PRINTED: 04/28/2022 FORM APPROVED OMB NO. 0938-0391

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 _			C 03/10	/2020
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611		00/10	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
	survey was conducte 03/10/2020. Correct	CFR Part 483 Federal Long					
E 015 SS=C	Subsistence Needs f CFR(s): 483.73(b)(1)		E	015			
		3.113(b)(6)(iii), §441.184(b) 182.15(b)(1), §483.73(b)(1), 5.625(b)(1)					
	develop and impleme policies and procedu plan set forth in para assessment at parag and the communicati this section. The pol be reviewed and upd	redures. [Facilities] must ent emergency preparedness res, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of icies and procedures must ated every 2 years [annually a minimum, the policies and liress the following:					
	and patients whether place, include, but ar (i) Food, water, medi supplies (ii) Alternate sources following:	subsistence needs for staff they evacuate or shelter in e not limited to the following: cal and pharmaceutical of energy to maintain the					
	safety and for the saf provisions. (B) Emergency lightir	e and sanitary storage of ng. tinguishing, and alarm					
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	=	TITLE		(X6	B) DATE

04/02/2020

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

Facility ID: VA0210

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		495140	B. WING		C 03/10/2020	
	ROVIDER OR SUPPLIER	В		STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	03/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
E 015	Continued From pa	ge 1	E 01	5		
	Policies and proced (6) The following ar hospice-operated in The policies and pro following: (iii) The provision of hospice employees evacuate or shelter limited to the follow (A) Food, water, me supplies. (B) Alternate source following: (1) Temperatures to safety and for the s provisions. (2) Emergency light (3) Fire detection, es systems. (C) Sewage and wa This REQUIREMEN by: Based on staff inte review it was deterr failed to have a con preparedness plan. provide documenta	e additional requirements for apatient care facilities only. occdures must address the f subsistence needs for and patients, whether they in place, include, but are not ing: edical, and pharmaceutical es of energy to maintain the protect patient health and afe and sanitary storage of exting.  In its not met as evidenced review and facility document mined that the facility staff and procedures for waste				
	On 03/10/2020 at 9 facility's emergency interview was cond member) # 9, maint	e: :50 a.m., a review of the r preparedness plan and ucted with OSM (other staff tenance director. Review of ency preparedness plan failed				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			11	TREET ADDRESS, CITY, STATE, ZIP CODE 10 CHALMERS COURT BERRYVILLE, VA 22611		10/2020
(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 SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 015	plan included policies disposal. OSM # 9 st documentation."	tation that the emergency and procedures for waste ated, "We don't have the	E	015			
E 026 SS=C	Roles Under a Waive CFR(s): 483.73(b)(8) §403.748(b)(8), §416 (iv), §441.184(b)(8),	n was provided prior to exit. r Declared by Secretary .54(b)(6), §418.113(b)(6)(C) §460.84(b)(9), §482.15(b) 83.475(b)(8), §485.625(b) 494.62(b)(7).	E	026			
	develop and impleme policies and procedur plan set forth in paragassessment at paragin and the communication this section. The policies reviewed and update the communication of the policies are the policies and update the policies and update the policies are the policies and update the policies and update the policies and update the policies and procedure plants are the policies and the policies are the policies are the policies and the policies are the polic	edures. The [facilities] must ant emergency preparedness res, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must rated at least every 2 years lities]. At a minimum, the res must address the					
	[facility] under a waive in accordance with se provision of care and	or (9)] The role of the er declared by the Secretary, ection 1135 of the Act, in the treatment at an alternate emergency management					
	procedures. (8) The r waiver declared by th with section 1135 of A	3.748(b):] Policies and ole of the RNHCl under a e Secretary, in accordance act, in the provision of care site identified by emergency					

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	ROVIDER OR SUPPLIER		1	1	TREET ADDRESS, CITY, STATE, ZIP CODE 10 CHALMERS COURT BERRYVILLE, VA 22611	1 001	10/2020
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E 026	by: Based on staff interv review it was determing failed to have a compute preparedness plan. To develop policies and emergency plan that a providing care and tresunder an 1135 waiver.  The findings include: On 03/10/19 at 9:50 at emergency prepared conducted with OSM maintenance director emergency prepared policies and procedur role in providing care care sites under an 1 stated, "We don't hav No further information INITIAL COMMENTS  An unannounced Me survey was conducted complaint was investing Corrections are required CFR Part 483 Federal requirements. The Lift will follow.  The census in this 12 114 at the time of the	is not met as evidenced iew and facility document ned that the facility staff lete emergency he facility staff failed to procedures in the describe the facility's role in eatment at altered care sites  a.m., a review of the facility's ness plan and interview was (other staff member) # 9, Review of the facility's ness plan failed to evidence tes that describe the facility's and treatment at altered 135 waiver. OSM # 9 ti"  In was provided prior to exit.  dicare/Medicaid standard di 3/8/20 through 3/10/20. A gated during the survey. Interest and standard gated for compliance with 42		026			

A95140  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)  F 000 Continued From page 4 closed record reviews.  F 580 Notify of Changes (Injury/Decline/Room, etc.) SS=E CFR(s): 483.10(g)(14) Notification of Changes.	CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED
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 DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 000  Continued From page 4 closed record reviews.  F 580 SS=E  (FR(s): 483.10(g)(14) Notification of Changes.	
ROSE HILL HEALTH AND REHAB  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 000 Continued From page 4 closed record reviews.  F 580 Notify of Changes (Injury/Decline/Room, etc.)  SS=E CFR(s): 483.10(g)(14) Notification of Changes.	B. WING 03/10/2020
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 000  Continued From page 4 closed record reviews.  Notify of Changes (Injury/Decline/Room, etc.)  SS=E  CFR(s): 483.10(g)(14) Notification of Changes.	110 CHALMERS COURT
closed record reviews.  Notify of Changes (Injury/Decline/Room, etc.)  SS=E  CFR(s): 483.10(g)(14)(i)-(iv)(15)  §483.10(g)(14) Notification of Changes.	JLL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION ON) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE
(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (iii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically	F 000 F 580  dent; tify, ent  uiring visical, sial lat is, to  oh (g) a that (c)(2) a my, ent all or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER	433140	D. Wille	_	STREET ADDRESS, CITY, STATE, ZIP CODE	03/	10/2020
ROSE HIL	L HEALTH AND REHAB				110 CHALMERS COURT BERRYVILLE, VA 22611		
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F 580	phone number of the representative(s).  §483.10(g)(15) Admission to a composite di §483.5) must disclose its physical configurat locations that compris part, and must specifications that comprise part, and must specifications changes between under §483.15(c)(9). This REQUIREMENT by:  Based on staff interviant clinical record reviate facility staff failed and/or responsible paincidents or the need 50 residents in the sufflex sufflex in the suff	mailing and email) and resident  posite distinct part. A facility stinct part (as defined in e in its admission agreement tion, including the various se the composite distinct by the policies that apply to en its different locations  is not met as evidenced  iew, facility document review wiew, it was determined that to notify the physician entry of resident to resident to alter treatment for one of provey sample, Residents failed to notify the physician entry of the physician e	F	580			
	a physician's order da	18's clinical record revealed ated 12/14/18 for simvastatin ) by mouth at bedtime, a					

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	03/10/2020
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F 580	10 mg by mouth on- order dated 11/7/19 (milligrams) by moute medications were so Resident #18's Dectadministration record on 12/31/19, LPN (failed to document strazodone was admitted the MAR. LPN #11 Other/ See Nurse Numedication adminissimvastatin, dated 1 "Waiting to be sent note regarding done documented, "Waiti (electronic medicati regarding trazodone documented, "Waiti There was no further the administration of trazodone on 12/31, that Resident #18's practitioner were not 12/18/19 and 12/19 Cardiovascular statt density lipoproteins ordered by physicia documented, "Imparelated to: Dementia physicianPotentia complications associated medications related	ated 1/3/19 for donepezil (2) ce a day, and a physician's for trazodone (3) 25 mg th at bedtime. The cheduled for 8:00 p.m. on ember 2019 MAR (medication rd).  licensed practical nurse) #11 simvastatin, donepezil and inistered to Resident #18 on documented the code, "7= lotes." An eMAR (electronic tration record) note regarding 12/31/19 documented, from pharmacy." An eMAR epezil, dated 12/31/19 ng for pharmacy." An eMAR on administration record) note e, dated 12/31/19 ng to be sent from pharmacy." er documentation regarding if simvastatin, donepezil or /19 and no documentation physician and/or nurse otified.  In prehensive care plan dated /18 documented, "Impaired us related to: HDL (high [cholesterol])Medications as n" The care plan further ired neurological status aMedication as ordered by	F 58		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	03/10/2020
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F 580	Continued From pa	ge 7	F 580		
	conducted with LPN regarding physician if medications are n stated the physician should be notified if administered becauneeded dose and siphysician/nurse prawhat actions they wow on 3/9/20 at 5:57 p conducted with LPN #18's medication at LPN #11 stated it hat 12/31/19 and he conducted simvator Resident #18 on physician and/or nursing) director of nursing) director of clinical sithe above concern.  The facility pharmate Administration- Ger "If two consecutive are withheld or refunctified"  No further information was references:  (1) Simvastatin is us This informations are not simply was a single physician and consecutive are withheld or refunctified"	statin, donepezil or trazodone that date or if he notified the trse practitioner.  .m., ASM (administrative staff tecutive director), ASM #2 (the and ASM #3 (the regional tervices) were made aware of			

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F 580	disorder that affects the	e 8 d to treat dementia (a brain he ability to remember, think , and perform daily activities	F	580			
	and may cause chang personality)." This int the website:						
F 584 SS=D	information was obtai https://medlineplus.go	ov/ency/article/002559.htm ble/Homelike Environment	F	584			
	§483.10(i) Safe Environments a rig comfortable and home but not limited to rece supports for daily living	ght to a safe, clean, elike environment, including iiving treatment and					
	homelike environmen use his or her person possible. (i) This includes ensu receive care and serv physical layout of the independence and do (ii) The facility shall ex	ide- clean, comfortable, and t, allowing the resident to al belongings to the extent  ring that the resident can rices safely and that the facility maximizes resident les not pose a safety risk, exercise reasonable care for esident's property from loss					
	. , , ,	eeping and maintenance maintain a sanitary, orderly,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495140	B. WING			C <b>03/10/2020</b>
	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611		00/10/2020
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F 584	Continued From pag		F 58	4		
	and comfortable inte	erior;				
	§483.10(i)(3) Clean in good condition;	bed and bath linens that are				
	( ( ( )	e closet space in each pecified in §483.90 (e)(2)(iv);				
	§483.10(i)(5) Adequ levels in all areas;	ate and comfortable lighting				
	levels. Facilities initi	rtable and safe temperature ally certified after October 1, a temperature range of 71 to				
	sound levels. This REQUIREMEN by: Based on observati record review, it was staff failed to mainta homelike environme the survey sample, le	T is not met as evidenced on, staff interview and clinical determined that the facility in a clean, comfortable, nt for one of 50 residents in Resident #18. Multiple brown d on the resident's privacy				
	The findings include	:				
	12/14/18. Resident were not limited to remajor depressive disannual MDS (minim an ARD (assessmer coded the resident's	dmitted to the facility on #18's diagnoses included but epeated falls, diabetes and sorder. Resident #18's um data set) assessment with at reference date) of 12/10/19, cognitive skills for daily moderately impaired.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		495140	B. WING _			C <b>3/10/2020</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	<u> </u>	0/10/2020
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F 600 SS=E	observation of Reside conducted. The reside Approximately 15 brothe privacy curtain. A approximately the size on 3/9/20 at approximately the size on 3/9/20 at approximately the size on 3/9/20 at approximately the facility clean privacy curtains curtains are removed during the room deep resident is discharge housekeeping staff in Resident #18's privace os M #6. The brown curtain. OSM #6 was of the stains and state come from food, drinthe stained privacy of the stained privacy of on 3/9/20 at 7:07 p.m. member) #1 (the exedirector of nursing) and director of clinical set the above concernor curtains was requested. No further information Free from Abuse and CFR(s): 483.12(a)(1) §483.12 Freedom from Exploitation The resident has the	n., and 3/9/20 at 8:21 a.m., ent #18's room was dent was lying in bed. own stains were observed on All of the stains were the of a penny or smaller.  mately 2:15 p.m., an observed with OSM (other staff sekeeping manager) process for maintaining soon of the stated privacy of and washed once a month observed with observed with stains remained on the soundable to identify the cause ed the stains may have the or feces. OSM #6 stated curtain was not homelike.  In., ASM (administrative staff cutive director), ASM #2 (the end ASM #3 (the regional revices) were made aware of A policy regarding privacy ed via a list given to ASM #1.	F 5			

