract infections through the				
1	next review period. I	NTERVENTION: Encourage				
[fluids. Monitor and resymptoms] of UTI [ur	eport ace infection!				39
i	symptoms; or OTT [ur	mary mace infections.				

changes in color, odor, or consistency of urine,

A review of the resident transfer form dated 10/27/21, documented in part, "Fever, altered level of consciousness. Transfer to hospital."

A review of the nursing progress note dated 10/27/21 at 10:35 PM, documented in part, "Entered room at approximately 9:45 PM for medication pass, observed client to be flushed

dysuria, frequency, fever, pain."

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	WENT OF REALITIAN				C	MB NO. 0938-0391
	S FOR MEDICARE & DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		X3) DATE SURVEY COMPLETED
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G		C
		495140	B. WING			12/02/2021
NAME OF B	ROVIDER OR SUPPLIER	495140		STREET ADDRESS, CITY, STATE, ZIP C	ODE	
				110 CHALMERS COURT		
ROSE HIL	L HEALTH AND REHAB			BERRYVILLE, VA 22611		nie.
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIAT	(X5) COMPLETION DATE
F 625	and altered mental st pulse-130 respiration pressure-151/101 una saturation due to clier removing monitor. No notified of client statuthospital for evaluation (responsible party). If approximately 10:15 limited mobility and reand transfer to stretcleft at approximately hospital." No additional progress a bed hold notice was and or resident represthe medical record. Request for evidence returned on 12/1/21 a (administrative staff readministrator, who veevidence of bed hold. An interview was con AM with ASM #1. Witholds, ASM #1 stated don't know who is do An interview was con AM with OSM (other services director. With responsible for comp stated, "Social Servicehold." When asked as	atus. Temperature-105.3 s-22 blood able to acquire oxygen nt restlessness and otified nurse practitioner s and order to send to n. Resident is own RP Rescue squad arrived PM. Informed of client's efusal of care. Evaluation ner via slide board. Resident 10:30 PM. Report called to as note or form documenting s provided to the resident sentative was evidenced in a of documentation was at 8:15 AM by ASM member) #1, the interim erbally stated, "There is no for this resident." ducted on 12/2/21 at 8:10 men asked, who does bed d, "That's a good question, I ing that." ducted on 12/2/21 at 8:25 staff member) #8, the social men asked who was leting bed holds, OSM #8 tes is responsible for the bed about the process followed,	F 6:	4,		
	hold." When asked a	bout the process followed, facility follows up with the				

patient or family within 24 hours to see if they want to hold the bed." When asked how that

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CENTERS FOR MEDICARE &	OMB NO. 0938		
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING	(X3) DATE SURVEY COMPLETED

495140	B. WING	12/02/2021
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NAME OF PROVIDER OR SUPPLIER

ROSE HILL HEALTH AND REHAB

STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611

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

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

(X5) COMPLETION DATE

F 625 Continued From page 68

process occurs and what evidence there is that it was completed, OSM #8 stated, "I'll have to get back with you. I've been here for 10 days and I haven't done social services at other facilities. I have a social services assistant has been here longer than I have and she will come into talk with you about the bed hold."

An interview was conducted on 12/2/21 at 9:10 AM with OSM #10, the social services assistant. When asked when she started, OSM #10 stated, "I started November 8, 2021." When asked about the bed hold process, OSM #10 stated, "Upon admission the resident or RP (responsible party) is given the bed hold policy to sign and a copy is kept in their chart. If they go to the hospital then a bed hold form is done. I keep everything in a binder since I have been here. I contact the patient or family the next morning to find out about the bed hold. I have not had any transfers to hospital since I have been here, but I would document in the chart that the bed hold was done, I keep copies of letters we mail out and faxes about bed holds in the binder."

On 12/1/21 at 5:00 PM, ASM #1, the interim administrator, ASM #2, the director of nursing, ASM #3, the director of nursing, ASM #4, the regional director of clinical operations and ASM #5, the regional vice president of operations were informed of the findings.

No further information was provided prior to exit.

References:

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 160.

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CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				OMB NO. 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	VIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED
AND PLAN OF		IDENTIFICATION NUMBER:	A. BUILDII	NG		
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		495140	B. WING		TIR GODE	12/02/2021
NAME OF PE	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE	
ROSE HILL HEALTH AND REHAB					CHALMERS COURT	
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			-	205		
F 625	Continued From page		۲۱	625		
	(2) Barron's Dictionar	y of Medical Terms for the				
		7th edition, Rothenberg and				
	Chapman, page 524.	y of Medical Terms for the				
	Non-Medical Reader.	7th edition, Rothenberg and				
	Chapman, page 54.	With a series of With the With				
F 641	Accuracy of Assessm	ents	F	641	F641	
SS=D	CFR(s): 483.20(g)				1. Resident #86 remain safely ir	1
		5.0			the center and assessment has	
	§483.20(g) Accuracy	or Assessments. t accurately reflect the				
	resident's status.	accurately reliese the			been updated to accurately	
	This REQUIREMENT	is not met as evidenced			reflect the resident status.	
	by: Based on observation	n, clinical record review and			Residents in the center that	
	staff interview, it was	determined that the facility			have oxygen have the potentia	
	staff failed to ensure a	an accurate MDS [minimum			to be affected. These residents	
		for one of 46 residents in			were reviewed and no issues	
	the survey sample, R	esident # 86.			with accurate MDS coding	
	The facility staff failed	I to code Resident # 86 for				
	the use of oxygen in	Section O "Special			noted.	
	Treatments" on the re	esidents 5 day MDS			3. The DON/designee provided	
	(minimum data set) a	ssessment with an ARD			re-education to the MDS team	
	(assessment reference	ce date) of 11/05/2021.				
	The Seldines includes				related to the accuracy of	
	The findings include:				assessments.	
	Resident # 86 was ac	imitted to the facility with			4. New admissions with oxyger	n
	diagnoses that includ	ed but were not limited to:				•
		respiratory failure [1], and			will be audited weekly for 1	
	congestive heart failu	re [2].			month to ensure accurate	
	Posident # 96's most	recent MDS (minimum data			coding for oxygen use if	
	set), a 5-day assessr	nent with an ARD			appropriate. Results will be	
	(assessment reference	ce date) of 11/05/2021,			presented to QAPI monthly.	
	coded Resident #86	as scoring a 10 on the brief status (BIMS) of a score of 0			presented to the	

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	MENT OF REALITIAN					OMB NO. 0938-0391
		MEDICAID SERVICES	1,000,000,00	IDLE C	ONETRICTION	(X3) DATE SURVEY
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED
		IDENTIFICATION OF THE PROPERTY				С
		495140	B_WING_			12/02/2021
		433140	- 177		REET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PI	ROVIDER OR SUPPLIER				CHALMERS COURT	
ROSE HILL HEALTH AND REHAB					RRYVILLE, VA 22611	
					PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	x	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION
F 641	Continued From page 70		F	641	Any noted trends will be	
		rately impaired of cognition			corrected immediately.	
	for making daily decis	ions. Section O "Special				
	Treatments, Procedures and Programs" faile code Resident # 86 for the use of oxygen.				5. Compliance Date: 01/04/22	
On 11/29/21 at approximately 3:45 P.M.,		ximately 3:45 P.M., an				
	observation of Resident # 86 revealed the resident lying in bed receiving oxygen by nasal cannula connected to an oxygen concentrator. Observation of the flow meter on the oxygen concentrator revealed Resident # 86 was					
	receiving oxygen at three liters per minute.					
	The comprehensive care plan for Resident # 86 dated 01/28/2020 documented. "FOCUS: I have					
	alteration in Respirate	ory Status Due to Chronic				
	Obstructive Pulmonary Disease, Congestive Heart Failure, risk for shortness of Breath and hx [history] of respiratory failure with hypoxia. Date					
	[history] of respiratory	" Under "Interventions" it				
	documented in part. "	Administer oxygen at 3 lpm				
	fliters per minutel via	[by] nasal cannula per				
	Physician order. Mon	itor oxygen saturations on				
	room air and/or oxyge	en. Monitor oxygen flow rate				
	and response. Date	Initiated: 01/28/2020.				
	Revision on: 03/31/2020."					
	The physician's order	for Resident # 86				
	documented, "O2 [ox	ygen] at 3L [three liters] via				
	[by] NC [nasal cannul	a] continuously every shift				
	for chf [congestive he 3/26/2020."	art failure]. Order Date:				
	On 11/30/2021 at app	proximately 3:35 p.m., an				
	interview was conduc	ted with RN [registered				
		dinator RN #1 reviewed				

Event ID: TH2611

Resident # 86's MDS assessment with an ARD of 11/05/2021, the comprehensive care plan dated 01/28/2020, and the physician's order for

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVE										
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					MB NO. 0938-0391			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			10	x3) DATE SURVEY COMPLETED			
		IDENTIFICATION NUMBER:	A, BUILDING				С			
							12/02/2021			
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ROSE HILL HEALTH AND REHAB			110 CHALMERS COURT							
ROSETIL	E (IEAE) (TANO (CE) (CE)			BERRYVILLE, VA 22611						
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACT		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION			
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IAG	MERICA MEDICAL									
F 641	Continued From page	71	F 6	641						
	Resident # 86's oxyge	en and was informed of the								
	above observation. F	RN #1 then stated, "Oxygen								
	should have been coo	ded on the MDS." When								
asked what she uses as guidance for complete										
	the MDS assessment	RN # 1 stated she uses								
		sessment Instrument)								
	manual.									
	CMS's (Centers for M									
CMS's (Centers for Medicare/Medicaid Services) Long-Term Care RAI (Resident Assessment Instrument) Version 3.0 Manual documented, "O0100: Special Treatments, Procedures, and										
	Programs (cont.) O0100C, Oxygen therapy, Code									
	continuous or intermittent oxygen administered									
	via mask, cannula, et	c., delivered to a resident to					×			
	relieve hypoxia in this	item. Code oxygen used in								
	Bi-level Positive Allwa	ay Pressure/Continuous sure (BiPAP/CPAP) here. Do								
	not code hyperhatic of	exveen for wound therapy in								
not code hyperbaric oxygen for wound therapy in this item. This item may be coded if the resident										
	places or removes his	s/her own oxygen mask,								
	cannula."									
	On 12/01/2021 at app	proximately 4:10 p.m., ASM								
[administrative staff member] # 1, the interim administrator, ASM # 2, director of nursing, ASM										
	administrator, ASM #	l operations and ASM # 5,								
	# 4, director of clinica	nt of operations, were made								
	aware of the findings.									
	No further information	n was provided prior to exit.								
	References:									
	[1] When not enough	oxygen passes from your								
	lungs into your blood.	This information was								

ilure.html.

obtained from the website:

https://www.nlm.nih.gov/medlineplus/respiratoryfa

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PREELY (FACH DEFIC	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) E COMPLETION ATE DATE
		35		
F 641 Continued From	page 72	F 641		
enough blood to failure does not not is about to sto heart is not able It can affect one information was https://medlinepl	which the heart can't pump meet the body's needs. Heart mean that your heart has stopped p working. It means that your to pump blood the way it should. or both sides of the heart. This obtained from the website: us.gov/heartfailure.html	F 656	F656	
	ent Comprehensive Care Plan	F 000	F030	
§483.21(b)(1) The implement a composition care plan for each resident rights see §483.10(c)(3), the objectives and timedical, nursing needs that are ideascribe the following for maintain the representation of maintain the representation of the physical, mental required under §483.24, §4 provided due to under §483.10, it reatment under (iii) Any specialize rehabilitative ser provide as a resident recommendation.	prehensive Care Plans are facility must develop and apprehensive person-centered the resident, consistent with the ext forth at §483.10(c)(2) and at includes measurable meframes to meet a resident's and mental and psychosocial mentified in the comprehensive extended comprehensive care plan must owing - that are to be furnished to attain mesident's highest practicable and psychosocial well-being as 483.24, §483.25 or §483.40; and that would otherwise be required §483.25 or §483.40 but are not the resident's exercise of rights including the right to refuse §483.10(c)(6). The deservices or specialized vices the nursing facility will		 Resident #62 remains safely in the center. The comprehensive care plan is being implemented for keeping the catheter collection bag off the floor and administering oxygen at two liters per minutes. Current residents in the center that have catheters and are on oxygen have the potential to be affected. These residents were reviewed and no issues noted. The DON/designee provided re-education to current licensed nurses, current CNA's in the center, and the current IDT team in the center regarding 	0
rationale in the re	esident's medical record. n with the resident and the		implementing a comprehensive	
(17)III CONSUITATIO				

care plan.