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F 600	includes but is not lim corporal punishment, any physical or chem treat the resident's more \$483.12(a) The facilit \$483.12(a) (1) Not use physical abuse, corporative involuntary seclusion; This REQUIREMENT by:  Based on staff intervand clinical record revand clinical record revand clinical record revand clinical record revand the facility staff failed right to be free from a residents in the surve #67, #650, #652, #7, On 1/22/19, facility serior Resident #69 and Reabuse from each other Resident #69, and the #67 back.  On 2/26/19, facility serior Resident #69 hit Resident #69 grabbed neck.  On 3/18/19, facility serior Resident #7 was free #69 hit Resident #7 ir On 6/20/19, facility serior Resident #651 was free #69 hit Resident #7 ir On 6/20/19, facility serior Resident #651 was free Resident #69 hit Resident #6	efined in this subpart. This ited to freedom from involuntary seclusion and ical restraint not required to edical symptoms.  y must- e verbal, mental, sexual, or oral punishment, or is not met as evidenced iew, facility document review view, it was determined that to maintain the resident buse for nine of 50 y sample, Residents #69, #651, #22, #41, and #39. staff failed to ensure that sident #67 were free from er. Resident #67 hit en Resident #69 hit Resident staff failed to ensure that ee from abuse, when dent #650 in the face on the staff failed to ensure that fee from abuse, when desident #652 by the staff failed to ensure that from abuse, when Resident for the face without injury. Staff failed to ensure that	F	600			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495140	B. WING				0 10/2020
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			1	STREET ADDRESS, CITY, STATE, ZIP CODE I10 CHALMERS COURT BERRYVILLE, VA 22611		10,2020
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F 600	Resident #22 was fre Resident #69 hit Res with a closed fist.  On 1/12/20, facility so Resident #41 was fre Resident #69 hit Resident #69 hit Resident #69 hit Resident #39 was fre Resident #39 was fre Resident #69 pulled for the floor.  The findings include:  A review of the facility dated February 2017 documented, "Policy: and dignity of each rebe afforded basic hur right to be free from a mistreatment, and/or property. The managerecognizes these right the following stateme procedures to protect	staff failed to ensure that e from abuse, when dent #22 on the left arm  staff failed to ensure that e from abuse from, when dent #41 in the right side of d fist.  aff failed to ensure that e from abuse, when Resident #39 out of his chair  y policy, "Resident Abuse" and revised January 2020, It is inherent in the nature esident at Facility that he/she man rights, including the abuse, neglect, misappropriation of mement of the facility ts and hereby establishes nts, policies, and these rights and to y policy, which results in the	F	600			
	resident abuseProc arise as to what actio resident. Any action actual physical, psycl which is not caused b constitutes abuseF Abuse: A. All incider	edure:c. Questions may ns constitute abuse of a that may cause or causes nological, or emotional harm,					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495140	B. WING		C 03/10/2020
	ROVIDER OR SUPPLIER	В		STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611	03/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 600	Once reported to or prescribed forms are delivered to the Abut designee for an investall report to the selaw enforcement er suspicion of a crime a resident of, or is resulted in serious or report within 2 hour of the events that caresult in serious bor report within 24 hour Abuse Coordinator shall take written st suspect(s) and all prother employees in abuse. He/she shall evidence. Upon condetailed report shall take written sha	Nursing, or the Administrator. ne of those three officials, the e to be completed and use Coordinator or his/her estigation. B. The facility tate agency and one or more utities any reasonable e against any individual who is ecceiving care from, the facility. Is that caused the suspicion codily injury the facility must s after forming the suspicion. It is after forming the suspicion and	F 600		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION		DATE SURVEY COMPLETED
		495140	B. WING		_	C <b>03/10/2020</b>
	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, S 110 CHALMERS COURT BERRYVILLE, VA 226		00/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Resident to Resider residents from dang applicable, move the to another room or use the incident. 3. Clo the behavior and co involved to evaluate recurrence of the incident and the incident: a. at responsible party. So by the Administrator designee must be inhours of our knowled. This investigation in (directly or indirectly residents involved a involved. Obtain wrinecessary. 6. An Ir must be completed. The Administrator in President or Operational Services of incidences of abuse investigation. 8. The Nursing, or their designee must be incidences of abuse investigation. 8. The Nursing, or their designee investigation. 9. The Nursing of their designee investigation of any specific protocols of incident. If no local notify the state Ombuy protected environment involved. 9. The St to be notified by the Nursing, or their designee.	resident property. Protocol: at Abuse: 1. Remove the ar immediately. 2. If a resident causing the danger unit, pending investigation of sely monitor and document adition of the residents for any injury and to prevent cident. 4. Notification must wing of all residents involved atending physician. b. a. A documented investigation b. A documented investigation citiated within twenty-four (24) adge of the alleged incident. Cludes talking with all involved any family involved, all and any visitors or volunteers atten statements as deemed acident/Accident Report form by the nurse in charge. 7. aust notify the Regional Vice ons and the Director of alleged and/or actual and the on-going and Administrator, Director of signee, must notify the Adult	F	600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING		(X3) DATE SURVEY COMPLETED			
		495140	B. WING		C 03/10/2020
	ROVIDER OR SUPPLIER  L HEALTH AND REHAE	A BUILDING  A BUILDING  B. WING  DEER OR SUPPLIER  EALTH AND REHAB  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Initioued From page 15 and in accordance with dier Justice Act. 11. If any injury has occurred the resident, or there is potential for a lawsuit, each administrator is to notify the Regional Vice esident of Operations immediately, and a copy the investigative report must be sent to the egional Clinical Director. 12. The facility must evelop measures to prevent reoccurrence and cument these measures in the resident's edical record to include revision of the plan of re. 13. Other measures to be considered ring this process include: a. Medication review d/or change; b. Obtaining orders for a psych		1 00/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE COMPLETION
F 600	which a resident is in physical intervention to a hospital is requi protocols. 10. The authorities are to be Director of Nursing, instance of resident neglect, or misapprowhich is a "Criminal Elder Justice Act. 1" to the resident, or the Administrator is President of Operati of the investigative r Regional Clinical Director develop measures to document these memedical record to incare. 13. Other meduring this process i and/or change; b. O consult to determine for the behavior, and	njured to the extent that and/or transfer or discharge red per state specific local law enforcement notified by the Administrator, or their designee of any abuse, mistreatment, priation of personal property Act" and in accordance with 1. If any injury has occurred ere is potential for a lawsuit, to notify the Regional Vice ons immediately, and a copy eport must be sent to the rector. 12. The facility must be prevent reoccurrence and assures in the resident's clude revision of the plan of assures to be considered include: a. Medication review bataining orders for a psych if there are organic reasons diff the resident can be ion or other treatment	F 600		
	Resident #69 and R abuse from each oth Resident #69, and th #67 back. Resident #69 was an 1/17/13; diagnoses i	ty staff failed to ensure that esident #67 were free from her. Resident #67 hit hen Resident #69 hit Resident dmitted to the facility on include, but are not limited to hehaviors, hemiplegia and esion, pain in leg and			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE COMP	SURVEY PLETED
		495140	B. WING				C 10/2020
	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 10 CHALMERS COURT BERRYVILLE, VA 22611	1 001	10/2020
(X4) ID 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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	MDS (Minimum Data (Assessment Referer the resident as being to make daily life dec coded as requiring to extensive care for tra and hygiene; supervisiocomotion; and was bowel and bladder.  Resident #67 was ad 11/21/12 with the diag stroke, diabetes, hem dementia with behavi insomnia, glaucoma, pulmonary disease, oblood pressure, and be quarterly MDS (Minim (Assessment Referer the resident as being)	Set) with an ARD noe Date) of 2/4/20 coded severely impaired in ability isions. The resident was tal care for bathing; nsfers, dressing, toileting sion for eating and frequently incontinent of mitted to the facility on gnoses of but not limited to niplegia, dysphagia, iors, adjustment disorder, chronic obstructive depression, convulsions, high	F	600			
	toileting; extensive as	ng total care for bathing and ssistance for transfers, e; and supervision for eating.					
	A review of the clinical revealed a nurse's not documented, "Reside arguing with another when the other reside swearing at him. Whother resident [Resident #69] in the	al record for Resident #69 bite dated 1/22/19 that ent [Resident #69] was resident [Resident #67] ent [Resident #67] began en approached by staff, the ent #67] punched him arm at which point he led back and exchanged					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495140	B. WING		C 03/10/2020
	ROVIDER OR SUPPLIER	В		STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	1 03/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 600	#69 revealed a phy (psychological evaluation documented, "Paties status and to adjust Plan / Recommend psychotropic medic for psychosis relate (behavioral and psydementia), Depakor monitor mood and be consideration, the bemedications in this risks of tardive dyst stroke. They help in that normal care is the nursing facility. Reduction) not indict has failed a previous is not a candidate for benefits of the med negative side effect. A review of the commercial Resident #69 reveal have a hx (history) which include follow wheeling behind stathings, claiming I armember. I can becand believe that the	ated by staff."  e clinical record for Resident sician psych evaluation) note dated 1/22/19 that nt seen to evaluate mental medications Treatment ations as follows: seroquel (1) d to dementia/BPSD schological symptoms of the (2) for mood stabilization, 3. Dehaviors After careful tenefits of anti-psychotic patient outweigh the potential tinesia, hyperglycemia and an modifying the behavior such possible while the patient is in GDR (Gradual Dose cated at this time. Resident is gradual dose reduction and or another attempt because location outweigh risks of	F 60		
	being aggressive to (residents) by grabb arm, calling out who	e behavior, I have a hx of wards staff/others rt's bing, hitting and squeezing en care needs have been ecting care when offered,			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
				-		(	С
		495140	B. WING				10/2020
NAME OF PR	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	10/2020
				1	110 CHALMERS COURT		
ROSE HIL	L HEALTH AND REHAB				BERRYVILLE, VA 22611		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLÉTION DATE
F 600	Continued From pag	e 18	F	600			
	· -	as needed), At times I will		000			
		hen encouraged/offered."					
	This care plan includ						
	interventions: "Aggre	•					
		separated" dated 10/17/19					
		"Ask me if I would like a cup					
	of coffee and see if I	would like to go to the					
	activities room and w	atch TV. Or if there is any					
		enjoy" dated 6/26/19.					
		others out of the way to clear					
		nove freely up and down the					
	-	19 and revised 1/14/20.					
		s before my behaviors					
	. •	and revised 6/26/19.					
		referral" dated 9/5/17. "Do					
		others who disturb me such ut" dated 6/20/19 and revised					
		urage) smaller groups to					
	,	n" dated 6/20/19 and revised					
		ny medications as my doctor					
		2/1/17. "Help me maintain					
		sit" dated 2/1/17. "Help me					
		people that are upsetting to					
		nd revised 6/26/19. "Keep					
	me separated from o	ther residents who are too					
		/20/19 and revised 6/26/19.					
		ow if I (sic) my behaviors are					
		aily living" dated 6/24/15.					
		in pain or uncomfortable"					
		me something I like as a					
		0/19 and revised 6/26/19.					
	, , ,	s own sugar packs" dated					
	2/1/17. "Please refer						
		trist as needed refer back to					
	psych for eval" dated						
		me what you are going to do				ĺ	
		ted 6/24/15. "Re-approach //combative, explain what					
		o do first" dated 12/30/19.				I	

TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED			
		495140	B. WING			C 03/10/2020
	AMME OF PROVIDER OR SUPPLIER  ROSE HILL HEALTH AND REHAB    (X4) ID PREFIX TAG     PREFIX TAG     Continued From page 19     "Resident requires a great distance from other residents. Feels crowded when people get too close to his space" dated 6/20/19 and revised 6/26/19. "Speak to me unhurriedly and in a calm voice" dated 6/26/19.  The comprehensive care plan for Resident #69 also included one dated 3/12/17 for "I sometimes have behaviors which include hitting during activities." This care plan included the following interventions: "Assess dining room seating set-up. Sit me where I am not too close to other residents" dated 6/20/19 and revised 6/26/19.  "Attempt interventions before my behavior begin. Offer me my favorite drink (coffee) or food" dated 6/20//19 and revised 6/26/19. "Do not seat me around others who disturb me" dated 10/17/19 and revised 10/20/19. "Give me my medications as my doctor has ordered" dated 8/1/18. "Help me maintain my favorite place to sit" dated		STREET ADDRESS, CITY, STATE, ZIP COD 110 CHALMERS COURT BERRYVILLE, VA 22611		03/10/2020	
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 600	"Resident requires a residents. Feels crow close to his space" da 6/26/19. "Speak to m voice" dated 6/26/19. The comprehensive calso included one dathave behaviors which activities." This care interventions: "Assesset-up. Sit me where residents" dated 6/20 "Attempt intervention. Offer me my favorite 6/20/19 and revised around others who diand revised 10/20/19 as my doctor has ord me maintain my favor 6/20/19 and revised 6/26/19.	great distance from other wided when people get too ated 6/20/19 and revised ne unhurriedly and in a calm care plan for Resident #69 ted 3/12/17 for "I sometimes in include hitting during plan included the following so dining room seating at I am not too close to other 1/19 and revised 6/26/19. It is before my behavior begin. I drink (coffee) or food" dated 6/26/19. It is before my medications are distributed at a dated 8/1/18. It is likely a sure of the properties of the pro	F 60			
	revealed a nurse's no documented, "Reside arguing with another					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  G		E SURVEY IPLETED
		495140	B. WING		0:	C 3/ <b>10/2020</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	1 00	5/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 600	[Resident #67] pundarm, when the other back, they began exwere separated."  Further review of the #67 failed to reveal this incident other the resident was status resident-to-resident any further behavior.  A review of the come Resident #67 failed any updates after the have a care plan, day (diagnoses) of Bipo Disorder." This care interventions: "Encoactivities related to be "Help me to keep in friends" dated 6/11/with similar interests me my medications depression and mare 6/11/15. "Please te are not improving to medication" dated 6/16/11/15. "Please te are not improving to medication" dated 6/16/11/15. "Please te are not improving to medication" dated 6/16/11/15. "Please te are not improving to medication" dated 6/16/11/15. "Please te are not improving to medication" dated 6/16/11/15. "All Please te are not improving to medication" dated 6/16/11/15. "Please te are not improving to medication" dated 6/11/15/15	by staff, this resident ched the other resident in the resident [Resident #69] hit schanging blows until they be clinical record for Resident any additional notes regarding than to document that the post aggressor of a incident and did not display	F 60			
	(Administrative Staf Director and Region Services) were mad incident. Additional	AM, ASM #1 and ASM #3  f Members, the Executive hal Director of Clinical le aware of the identified information such as an requested. None was				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION  G		OATE SURVEY OMPLETED
		495140	B. WING _			C 03/10/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	I	03/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	of the process is to responsible party, ar following the resident interventions are need should be looked at a due to the cognitive facility did not considere portable, and did not the incident.  On 3/10/20 at 2:30 For of the concern. No fiprovided.  References:  (1) Seroquel is an arraymptoms of schizogmania or depression Information obtained https://medlineplus.gtml  (2) Depakote is used symptoms of mania Information obtained https://medlineplus.gtml  2. On 2/26/19, facility Resident #650 was find Resident #69 hit Resident #6	PM, ASM #1 stated that part notify the doctor and the aid if psych [psychiatric] is to to the indifference of the care plan and updated. ASM #1 stated status of the residents, the ler this as abuse, or ot complete an investigation of the information was a state of the information was a state of the care plan and updated. ASM #1 stated status of the residents, the ler this as abuse, or ot complete an investigation of the care plan and the care plan and updated. ASM #1 was made aware for the information was a state plan and the care plan and updated to bipolar disorder. It is treat seizures or related to bipolar disorder.	F 6			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495140	B. WING		C 03/10/2020
	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611	1 00/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 600	stroke, dementia with hemiparesis, depression shoulder, dysphagia epilepsy, and high be MDS (Minimum Date (Assessment Reference the resident as being to make daily life decoded as requiring the extensive care for the resident and hygiene; supervoluce of the resident and bladder.  Resident #650 was 3/14/18; diagnoses femur fracture, deprosible papnea, high be atrial fibrillation, con respiratory failure, a resident expired at the time of survey MDS (Minimum Date (Assessment Reference the resident as being to make daily life decoded as requiring the model of the should be	include, but are not limited to the behaviors, hemiplegia and a sion, pain in leg and a dijustment disorder, alood pressure. The quarterly a Set) with an ARD ence Date) of 2/4/20 coded g severely impaired in ability cisions. The resident was otal care for bathing; ansfers, dressing, toileting vision for eating and as frequently incontinent of admitted to the facility on include but are not limited to ession, chronic obstructive lood pressure, heart disease, gestive heart failure, acute nd cardiac pacemaker. The he facility on 8/5/19 and current resident in the facility of the facility of the significant change a Set) with an ARD ence Date) of 6/28/19 coded g severely impaired in ability cisions. The resident was otal care for bathing, hygiene, dressing; and extensive	F 600		
	revealed a nurses n documented, "Resid	cal record for Resident #69 ote dated 2/26/19 that lent to resident altercation at 1730 (5:30 PM). Staff			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		COMF	(X3) DATE SURVEY COMPLETED		
	495140	B. WING			C / <b>10/2020</b>
	AB		110 CHALMERS COURT	•	10/2020
(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE
IA (Certified Nurse ter that resident 19] w/c (wheel cheel) turned around he face. Resides taken into rest of LPN's (Licenson the face) taken into rest of the face of the design of the review of the review of the review of the staff. Found the staff. Found he hall way (Sich alert to him self (per staff he doel lant (sic). 2/7/19 el 23.0, electroly into resident claychological] for of the review of the review of the staff. Found he hall way (Sich alert to him self (per staff he doel lant (sic). 2/7/19 el 23.0, electroly into resident claychological] for of the review of the revealed a psychological of the review of the review of the review of the review of the revealed a psychological of the review of the re	sing Assistant) alerted this (#650) bumped into residents hair) in dining room. Resident d and hit resident [#650] twice ent separated from area and corative dining room with two ed Practical Nurse) to eat his sident alert times one. When ed resident [#69] about allegations. No further Resident [#69] cooperative with dents. Resident [#69] dy for inappropriate behaviors. In alternative dining room and was witnessed diresident sitting in wheelchair coloning out the window. He Sic.) and denied the episode. In a shave a tendency to get the blood work with Valproic acid area witnessed diresident effect of the psychological sted 3/4/19, that documented, aluate mental status and to	F 600			
	SUMMARY (EACH DEFICIE REGULATORY CONTINUED FROM NUMBER 1) Wheel of 19 turned around the face. Resides taken into rest ff LPN's (Licensering mealRest writer question ident he denied naviors noted. Fff and other resident for poar plan updated of the review of the prevented apply to documented, "incident. Resides twice at the determination of the review of the prevented apply to documented, "incident. Resides twice at the determination of the staff. Found the staff. Found the staff. Found the staff. Found the staff he documented, "incident. Resides twice at the determination of the staff he documented in the staff. Found the staff. Found the staff he documented in the staff he documented in the staff. Found the staff he documented in the st	RECTION IDENTIFICATION NUMBER:	DER OR SUPPLIER  SALTH AND REHAB  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  THIN THE RESIDENT (#650) bumped into residents (P) W/c (wheel chair) in dining room. Resident (P) W/c (wheel chair) in dining room with two ff LPN's (Licensed Practical Nurse) to eat his ening mealResident alert times one. When swriter questioned resident [#69] about ident he denied allegations. No further naviors noted. Resident [#69] cooperative with ff and other residents. Resident [#69] mitored frequently for inappropriate behaviors. [nurse practitioner], DON [director of nursing] d POA [power of attorney] aware of incident. re plan updated."  "ther review of the clinical record for Resident d revealed a physician's note dated 2/26/19 t documented, "Called by the nurse to report incident. Resident had hit a resident in her set wice at the dining room and was witnessed the staff. Found resident sitting in wheelchair he hall way (Sic.) looking out the window. He alert to him self (Sic.) and denied the episode. per staff he does have a tendency to get lant (sic). 2/7/19 blood work with Valproic acid el 23.0, electrolytes WNL (within normal limits), nitor resident closely. Will refer to the psych ychological] for evaluation of his medications."  "ther review of the clinical record for Resident of revealed a psych eval (psychological aduation) note dated 3/4/19, that documented, attent seen to evaluate mental status and to ust medications Follow up requested by	A BUILDING  495140  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  A CONSS-REFERENCED TO DEFICIENCY  TAG  PREFIX FACTOR SUMPLER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  FOOD  TAG  FOOD  FOOD  FREFIX FACTOR  FACTOR  FREFIX FACTOR  FROM  FROM  FACTOR  FREFIX FACTOR  FREFIX FACTOR  FREFIX FACTOR  FROM  FACTOR  F	DER OR SUPPLIER  A 95140  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  B. WING  SUMMARY STATEMENT OF DEPICIENCIES  (REACH DEPICIENCY MUST BE PRECEDED BY YILL  REGULATORY OR LSC IDENTIFYING INFORMATION)  A (Certified Nursing Assistant) alerted this ter that resident (#650) bumped into residents 9) wic (wheel chair) in dining room. Resident 191 turned around and hit resident (#650) twice he face. Resident separated from area and staken into restorative dining room with two fit LPN's (Licensed Practical Nurse) to eat his sining meal Resident alert times one. When swirter questioned resident [#69] about ident he denied allegations. No further avoivers noted. Resident [#69] cooperative with fit and other residents. Resident [#69] around a phair resident in her see have a physician's note dated 2/26/19 to documented, "Called by the nurse to report incident. Resident shall be resident in her set wice at the dining room and was witnessed the staff. Found resident sitting in wheelchair he hall way (Sic.) looking out the window. He later to him self (Sic.) and denied the episode. per staff he does have a tendency to get lant (sic.) 2/7/19 blood work with Valiproic acid el 23.0, electrolytes WNL (within normal limits). nitor resident closely. Will refer to the psych ychologicall for evaluation of his medications."  ther review of the clinical record for Resident 9 revealed a psych eval (psychological situation) note dated 3/4/19, that documented, sitent seen to evaluate mental status and to sut medications Follow up requested by

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495140	B. WING		03/10/2020	
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	03/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION	
F 600	WCTreatment Plan Continue current psy follows: seroquel (1) dementia/BPSD (ber symptoms of dement BID (twice a day] due including physical ag mood stabilization, 3 behaviorsAfter car benefits of anti-psych patient outweigh the dyskinesia, hyperglyd in modifying the behap possible while the parameter of the comp Resident #69 revealed have a hx (history) of which include following wheeling behind staft things, claiming I am member. I can becound believe that they going to take me hon sexual inappropriate being aggressive tow (residents) by grabbiliarm, calling out where addressed, and reject refuses therapy prn (refuse rest periods we This care plan includinterventions: "Aggrealtercation, residents and revised 1/14/20.	ntally bumped into his in / Recommendations2. chotropic medications as for psychosis related to havioral and psychological ia) - change to 50 mg oral enegative behaviors gression, Depakote (2) for a monitor mood and eful consideration, the notic medications in this potential risks of tardive demia and stroke. They help avior such that normal care is tient is in the nursing facility."  The following behaviors in the following at staff, if desk and packing up my going home with a staff are my partner and are ne with them. I have a hx of behavior, I have a hx of the following and squeezing in care needs have been string care when offered, as needed), At times I will hen encouraged/offered."  ed the following	F 60	0		
	activities room and w	ratch TV. Or if there is any enjoy" dated 6/26/19.				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILD	_		, ا	3
		495140	B. WING				10/2020
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
ROSE HIL	L HEALTH AND REHAB				10 CHALMERS COURT		
				E	BERRYVILLE, VA 22611		
(X4) ID 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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	a path so that I can in hall way" dated 6/20/19 "Attempt intervention begin" dated 6/20/19 "Complete an activity not seat me around cas people who yell or 6/26/19. "Enc (encoravoid over stimulation 6/26/19. "Give me mhas ordered" dated 2 my favorite place to so to avoid situations or me" dated 6/20/19 arme separated from or close to me" dated 6/3 "Let my physician know interfering with my da "Make sure I am not dated 2/1/17. "Offer diversion" dated 6/20 "Offer rt (resident) his 2/1/17. "Please refer psychologist/psychiatingsych for eval" dated 1/14/20. "Please tell before you begin" dated 1/14/20. "Please tell before you begin" dated 1/14/20. "Resident requires a residents. Feels crow close to his space" dated 6/26/19. "Speak to myoice" dated 6/26/19. "The comprehensive of the search of the comprehensive of the search of the comprehensive of the search of the search of the comprehensive of the search of the searc	others out of the way to clear move freely up and down the 19 and revised 1/14/20. It is before my behaviors and revised 6/26/19. It referral dated 9/5/17. "Do others who disturb me such cut" dated 6/20/19 and revised urage) smaller groups to in dated 6/20/19 and revised urage) smaller groups to in dated 6/20/19 and revised urage) smaller groups to in dated 6/20/19 and revised urage) smaller groups to in dated 6/20/19 and revised urage) smaller groups to in dated 6/20/19. "Help me people that are upsetting to ind revised 6/26/19. "Keep ther residents who are too 1/20/19 and revised 6/26/19. It in pain or uncomfortable in pain or uncomfortable in me something I like as a 1/19 and revised 6/26/19. It is own sugar packs dated in me to my trist as needed refer back to 6/24/15 and revised me what you are going to do it de 6/24/15. "Re-approach 1/combative, explain what do first" dated 12/30/19. It is great distance from other wided when people get too in ated 6/20/19 and revised in eunhurriedly and in a calm	F	600			
		n include hitting during					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495140	B. WING		C 03/10/2020	
	NAME OF PROVIDER OR SUPPLIER  ROSE HILL HEALTH AND REHAB  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES		1	TREET ADDRESS, CITY, STATE, ZIP CODE  10 CHALMERS COURT  BERRYVILLE, VA 22611	1 00/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 600	interventions: "Asseset-up. Sit me where residents" dated 6/20 "Attempt intervention Offer me my favorite 6/20//19 and revised around others who dand revised 10/20//19 as my doctor has orome maintain my favorite 6/20/19 and revised situations or people dated 6/20/19 and ream not in pain or und "Pharmacy medicatic "Please refer me to ras needed" dated 3/another (sic) resident	e plan included the following ass dining room seating e I am not too close to other 0/19 and revised 6/26/19. In sefore my behavior begin. In drink (coffee) or food dated 6/26/19. In seat me listurb me" dated 10/17/19 or give me my medications dered dated 8/1/18. In Help or the place to sit dated 6/26/19. In Help me to avoid that are upsetting to me evised 6/26/19. In Make sure I comfortable dated 8/1/18. In review dated 3/13/17. In my psychologist/psychiatrist 12/17. In Separate me from the first sit to (sic) close the deformance of the place of the sit to (sic) close the deformance of the place of the sit to (sic) close the deformance of the place of the pla	F 600			
	revealed a physician documented, "Called resident [#650] as she dining room she was another resident. She No injuries. No bruis dorsum of the nose of the review of the #650 revealed a nursed documented, "Assauduring supper in the	ral record for Resident #650 in note dated 2/26/19 that id by the nurse to evaluate the was assaulted. At the is punched in to her nose by the was tearful and anxious. Sing but mild erythema on moted.  Reclinical record for Resident is se's note dated 2/26/19 that fulted by another resident dining hall. No injuries rful and upset. Slight				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495140	B. WING				C 10/2020
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			1	TREET ADDRESS, CITY, STATE, ZIP CODE 10 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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	after consoling from a Practitioner], POA [Po [Director of Nursing] roalm and sociable threvening. Will continue A review of the compound Resident #650 failed behaviors, potential for address this incident.  On 3/9/20 at 10:10 Al (Administrative Staff I Director and Regional Services) were made incident. Additional in incident report was report was reported. Per this request, the form the modern of the modern of the modern of the modern of the commented, "Resided in face on nose and for the commented of the com	ally. Resident calmed down staff. NP [Nurse ower of Attorney], DON notified. Resident remained ough the rest of the e to monitor."  The hensive care plan for to reveal any care plans for or abuse, or any revisions, to the executive of Clinical aware of the identified and aware of the identified incident (#650) or ehead in the dining of the identified incident incident aware of the residents, the facility as abuse, or reportable, and aware identified incident report, which and thorough investigation.  M. ASM #1 was made aware	F	600			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495140	B. WING		C 03/10/2020		
	ROVIDER OR SUPPLIER  L HEALTH AND REHA	В		STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611	1 00/10/2020		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION		
F 600	Continued From pa	ge 28	F 600				
	symptoms of schizo mania or depression Information obtained https://medlineplus. tml  (2) Depakote is use symptoms of mania Information obtained https://medlineplus.	gov/druginfo/meds/a698019.h d to treat seizures or related to bipolar disorder.					
	Resident #652 was #69 grabbed Resident #69 was a 1/17/13; diagnoses stroke, dementia wi hemiparesis, depresshoulder, dysphagia epilepsy, and high b MDS (Minimum Dat (Assessment Refer the resident as bein to make daily life decoded as requiring extensive care for trand hygiene; super	ity staff failed to ensure that free from abuse, Resident ent #652 by the neck admitted to the facility on include, but are not limited to the behaviors, hemiplegia and assion, pain in leg and a, adjustment disorder, blood pressure. The quarterly as Set) with an ARD ence Date) of 2/4/20 coded ag severely impaired in ability ecisions. The resident was total care for bathing; ransfers, dressing, toileting vision for eating and is frequently incontinent of					
	Resident #652 was	admitted to the facility on					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495140	B. WING			C 03/10/2020	
	ROVIDER OR SUPPLIER	100110		s 1	STREET ADDRESS, CITY, STATE, ZIP CODE  10 CHALMERS COURT  BERRYVILLE, VA 22611	<u> </u>	10/2020
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	heart failure, insomnia behaviors, and high be expired on 2/19/19 are in the facility at the tin admission MDS (Mini (Assessment Referent the resident as being to make daily life deci- coded as requiring to	aclude but are not limited to a, dysphagia, dementia with blood pressure. The resident and was not a current resident are of the survey. The mum Data Set) with an ARD ace Date) of 2/6/19 coded severely impaired in ability isions. The resident was tal care for bathing; ansfers, dressing, toileting	F	600			
	revealed a nurses not documented, "Resider resident [#652] by the dining room. Remove room and kept him with Resident [#69] has referenced removing. Other residinjuries. Notified POA Notified DON (Director (Nurse Practitioner)."  Further review of the #69 revealed a physical (psychological evaluated documented, "Patient status and to adjust noticident in which residered resident to resident at the documented of the provided resident and the side of the provided resident and the provided resident resident and the provided resident resident and the provided resident re	ent [#69] grabbed another e neck during supper in the ed resident [#69] from dining ith nurse for supper. emained calm since dent [#652] has no apparent A (Power of Attorney). or of Nursing). Notified NP clinical record for Resident cian psych eval attion) note dated 2/19/19 that it seen to evaluate mental medicationsRecent dent was an aggressor in					
	•	unit in WC (wheel chair) ous failure to reduce					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		495140	B. WING _			03/10/2020	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT			
RUSE 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 CORF ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 600	psychosis related to cand psychological syn Depakote (2) for moo mood and behaviors. consideration, the being medications in this parisks of tardive dyskinstroke. They help in that normal care is pothe nursing facility."  A review of the composite Resident #69 reveale have a hx (history) of which include following wheeling behind staff things, claiming I ammember. I can becord and believe that they going to take me hom sexual inappropriate being aggressive tow (residents) by grabbinarm, calling out when addressed, and reject refuses therapy prn (arefuse rest periods with this care plan include interventions: "Aggrealtercation, residents and revised 1/14/20. of coffee and see if I activities room and wother activity I would	2. Continue current ions as follows: seroquel for lementia/BPSD (behavioral mptoms of dementia), d stabilization, 3. monitorAfter careful nefits of anti-psychotic tient outweigh the potential esia, hyperglycemia and modifying the behavior such esible while the patient is in rehensive care plan for d one dated 6/24/15 for "I the following behaviors ag and cursing at staff, desk and packing up my going home with a staff are my partner and are see with them. I have a hx of behavior, I have a hx of cards staff/others rt's ag, hitting and squeezing care needs have been ting care when offered, as needed), At times I will nen encouraged/offered."  The details the following sor of Resident to separated dated 10/17/19 "Ask me if I would like a cup would like to go to the atch TV. Or if there is any	F6				
	a path so that I can m	nove freely up and down the 19 and revised 1/14/20.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILD			(	C
		495140	B. WING			03/	10/2020
	ROVIDER OR SUPPLIER	3	•	11	REET ADDRESS, CITY, STATE, ZIP CODE  O CHALMERS COURT  ERRYVILLE, VA 22611		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	begin" dated 6/20/19 "Complete an activity not seat me around as people who yell of 6/26/19. "Enc (enco avoid over stimulation 6/26/19. "Give me in has ordered" dated 2/26/19 and me separated from ordered dated 6/20/19 and me separated from ordered dated 6/20/19. "Offer it (resident) his 2/1/17. "Please refe psychologist/psychiate psych for eval" dated 1/14/20. "Please tell before you begin" dated 1/14/20. "Speak to residents. Feels croclose to his space" of 6/26/19. "Speak to recide dated 6/26/19. "Speak to recide dated 6/26/19. "The comprehensive also included one date have behaviors which	as before my behaviors and revised 6/26/19. The property of th	F	600			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495140	B. WING _				C <b>10/2020</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 110 CHALMERS COURT BERRYVILLE, VA 22611	DE	1 00,	10/2020
(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 C ( (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD B E APPROPRIA		(X5) COMPLETION DATE
F 600	"Attempt interventions Offer me my favorite 6/20//19 and revised around others who di and revised 10/20/19 as my doctor has ord me maintain my favor 6/20/19 and revised 6 situations or people the dated 6/20/19 and revised 6 am not in pain or unco "Pharmacy medication" Please refer me to mas needed" dated 3/1 another (sic) resident	/19 and revised 6/26/19. s before my behavior begin. drink (coffee) or food" dated 6/26/19. "Do not seat me sturb me" dated 10/17/19 . "Give me my medications ered" dated 8/1/18. "Help	F6	500			
	revealed a nurses no also been crossed ou Entry:On 2.15.19 [F (sic) by another resid had been monitoring further abrasions had increased anxiety and Family members had A review of the compi Resident #652 reveal revised on 2/21/19 the sometimes have been Screaming/Yelling ou constantly. This care	d distress had been noted. been notified."  rehensive care plan for ed one dated 2/5/19 and at documented, "I aviors which include t, calls "help, help" plan included the following not seat me around others					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495140	B. WING			C 03/10/2020	
	ROVIDER OR SUPPLIER			3	STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611	1 03/	10/2020
(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 SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	that are upsetting to r revised 2/21/19. "Off diversion" dated 2/5/1 On 3/9/20 at 10:10 Al	avoid situations or people ne" dated 2/5/19 and er me something I like as a 19 and revised 2/21/19. M, ASM #1 and ASM #3	F	600			
	Director and Regiona Services) were made	aware of the identified nformation such as an					
	or Staff Member" form documented, "(Residencesident (#652) whee (Resident #69) and (F	Assault of Another Resident n dated 2/15/19. This form ent #69) was at dinner table,					
	to the cognitive status did not consider this a did not complete an in beyond the above ide	M, ASM #1 stated that due s of the residents, the facility as abuse, or reportable, and expressing the state of the state					
	On 3/10/20 at 2:30 PI of the concern. No fu provided.	M, ASM #1 was made aware irther information was					
	References:						
	symptoms of schizop mania or depression Information obtained	tipsychotic used to treat hrenia, or symptoms of related to bipolar disorder. from ov/druginfo/meds/a698019.h					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION  G	COMPLETED	
		495140	B. WING		C 03/10/2020	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	03/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION	
F 600	Information obtained https://medlineplus.gtml  4. On 3/18/19, facility Resident #7 was free #69 hit Resident #7 if Resident #69 was ad 1/17/13; diagnoses if stroke, dementia with hemiparesis, depressionalder, dysphagia epilepsy, and high bly MDS (Minimum Data (Assessment Refere the resident as being to make daily life decoded as requiring to extensive care for train and hygiene; supervolocomotion; and was bowel and bladder.  Resident #7 was add 2/19/19, diagnoses if stroke, hemiplegia, hemiple	I to treat seizures or related to bipolar disorder. from lov/druginfo/meds/a682412.h  y staff failed to ensure that e from abuse, when Resident in the face without injury.  Imitted to the facility on include, but are not limited to in behaviors, hemiplegia and sion, pain in leg and adjustment disorder, lood pressure. The quarterly a Set) with an ARD ince Date) of 2/4/20 coded in severely impaired in ability cisions. The resident was lotal care for bathing; ansfers, dressing, toileting ision for eating and frequently incontinent of include but are not limited to be include but are not limited to be include but are not limited to be included but are not limited to be include	F 60			