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES	_			(X3) DATE SURVEY
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION	COMPLETED
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ROSE HIL	L HEALTH AND REHAB			BEI	RRYVILLE, VA 22611	
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F 656	Continued From page resident's representa (A) The resident's godesired outcomes.	tive(s)- als for admission and	F	656	4. Room rounds will be conducted 5x a week for 1 month to ensure comprehensive care plan is	
	(B) The resident's pre-	ference and potential for			•	
	future discharge. Fac	ilities must document s desire to return to the			implemented for catheter bags	,
	community was asset	ssed and any referrals to			and oxygen. Results will be	
	local contact agencie	s and/or other appropriate			presented to QAPI monthly.	
	entities, for this purpo	se.			Any noted trends will be	
	(C) Discharge plans i	n the comprehensive care			corrected immediately.	
	requirements set forth section.	in accordance with the n in paragraph (c) of this			5. Compliance Date 01/04/22	
		is not met as evidenced				
	review, it was determ failed to implement th	iew and clinical record ined that the facility staff e comprehensive care plan s in the survey sample,				
	comprehensive care collection bag off the	I implement Resident # 62's plan to keep the catheter floor and failed implement prehensive care plan to two liters per minute.				
	The findings include:					
	diagnoses that include obstructive uropathy recent MDS (minimulassessment with an Adate) of 11/02/2021, scoring a 9 [nine] on status (BIMS) of a scoriage of the scoriage of t	Imitted to the facility with ed but were not limited to: [1]. Resident # 62's most in data set), a quarterly ARD (assessment reference coded Resident # 62 as the brief interview for mental ore of 0 - 15, 9 - being of cognition for making daily				

decisions. Section H "Bladder and Bowel" coded

Facility ID: VA0210

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		ID HUMAN SERVICES				0	MB NO. 0938-0391
CENTER	S FOR MEDICARE &	MEDICAID SERVICES		_			X3) DATE SURVEY
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ROSE HIL	L HEALTH AND REHAB				RRYVILLE, VA 22611		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	Continued From page Resident # 62 as hav Observations of Resident page 2,45 a. p.m., revealed the resoxygen by nasal cannoncentrator. During meter on the resident revealed an oxygen fland one liter per minurevealed Resident #6 was lying on the floor Review of Resident part the for "Change catheter Q [Ineeded]/when collect french/10cc [cubic ce Order Date: 3/16/202 "O2 [oxygen] @ [at] 2 check O2 sats [saturated of Change catheter Q [Ineeded] pate 2/15/202 The comprehensive of dated 04/22/2020 door elimination of bower Urinary Catheter Date	ing an indwelling catheter, dent # 62 on 11/30/21 at .m., 10:17 a.m., and 1:00 sident lying in bed receiving nula connected to an oxygen each observation the flow 's oxygen concentrator low rate between one-half ute. Each observation 2's catheter collection bag next to the bed. 62's physician orders collowing: every] month and prn [as ing urine specimen with 16 ntimeter] coude catheter. 1." I [two] liters continuously ation (1)] Q [every] shift for stive pulmonary disease].	F	656	DEFICIENCY)		
	drainage bag of cathe bladder at all times at 04/22/2020." The comprehensive of	eter below the level of the end off floor. Date Initiated: care plan for Resident # 62 currented in part, "Focus:					

Hypertension....Date Initiated: 01/11/2017."
Under "Intervention" it documented, "Administer

Impaired Cardiovascular status related to: Congestive Heart Failure (CHF),

Facility ID: VA0210

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	MENT OF HEALTH AN					OMB NO. 0938-0391
	S FOR MEDICARE &		(Y2) MULT	IPLE CONSTRUCTION		(X3) DATE SURVEY
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILDII			COMPLETED
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				6		
F 656	Continued From page	e 75	F	556		
	Oxygen 2L/NC [two li	ters by nasal cannula] per				
	MD [medical doctor]	order for COPD. Date				
	Initiated: 06/21/2019.	Revision on: 03/15/2020."				
	On 12/01/2021 at ann	proximately 2:37 p.m. an				
		censed practical nurse] # 1				
	After reviewing Resid	ent # 62's comprehensive				
	care plan for an indw	elling catheter and the				
	administration of oxyg	gen, LPN # 1 was asked if lan was being followed				
	hased on the observa	itions documented above.				
	LPN # 1 stated, "No."	When asked to describe				
	the purpose of a care	plan LPN # 1 stated, "So				
	we can meet their spe	ecific cares."				
	On 11/29/2021 at and	proximately 3:00 p.m., during				
	the entrance conferer	nce with ASM [administrative				
	staff member] # 1, int	erim administrator, they				
	were asked what star	idard of practice the nursing				
	staff follows. ASM #	1 stated, that they follow ed a copy of the cover of the				
	etandard that docume	ented in part, "LIPPINCOTT.				
	Nursing EIGHT EDIT	ION. Copyright @ 2019."				
	Review of the "LIPPI"	NCOTT. Nursing EIGHT				
	EDITION, Copyright (@ 2019" page 130 "Care vided by the facility on				
	12/02/2021 failed to 0	locument information				
	regarding the implem	entation of a resident's care				
	plan.					
	0= 12/01/2021 of one	proximately 4:10 p.m., ASM				
	ladministrative staff n	nember] # 1, the interim				
	administrator, ASM #	2, director of nursing, ASM				
	# 4, director of clinica	l operations and ASM # 5,				
	regional vice presider	nt of operations, were made				

aware of the findings.

No further information was provided prior to exit.

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CENTERS FOR M	EDICARE &	MEDICAID SERVICES	_	_		ONID INC. 0900-0001
STATEMENT OF DEFICIEN	CIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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		495140	B. WING			12/02/2021
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ROSE HILL HEALTH	AND REHAB			В	ERRYVILLE, VA 22611	
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F 656 Continue	ed From page	76	F	656		
blocked. injure on obtained https://m F 657 Care Pla SS=D CFR(s): §483.21 §483.21 be- (i) Devel the comp (ii) Prepaincludes (A) The (B) A reg resident. (C) A nu resident. (D) A me (E) To the the resid An expla medical and their not prac resident! (F) Othe discipling or as rec (iii)Revie team aft	ndition in which This causes are or both kiding from the well edline plus. Go an Timing and 483.21(b)(2)(b) Comprehe (b)(2) A comprehensive as ared by an interpretation must be extent practicable for the process of the process as determing uested by the each asset in a cause of the propriate and the process of the proce	ev/ency/article/000507.htm. Revision i)-(iii) ensive Care Plans brehensive care plan must days after completion of esessment. erdisciplinary team, that ited to— sician. e with responsibility for the responsibility for the and nutrition services staff. ticable, the participation of esident's representative(s). be included in a resident's contribution of the resident resentative is determined development of the staff or professionals in ned by the resident's needs	F	657	1. Resident #3, #31, and #15 remain safely in the center. Resident #3 comprehensive care plan was revised to reflect the restorative program. Resident #31 care plan was revised to include the use of bed rails. Resident #15 care plan was revised to address the administration of an anticoagulant. 2. Current residents in the center have the potential to be affected. These residents were reviewed and no issues noted.	

Facility ID: VA0210

This REQUIREMENT is not met as evidenced

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CENTERS FOR MEDICAR	RE & MEDICAID SERVICES			OMB NO. 0938-039
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NAME OF PROVIDER OR SUPPLIER

ROSE HILL HEALTH AND REHAB

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 77

(X4) ID

PREFIX

Based on observation, staff interview and facility document review it was determined facility staff failed to review and revise the comprehensive care plan for three of 46 residents in the survey sample, Resident #3, Resident #31 and Resident #15.

- 1. The facility staff failed to revise the Resident #3's comprehensive care plan to address the resident beginning a restorative program following completion of physical therapy on 3/26/21.
- 2. The facility staff failed to review and revise Resident #15's comprehensive care plan to address the administration of an anticoagulant prescribed by the physician on 05/27/2021.
- 3. The facility staff failed to review and revise Resident #31's comprehensive care plan for the use of bed rails.

The findings include:

1. Resident #3 was admitted to the facility on 7/25/18 with diagnosis that included but were not limited to: multiple sclerosis (progressive disease in which the nerve fibers of the brain and spinal cord lose their myelin cover) (1), scoliosis (abnormal lateral or sideward curve to the spine) (2) dementia (progressive state of mental decline, including memory function and judgement) (3).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/17/21, coded Resident #3 as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, F 657

110 CHALMERS COURT

BERRYVILLE, VA 22611

- 3. The DON/designee provided re-education to current licensed nurses and the current IDT team regarding revising a comprehensive care plan when they are on a restorative program, anticoagulant and use bed rails.
- 4. Residents comprehensive care plan will be reviewed 5x a week for 1 month to ensure that care plans are revised for residents with new orders for restorative program, anticoagulants and bed rails. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately.
- 5. Compliance Date: 01/04/22

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				74		
F 657	Continued From page	∍ 78	F	657		
	indicating the residen	t was cognitively intact. A				
	review of the MDS Se	ection G-functional status				
	coded Resident #3 as	s requiring extensive				
	assistance for bed me	obility, transfer, locomotion,				
	dressing, hygiene; de	ependent for bathing and g. Walking did not occur.				
	supervision for eating	. Warking did flot coods.				
	A review of the physic	cal therapy notes				
	documented in part, '	'Treatment began 3/6/21				
	ended 3/26/21. Discl	harge Plans: to remain in				
ŀ	the same skilled nurs	ing facility with reduced				
	burden on caregivers	and continue RNP				
	(restorative nursing p	rogram).				
	A review of the facility	y "Restorative Program"				
	form, which was not o	dated, documented the				
	following: Restorativ	e Program: Active ROM				
	(range of motion) and	d ambulation. Precaution:				
	gait belt and monitor	exertion.				
	A review of the order	s failed to evidence orders				
	for restorative progra	m for Resident #13				
	beginning March 202					
	A review of the comp	rehensive care plan initiated				
	on 7/26/18 with revisi	ion 11/24/21, documented in				
	part, "FOCUS: At ris	k for falls related to multiple				
	sclerosis. Intervention	ns: Restorative programs				
	and Therapy referral-	- dated 7/26/18 with revision				
	11/7/18. The compre	hensive care plan failed to				
	evidence a revision to	o address include a				

restorative program for Resident #13 beginning after the 3/26/21, completion of physical therapy.

An interview was conducted on 12/1/21 at 1:55 PM with ASM (administrative staff person) #2, the director of nursing. When asked about the

CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 657 Continued From page 79

stated, "The care plan is to provide the framework and goals of care for the resident." When asked who is responsible for reviewing and revising the care plan, ASM #2 stated, "The care plan is updated by the MDS person after our meeting on Mondays."

An interview was conducted on 12/1/21 at 2:10 PM with RN (registered nurse) #1, the MDS Coordinator. When asked, who is responsible to review and revise the care plan, RN #1 stated, "Interdisciplinary team, MDS coordinator and nursing, nursing is ultimately responsible. Both to develop and review/revise the care plan."

An interview was conducted on 12/2/21 at 8:30 AM with LPN (licensed practical nurse) #1. When asked who is responsible to review and revise the care plan, LPN #1 stated, "All nursing, the MDS coordinator, social services and the IDT." LPN #1 stated, "Revisions are usually made when there is a change in the resident's condition, goals or treatment.

On 12/1/21 at 5:00 PM, ASM #1, the interim administrator, ASM #2, the director of nursing, ASM #3, the director of nursing, ASM #4, the regional director of clinical operations and ASM #5, the regional vice president of operations were informed of the findings.

A review of the facility's policy "Care Plan Preparation", which documented in part, "A care plan directs the patient's nursing care from admission to discharge. A nursing care plan serves as a database for planning assignments, giving change-of-shift reports, conferring with the practitioner or other members of the health care team, planning patient discharge and

F 657

Facility ID: VA0210

SERVICES

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DEPART	MENT OF MEALTH AN	D HOWAR SERVICES			OM	B NO. 0938-0391
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	CLIMMA DV ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5) COMPLETION
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F 057	O-stinued From page	. 90	F 6	57		
F 657	Continued From page		, ,			i i
	documenting patient	care.				
	No further information	n was provided prior to exit.				
	References:	# Manager Towns for the				
	(1) Barron's Dictionar	y of Medical Terms for the , 5th edition, Rothenberg and				
	Chapman, page 378.					
	(2) Barron's Dictionar	y of Medical Terms for the				
	Non-Medical Reader,	5th edition, Rothenberg and				
	Chapman, page 519.					
	(3) Barron's Dictionar	y of Medical Terms for the				
		5th edition, Rothenberg and				
	Chapman, page 154.					
	2. Resident #15 was	admitted to the facility on				
	9/14/18, and most red	cently readmitted on oses including chronic				
	10/12/20, with diagric	ase, heart disease, and				
	chronic blood clots. C	On the most recent MDS				
	(minimum data set), a	a quarterly assessment with				
	an ARD (assessment	reference date) of 9/7/21,				
	Resident #15 was co	ded as having no cognitive				
	impairment for makin	g daily decisions, having				
	scored 15 out of 15 of for mental status).	on the BIMS (brief interview				
	ioi ilientai status).					
	A review of Resident	#15's clinical record				
	revealed the following	g physician's order: "Eliquis				
	[Apixaban (1)] Tablet	5 MG (milligrams) Give 5				
	mg by mouth two time	es a day for DVT (deep vein				
	of blooding/bruising	or s/s [signs and symptoms] .Order Date 05/27/2021				
	10:06 a.m."	Olda Bata oo, Elizot i				
	10.00 0.1111					

Event ID: TH2611

A review of Resident #15's MARs (medication administration records) for September, October and November 2021 revealed the resident

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	O FOR MEDICARE &				OMB NO. 0938-0391
		MEDICAID SERVICES	(X2) MULTI	IPLE CONSTRUCTION	(X3) DATE SURVEY
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	, ,	IG	COMPLETED
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		495140	B. WING		12/02/2021
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NAME OF PR	KOVIDER OR SUFFLIER		- 1	110 CHALMERS COURT	
ROSE HIL	L HEALTH AND REHAB			BERRYVILLE, VA 22611	
	a walland a state of the state	ATEMENT OF DESIGNATES	iD	PROVIDER'S PLAN OF CORF	RECTION (X5)
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			- 0		
F 657	Continued From page		F6	157	
	received the Eliquis a	s ordered.			
	A review of Resident	#15's comprehensive care			
	plan, dated 9/20/18, v	with an updated date of			
	3/19/21, failed to reve	eal information regarding			
	Resident #15 receiving	ng the anticoagulant Eliquis.			
	On 11/20/21 at 2:24 p	om, RN (registered nurse)			
	#1 the MDS coordina	ator, was interviewed. She			
	stated she is respons	ible for developing the care			
	plan for medications	which residents are			
	receiving. RN #1 state	ed the purpose of the care		9	
	plan is to individualize	e resident care, and to make			
	sure the staff know ex	ractly what the residents			
		eir needs. When asked			
	about Resident #15's	care plan for 1 stated she would need to			
	check.	I stated site would need to			
	CHECK.				
	On 11/30/21 at 4:45 p	o.m., RN #1 stated she had			
	checked Resident #1.	5's care plan, and did not			
	find any information r	elated to the Eliquis. RN #1			
	stated, "I will add it. It	should have been on			
	there." RN #1 stated	she must have "just missed			
	it," as her usual proce	ess is to develop a care plan			
	for any anticoagulant	s a resident is receiving.			
	An interview was con	ducted on 12/1/21 at 1:55			
	p.m. with ASM (admir	nistrative staff person) #2,			
	the director of nursing	g. When asked the purpose			
	of the comprehensive	e care plan, ASM #2 stated,			
	"The care plan is to p	rovide the framework and			
	goals of care for the	esident." When asked who			
	is responsible for revi	ewing and revising the care			
	by the MDS person a	"The care plan is updated			
	Mondays."	ner our meeting on			
	เขเบเเนตขอ.				

An interview was conducted on 12/1/21 at 2:10

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	C COD MEDICARE &				OMB NO. 0938-039
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 " " "	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED C	
		495140	B. WING _		12/02/2021
	ROVIDER OR SUPPLIER L HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611	
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F 657	Continued From page	∍ 82	Fé	557	
	Coordinator. When a comprehensive care provide goals and intresident's needs." What responsible for the recomprehensive care "Interdisciplinary tear and nursing, nursing	view and revision of the			
	a.m. with LPN (licens	ducted on 12/2/21 at 8:30 ed practical nurse) #1. esponsible to review and			

condition, goals or treatment." On 12/1/21 at 4:50 p.m., ASM (administrative staff member) #1, the interim administrator, ASM #2, the director of nursing, ASM #4, the regional director of clinical operations, and ASM #5, the regional vice president of operations, were informed of these concerns.

revise the care plan, LPN #1 stated, "All nursing, the MDS coordinator, social services and the IDT." LPN #1 stated, "Revisions are usually made

when there is a change in the resident's

No further information was provided prior to exit.

REFERENCES

(1)"Apixaban is used help prevent strokes or blood clots in people who have atrial fibrillation (a condition in which the heart beats irregularly, increasing the chance of clots forming in the body and possibly causing strokes) that is not caused by heart valve disease. Apixaban is also used to prevent deep vein thrombosis (DVT; a blood clot, usually in the leg) and pulmonary embolism (PE; a blood clot in the lung) in people who are having

If continuation sheet Page 83 of 122

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 12/02/2021 B. WING 495140 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 110 CHALMERS COURT **ROSE HILL HEALTH AND REHAB** BERRYVILLE, VA 22611 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL ID (EACH CORRECTIVE ACTION SHOULD BE

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F 657 Continued From page 83 hip replacement or knee replacement surgery. Apixaban is also used to treat DVT and PE and may be continued to prevent DVT and PE from happening again after the initial treatment is completed. Apixaban is in a class of medications called factor Xa inhibitors. It works by blocking the action of a certain natural substance that helps blood clots to form." This information was taken from the website https://medlineplus.gov/druginfo/meds/a613032.h

REGULATORY OR LSC IDENTIFYING INFORMATION)

3. Resident #31 was admitted to the facility on 4/16/20. Resident #31's diagnoses included but were not limited to muscle weakness, high blood pressure and seizures. Resident #31's quarterly minimum data set assessment with an assessment reference date of 10/4/21, coded the resident as being cognitively intact.

Review of Resident #31's clinical record revealed a physician's order dated 4/22/21 for halos (bed rails) to bilateral sides of the bed to aid in repositioning and turning.

Review of Resident #31's comprehensive care plan dated 4/23/20 failed to reveal documentation regarding bed rails.

On 12/1/21 at 2:07 p.m., an interview was conducted with RN (registered nurse) #1 (the minimum data set coordinator)... RN #1 stated the purpose of the care plan is to come up with the plan of care for that patient during their time in the facility so that everyone including the patient is aware of what the goals are. RN #1 stated the reviewing and revising of care plans is shared by the interdisciplinary team but the nurses are ultimately responsible. RN #1 stated the care plan should be reviewed and revised for the use

F 657

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DATE

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ROSE HIL	L HEALTH AND REHAB			BERRYVILLE, VA	22611	
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F 657		he use of bed rails is a part	F 65	57		
	staff member) #1 (the #2 (the director of nur director of clinical ope regional vice presider aware of the above of	m., ASM (administrative interim administrator), ASM sing), ASM #4 (the regional erations) and ASM #5 (the lat of operations) were made				
F 684			F 68	34 F684		
SS=D	applies to all treatment facility residents. Base assessment of a resident residents receive accordance with professor practice, the compreherance plan, and the resident REQUIREMENT by: Based on clinical receive and staff intentified the facility staff failed care in accordance with the facility staff failed care in accordance with assessment of the facility staff failed care in accordance with assessment of the facility staff failed care in accordance with assessment of the facility staff failed care in accordance with assessment of a received and the facility staff failed care in accordance with assessment of a residual staff failed care in accordance with assessment of a residual staff and accordance with professor accordance with p	ndamental principle that and care provided to sed on the comprehensive streatment and care in essional standards of sensive person-centered sidents' choices. To be a comprehensive streatment and care in sesional standards of sensive person-centered sidents' choices. To be a comprehensive person can be a comprehensive person care that to ensure treatment and sith professional standards of prehensive plan of care for		2. Current potential to 3. The DON re-education medication 4. 5x per we MAR's will lensure med available or the STAT bo	t #201 is no longer in . residents have the o be affected. I/designee provided on to current licensed now to obtain is from the STAT box. eek new admissions be reviewed to dications were reviewed from the pulled from the presented to be presented to	
	The facility staff failed to Resident #201 on 0 physician's orders.	to administer Gabapentin 05/22/2021, according to the		QAPI month	hly. Any noted be corrected	

The findings include:

immediately.

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	VIDER OR SUPPLIER HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611	(X5)
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F 684 Continued From page 85

Resident # 210 was admitted to the facility with diagnoses that included but were not limited to: breast cancer, pain, diabetes mellitus [2] and kidney disease, high blood pressure.

Resident # 201's MDS (minimum data set), an admission 5-day assessment with an ARD (assessment reference date) of 05/24/2021 coded Resident # 201 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions.

Review of Resident #201's clinical record revealed a physician's order dated 5/21/21 and signed by the physician on 5/24/21 documented in part: Gabapentin Capsule. Give 300 mg (milligram) by mouth two times a day for neuropathy."

Review of Resident #201's eMAR [electronic medication administration record] dated May 2021 documented the physician's orders as stated above from 05/21/2021 through 05/24/2021. The eMAR further documented the code "3 [three] = Hold/See Nurse's Notes" for the Gabapentin on 05/22/2021 at 9:00 a.m.

The nurse's "Progress Notes" dated 05/22/2021 for Resident # 201 documented, "Gabapentin Capsule. Give 300 mg by mouth two times a day for neuropathy. Pharm [pharmacy] sent wrong dose."

The facility's STAT [immediate]-drug box inventory list documented in part, "Gabapentin 100mg Tablet. Qty [quantity] 10."

F 684 5. Compliance Date 01/04/22

Facility ID: VA0210

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		NEDICAID SERVICES			OMB NO. 0938-039
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		495140	B. WING		12/02/2021
NAME OF PROVIDER OR SUPPLIER ROSE HILL HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611		
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F 684 Continued From page 86

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On 12/01/2021 at 8:18 a.m., a request to interview the nurse who admitted resident # 201 was made to ASM [administrative staff member] # 1, interim administrator. ASM # 1 stated that the nurse was no longer employed by the facility.

On 12/01/2021 at approximately 10:05 a.m., an interview was conducted with ASM # 2, director of nursing. ASM #2 was asked to describe the procedure the nursing staff follows to obtain medications for newly admitted residents. ASM # 2 stated, "Before they arrive, we get a report from the hospital or they arrive with a discharge summary with their medications. The admitting nurse calls the nurse practitioner [NP] or the physician to go over the resident's medications and make any necessary changes and then they give a verbal order for the medications. The order is then faxed to the pharmacy if there is a narcotic, the nurse gets a written order. If the resident is a late day admission the medications arrive the next moming, if the admission is early in the day, the medication arrives by the end of the day." When asked about the procedure staff follows when a resident's medications are not available, ASM # 2 stated, "They [nurse] checks the STAT-drug box [prepared by the pharmacy to provide for initiating therapy prior to the receipt of ordered drug from the pharmacy] and the house stock of medications. If they are not in the STAT-drug box or in the house stock, the nurse should call the pharmacy, notify the NP or physician, and let the resident and/or responsible party know." After reviewing Resident # 201's eMAR dated May 2021, nurse's progress notes dated 05/22/2021, the STAT-drug box list and the facility's house stock list, ASM # 2 was asked if the facility STAT-drug box contained the appropriate dosage of gabapentin that could have

F 684

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 12/02/2021 495140 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 110 CHALMERS COURT **ROSE HILL HEALTH AND REHAB** BERRYVILLE, VA 22611 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX TAG REGULATORY OR LSC (DENTIFYING INFORMATION) TAG DEFICIENCY) F 684 F 684 Continued From page 87 been administered to Resident # 201 on 05/22/2021. ASM # 2 stated yes. The facility policy for medication administration failed to document instructions for obtaining medications from the STAT-drug box. On 12/01/2021 at approximately 4:10 p.m., ASM [administrative staff member] # 1, the interim

No further information was provided prior to exit.

administrator, ASM # 2, director of nursing, ASM # 4, director of clinical operations and ASM # 5, regional vice president of operations, were made

Complaint deficiency

aware of the findings.

References:

[1] Used to help control certain types of seizures in people who have epilepsy. Gabapentin capsules, tablets, and oral solution are also used to relieve the pain of postherpetic neuralgia (PHN; the burning, stabbing pain or aches that may last for months or years after an attack of shingles). This information was obtained from the website:

https://medlineplus.gov/druginfo/meds/a694007.h tml.

[2] A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/ 001214.htm.