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		(X3) DATE SURVEY COMPLETED	
	495140	B WING		C	
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	03/10/2020	
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRICIENCY)	ULD BE COMPLETION	
' '	-	F 60	0		
Resident #69:					
revealed a nurses n documented, "Resic dining room at 1730 behind resident (#7) his w/c (wheel chair became agitated an side of the face. No separated and resid room to eat his mea notified. DON, POA power of attorney, n	ote dated 3/18/19 that dent [Resident #69] was in (5:30 PM). He was going then [Resident #7] back into ). Resident [Resident #69] d hit her [Resident #7] on the injuries noted. Residents ent taken to restorative dining I. Resident (#7) nurse was a, and NP [director of nursing, urse practitioner] aware of				
#69 revealed a psycevaluation) note dat "Patient seen to evaluations to have some period residents. Seroquel mg oral BID on 3/4/Recommendations psychotropic medical psychosis related to and psychological schange to 50 mg orabehaviors including Depakote (2) for mod and behaviors consideration, the bemedications in this particular to the service of the service	ch eval (psychological ed 4/4/19 that documented, shuate mental status and toPer chart, patient continues dic aggression with other (1) recently increased to 50 19Treatment Plan /2. Continue current ations as follows: seroquel for dementia/BPSD (behavioral ymptoms of dementia) - all BID to due negative physical aggression, and stabilization, 3. monitor sAfter careful enefits of anti-psychotic patient outweigh the potential				
	ROVIDER OR SUPPLIER  L HEALTH AND REHAI  SUMMARY S (EACH DEFICIEN REGULATORY OF REGULA	A95140  ROVIDER OR SUPPLIER  L HEALTH AND REHAB  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 35 hygiene; and as requiring supervision for eating.	ROVIDER OR SUPPLIER  L HEALTH AND REHAB  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 35 hygiene; and as requiring supervision for eating.  Resident #69:  A review of the clinical record for Resident #69 revealed a nurses note dated 3/18/19 that documented, "Resident [Resident #69] was in dining room at 1730 (5:30 PM). He was going behind resident (#7) then [Resident #7] back into his w/c (wheel chair). Resident [Resident #69] became agitated and hit her [Resident #7] on the side of the face. No injuries noted. Residents separated and resident taken to restorative dining room to eat his meal. Resident (#7) nurse was notified. DON, POA, and NP [director of nursing, power of attorney, nurse practitioner] aware of incident. Care plan updated."  Further review of the clinical record for Resident #69 revealed a psych eval (psychological evaluation) note dated 4/4/19 that documented, "Patient seen to evaluate mental status and to adjust medicationsPer chart, patient continues to have some periodic aggression with other residents. Seroquel (1) recently increased to 50 mg oral BID on 3/4/19Treatment Plan / Recommendations2. Continue current psychotropic medications as follows: seroquel for psychosis related to dementia/BPSD (behavioral and psychological symptoms of dementia) - change to 50 mg oral BID to due negative behaviors including physical aggression, Depakote (2) for mood stabilization, 3. monitor mood and behaviorsAfter careful consideration, the benefits of anti-psychotic medications in this patient outweigh the potential risks of tardive dyskinesia, hyperglycemia and	ROVIDER OR SUPPLIER  L HEALTH AND REHAB  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL (REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 35 hygiene; and as requiring supervision for eating.  Resident #69:  A review of the clinical record for Resident #69 revealed a nurses note dated 3/18/19 that documented, "Resident [Resident #69] was in dining room at 1730 (5:30 PM). He was going behind resident (#7) then [Resident #7] on the side of the face. No injuries noted. Resident's separated and resident taken to restorative dining room to eat his meal. Resident (#7) push reproved to a future was notified. DON, POA, and NP [director of nursing, power of attorney, nurse practitioner] aware of incident. Care plan updated.*  Further review of the clinical record for Resident #69 revealed a psych eval (psychological evaluation) note dated 4/4/19 that documented, "Patient seen to evaluate mental status and to adjust medicationsPer chart, patient continues to have some periodic aggression with other residents. Seroquel (1) recently increased to 50 mg oral BID on 3/4/19Treatment Plan / Recommendations2. Continue current psychotropic medications as follows: seroquel for psychosize related to demential/BPSD (behavioral and psychological symptoms of dementia) - change to 50 mg oral BID to due negative behaviors including physical aggression, Depakote (2) for mood stabilization, 3. monitor mood and behaviorsAfter careful consideration, the benefits of anti-psychotic medications in this patient outweigh the potential risks of tardity dyskinesia, hyperglycemia and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPI IDENTIFICATION NUMBER: A. BUILDING			CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495140	B. WING			C 03/10/2020			
NAME OF PI	ROVIDER OR SUPPLIER		1	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2020		
ROSE HII	L HEALTH AND REHAB			11	0 CHALMERS COURT				
NOSE IIIL	L IILALIII AND NLIIAD			В	ERRYVILLE, VA 22611				
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	e 36	F 6	800					
	that normal care is po the nursing facility."	essible while the patient is in							
		rehensive care plan for							
		d one dated 6/24/15 for "I							
	\ ,	the following behaviors and cursing at staff,							
		desk and packing up my							
		going home with a staff							
	member. I can becor	ne attached to certain staff							
	and believe that they	are my partner and are							
	going to take me hom								
		behavior, I have a hx of							
	being aggressive tow								
	,	ng, hitting and squeezing							
		care needs have been							
		ting care when offered,							
		as needed), At times I will nen encouraged/offered."							
	This care plan include	<u> </u>							
	interventions: "Aggre	<del>-</del>							
		separated" dated 10/17/19							
	I .	"Ask me if I would like a cup							
	of coffee and see if I	•							
		atch TV. Or if there is any							
	other activity I would								
		thers out of the way to clear							
	a path so that I can m	ove freely up and down the							
	hall way" dated 6/20/	19 and revised 1/14/20.							
	1	s before my behaviors							
	begin" dated 6/20/19								
		referral" dated 9/5/17. "Do							
	I .	thers who disturb me such							
	' '	it" dated 6/20/19 and revised				ſ			
		rage) smaller groups to							
	I .	n" dated 6/20/19 and revised							
		y medications as my doctor				ĺ			
		/1/17. "Help me maintain it" dated 2/1/17. "Help me							
	i my lavonie diace to s	ii ualeu z/1/1/. Helb me	1	- 1					