F 688 Increase/Prevent Decrease in ROM/Mobility

CFR(s): 483.25(c)(1)-(3)

F 688 F688

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES			OMB NO. 0938-0391
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			(X3) DATE SURVEY
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F 000	O Haved From page	. 09	F 688	1. Resident #3 remains safely i	n
F 688	Continued From page	e 00	, 500	the center. Referral was made	
	§483.25(c) Mobility.	willte must oncure that a		to therapy to evaluate.	
	resident who enters to	cility must ensure that a he facility without limited		2. Current residents in the	
	range of motion does	not experience reduction in state the resident's clinical		center that have limited	
	condition demonstrate	es that a reduction in range		mobility have the potential to	
	of motion is unavoida	ble; and		be affected. These residents	
	8483 25(c)(2) A resid	lent with limited range of		were reviewed and no concer	ns
	motion receives appr	opriate treatment and range of motion and/or to		noted.	
	prevent further decre	ase in range of motion.		The DON/designee provided	d
	E492 25/c)(3) A racid	ent with limited mobility		re-education to the therapy	
	receives appropriate	services, equipment, and		provider to give new referrals	
	assistance to maintai	in or improve mobility with able independence unless a		for restorative nursing progra	m
	reduction in mobility i	is demonstrably unavoidable.	to DON so they can be		
	This REQUIREMENT	F is not met as evidenced		implemented timely for the	
	by: Based on observatio	on, resident interview staff		residents as appropriate.	
	interview and facility	document review it was		4. Once a week restorative	
	determined that the fa	acility staff failed to provide es to maintain or improve		referrals will be reviewed to	
	mobility for one of 46	residents in the survey		ensure services were	
	sample, Resident #3.			implemented timely. Results	
	The facility staff failed	d to implement a RNP		will be presented to QAPI	:11
	(restorative nursing p	program) for Resident #3		monthly. Any noted trends w	III
	following completion	of physical therapy 3/26/21.		be corrected immediately.	
	The findings include:			5. Compliance Date 01/04/22	2
	Resident #3 was adn 7/25/18 with diagnos	nitted to the facility on is that included but were not			

limited to: multiple sclerosis (progressive disease in which the nerve fibers of the brain and spinal cord lose their myelin cover) (1), scoliosis

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	MENT OF HEALTH AN					OMB NO. 0938-0391
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				000		
F 688	Continued From page		F-1	688		
	(abnormal lateral or s	ideward curve to the spine)				
	(2) dementia (progres including memory fun	sive state of mental decline, ction and judgement) (3).				
	The most recent MDS	(minimum data set)				
	assessment, a quarte	rly assessment, with an				
	ARD (assessment ref	erence date) of 11/17/21,				
	coded Resident #3 as	s scoring a 14 out of 15 on iew for mental status) score,				
	the BIMS (brief intervi	t was cognitively intact. A				
	roviou of the MDS Se	ection G-functional status				
	coded Resident #3 as					
	assistance for hed mo	obility, transfer, locomotion,				
	dressing hygiene: de	pendent for bathing and				
	supervision for eating	. Walking did not occur.				
		ducted on 11/29/21 at 5:15				
	PM with Resident #3.	When asked if she was				
	receiving therapy sen	vices, Resident #3 stated, "I				
	have multiple sclerosi	s. I finished physical				
	therapy many months	ago and was supposed to				
	start another program					
	A review of the physic	cal therapy notes				
	documented in part, "	Treatment began 3/6/21				
	ended 3/26/21. Disch	narge Plans: to remain in				
	the same skilled nursi	ing facility with reduced				
	burden on caregivers (restorative nursing p	rogram).				
	A review of the facility	"Restorative Program"				
	form, which was not o	dated, documented the				
	following: Restorative	e Program: Active ROM				
	(range of motion) and gait belt and monitor	ambulation. Precaution:				
	gait beit and monitor	EXCLUOIT.				

Event ID: TH2611

A review of the physician's orders failed to evidence orders for restorative program for Resident #13 beginning March 2021.

		ID HUMAN SERVICES			OMB NO. 0938-039
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
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F 688 Continued From page 90

A review of Resident #3's comprehensive care plan initiated on 7/26/18 with revision 11/24/21, documented in part, "FOCUS: At risk for falls related to multiple sclerosis. Interventions: Restorative programs and Therapy referral-dated 7/26/18 with revision 11/7/18. The comprehensive care plan failed to evidence a revision to address include a restorative program for Resident #13 beginning after the 3/26/21, completion of physical therapy.

An interview was conducted on 11/30/21 at 3:50 PM with OSM (other staff member) #1, the physical therapist. When asked if services were being provided for Resident #3, OSM #1 stated, "No, we finished therapy with her in March 2021 and she was transitioned to RNP." When asked who provides RNP, OSM #1 stated, "Nursing provides those services." When asked why there was not an order for the RNP, OSM #1 stated, "I don't know why, we give nursing the papers for RNP and they put in the order." OSM #1 stated I didn't know she wasn't receiving restorative.

An interview was conducted on 11/30/21 at 4:30 PM with Resident #3. When asked if she was receiving restorative nursing services, Resident #3 stated, "No, there is no restorative program and I do not know why. I have tried to find out but cannot get an answer."

An interview was conducted on 12/1/21 at 8:37 AM with CNA (certified nursing assistant) #1, the restorative aide. CNA#1 was asked about the process staff follows for a resident to be placed into the RNP. CNA #1 stated, "The resident goes to therapy and then therapy fills out restorative papers with one copy to myself and the other

F 688

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		ID HUMAN SERVICES			FORM APPROVED OMB NO. 0938-0391
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
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ROSE HIL	L HEALTH AND REHAB			BERRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFEREN	PLAN OF CORRECTION (X5) TIVE ACTION SHOULD BE COMPLETION ICED TO THE APPROPRIATE DATE DEFICIENCY)
F 688	restorative aide and t restorative nurse who computer. We canno do not have orders. I	he second copy goes to the puts the order into the to restorative nursing if we believe we have the	F	688	
	you. We have not ha restorative program for asked if they had, a n program back in Maro stated, "I don't believe	Resident #3, and will bring to d a nurse in charge of the or several months." When turse in charge of the ch or April 2021, CNA #1 e so, but I can't be certain. If sen't received the services, I			
	AM with ASM (adminithe interim administrate restorative order form asked about the form is the order for restorative. I do not know the recent paper from PT know what the process into the EMR (electro is not a restorative nurse possitated, "I'm not sure a process, but I will find had stated the position April, ASM #1 stated, An interview was con AM with OSM #2, phy	ition was filled. ASM #1 and I don't know the I out." When informed staff on was vacant in March or "That is possible." ducted on 12/1/21 at 9:43			

Resident #3, OSM #2 stated, "Yes, this is the form we fill out when the resident is finished with PT (physical therapy), when they are completed with their skilled therapy, so the RNP can carry on

their function and it is the plan to follow."

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES			2	FORM APPROVED
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C
	10	495140	B. WING			12/02/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	, ZIP CODE	
				110 CHALMERS COURT		
ROSE HIL	L HEALTH AND REHAB			BERRYVILLE, VA 22611		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	(ID PREF TAG	X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE D TO THE APPROPRIA ICIENCY)	E COMPLETION TE DATE
F 688	Continued From page	92	F	688		
	AM with ASM #2, the asked about the procestated, "I was hired 6/honest with you, we have not had a rest There has not been a of the program. We juthat position and there up. I don't know if Recare." On 12/1/21 at 5:00 PM administrator, ASM #2 ASM #3, the director of regional director of climates of the finding and the restorative nursing serve as a guide in estimated to the service of the highest independence possible nursing interventions a billity to adapt and addingendently and sat Restorative nursing is	ave restorative aides and storative nurse in this year. In nursing in charge ust have not had staff to fill the is not any designated back sident #3 is getting the M. ASM #1, the interim 2, the director of nursing, of nursing, ASM #4, the inical operations and ASM oresident of operations were get. I's "Restorative Nursing and 2017, documents in part, ing program is developed to stablishing individualized sist each resident in level of self-care and the Restorative care refers to that promote the resident's lijust to living as				

licensed nurse."

the end of therapy or has achievable goals for functional improvement through restorative care. Restorative nursing is essential for carryover of therapeutic teaching. Implementation of restorative interventions is provided by Certified Nursing Assistants, under the supervision of a

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			VALUE VIEW III
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING		С
		495140	B, WING		12/02/2021
		495140		STREET ADDRESS, CITY, STATE, ZIP CODE	1 ILIULILUU I
NAME OF PI	ROVIDER OR SUPPLIER			110 CHALMERS COURT	
ROSE HIL	L HEALTH AND REHAB			BERRYVILLE, VA 22611	
		TO THE REPORT OF THE PERSON OF	ID.	PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD E	3E COMPLETION
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ALL
E 600	Continued From page	. 03	F 688		
F 000	Continued From page	; 33	, 000	•	
	No further information	was provided prior to exit.			
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
	References:				
	(1) Barron's Dictionar	y of Medical Terms for the			
	Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 378. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and				
	Chapman, page 519.	611 11 1 T			
	(3) Barron's Dictionar	y of Medical Terms for the 5th edition, Rothenberg and			
	Chapman, page 154	Stredition, Notherberg and			
F 690	Bowel/Bladder Incont	inence, Catheter, UTI	F 690	F690	
SS=D	CFR(s): 483.25(e)(1)-	-(3)		1. Resident #62 remains safely	
	C402 05(-) times			in the center. The catheter	
	§483.25(e) Incontiner §483.25(e)(1) The fac			collection bag was removed	
	resident who is contin	nent of bladder and bowel on			
		ervices and assistance to		from the floor on the day of	
		unless his or her clinical		survey.	
	not possible to mainta	es such that continence is		2. Current residents in the	
	not possible to mainte	2011.		center that have catheters have	<u> </u>
	§483.25(e)(2)For a re	esident with urinary		the potential to be affected.	•
	incontinence, based of	on the resident's		These residents were reviewed	
	comprehensive asses ensure that-	ssment, the facility must			
	(i) A resident who ent	ers the facility without an		and no concerns noted.	
	indwelling catheter is	not catheterized unless the		3. The DON/designee provided	
		dition demonstrates that		re-education to the licensed	
	catheterization was no	ecessary; ters the facility with an		nurses and CNA's regarding the	
	indwelling catheter or	subsequently receives one			
	is assessed for remov	val of the catheter as soon		proper placement of catheter	
	as possible unless the	e resident's clinical condition		collection bags.	
	demonstrates that car	theterization is necessary;			

and

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OMB NO.	0938-0391

CENTERS FOR MEDICARE & I	MEDICAID SERVICES			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
				С
	495140	B, WING		12/02/2021
NAME OF PROVIDER OR SUPPLIER ROSE HILL HEALTH AND REHAB		1	STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611	
PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	

F 690 Continued From page 94

(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, and clinical record review, it was determined that facility staff failed to ensure care and services for an indwelling catheter to prevent infection for one of 46 residents in the survey sample, Residents # 62.

The facility staff failed to keep Resident # 62's catheter collection bag off the floor.

The findings include:

Resident # 62 was admitted to the facility with diagnoses that included but were not limited to: obstructive uropathy [1]. Resident # 62's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/02/2021, coded Resident # 62 as scoring a 9 [nine] on the brief interview for mental status (BIMS) of a score of 0 - 15, 9 - being moderately impaired of cognition for making daily decisions. Section H "Bladder and Bowel" coded Resident # 62 as having an indwelling catheter.

F 690 4. Weekly audits will be competed for 1 month on residents with catheters collection bags to ensure they are not on the floor. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately.

5. Compliance Date: 01/04/22

On 11/30/21 at approximately 8:45 a.m., an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495140 (X2) MULTIPLE CONSTRUCTION A, BUILDING (X3) DATE S COMPL A, BUILDING D 12/0	LETED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A, BUILDING COMPLETED A, BUILDING D, WING 12/0	LETED
495140 B, WING 12/0	CHARGE SHOWS AND THE
495140 B, WING 12/0	CHARLEST CONTRACTOR
493140	12/2024
	12/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
ROSE HILL HEALTH AND REHAB BERRYVILLE, VA. 22611	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID PROVIDER'S PLAN OF CORRECTION SHOULD BE	(X5) COMPLETION
PREFIX (EACH DEFICIENCY MOST BE PROPERTY OF THE APPROPRIATE PROPERTY OF THE PROPERTY OF THE APPROPRIATE PROPERTY O	DATE
TAG REGULATORY OR ESCIDENTIF TING INPORTING IN	
F 690 Continued From page 95 F 690	
observation of Resident # 62's catheter collection	
bag revealed it was lying on the floor next to the	
bed.	
Dea.	
On 11/30/21 at approximately 10:17 a.m., an	
observation of Resident # 62's catheter collection	
bag revealed it was lying on the floor next to the	
bed.	
On 11/30/21 at approximately 1:00 p.m., an	
observation of Resident # 62's catheter collection	
bag revealed it was lying on the floor next to the	
bed.	
The physician's order for Resident # 62	
documented, "Change catheter Q [every] month	
and prn [as needed]/when collecting urine	
specimen with 16 french/10cc [cubic centimeter]	
coude catheter. Order Date: 3/16/2021."	
The comprehensive care plan for Resident # 62	
dated 04/22/2020 documented, "Focus: Alteration	
in elimination of bowel and bladder Indwelling	
Urinary Catheter Date Initiated: 04/22/2020."	
Under "Interventions" it documented, "Keep	
drainage bag of catheter below the level of the	
bladder at all times and off floor. Date Initiated:	
04/22/2020."	
On 11/30/2021 at approximately 2:37 p.m. an	
(In 11/30/2021 At Approximately 4.57 p.m. an	
1. Lead a hospitation of Posident # 62's	
interview and observation of Resident # 62's	
interview and observation of Resident # 62's catheter collection bag was conducted with LPN	
interview and observation of Resident # 62's catheter collection bag was conducted with LPN [licensed practical nurse] # 7. Upon entering	
interview and observation of Resident # 62's catheter collection bag was conducted with LPN	

Facility ID: VA0210

stated that it was lying on the floor next to the bed. LPN #7 further stated that the collection

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	C
		40.51.40	B_WING_		12/02/2021
		495140	D WING	STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			110 CHALMERS COURT	
ROSE HIL	L HEALTH AND REHAB			BERRYVILLE, VA 22611	
				PROVIDER'S PLAN OF COR	RRECTION (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	THE PROPERTY OF A CTION	SHOULD BE COMPLETION
F 000	0 "	.06	F 6	90	
F 690			Γ0	50	
	the floor. When aske	d why it was important to ection bag off the floor, LPN			
	# 7 stated, "To prever				
	On 11/29/2021 at app	roximately 3:00 p.m., during			
	the entrance conferer	nce with ASM [administrative			
	staff member] # 1, int	erim administrator, they idard of practice the nursing			
	staff follow ASM # 1	stated, that they follow			
	Lippincott and provide	ed a copy of the cover of the			
	standard that docume	ented in part, "LIPPINCOTT.			
	Nursing EIGHT EDIT	ON. Copyright @ 2019."			
	According "LIPPINCO	OTT. Nursing EIGHT			
	EDITION. Copyright (@ 2019" documented in			
	part. "Nursing Alert: D	on't place the drainage bag			
	on the floor to reduce p387."	the risk of contamination			
	μ367.				
		proximately 4:10 p.m., ASM			
	[administrative staff m	nember] # 1, the interim			
	# 4 director of clinica	2, director of nursing, ASM operations and ASM # 5,			
	regional vice presider	nt of operations, were made			
	aware of the findings.				
	No further information	was provided prior to exit.			
	References:				
	[1] A condition in whi	ch the flow of urine is			
	blocked. This causes	the urine to back up and			
	obtained from the well	neys. This information was			
	https://medlineplus.go	ov/ency/article/000507.htm			
F 695	Respiratory/Tracheos	tomy Care and Suctioning	F 6	95 F695	
	CFR(s): 483.25(i)			a positional MCO nombles	cafely
	C 400 OF/!\ D!	a para including		1. Resident #62 remains	saiciy
	§ 483.25(i) Respirator	y care, including		in the center. Resident	

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CENTE	RS FOR MEDICARE &	MEDICAID SERVICES			FORM APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
NAMEOF		495140	B. WING_		C 12/02/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611	12/02/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PREC EDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	BE COMPLETION
tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to provide respiratory services according to the physician's orders one of 46 residents in the survey sample, Residents # 62. The facility staff failed to administer Resident # 62's oxygen at two liters per minute according to the physician's orders. The findings include: Resident # 62 was admitted to the facility with diagnoses that included but were not limited to: respiratory failure [1] and chronic obstructive pulmonary disease [2]. Resident # 62's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/02/2021, coded Resident # 62 as scoring a 9 [nine] on the brief interview for mental		F 69	treatment orders for oxygen were reviewed and no further issues were identified. 2. Current residents in the center that have oxygen prescribed have the potential to be affected. These residents were reviewed and no concerns noted. 3. The DON/designee provided re-education to the licensed nurses regarding following physician orders related to oxygen use.		
		4. Weekly audits will be competed for 1 month on residents with prescribed oxygen to ensure they are receiving as prescribed. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5. Compliance Date: 01/04/22			

status (BIMS) of a score of 0 - 15, 9 - being moderately impaired of cognition for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded Resident # 15

for "Oxygen Therapy" while a resident.

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CENTERS FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED
				С
	495140	B. WING		12/02/2021
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
			110 CHALMERS COURT	
ROSE HILL HEALTH AND REHAB			BERRYVILLE, VA 22611	
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
cannula connected to Observation of the flo Resident #62's oxyge oxygen flow rate between per minute. On 11/30/21 at approximate of Resident lying in bed resident lying in bed resident lying in bed resident #62's oxyge oxygen flow rate between minute. On 11/30/21 at approximate of Resident resident lying in bed resident lying in bed resident lying in bed resident lying in bed resident #62's oxyge oxygen flow rate between minute. The physician order for documented "O2 [oxygen minute.] The physician order for documented "O2 [oxygen flow rate between minute.] The comprehensive control of the flow	ent # 62 revealed the ecciving oxygen by nasal an oxygen concentrator. w meter on oxygen in concentrator revealed an even one-half and one liter eximately 10:17 a.m., an ent # 62 revealed the ecciving oxygen by nasal an oxygen concentrator. w meter on oxygen in concentrator revealed an even one-half and one liter eximately 1:00 p.m., an ent # 62 revealed the ecciving oxygen by nasal an oxygen concentrator. w meter on oxygen in concentrator revealed an even one-half and one liter eximately 1:00 p.m., an ent # 62 revealed the ecciving oxygen by nasal an oxygen concentrator. w meter on oxygen in concentrator revealed an even one-half and one liter even even one-half and one liter even even one-half and one liter even even even one-half and one liter even even even even even even even ev	F	695	

Facility ID: VA0210

Under "Intervention" it documented, "Administer Oxygen 2L/NC [two liters by nasal cannula] per

		ID HUMAN SERVICES				FORM APPROVED OMB NO. 0938-0391
CENTER	S FOR MEDICARE &	MEDICAID SERVICES		_		1
STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		NSTRUCTION	(X3) DATE SURVEY COMPLETED
7,110 1 0 11 0 1			1000			С
		495140	B, WING			12/02/2021
NAME OF PR	OVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE	
ROSE HILI	L HEALTH AND REHAB				HALMERS COURT RYVILLE, VA 22611	
			143	DEI	PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG	FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IC PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION ATE DATE
F 695	Continued From page		F	695		
	MD [medical doctor] of Initiated: 06/21/2019.	order for COPD. Date Revision on: 03/15/2020."				
	Op 11/30/2021 at and	proximately 2:37 p.m. an				
	interview and observa	ation of Resident # 62's				
	oxygen concentrator	flow meter was conducted				
	with LPN [licensed pr	actical nurse] # 7. Upon				
	entering Resident # 6	2's room, LPN # 7 was v meter on Resident # 62's				
	asked to read the nov	LPN # 7 stated that the				
	flow meter read one I	iter per minute. When				
	asked what the oxyge	en flow rate should be for				
	Resident # 62, LPN #	7 stated they would need to				
	check the physician's	order. After LPN #7 looked der for Resident # 62's				
	oxygen flow rate I PN	N # 7 stated, "It is two liters				
	per minute." When a	sked why it was important				
	for a resident to recei	ve the correct amount of				
		ed, "A low rate could cause				
	hypoxia [3]."					
	On 12/01/2021 at and	proximately 4:10 p.m., ASM				
	[administrative staff n	nember] # 1, the interim				
	administrator, ASM #	2, director of nursing, ASM				
	# 4, director of clinica	l operations and ASM # 5,				
	aware of the findings	nt of operations, were made				
	aware or the initings	•				
	No further information	n was provided prior to exit.				
	References:					
	[1] When not enough	oxygen passes from your				
		This information was				
l	obtained from the we	Dalle.				

ilure.html.

https://www.nlm.nih.gov/medlineplus/respiratoryfa

[2 Disease that makes it difficult to breath that

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CENTER	MEDICAID SERVICES				OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL		(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION IDE		IDENTIFICATION NUMBER:	A, BUILD	ING		С
		495140	B. WING			12/02/2021
	DOLUMEN OR OUR DELIER	453140			REET ADDRESS, CITY, STATE, ZIP CODE	1
NAME OF PE	ROVIDER OR SUPPLIER			110	CHALMERS COURT	
ROSE HIL	L HEALTH AND REHAB			BE	ERRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION ATE DATE
F 695	[3] Hypoxia: a state in	e website: ov/medlineplus/copd.html.	. F	695		
	to maintain adequate from inadequate oxygeither due to low blood content in the blood (information was obtain https://pubmed.ncbi.n	homeostasis; this can result gen delivery to the tissues d supply or low oxygen	F	730	F730	
	§483.35(d)(7) Regular The facility must come of every nurse aide at months, and must proceducation based on the reviews. In-service the requirements of §483 This REQUIREMENT by: Based on staff interviewe, it was determed failed to complete an nursing aide) perform CNA record reviews, The facility staff failed	by ide regular in-service the outcome of these aining must comply with the .95(g). It is not met as evidenced the and facility document ined that the facility staff annual CNA (certified ance review for two of five CNA #6 and CNA #7. It to complete an annual or CNA #6, hired on 8/29/19			 1. CNA #6 and CNA #7 remain employed at the center. Performance reviews were completed and delivered. 2. Current CNAs in the center have the potential to be affected. Current CNAs were reviewed and any concerns were addressed. 3. The Administrator provided re-education to DON and HR Director regarding the requirement to complete annual CNA reviews and provide education based on these reviews. 	
	CNA #6 was hired on	8/29/19. Review of CNA			these reviews.	

no date.

#6's record revealed a performance review with

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		ALDICAID SERVICES			OMB NO. 0938-0391		
		MEDICAID SERVICES	(V2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY		
	OF DEFICIENCIÉS F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		NG	COMPLETED		
		495140	B. WING _		12/02/2021		
NAME OF P	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE			
MAINEO	NOVIDEN ON OUT TELES		1	110 CHALMERS COURT			
ROSE HIL	L HEALTH AND REHAB			BERRYVILLE, VA 22611			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILE DEFICIENCY)	D BE COMPLETION		
F 730	Continued From page	101	F 7	730 4. Monthly audit will be			
1 730	Continued 1 tom page	, 101		completed to ensure annual			
	CNA #7 was hired on	4/2/18. Review of CNA #7's		CNA reviews are compliant.			
		ast performance review was					
	completed on 1/7/20.			Results will be presented to			
	0- 40/4/04 -4 4:50 -	m on intonious was		QAPI monthly. Any noted			
	On 12/1/21 at 4:56 p. conducted with ASM	m., an interview was		trends will be corrected			
	member) #5 (the region	onal vice president of	immediately.				
	operations). ASM #5	stated CNA performance	5. Compliance Date: 01/04/2022				
	reviews should be con	mpleted by the CNA's		-1			
	supervisor annually.	At this time, ASM #1 (the , ASM #2 (the director of					
	nursing) ASM #4 (the	regional director of clinical					
	operations) and ASM	#5 were made aware of the					
	above concern.						
	The facility policy title	d. "Performance					
	Evaluations" documer	nted, "2. A performance					
	evaluation must be co	impleted on each employee					
	within 30 days of their	r original service date					
		erformance Review Forms-					
	employee and manag	iomont					
		was presented prior to exit.					
		edures/Pharmacist/Records	F 7	755			
SS=D	CFR(s): 483.45(a)(b)((1)-(3)					
	§483.45 Pharmacy Se	ervices					
	The facility must provi	ide routine and emergency					
	drugs and biologicals	to its residents, or obtain					
	them under an agreer	ment described in ity may permit unlicensed					
	personnel to administ	er drugs if State law					
	permits, but only under	er the general supervision of					
	a licensed nurse.						

Facility ID: VA0210

§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 12/02/2021 B. WING 495140 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 110 CHALMERS COURT **ROSE HILL HEALTH AND REHAB** BERRYVILLE, VA 22611 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY)

F 755 Continued From page 102

that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-

§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.

§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced bv:

Based on clinical record review and staff interview it was determined that the facility staff failed to provide pharmacy services for one of 46 residents in the survey sample, Resident # 201.

The facility staff failed to ensure the medications, Metoprolol [1] Zestoretic [2], Glimepiride [3] and Ozempic [4] were available for administration to Resident # 201 as ordered by the physician on 5/22/21, 5/23/21 and 5/24/21.

The findings include:

Resident # 210 was admitted to the facility with diagnoses that included but were not limited to: breast cancer, pain, diabetes mellitus [5] and kidney disease, high blood pressure.