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 20.22.	<del></del>		С	
		495140	B. WING				10/2020
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	, 00,	10/2020
				1	10 CHALMERS COURT		
ROSE HIL	L HEALTH AND REHAB			В	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 SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	me" dated 6/20/19 and me separated from of close to me" dated 6/20/19 and me separated from of close to me" dated 6/20/12. "Let my physician know interfering with my dated 1/14/20. "Offer it (resident) his 2/1/17. "Please refer psychologist/psychiat psych for eval" dated 1/14/20. "Please tell before you begin" dated 1/14/20. "Speak to movice" dated 6/26/19. "Speak to movice" dated 6/26/19. "Speak to movice" dated 6/26/19. "The comprehensive calso included one dath have behaviors which activities." This care interventions: "Assesset-up. Sit me where residents" dated 6/20 "Attempt interventions Offer me my favorite 6/20//19 and revised 10/20/19 as my doctor has order me maintain my favor 6/20/19 and revised 6/20/19 and 6/20/	people that are upsetting to d revised 6/26/19. "Keep ther residents who are too 20/19 and revised 6/26/19. ow if I (sic) my behaviors are ily living" dated 6/24/15. In pain or uncomfortable" me something I like as a /19 and revised 6/26/19. It own sugar packs dated me to my rist as needed refer back to 6/24/15 and revised me what you are going to do ed 6/24/15. "Re-approach /combative, explain what do first" dated 12/30/19. Igreat distance from other yield when people get too ated 6/20/19 and revised ine unhurriedly and in a calm revised hitting during plan included the following is dining room seating I am not too close to other /19 and revised 6/26/19. Is before my behavior begin. drink (coffee) or food" dated 6/26/19. "Do not seat me sturb me" dated 10/17/19 is "Give me my medications ered" dated 8/1/18. "Help"	F	600			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495140	B. WING		C 03/10/2020	
	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	1 00/10/2020	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 600	am not in pain or un "Pharmacy medicat "Please refer me to as needed" dated 3, another (sic) resider	ge 38 evised 6/26/19. "Make sure I comfortable" dated 8/1/18. on review" dated 3/13/17. my psychologist/psychiatrist (12/17. "Separate me from hts if they sit to (sic) close ted 6/20/19 and revised	F 600			
	revealed a nurses in documented, "Resid smacked by anothe during dinner. The was removed from to on the face [of Residupset but remained supper with others. but no redness or in There was no further this incident other thresident had exhibit A review of the com Resident #7 failed to behaviors, potential a result of this incident of this incident of this incident of the com Resident #7 failed to behaviors, potential a result of this incident of this incident of this incident and Regional Clinical Regional Clinical Regional Clinical smacked by another serior s	or documentation regarding than to document that the ed no emotional distress.  prehensive care plan for or reveal any care plans for for abuse, or any revisions as				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION  G	, ,	COMPLETED		
		495140	B. WING			C 03/10/2020		
	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	1 00/10/2020			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 600	or Staff Member" for documented, "Resid face in dining room. (Resident #7) and si chair)."  On 3/09/20 at 3:20 Fto the cognitive statudid not consider this did not complete an beyond the above ic was not a complete.  On 3/10/20 at 2:30 Fto the concern. Not in provided.  References:  (1) Seroquel is an an asymptoms of schizo mania or depression Information obtained that is symptoms of mania. (2) Depakote is used symptoms of mania. Information obtained that is symptoms of mania.	facility provided a t Assault of Another Resident m dated 3/18/19. This form lent (#69) hit Resident (#7) on (Resident #69) was behind he backed into his w/c (wheel PM, ASM #1 stated that due us of the residents, the facility as abuse, or reportable, and investigation on the incident lentified incident report, which and thorough investigation.  PM, ASM #1 was made aware further information was  httpsychotic used to treat phrenia, or symptoms of a related to bipolar disorder. If from gov/druginfo/meds/a698019.h	F 60					
	Resident #651 was	ty staff failed to ensure that free from abuse, when sident #651 in the chest and mall laceration.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495140	B. WING		C 03/10/2020	
	NAME OF PROVIDER OR SUPPLIER  ROSE HILL HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611	1 03/10/2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 600	1/17/13; diagnoses i stroke, dementia with hemiparesis, depres shoulder, dysphagia epilepsy, and high bl MDS (Minimum Data (Assessment Refere the resident as being to make daily life decoded as requiring to extensive care for train and hygiene; supervolocomotion; and was bowel and bladder.  Resident #651 was a 11/3/17; diagnoses in dementia with behave pressure, and chronic resident expired in the therefore was not a contract the survey. The annumber of the survey. The annumber of the survey is the stroke with the survey. The annumber of the survey is the survey is the survey in the survey. The annumber of the survey is the survey in the survey is the survey in the survey. The annumber of the survey is the survey is the survey in the survey is the survey is the survey in the survey in the survey is the survey is the survey in the	dmitted to the facility on include, but are not limited to in behaviors, hemiplegia and sion, pain in leg and adjustment disorder, lood pressure. The quarterly a Set) with an ARD ince Date) of 2/4/20 coded greverely impaired in ability cisions. The resident was otal care for bathing; ansfers, dressing, toileting	F 600	,		
	The resident was co- care for hygiene, toil and supervision for e Resident #69:	make daily life decisions.  ded as requiring extensive eting, dressing and transfers; eating.  al record for Resident #69				
	revealed a nurse's n documented, "This re [#651] was sitting in	ote dated 6/20/19 that esident [#69] and resident the lobby beside each other. it [Resident #651] in the				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
		495140	B. WING _			C 03/10/2020
	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP COE 110 CHALMERS COURT BERRYVILLE, VA 22611	DE	337.107.232.0
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD B APPROPRIA	DATE
F 600	Continued From page chest with a closed attempted to separate were separated this in the left eye with a separated immediate.  Further review of the #69 revealed a social that documented, "Noticident with resident shows no signs of element baseline. Resident services at next visite.  Further review revealed a social that documented, "Noticident with resident shows no signs of element baseline. Resident services at next visite.  Further review revealed 20/19 that documente in the services at next visite. Witness by staff as it wheelchair he hit the apparent reason. Finacross the other resident is arm around the resident in the services are around the resident in the services in	ge 41 fist. The receptionist te the 2 men and before they resident hit [Resident #651] closed fist. Residents ely."  e clinical record for Resident al worker note dated 6/20/19 Met with resident due to at [#651]. Resident [#69] motional distress and is at [#69] to be seen by psych"  alled a physician note dated ented, "Reported by the nurse other resident [#651]. The [#69] was sitting in the other resident [#651] for no first he [#69] swung his arm fident [#651] and then swung resident [#651] eyes. He is information due to aphasia. The words with expressions.	F 6			
	has a past history of medications reviewed Dementia with beha (Depakote) (1) 250n Psychology input ap 650mg x1 for heada Further review of the #69 revealed a psychology input ap 6/25/19 that docume another resident. H Follow up requested	ng BID. Seroquel 25 mg BID. preciated. Give Tylenol (2)				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495140	B. WING		C 03/10/2020	
	NAME OF PROVIDER OR SUPPLIER  ROSE HILL HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611	7 30/10/2020	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 600	sustained a laceration of recall altercation up to discuss with hi and periodic physical current meds [medicindicated The paticurrent medications not appear to require the medications due increased agitation to monitor closely for in adjustments in medications and increased agitation to monitor closely for in adjustments in medications due increased agitation to monitor closely for in adjustments in medication and increased agitation to monitor closely for in adjustments in medication and increased agitation to monitor closely for in adjustments in medication and increased agitation to monitor closely for in adjustments in medication and increased agitation to monitor closely for in adjustments in medication and include anti-psychotic medication and fellowing wheeling behind staff things, claiming I ammember. I can become and believe that they going to take me hor sexual inappropriate being aggressive tow (residents) by grabbic arm, calling out where addressed, and reject refuses the appy printer fuse rest periods with the production and	the hit another resident who on to left eyePatient does when this provider brings it m History of labile moods a laggression Continue ations], Tapering meds is not ent will be continued on the for now as the patient does any immediate change in to no signs or symptoms of oday. Will continue to coreased agitation as further cations may be necessary aration, the benefits of ations in this patient al risks of tardive dyskinesia, stroke. They help in for such that normal care is atient is in the nursing facility."  Torehensive care plan for ed one dated 6/24/15 for "I feed one dated 6/24/15 for "I feed one dated 6/24/15 for "I feed one dated to certain staff or are my partner and are me with them. I have a hx of behavior, I have a hx of behavior, I have a hx of the patient of the	F 600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	, , ,	(X3) DATE SURVEY COMPLETED	
		495140	495140 B. WING		0	C <b>3/10/2020</b>	
	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CO 110 CHALMERS COURT BERRYVILLE, VA 22611		0/10/2020	