F 755 F755

- 1. Resident #201 no longer resides in the center.
- 2. Current residents on metoprolol, zestoretic, glimepiride and ozempic in the center have the potential to be affected. Residents reviewed and no concerns noted.
- 3. The DON/designee will reeducate licensed nurses on obtaining medications as ordered from the pharmacy.
- 4. A report will be generated of metoprolol, zestoretic, glimepiride and ozempic medications to ensure they were available for administration 5 times a week. Results will be presents to QAPI monthly for continued monitoring. Any noted trends will be addressed immediately.
- 5. Compliance Date: 01/04/22

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		MEDICAID CERVICES			OMB NO. 0938-039	
STATEMENT OF DE AND PLAN OF COR	FICIENCIES			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495140	B. WING		12/02/2021	
NAME OF PROVIDER OR SUPPLIER ROSE HILL HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC (DENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION		

F 755 Continued From page 103

Resident # 201's MDS (minimum data set), an admission 5-day assessment with an ARD (assessment reference date) of 05/24/2021 coded Resident # 201 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions.

Review of Resident #201's clinical record revealed a physician's order dated 5/21/21, signed by the physician on 5/24/21, that documented in part: Metoprolol ER [extended release] 25mg [milligrams]. Give 1 [one] tablet by mouth one time a day for htn [hypertension - high blood pressure]; Zestoretic 20-25 mg. Give 1 [one] tablet by mouth one time a day for htn [hypertension - high blood pressure]; Glimepiride Tablet. Give 2mg by mouth two times a day for DM [diabetes mellitus]; Ozempic [5] (0.25 or 0.5 MG/DOSE) Solution Pen-Injector 2 MG/1.5ML [milliliter]. Inject 0.5 mg subcutaneously [beneath the skin] one time a day every Sun [Sunday] for dm."

Review of the Resident #201's eMAR [electronic medication administration record] dated May 2021, documented the physician's orders as stated above from 05/21/2021 through 05/24/2021. The eMAR further documented the code "3 [three] = Hold/See Nurse's Notes" for metoprolol on 5/22/2021 and 05/23/2021 at 9:00 a.m.; ozempic on 05/23/2021 at 9:00 a.m.; zestoretic on 05/22/2021 and 05/23/2021 at 9:00 a.m.; glimepiride 5/22/2021 and 05/23/2021 at 9:00 a.m. and coded "7 [seven] = See Nurse's Notes" on 05/24/2021 at 9:00 a.m.

The nurse's "Progress Notes" dated 05/22/2021

F 755

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		D HUMAN SERVICES			OMB NO. 0938-0391
CENTER	S FOR MEDICARE &			IDLE CONCERNICATION	(X3) DATE SURVEY
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495140		1 ' '	IPLE CONSTRUCTION	COMPLETED	
		B. WING _		C 12/02/2021	
NAME OF B	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			110 CHALMERS COURT	
ROSE HIL	L HEALTH AND REHAB			BERRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
		104	C :	² 55	
F 755	Continued From page		F/	755	
	and 05/23/2021 for R	esident # 201 documented,			
		. Give 300 mg by mouth			
	two times a day for ne	nt wrong dose; Metoprolol			
	Succinate FR Tablet I	Extended Release 24 Hour			
	25 MG. Give 1 tablet	by mouth one time a day for			
	htn. awaiting delivery	r; Glimepiride Tablet. Give 2			
	mg by mouth two time delivery."	es a day for DM. awaiting			
	The nurse's "Progress Notes" dated 05/23/2021" Ozempic (0.25 or 0.5 MG/DOSE) Solution Pen-injector 2 MG/1.5ML. Inject 0.5 mg subcutaneously one time a day every Sun for dm. awaiting delivery."				
	The facility's STAT [immediate]-drug box inventory list was reviewed. The STAT-drug box failed to evidence the medications metoprolol,				
	zestoretic, glimepiride	e and ozempic.			
	was made to ASM [ad	8 a.m., a request to ho admitted resident # 201 dministrative staff member] # or. ASM # 1 stated that the employed by the facility.			
	interview was conducted of nursing. When ask procedure the nursing medications for newly 2 stated, "Before they at the hospital or they at summary with their medications."	g staff follows to obtain v admitted residents, ASM # v arrive, we get a report from			

physician to go over the resident's medications and make any necessary changes and then they give a verbal order for the medications. The

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	MENT OF HEALTH AN				2	OMB NO. 0938-0391
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495140	B. WING			C 12/02/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE	
10000				110 CHALMERS COURT		
ROSE HIL	L HEALTH AND REHAB			BERRYVILLE, VA 22611		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIA	(X5) COMPLETION TE DATE
TAG	Continued From page order is then faxed to narcotic, the nurse ge resident is a late day arrive the next momin in the day, the medicated." When asked at follows when a reside available, ASM # 2 st the STAT-drug box [p provide for initiating the ordered drug from the stock of medications. STAT-drug box or in the should call the pharm physician, and let the party know." After reeMAR dated May 202 dated 05/21/2021 through the stock of medications. STAT-drug box contains for Resident # 201's reside	e 105 the pharmacy If there is a sets a written order. If the admission the medications and, if the admission is early ation arrive by the end of the cout the procedure staff and the medications are not ated, "They [nurse] checks repared by the pharmacy to merapy prior to the receipt of a pharmacy] and the house of the house stock, the nurse acy, notify the NP or resident and/or responsible wiewing Resident # 201's 21, nurse's progress notes ough 05/24/2021, and the SM # 2 was asked if the ined the above medications medications. ASM # 2 policy titled, "Medication of specifically document ication is not available and proximately 4:10 p.m., ASM	TAG	CROSS-REFERENCED TO		TE DAIL
	[administrative staff m administrator, ASM # #4, director of clinica regional vice presider aware of the findings.	nember] # 1, the interim 2, director of nursing, ASM I operations and ASM # 5, nt of operations, were made				
	No further information	I Was provided prior to exit.				

Complaint deficiency

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			. OV	MB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULT	TIPLE CONSTRUCTION	(X	3) DATE SURVEY COMPLETED
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDI	NG		
						C
		495140	B, WING			12/02/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	Ē	
				110 CHALMERS COURT		
ROSE HIL	L HEALTH AND REHAB			BERRYVILLE, VA 22611		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE. DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 755	Continued From page	106	F	755		
	References:					
	[1] Used alone or in c	ombination with other				
		igh blood pressure. This				
	information was obtain					
	· ·	ov/druginfo/meds/a682864.h				
	tml.					
	[2] The combination of	of lisinopril and				
		s used to treat high blood				
	pressure. This inform	nation was obtained from the				
	website:					
	https://medlineplus.go	ov/druginfo/meds/a601070.h				
	tml.					
	[3] Used along with di	ot and evereise and				
		medications, to treat type 2				
		which the body does not				
	use insulin normally a					
		sugar in the blood). This				
	information was obtain					
		v/druginfo/meds/a696016.h				
	tml.					
	Milleod along with a	diet and exercise program				
		levels in adults with type 2				
	_	which the body does not				
		nd therefore cannot control				
		n the blood) when other				
	medications did not co	ontrol the sugar levels well				
		tion was obtained from the				
	website:	/ : - :				
	https://medlineplus.go tml.	v/druginfo/meds/a618008.h				
	[5] A chronic disease i	n which the body cannot				
	regulate the amount o	f sugar in the blood. This				
	information was obtain	ned from the website:				

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	MENT OF HEALTH AN				OMB NO. 0938-0391
CENTER	S FOR MEDICARE & 1		Turan Military	CONSTRUCTION	(X3) DATE SURVEY
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER.		1	COMPLETED		
AND PLAN OF	CORRECTION	DENTIFICATION NOMBERS	A BUILDING _		c
			B. WING		12/02/2021
		495140		TREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PE	ROVIDER OR SUPPLIER				
DOSE WILL	L HEALTH AND REHAB			10 CHALMERS COURT	
KOSE TIL	L HEALTH AND KEIND			BERRYVILLE, VA 22611	(X5)
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E COMPLETION
PREFIX TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE
				BEHEIROT	
F 755	Continued From page	: 107	F 755		
	001214.htm.		E 704		
F 761	Label/Store Drugs an	d Biologicals	F 761	F761	
SS=E	CFR(s): 483.45(g)(h)(1)(2)		1. South Wing Cart One and	
	8499 45(a) Labelina d	of Drugs and Biologicals			
	Drugs and biologicals	used in the facility must be		Three have medications labeled	
	labeled in accordance	with currently accepted		and stored in a secure manner.	
	professional principle	s, and include the		2. Medication carts in the	
	appropriate accessor	y and cautionary			
	instructions, and the	expiration date when		facility were audited to ensure	
	applicable.			medications were labeled and	
	§483.45(h) Storage o	f Drugs and Biologicals		stored in a secure manner.	
	§483.45(h)(1) in acco	rdance with State and		3. The DON/designee will re-	
	S483.45(II)(I) III acco	lity must store all drugs and		educate licensed nurses on	
	biologicals in locked	compartments under proper			
	temperature controls,	and permit only authorized		medication labeling and	
	personnel to have acc	cess to the keys.		storage.	
	0.400 45/EVO) The for	silitu must provide separately		4. An audit will be completed	
	§483.45(h)(2) The fac	sility must provide separately affixed compartments for			
	storage of controlled	drugs listed in Schedule II of		weekly for 1 month to ensure	
	the Comprehensive D	rug Abuse Prevention and		that medications are labeled	=
	Control Act of 1976 a	nd other drugs subject to		and stored in a secure manner.	
	abuse, except when t	he facility uses single unit		Results will be presents to QAPI	
	package drug distribu	ition systems in which the		monthly for continued	
	duantity stored is min be readily detected.	imal and a missing dose can		monitoring. Any noted trends	
	This REQUIREMENT	is not met as evidenced		will be addressed immediately.	
	bv:				
	Based on observatio	n, staff interview and facility		5. Compliance Date: 01/04/22	

document review it was determined that the facility staff failed to ensure medications were labeled and stored in a secure manner in two of four medication carts, (South Wing medication cart-one and South Wing medication cart-three).

	MENT OF HEALTH AN				OMB NO. 0938-0391
STATEMENT C	S FOR MEDICARE & DEPTITION OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495140	B. WING		12/02/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611	
(X4) ID PREFIX TAG	FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) BE COMPLETION ATE DATE
F 761	in drawer one, three win drawer three and opill in drawer four of the Observation of the Screvealed, one whole-ledrawer two, two half apills in drawer three of The findings include: On 11/29/21 at approaphers of South was conducted with Lanurse) #5. Observation of South wing-medication following: -Drawer one: two half -Drawer four: one whole-leaves the server one whole-leaves four: one	buth wing medication In half-loose unidentified pills In whole-loose unidentified pills In whole-loose unidentified In emedication cart. In the wing-cart three In oose unidentified pill in In one-loose unidentified If the medication cart.	F 7	761	

On 11/29/21 at approximately 5:55 PM, an observation of South wing medication cart three was conducted with LPN #4. Observation inside the drawers of South wing-medication cart-three revealed the following:

-Drawer two: one whole-loose unidentified pills. -Drawer three: two half and one whole-loose unidentified pills.

The loose pills in each drawer above were observed located behind the medication cards stored in each drawer.

An interview was conducted on 11/29/21 at 5:35 PM with LPN #5. When asked about the loose medications in the medication cart drawers, LPN #5 stated, "I need to throw those pills away. I

PRINTED: 12/13/2021

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				C	MB NO. 0938-0391
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			TO LOT ION	-	X3) DATE SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONST	RUCTION	1	COMPLETED
AND PLAN OF	CORRECTION	IDENTIFICATION NOW DELA	A BUILDIN	IG	-		С
		495140	B, WING				12/02/2021
		495140		STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PR	ROVIDER OR SUPPLIER				LMERS COURT		
ROSE HIL	L HEALTH AND REHAB				VILLE, VA 22611		
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API	HOULD BE	(X5) COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	IAG		DEFICIENCY)		
F 761			F 7	61			¥
	don't know what the p	pills are, so we cannot use					
	them because they a	re out of the packaging."					
	An interview was con	ducted on 11/29/21 at 5:55					
	PM with LPN #4. Wh	en asked about the loose					
	pills in the medication	cart drawers, LPN #4					
	stated, "No, they sho	uld not be in the drawers					
	loose like that. You o	lo not know what the pill is					
	and you have to dispe	ose of them. If I knew they ike that, I would have thrown					
	them out."	ine triat, i would have the out					
		DAA AOSA (- durinistanting					
	On 11/29/21 at 5:40 F staff member) #1, the	PM, ASM (administrative					
	provided us with the	title page to Lippincott					
	Nursing Procedures,	8th Edition.					
	On 12/1/21 at 5:00 P	M, ASM #1, the interim					
	administrator, ASM #	2, the director of nursing,					
	ASM #3, the director	of nursing, ASM #4, the					
	regional director of cl	inical operations and ASM					
	#5, the regional vice	president of operations were					
	informed of the finding	gs.					
	According to the facil	ity's "Medication Storage"					
	policy, dated Septem	ber 2010, documents in part,					
	"Medications and bio	logicals are stored properly,					
	following manufactur	ers or pharmacy provider					
	recommendations to	maintain their integrity and tive drug administration.					
	Outdated, contamina	ted, discontinued or					
	deteriorated medicati	ons and those in containers					
	that are cracked, soil	ed or without secure					
	closures are immedia	ately removed from stock,					
	disposed of according	g to procedures for					
	medication disposal.	•					

No further information was provided prior to exit.