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 600	of coffee and see if activities room and woother activity I would "Assist with moving a path so that I can hall way" dated 6/20 "Attempt intervention begin" dated 6/20/15 "Complete an activit not seat me around as people who yell of 6/26/19. "Enc (enco avoid over stimulation 6/26/19. "Give me rhas ordered" dated my favorite place to to avoid situations of me" dated 6/20/19 ame separated from a close to me" dated 6 "Let my physician krinterfering with my de "Make sure I am not dated 2/1/17. "Offer diversion" dated 6/2 "Offer rt (resident) he 2/1/17. "Please reference you begin" dated 1/14/20. "Please tell before you begin" dated me if I become upser you want/need me to "Resident requires a residents. Feels croclose to his space" of	"Ask me if I would like a cup would like to go to the watch TV. Or if there is any I enjoy" dated 6/26/19. others out of the way to clear move freely up and down the //19 and revised 1/14/20. Ins before my behaviors 2 and revised 6/26/19. If y referral dated 9/5/17. "Do others who disturb me such out" dated 6/20/19 and revised ourage) smaller groups to on" dated 6/20/19 and revised my medications as my doctor 2/1/17. "Help me maintain sit" dated 2/1/17. "Help me repople that are upsetting to ond revised 6/26/19. "Keep other residents who are too 6/20/19 and revised 6/26/19. In pain or uncomfortable" reme something I like as a 0/19 and revised 6/26/19. Is own sugar packs" dated for me to my eatrist as needed refer back to de 6/24/15. "Re-approach of 1/20/15 and revised 1 me what you are going to do ated 6/24/15. "Re-approach of 1/20/19 and revised 1 me what you are going to do ated 6/24/15. "Re-approach of 1/20/19 and revised 1 me what you are going to do ated 6/24/15. "Re-approach of 1/20/19 and revised 1 me what you are going to do ated 6/24/15. "Re-approach of 1/20/19 and revised 1 me what you are going to do ated 6/24/15. "Re-approach of 1/20/19 and revised 1 me what you are going to do ated 6/24/15. "Re-approach of 1/20/19 and revised 1 me what you are going to do ated 6/24/15. "Re-approach of 1/20/19 and revised 1 me what you are going to do ated 6/24/15. "Re-approach of 1/20/19 and revised 1 me what you are going to do ated 6/24/15. "Re-approach of 1/20/19 and revised 1 me what you are going to do ated 6/20/19 and revised 1 me what you are going to do ated 6/20/19 and revised 1 me unhurriedly and revised 1 me unhurriedly and in a calm	F	600			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		495140	B. WING			C <b>03/10/2020</b>	
	NAME OF PROVIDER OR SUPPLIER  ROSE HILL HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP COD 110 CHALMERS COURT BERRYVILLE, VA 22611	•	03/10/2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 600	Continued From pag	e 44	F 6	00			
	also included one da have behaviors which activities." This care interventions: "Assesset-up. Sit me where residents" dated 6/20 "Attempt intervention Offer me my favorite 6/20/19 and revised around others who dand revised 10/20/19 as my doctor has orome maintain my favorite 6/20/19 and revised situations or people dated 6/20/19 and ream not in pain or und "Pharmacy medicatic" "Please refer me to mas needed" dated 3/another (sic) resident	care plan for Resident #69 Ited 3/12/17 for "I sometimes h include hitting during plan included the following is dining room seating le I am not too close to other 10/19 and revised 6/26/19. It is before my behavior begin. Indirink (coffee) or food" dated 6/26/19. "Do not seat me disturb me" dated 10/17/19 If it is included the me my medications dered" dated 8/1/18. "Help porter place to sit" dated 6/26/19. "Help me to avoid that are upsetting to me" existed 6/26/19. "Make sure I comfortable" dated 8/1/18. On review" dated 3/13/17. In my psychologist/psychiatrist 12/17. "Separate me from the if they sit to (sic) close the ded 6/20/19 and revised 19/19/19/19/19/19/19/19/19/19/19/19/19/1					
	Resident #651:						
	revealed a physician documented, "Report got assaulted by and [#651] was sitting in resident [#69] repeat hitting his chest by schest, and next swin	al record for Resident #651 note dated 6/20/19 that ted by nurse resident [#651] other resident [#69]. Resident wheelchair while another tedly assaulted him twice by winging the arm across his ging the arm in his eyes. He ies pain in eyes or chest approximately 2cm					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495140	B. WING	B WING		С	
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB	430140	1	1	STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	1 03/	10/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Lt (left) eye area active color purple/blue. Note eye"  Further review of the #651 revealed a nurse documented, "This resident [#69] was sitting in the this resident [#651] in The receptionist atter and before she could [#69] hit this resident Residents separated [#651] has a open are discoloration r/t (related Response: NP (nursed (Executive Director), ADON (Assistant Director), ADON (Assistant Director), ADON (Assistant Director), Consultant notified."  Further review of the #651 revealed a social that documented, "Maincident with resident recall incident that has emotional distress."  A review of the composition of the compos	couter canthus out side the vely bleeding. Area skin visible damage to the clinical record for Resident es note dated 6/20/19 that sident [#651] and resident elobby. Resident [#69] hit the chest with a closed fist. Inpted to separate the 2 men move this resident, resident [#651] again in the left eye. immediatelyResident ea under his left eye with ed to) the altercation. elepractitioner), ED DON (Director of Nursing), ector of Nursing), um (Unit al Services) and RP notifiedRegional Nurse clinical record for Resident eal worker note dated 6/20/19 et with resident [#651] due to [#69]. Resident could not ppened and exhibits no rehensive care plan for ed one dated 11/6/17 and relations included the	F	600			
	following: "Attempt in behaviors begin" date	nterventions included the nterventions before my ed 6/20/19 and revised me around others who					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE COMP	SURVEY LETED
		495140	B. WING _	B. WING			C 10/2020
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			1	TREET ADDRESS, CITY, STATE, ZIP CODE  10 CHALMERS COURT  BERRYVILLE, VA 22611		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	"Help me maintain my 6/20/19 and revised 8 situations or people the dated 6/20/19 and revised 6/20/19 and	0/19 and revised 8/12/19, y favorite place to sit" dated s/12/19, "Help me avoid hat are upsetting to me" vised 8/12/19"  M, ASM #1 and ASM #3	F	600			
	Director and Regiona Services) were made	aware of the identified nformation such as an					
	or Staff Member" forn documented, "This re	acility provided a Assault of Another Resident a dated 6/20/19. This form sident (Resident #69) hit chest and the left eye with a					
	dated 6/20/19 docum primary diagnosis of overy close proximity of Resident #69) struck #651) hitting him in the face. Staff intervened occurrence. Residen nursing. Responsible notified. Initial assess	•					
		M, ASM #1 stated that due sof the residents, the facility as abuse.					
	On 3/10/20 at 2:30 PI	M, ASM #1 was made aware					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  B	(X3) DATE SURVEY COMPLETED		
		495140	B. WING		03/10/2020	
	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	03/10/2020	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION	
F 600	provided.  References:  (1) Depakote is use symptoms of mania Information obtained https://medlineplus.tml  (2) Tylenol is used to pain. Information obtained https://medlineplus.tml  6. On 10/17/19, fact Resident #22 was fit Resident #69 hit Rewith a closed fist.  Resident #69 was a	d to treat seizures or related to bipolar disorder. d from gov/druginfo/meds/a682412.h o relieve mild to moderate d from gov/druginfo/meds/a681004.h dility staff failed to ensure that the from abuse, when sident #22 on the left arm	F 60	,		
	stroke, dementia wi hemiparesis, depres shoulder, dysphagia epilepsy, and high b MDS (Minimum Dat (Assessment Refere the resident as bein to make daily life de coded as requiring t extensive care for tr and hygiene; super	ence Date) of 2/4/20 coded g severely impaired in ability cisions. The resident was otal care for bathing; ansfers, dressing, toileting				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495140	B. WING				0 10/2020
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			1	TREET ADDRESS, CITY, STATE, ZIP CODE  10 CHALMERS COURT  BERRYVILLE, VA 22611		
(X4) ID 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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	9/28/18; diagnoses in dementia with behaving hallucinations, and dy (Minimum Data Set) or Reference Date) of 12 as being severely implife decisions. The resequiring total care for dressing, eating, the supervision for transference Date) of 12 as being severely implife decisions. The resequiring total care for dressing, eating, the supervision for transference decisions of transference decisions. A review of the clinical revealed a nurses not documented, "This resequence decisions of the provided research punched resewith a closed fist. Resultant provided in the provided research punched research punched resewith a closed fist. Resultant provided in the provided research punched a psychological distortant provided and psychological distortant provided research provided and provided research pro	mitted to the facility on aclude but are not limited to ors, anxiety disorder, aspnea. The quarterly MDS with an ARD (Assessment 2/10/19 coded the resident paired in ability to make daily sident was coded as a bathing; limited assistance oileting and hygiene; and	F	600			
	continue to monitor cas further adjustment	appear to require any the medications. Will losely for increased agitation s in medications may be eful consideration, the					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	COMPLETED
		495140	B. WING		C 03/10/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611	03/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 600	patient outweigh the dyskinesia, hypergly in modifying the belt possible while the possible that the going to take me has been and believe that the going to take me has sexual inappropriate being aggressive to (residents) by grabble arm, calling out who addressed, and rejectives therapy proprefuse rest periods. This care plan incluinterventions: "Aggaltercation, resident and revised 1/14/20 of coffee and see if activities room and	chotic medications in this e potential risks of tardive ycemia and stroke. They help navior such that normal care is atient is in the nursing facility."  prehensive care plan for led one dated 6/24/15 for "I of the following behaviors ying and cursing at staff, aff desk and packing up my in going home with a staff ome attached to certain staff by are my partner and are ome with them. I have a hx of e behavior, I have a hx of wards staff/others rt's bing, hitting and squeezing en care needs have been ecting care when offered, (as needed), At times I will when encouraged/offered."	F 600	,	
	"Assist with moving a path so that I can hall way" dated 6/20 "Attempt interventio begin" dated 6/20/1 "Complete an activi not seat me around as people who yell 6/26/19. "Enc (enco	others out of the way to clear move freely up and down the 0/19 and revised 1/14/20. ns before my behaviors 9 and revised 6/26/19. ty referral" dated 9/5/17. "Do others who disturb me such out" dated 6/20/19 and revised ourage) smaller groups to on" dated 6/20/19 and revised			