DEPART	MENT OF HEALTH AN	D HUMAN SERVICES			OMB NO. 0938-0391
		MEDICAID SERVICES	(NO) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION.	COMPLETED
					С
		495140	B. WING		12/02/2021
NAME OF PE	OVIDER OR SUPPLIER		S1	FREET ADDRESS, CITY, STATE, ZIP CODE	
			10	0 CHALMERS COURT	
ROSE HILI	HEALTH AND REHAB		В	ERRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) E COMPLETION ATE DATE
		10 O itani	F 812	F812	
		ore/Prepare/Serve-Sanitary	F 012	1012	
SS=E	CFR(s): 483.60(i)(1)(-)		1. The south and north	
	§483.60(i) Food safet	y requirements.		nourishment rooms have food	
	The facility must -			stored in accordance with	
		8 78		professional standards for food	
	§483.60(i)(1) - Procur	ed satisfactory by federal,		service safety.	
	state or local authoriti			Service sarety.	
	(i) This may include for	ood items obtained directly		2. An audit of current	
		subject to applicable State		nourishment rooms were	
	and local laws or regu	ilations. s not prohibit or prevent		completed to ensure food was	
	(II) This provision use	roduce grown in facility		stored in accordance with	
	gardens, subject to co	ompliance with applicable		professional standards for food	
	safe growing and food	d-handling practices.		· _	
	(iii) This provision doe	es not preclude residents		safety.	
	from consuming tood:	s not procured by the facility.		3. The Administrator/designee	
	8483 60(i)(2) - Store.	prepare, distribute and		will re-educate dining services	
	serve food in accorda	ince with professional		proper food storage.	
	standards for food se	rvice safety.		proper rood storage.	
		is not met as evidenced		4. A bi- weekly audit of the	
	by:	n, staff interview, and facility		nourishment rooms will be	
	document review it w	as determined that the		completed for 2 month to	
	facility staff failed to s	tore food in two of two		<u> </u>	
	nourishment rooms in	accordance with		ensure food storage	
	professional standard	ls for food service safety.		compliance. Results will be	
	The findings include:			presents to QAPI monthly for	
	The linumys molude.			continued monitoring. Any	
	A. The facility failed to	to properly label and date		noted trends will be addressed	
	resident food items o	n the North unit nourishment		immediately.	
	room.				
		5		5. Compliance Date: 01/04/22	

On 11/30/2021 at 8:45 a.m., an observation was conducted of the nourishment room on the north unit. Observation of the refrigerator revealed a salad in a plastic container with no date or name,

		D HUMAN SERVICES					B NO. 0938-0391
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					DATE SURVEY
STATEMENT OF	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	NG	ISTRUCTION		COMPLETED
		495140	B, WING				C 12/02/2021
NAME OF DE	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF T	TO TIBELLO TO TO THE TENE			110 CI	HALMERS COURT		
ROSE HIL	L HEALTH AND REHAB			BERF	RYVILLE, VA 22611		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	DATE (X5)
E 012	Continued From page	111	F	812			
F 812	Continued From page			012			
	a 31 ounce container	of spinach anichoke					
	parmesan dip without	a name or date, a container en paste without a name or					
	or an unidentified gre	containers undated without					
	names and a foil nach	ket with the contents not					
	visible and no date or	name on them. Further					
	observation revealed	a pitcher of an orange					
	colored liquid approxi	mately 1/4 full without a					
	cover, label identifyin	g the contents or a date.					
	Observation of the fre	eezer revealed one ham and					
	cheddar hot pocket w	ithout a name or date and a					
	frozen meal out of it's	box without a label or date.					
	On 11/30/2021 at 9:0	0 a.m., aп interview was					
	conducted with OSM	(other staff member) #4,					
	interim dietary manag	ger. OSM #4 stated that they					
	had been at the facility	ty for about a week covering					
	and were not sure wi	no was responsible for					
	maintaining the nour	shment rooms on the units.					
	OSM #4 stated that the	nere were no current dietary rocess and they did not know					
	staπ who knew the pri if dietary or nursing w	as responsible for this.					
		0 a.m., an interview was					
	conducted with I PN	(licensed practical nurse) #8.					
	I PN #8 stated that di	etary was responsible for					
	checking the nourish	ment rooms daily and for					
	throwing away anythi	ng that was not labeled or					
	dated or expired. LP	N #8 stated that nursing was					
	responsible for dating	and labeling anything that					
	they received from re	sidents and put in the					
	nourishment room. L	.PN #8 observed the food					
	items in the refrigerat	tor and freezer of the North					
	unit nourishment rooi	m and stated that they					
	should all be thrown:	away because they were not					

Facility ID: VA0210

labeled or dated and they could not identify how old they were or who they belonged to. LPN #8 stated that the orange liquid in the pitcher should

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RTMENT OF HEALTH AND HUMAN SERVICES	OMB NO. 0938-039
ERS FOR MEDICARE & MEDICAID SERVICES	
Lite i ditilizzio il la	LVOLDATE SLIDVEY

DECARTI	MILITAL OF THE RETURNS	HERIOAIR REDVICES				OMB NO. 0938-0391
CENTER	S FOR MEDICARE &	MEDICAID SERVICES	T	TIDI E A	CONSTRUCTION	(X3) DATE SURVEY
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COMPLETED
AND PLAN OF	CORRECTION	IDENTIFICATION NOWIBER.	A, BUILD	ING		c
			D 14/1010			12/02/2021
		495140	B. WING		70,000	12/02/2021
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	
					CHALMERS COURT	
ROSE HIL	L HEALTH AND REHAB			BE	RRYVILLE, VA 22611	
040.15	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION
(X4) ID PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	Ne o tree
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	j	DEFICIENCY)	3800
				-		
				0.40		
F 812	Continued From page	e 112	F	812		
	would be thrown awa	y.				
	B. The facility staff fa	ailed to dispose of expired				
	food items in the Sou	th unit nourishment room.				
	On 11/30/2021 at 4:2	0 p.m., an observation was				
	conducted of the nou	rishment room on the south				
	unit. Observation rev	realed one half pint of 2%				
	milk with an expiratio	n date of 11/28/21 on the				
	carton and a 46 ound	e container of thickened				
	lemon flavored water	dated 10/22/2021.				
		- 3				
	On 11/30/2021 at 4:2	5 p.m., an interview was				
	conducted with LPN	(licensed practical nurse) #3.				
	LPN #3 observed the	one half pint of 2% milk with				
	the date 11/28/21 and	d the carton of thickened				
	lemon water dated 10	0/22/2021 and stated, "Yes,				
	they should have bee	en thrown out because they				
		ates. I'll throw them out				
	now."					
	G 40/4/0004 -1	reviewotaly 5:30 p.m. 3				
	On 12/1/2021 at app	roximately 5:30 p.m., a				
	request was made to	ASM (administrative staff				
	member) #1, the inte	rim administrator for the				
		ntaining the nourishment				
	rooms in the facility.					
	The facility policy "Ba	asic Food Storage"				
	the facility policy be	"4. Discard foods that				
	documented in part,	evaluation date. "				
	have exceeded their	expiration date				

The facility policy "Use and Storage of Foods Brought to Residents by Family and Visitors" dated 10/2017 documented in part, "...Food item(s) will be labeled with the resident's name,

content, the date it was prepared, if known, and a discard/use by date..."

On 12/1/2021 at approximately 5:10 p.m., ASM

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			WAY DATE SUBJEY
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		495140	B. WING		12/02/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				110 CHALMERS COURT	
ROSE HIL	L HEALTH AND REHAB			BERRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	
5.040		. 440	F 81:	7	
F 812	Continued From page		roi.	2	
	#1, the interim administrator, ASM #2, the director of nursing, ASM #4, the regional director of				
	clinical operations an	d ASM #5, the regional vice			
	·	ns were made aware of the			
	findings.				
	No further information	was provided prior to exit.			
	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)		F 842	2 F842	
30 B	0111(0). 100.20(.)(0)/			 Resident #29 remains safely 	
		nt-identifiable information. elease information that is		in the center.	
	resident-identifiable to	o the public.		2. Current residents in the	
		lease information that is		center that have an order for	
	resident-identifiable to	o an agent only in ntract under which the agent		treatments have the potential	
	accordance with a co	disclose the information		to be affected.	
	except to the extent the	he facility itself is permitted		to be affected.	
	to do so.			3. The DON/designee will re-	
	0.400 70(1) \$4111			educate licensed nurses on	
	§483.70(i) Medical re §483.70(i)(1) In accor	dance with accepted		completing documentation on	
	professional standard	s and practices, the facility		the eTAR.	
	must maintain medica	al records on each resident			
	that are-			4. 5 times a week, a report will	
	(i) Complete;	antod:		be reviewed for proper	
	(ii) Accurately docume (iii) Readily accessible			documentation in eTAR. Results	
	(iv) Systematically org			will be presents to QAPI	
				monthly for continued	
	§483.70(i)(2) The fac	ility must keep confidential		monitoring. Any noted trends	
		ned in the resident's records, n or storage method of the		will be addressed immediately.	
	regardless of the form			will be dudiessed littlifediately.	
	(i) To the individual, o	r their resident		5. Compliance Date: 01/04/22	
		permitted by applicable law;			
	(ii) Required by Law;				
	(iii) For treatment, pay	yment, or health care			

OF HEALTH AND HUMAN SERVICES

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		ID HUMAN SERVICES				OMB NO. 0938-0391
		MEDICAID SERVICES			NIGTELICTION	(X3) DATE SURVEY
STATEMENT OF	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		DISTRUCTION	COMPLETED
		495140	B. WING	u		C 12/02/2021
NAME OF PI	ROVIDER OR SUPPLIER			STRI	EET ADDRESS, CITY, STATE, ZIP CODE	
				110	CHALMERS COURT	The state of the s
ROSE HIL	L HEALTH AND REHAB			BEF	RRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	I D PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DE COMPLETION
F 842	Continued From page		F	842		
	operations, as permits with 45 CFR 164.506	ted by and in compliance ;				
	(iv) For public health a	activities, reporting of abuse,				
	neglect, or domestic	violence, health oversight				
	activities, judiciai and	administrative proceedings, loses, organ donation				
	purposes, research p	urposes, or to coroners,				
	medical examiners, fu	ineral directors, and to avert				
	a serious threat to he	alth or safety as permitted				
	by and in compliance	with 45 CFR 164.512.				
	\$483,70(i)(3) The faci	ility must safeguard medical				
	record information ag	ainst loss, destruction, or				
	unauthorized use.					
	§483.70(i)(4) Medical for-	records must be retained				
		required by State law; or				
	(ii) Five years from the	e date of discharge when				
	there is no requireme	nt in State law; or				
		ars after a resident reaches				
	iegal age under State	law.				
	§483.70(i)(5) The me	dical record must contain-				
	(i) Sufficient informati	on to identify the resident;				
	(ii) A record of the res	sident's assessments;				
	• •	ve plan of care and services				
	provided; (iv) The results of any	preadmission screening				
	and resident review e	valuations and				
	determinations condu	icted by the State;				
	(v) Physician's, nurse	's, and other licensed				
	professional's progres	ss notes; and				
	(vi) Laboratory, radiol	ogy and other diagnostic				
		equired under §483.50.				

by: Based on observation, clinical record review and facility staff interview it was determined that the

		D HUMAN SERVICES				OMB NO. 0938-0391
CENTER	S FOR MEDICARE &	MEDICAID SERVICES	1		NICTORICTION	(X3) DATE SURVEY
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CO	DISTRUCTION	COMPLETED
		4054.45	B, WING			C 12/02/2021
		495140	B. WING	CTDS	EET ADDRESS, CITY, STATE, ZIP CODE	ILIOZIACE
NAME OF P	ROVIDER OR SUPPLIER			ı	CHALMERS COURT	
BOSE DII	L HEALTH AND REHAB					
KUSE HIL	L HEALTH AND REIM			BER	RRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 842	Continued From page	÷ 115	F	842		
	accurate record for or	naintain a complete and ne of 46 residents in the				
	survey sample, Resid	ent #29.				
	The findings include:					
,	diagnoses that includ sepsis (1) and gastros most recent MDS, a c ARD of 9/3/2021, cod moderately impaired Section M documents stage III pressure ulco	mitted to the facility with ed but were not limited to stomy (2). Resident #29's quarterly assessment with an led Resident #29 as being for making daily decisions. Ed Resident #29 having one er (3) on admission and re ulcers, one being present				
	record) for Resident # 10/1/2021-10/31/202 documentation of the completed on the followard of the completed on the followard ground to ground	I failed to evidence following treatments owing dates, 10/21/2021- "Night, Cleanse ostomy tube) site with wound by zinc oxide around g-tube ressing QD (every day), round prevention. Order 0/17/2021- "Eve 3 (evening bilateral hips as follows: eleanser, apply calcium d and cover with dry hilly every evening shift for				

Event ID: TH2611

cleanse with wound cleanser, apply calcium alginate to wound bed and cover with dry

		ID HUMAN SERVICES				OMB NO. 0938-0391
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES	1			(X3) DATE SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	UI .	IPLE CONSTRUCTION	N	COMPLETED
AND PLAN OF	CORRECTION	IDENTIFICATION NOMBER	A, BUILDII	NG		c
		405440	B. WING			12/02/2021
		495140	10.11.10	STREET ADDRESS	S, CITY, STATE, ZIP CODE	I ILIVEIDU.
NAME OF PI	ROVIDER OR SUPPLIER			110 CHALMERS		
ROSE HIL	L HEALTH AND REHAB			BERRYVILLE,		
71002						(X5)
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID PREFII	(EAC	ROVIDER'S PLAN OF CORRECTION CHICORRECTIVE ACTION SHOULD E	BE COMPLETION
PREFIX TAG	REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	TAG	CROSS	S-REFERENCED TO THE APPROPRI	ATE DATE
IAG		And additional to			DEFICIENCY)	
				Ø.		
F 842	Continued From page	÷ 116	F 8	342		
	dressing. Change da	ily every evening shift for				
	stage III pressure ulce	er. Order Date:				
	09/22/2021."					
	TI	or Resident #29 failed to				
	The progress notes it	ion of the treatments listed				
		the dates listed above.				
	above completed on .					
	On 12/1/2021 at 3:20	p.m., an interview was				
	conducted with LPN (licensed practical nurse) #9.				
		eatments were completed as				
		nted on the eTAR. LPN #9				
		re blanks on the eTAR in nat the nurse who was				
	the treatment areas to	ably forgot to sign off on it				
	after they did the trea					
	and they did the free					
	On 12/1/2021 at 4:30	p.m., an interview was				
	conducted with LPN #	#10. LPN #10 stated that				
		mented on the eTAR after				
		LPN #10 stated that				
		or pulled away for an				
	emergency and may I	forget to sign off on the stated that there would be				
		the nurse forgot to sign off				
	but it did not mean that					
	provided.					
	On 11/29/2021 at app	proximately 3:15 p.m., the				
	ASM (administrative s	staff member) #1, the interim				
	administrator was ask	ked about the standard of				
	practice that the facili	ty nurse's follow. ASM #1				
	stated that they would	m. ASM #1 stated that the				
	nursing staff follow Lie	ppincott as their standard of				
	practice.	Pp				

On 11/29/2021 at 5:40 p.m., ASM #1 provided via email a copy of the cover and table of contents

		D HUMAN SERVICES				OMB NO. 0938-039	31
		MEDICAID SERVICES	(VO) MUII	TIPLE CONS	ETRUCTION	(X3) DATE SURVEY	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI			COMPLETED	
		495140	B. WING			C 12/02/2021	
NAME OF PE	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE		
10 1112 01 11				110 CH.	ALMERS COURT		
ROSE HIL	L HEALTH AND REHAB			BERRY	YVILLE, VA 22611		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ULD BE COMPLETION	7
5.040		447	_	842			
F 842	Continued From page		Г	5 4 2			
	for "Lippincott Nursing 2019."	g Eighth Edition Procedures,					
	Williams and Wilkins I "Accurate documenta (nurses) provide meet expressed wishes. It accepted standards of the law, your professifacility" and on page the main source of informunication amontherapists, social work Everyone's notes and because together the picture of the patient's On 12/1/2021 at apprefixing the interim adminition of nursing, ASM #4, the clinical operations and president of operation findings.	g nurses, doctors, physical kers, and caregivers. documentation is important y represent a complete care." example of the care of the car					
	No further information	was provided prior to exit.					
	References:						
	severe, inflammatory other germs. The syr caused by the germs chemicals the body re This information was	in which the body has a response to bacteria or inptoms of sepsis are not themselves. Instead, eleases cause the response obtained from the website: gov/ency/article/000666.htm					

2. Gastrostomy (G-Tube): A gastrostomy feeding

>.

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OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			(X3) DATE SURVEY
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	COMPLETED
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		l c
					12/02/2021
_		495140	B. WING	AND	12/02/2021
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
	UEALTU AND DEUAR			110 CHALMERS COURT	
KOSE HIL	L HEALTH AND REHAB			BERRYVILLE, VA 22611	(1/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
				7.6	
F 842	Continued From page	e 118	F 84	2	
		lacement of a feeding tube			
	through the skin and	the stomach wall. It goes			
	directly into the stoma	ach. This information was			
1	obtained from the we				
		ov/ency/article/002937.htm.			
		•			
	3. Pressure ulcer: A	pressure sore is an area of			
	the skin that breaks d	lowп when something keeps			
rubbing or pressing against the skin. Pressure sores are grouped by the severity of symptoms. Stage I is the mildest stage. Stage IV is the worst.		gainst the skin. Pressure			
	Stage I: A reddened,	painful area on the skin that			
	does not turn white w	hen pressed. This is a sign			
	that a pressure ulcer	is forming. The skin may be			
	warm or cool, firm or	soft. Stage II: The skin			
	blisters or forms an o	pen sore. The area around			
	the sore may be red a	and irritated. Stage III: The			
	skin now develops ar	open, sunken hole called a			
	crater. The tissue bel	ow the skin is damaged. You			
	may be able to see b	ody fat in the crater. Stage			
	IV: The pressure ulce	er has become so deep that			
	there is damage to th	e muscle and bone, and			
	sometimes to tendon	s and joints. This			
		ined from the website:			
		ov/ency/patientinstructions/0			
	00740.htm.	A 12 112	F 86	7 F867	
F 867	QAPI/QAA Improvem		1 00	1007	
SS=E	CFR(s): 483.75(g)(2)	(11)		1. LNHA met with Medical	
	9402.75/a\ Ovality as	ssessment and assurance.			
	9483.75(g) Quality as	ssessment and assurance.		Director and reviewed past	
	8483 75/m\/2\ The gri	ality assessment and		QAPI minutes.	
	assurance committee	e must:			
	(ii) Develop and imple	ement appropriate plans of		Current residents in the	
	action to correct iden	tified quality deficiencies;		center have the potential to be	
	This REOUREMENT	is not met as evidenced		affected.	
	by:			anected.	
	Based on staff interv	iew and facility document			
1		•			

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 12/02/2021 B. WING 495140 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 110 CHALMERS COURT

(X4) ID

PREFIX

TAG

ROSE HILL HEALTH AND REHAB

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

PREFIX TAG

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

(X5) COMPLETION

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F 867 Continued From page 119

review, it was determined that the facility staff failed to maintain an effective Quality Assurance program.

The facility staff failed to ensure the physician attended quarterly quality assurance meetings for three of three quarters

The findings include:

On 12/02/2021 at approximately 10:30 a.m., a review of the facility, "QAPI [quality assurance performance improving] Meeting" sign-in sheets" dated April 2021 through October 2021 failed to evidence the signature of the facility's medical director.

On 12/02/2021 at approximately 10:45 a.m., an interview was conducted with ASM [administrative staff member] # 1, interim administrator, regarding the missing signature of the medical director for the dates listed above. When asked about the missing signature of the facility's medical director ASM # 1 stated that they did not have any evidence that the medical director had attended.

The facility's policy "Quality Assurance Improvement Process" documented in part, "Procedure: 1. The committee may consist of: A. Medical Director. B. Administrator. C. Director of Nursing. D. At least three other staff members, which may include: i. Rehabilitation Manager, ii. Social Worker, iii. Activities Director, iv. Medical Records, v. Designated Staff Development, vi. Director of Dining Services, vii. Business Office, viii. Employee Health, ix. Laboratory Services Representative, x. Others as deemed by committee on consultant basis, xi. Pharmacy

3. The Administrator/designee will re-educate Medical Director that attendance is required at least quarterly.

BERRYVILLE, VA 22611

- 4. Quarterly schedule of QAPI meetings will be sent to Medical Director. Attendance of required team members will be audited monthly. Results will be presents to QAPI monthly for continued monitoring. Any noted trends will be addressed immediately.
- 5. Compliance Date: 01/04/22

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CENTERS FOR MEDICARE & MEDICAID SERVICES						
			(X2) MULTIPLE	OMB NO. 0938-0391 (X3) DATE SURVEY		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING	COMPLETED		
ANDFLANCI	OOI (ILEO FIG.)		A. BOILDING		С	
		495140	B. WING		12/02/2021	
VANE OF B	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PI	ROVIDER OR SOFFEIER		1.	110 CHALMERS COURT		
ROSE HILL HEALTH AND REHAB			BERRYVILLE, VA 22611			
	CUMMADV CT	ATEMENT OF DEFICIENCIES	D	PROVIDER'S PLAN OF CORRECTION	(X5)	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE COMPLETION DATE	
TAG	REGULATORY OR LSC (DENTIFYING INFORMATION)		TAG	DEFICIENCY)	WASSE	
				((
F 067	Continued From page 120		F 867	,		
F 867			1 007			
	Consultant."					
	No further information	was provided by the end of				
	the survey.					
F 947	Required In-Service	Fraining for Nurse Aides	F 947	' F947		
SS=D	CFR(s): 483.95(g)(1)-	-(4)		4 CNA H2 J CNA HD vomoin		
	CARR DE(=) Flaguized	in-service training for nurse		1. CNA #2 and CNA #8 remain		
	aides.	III-service training for harse		employed at the center.		
	In-service training mu	ist-		Dementia education was		
				completed.		
	§483.95(g)(1) Be suff	icient to ensure the		2. Current CNA's in the center		
		ce of nurse aides, but must		have the potential to be		
	be no less than 12 ho	urs per year.		affected.		
	§483.95(g)(2) Include dementia management training and resident abuse prevention training.			a T. Ad-inistrator provided		
				3. The Administrator provided		
	D 100 05(-)(0) A dd	a areas of weakness as		re-education to the DON and		
§483.95(g)(3) Address area		aides' performance reviews		HR Director regarding the		
	and facility assessment at § 483.70(e) and may			requirement for annual CNA		
	address the special n	eeds of residents as		training.		
	determined by the fac	cility staff.				
	0.400.05/ \/4\ F	cides providing convices		4. A report will be generated of		
	\$483.95(g)(4) For null	se aides providing services gnitive impairments, also		annual dementia training		
	address the care of th	ne cognitively impaired.		completions weekly, for one		
	This REQUIREMENT	is not met as evidenced		month. Results will be presents		
	by:			to QAPI monthly for continued		
	Based on staff interv	iew and facility document		monitoring. Any noted trends		
	review, it was determined failed to ensure CNAs	ined that the facility staff s (certified nursing aides)		will be addressed immediately.		
	completed required a	nnual in-service training for		will be dudiessed intillediately.		
	two of five CNA recor	d reviews, CNA #2 and CNA		5. Compliance Date: 01/04/22		
	#8.			•		
	T	the against CNA #2 and CNA				
	The facility staff failed	I to ensure CNA #2 and CNA				

#8 completed annual dementia training.

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DEFAIL	O FOR HERICARE	MEDICAID SERVICES				OMB NO. 0938-0391
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED
			A, BUILDI	NG		С
		495140	B. WING			12/02/2021
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	
			110	CHALMERS COURT		
ROSE HIL	L HEALTH AND REHAB			BEF	RRYVILLE, VA 22611	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 947	Continued From page	: 121	F S	947		
	The findings include:					
	CNA #2 was hired on 12/16/16. Review of CNA #2's record failed to reveal evidence that the CNA had completed annual dementia training.					
	CNA #8 was hired on 12/16/16. Review of CNA #8's record failed to reveal evidence that the CNA had completed annual dementia training.					
	On 12/1/21 at 4:56 p.m., an interview was conducted with ASM (administrative staff member) #5 (the regional vice president of operations). ASM #5 stated dementia training should be completed annually by the CNAs within the computer training system and the human resources department tracks the percentage of completion in the computer training system. At this time, ASM #1 (the interim administrator), ASM #2 (the director of nursing), ASM #4 (the regional director of clinical operations) and ASM #5 were made aware of the above concern.					
	On 12/2/21 at 10:20 a facility did not have a annual CNA training.	.m., ASM #1 stated the policy regarding required				
	No further information	was presented prior to exit.				