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION	, , ,	(X3) DATE SURVEY COMPLETED		
		495140	B. WING			C 03/10/2020		
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CO 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 PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 600	has ordered" dated 2 my favorite place to set to avoid situations or me" dated 6/20/19 arme separated from or close to me" dated 6/"Let my physician know interfering with my dated 2/1/17. "Offer diversion" dated 6/20 "Offer rt (resident) his 2/1/17. "Please refer psychologist/psychiat psych for eval" dated 1/14/20. "Please tell before you begin" dated 1/14/20. "Please tell before you begin" date if I become upset you want/need me to "Resident requires a residents. Feels crow close to his space" dated 6/26/19. "Speak to my voice" dated 6/26/19. "Speak to my voice" dated 6/26/19. The comprehensive of also included one date have behaviors which activities." This care interventions: "Assesset-up. Sit me where residents" dated 6/20 "Attempt interventions Offer me my favorite 6/20//19 and revised around others who di and revised 10/20/19	y medications as my doctor (1/17. "Help me maintain it" dated 2/1/17. "Help me people that are upsetting to d revised 6/26/19. "Keep ther residents who are too 20/19 and revised 6/26/19. ow if I (sic) my behaviors are illy living" dated 6/24/15. In pain or uncomfortable me something I like as a (1/19) and revised 6/26/19. It is own sugar packs dated me to my rist as needed refer back to 6/24/15 and revised me what you are going to do ded 6/24/15. "Re-approach (combative, explain what do first" dated 12/30/19. It is great distance from other yield when people get too ated 6/20/19 and revised die unhurriedly and in a calm	F 60					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  IG	_	(X3) DATE SURVEY COMPLETED
		495140	B. WING _			C 03/10/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S 110 CHALMERS COURT BERRYVILLE, VA 226		1 00/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORR	R'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)	
F 600	6/20/19 and revised situations or people dated 6/20/19 and re am not in pain or une "Pharmacy medicatic" "Please refer me to as needed" dated 3/ another (sic) resident within my space" date 6/26/19.  Resident #22:  A review of the clinic revealed a nurse not documented, "This rehallway near north not in a provocative mare [#69] who, for not applin upper right arm. In quickly separated and The resident suffered this incident. Appropriately manner."  A review of the companies incident and auditory hallucing seeing and hearing for care, easily agitated the floor intentionally but has not injuries the with male rt's (resident husband, altercation walker at different please."	rite place to sit" dated 6/26/19. "Help me to avoid that are upsetting to me" evised 6/26/19. "Make sure I comfortable" dated 8/1/18. on review" dated 3/13/17. my psychologist/psychiatrist 12/17. "Separate me from ts if they sit to (sic) close ed 6/20/19 and revised  all record for Resident #22 ed dated 10/17/19 that esident [#22] walking in urses station. Not behaving oner. Encountered resident carent reason, punched her the two residents were do no further conflict ensued. do no injuries as a result of oriate notifications done in a  orehensive care plan for ed one dated 10/5/18 for "I lavior which include visual lations, esp (especially) about amily members, refuses are Resident places herself on and is acting out behavior lese falls. Will get into bed onts) thinks they are her with another rt. She leaves aces and at times undresses ef." This care plan included	F6			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495140	B. WING		C 03/10/2020
	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	1 00/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 600	before my behaviors revised 6/18/19. "D who disturb me" dat maintain my favorite "Help me to avoid si upsetting to me" dat 6/18/19. "Keep me may become agitate 10/17/19 and revise On 3/9/20 at 10:10 / (Administrative Staf Director and Regior Services) were mad incident. Additional incident report was Per this request, the "Behavioral Outburs or Staff Member" for documented, "This passing resident (#2 punched resident (#5 to the cognitive state did not consider this did not complete an beyond the above it was not a complete On 3/10/20 at 2:30 let with the cognitive state did not complete and beyond the above it was not a complete On 3/10/20 at 2:30 let.	Intions: "Attempt interventions is begin" dated 10/5/18 and o not seat me around others ed 10/5/18. "Help me is place to sit" dated 10/5/18. ituations or people that are used 10/5/18 and revised separated from people that ed from my behaviors" dated d 10/20/19.  AM, ASM #1 and ASM #3 if Members, the Executive is all Director of Clinical e aware of the identified information such as an requested.	F 600		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		NSTRUCTION	(X3) DATE COMF	SURVEY
		495140	B. WING _				C 1 <b>10/2020</b>
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			110 C	EET ADDRESS, CITY, STATE, ZIP CODE CHALMERS COURT RYVILLE, VA 22611	1 03/	10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	7. On 1/12/20, facility Resident #41 was free Resident #69 hit Resident #69 was and 1/17/13; diagnoses in stroke, dementia with hemiparesis, depress shoulder, dysphagia, epilepsy, and high blom MDS (Minimum Data (Assessment Referenthe resident as being to make daily life decoded as requiring to extensive care for train and hygiene; supervilocomotion; and was bowel and bladder.  Resident #41 was and 4/21/18; diagnoses in congestive heart failed dementia with behav pressure. The quarter	w staff failed to ensure that the from abuse, when ident #41 in the right side of dist.  Imitted to the facility on include, but are not limited to in behaviors, hemiplegia and sion, pain in leg and adjustment disorder, bod pressure. The quarterly Set) with an ARD ince Date) of 2/4/20 coded severely impaired in ability sisions. The resident was stall care for bathing; insfers, dressing, toileting sion for eating and frequently incontinent of mitted to the facility on include but are not limited to are, dysphagia, depression, iors, and high blood serly MDS (Minimum Data issessment Reference Date)	F	600			
	moderately impaired decisions. The resid total care for bathing transfers, dressing, to supervision for eating Resident #69:  A review of the clinical	in ability to make daily life ent was coded as requiring ; extensive assistance for bileting, and hygiene; and					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		SURVEY ETED
		495140	B. WING		O3/1	0/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	03/1	0/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 600	time. It was told this was sitting at the nu chair. Staff/CAN [ce passing by resident room [Resident #41] member) and tried k front of her to move resident (#69) saw the closed fist on the rig face. [Resident #41 holding the right side practitioner] was made a proper side of the practitioner was made a proper side of the patient was properly altercation with another aggressor. No in residentHistory of physical aggression. Risk/Benefits analyst [medications], Taper Monitor mood behave continued on the curther patient does not immediate change in continue to monitor as further adjustmer necessaryWill confine the patient does not immediate change in continue to monitor as further adjustmer necessaryWill confine as further adjustmer necessaryWill confine as further adjustmer necessary was perfectly the comparence of	11 shift 1/11/20 around dinner writer that, resident [#69] reses station in his wheel entified nursing assistant] was with meal cart and resident in was behind her (the staff icking at the CNA who was in out of her way. When this his take place he landed his hit side of her [Resident #41] hollered out and was en of her face. NP [nurse de aware."  The clinical record for Resident hiatric progress note dated ented, "Follow up requested rector) due to recent her resident in which he was highly sustained by other labile moods and periodicReviewed SE and is, Continue current meds ing meds is not indicated, viorThe patient will be rent medications for now as appear to require any in the medications. Will closely for increased agitation at in medications may be attinue to monitor closely for as further adjustments in	F 60			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILD	_		، ا	c
		495140	B. WING				10/2020
NAME OF P	ROVIDER OR SUPPLIER	100000			STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	10/2020
	101.02.1 01.1 00.1 2.2.1				10 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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page things, claiming I am	e 55 going home with a staff	F	600			
		me attached to certain staff					
	and believe that they	are my partner and are					
	going to take me hon	ne with them. I have a hx of					
	sexual inappropriate	behavior, I have a hx of					
	being aggressive tow						
	, , , ,	ng, hitting and squeezing					
		care needs have been					
		eting care when offered,					
		as needed), At times I will					
	This care plan include	hen encouraged/offered."					
	interventions: "Aggre						
		separated" dated 10/17/19					
		"Ask me if I would like a cup					
		would like to go to the					
		ratch TV. Or if there is any					
	other activity I would	enjoy" dated 6/26/19.					
	"Assist with moving of	thers out of the way to clear					
	a path so that I can n	nove freely up and down the					
		19 and revised 1/14/20.					
	·	s before my behaviors					
		and revised 6/26/19.					
	'	referral" dated 9/5/17. "Do					
		others who disturb me such					
		ut" dated 6/20/19 and revised					
		urage) smaller groups to n" dated 6/20/19 and revised					
		y medications as my doctor					
		/1/17. "Help me maintain					
		sit" dated 2/1/17. "Help me					
		people that are upsetting to					
		nd revised 6/26/19. "Keep					
		ther residents who are too					
		/20/19 and revised 6/26/19.					
		ow if I (sic) my behaviors are					
		aily living" dated 6/24/15.				ĺ	
	"Make sure I am not	in pain or uncomfortable"					
		me something I like as a					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  IG	_	(X3) DATE S COMPL	ETED
		495140	B. WING _			O 03/1	0/2020
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			STREET ADDRESS, CITY, 110 CHALMERS COURT BERRYVILLE, VA 220	Г	1 03/1	0/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BI RENCED TO THE APPROPRIA DEFICIENCY)	I .	(X5) COMPLETION DATE
F 600	"Offer rt (resident) his 2/1/17. "Please refer psychologist/psychiar psych for eval" dated 1/14/20. "Please tell before you begin" da me if I become upset you want/need me to "Resident requires a residents. Feels crow close to his space" di 6/26/19. "Speak to notice" dated 6/26/19. "Speak to notice" dated 6/26/19. The comprehensive also included one dathave behaviors which activities." This care interventions: "Assesset-up. Sit me where residents" dated 6/20/19 and revised around others who di and revised 10/20/19 as my doctor has ord me maintain my favo 6/20/19 and revised 10/20/19 and 1	and revised 6/26/19. If you want to my trist as needed refer back to 6/24/15 and revised me what you are going to do ted 6/24/15. "Re-approach combative, explain what do first" dated 12/30/19. If you want de distance from other wided when people get too ated 6/20/19 and revised me unhurriedly and in a calm	F				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE COMP	SURVEY PLETED
		495140	B. WING _			l	C 1 <b>10/2020</b>
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CO 110 CHALMERS COURT BERRYVILLE, VA 22611	DE	1 00	10/2020
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BI IE APPROPRIA		(X5) COMPLETION DATE
F 600	Continued From page	e 57	F6	600			
	revealed a nurses no documented, "Alert, so recipient in a res to realtercation. Denied proparent injuries not episode. OOB (out of tolerated. Needs to be time to her room and [resident] doorway	sip (status post) being the es (resident to resident) ain or discomfort. No ed to right eye area s/p of bed) in w/c (wheelchair) as per re-directed from time to away from other res "  Trehensive care plan for done dated 5/22/18 for "I environ which include yelling and during care, cursing, empting to take things that adering." This care plan interventions: "Attempt my behaviors begin. To be separated from other en her behavior escalates" sed 12/18/19. "Do not seat to disturb me" dated 7/4/19. To disturb me dated 7/4/19 and off will key into precursors to viors and attempt to eany adverse behaviors are					
	(Administrative Staff I	M, ASM #1 and ASM #3 Members, the Administrator Nurse) were made aware of					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
		495140	B. WING _			C 03/10/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 110 CHALMERS COURT BERRYVILLE, VA 22611	CODE	33/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BI	DATE
F 600	was requested.  Per this request, the "Behavioral Outburs or Staff Member" for This form document nurses station sitting this resident (#41) ki that was pushing a fe #69) right fist and coresident (#41) right of was defending aide's On 3/09/20 at 3:20 Fe stated, "There was as he was trying to ge residents sitting in the reached out attempt kitchen. (Resident #staff member. ASM cognitive status of the not consider this as not complete an invebeyond the above id was not a complete.  On 3/10/20 at 2:30 Fe of the concern. No fe provided.  8. On 3/6/20, facility Resident #39 was from Resident #69 pulled to the floor.  Resident #69 was according to the staff was according to the staff was from Resident #69 was according to the floor.	facility provided a t Assault of Another Resident m dated 1/11/20 (misdated?). ed, "Resident (#69) in front of beside resident (#41). Saw cking at her (a staff member cod cart). Took his (Resident nnected with the other cheekhe (Resident #69)	F6			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION  NG			LETED
		495140	B. WING _			l	C 10/2020
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB		1	STREET ADDRESS, CITY, STATE, ZIP COI 110 CHALMERS COURT BERRYVILLE, VA 22611	DE	1 00,	10/2020
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
F 600	hemiparesis, depress shoulder, dysphagia, epilepsy, and high blo MDS (Minimum Data (Assessment Referer the resident as sever make daily life decisic coded as requiring to extensive care for tra and hygiene; supervis locomotion; and was bowel and bladder.  Resident #39 was ad 6/15/18; diagnoses in brain disorders, deme alcohol dependence, stress disorder, epilely dystonia. The quarte Set) with an ARD (As of 1/14/20 coded the impaired in ability to rather than the resident was code bathing and extensive areas of activities of compared in the clinical revealed a nurses not documented, "Residents [#69] grabbed his [Residents [#69]] grabbed his [Residents [#69]]	behaviors, hemiplegia and ion, pain in leg and adjustment disorder, bod pressure. The quarterly Set) with an ARD ace Date) of 2/4/20 coded ely impaired in ability to ons. The resident was tal care for bathing; ansfers, dressing, toileting sion for eating and frequently incontinent of mitted to the facility on clude but are not limited to entia without behaviors, depression, post-traumatic psy, high blood pressure and rly MDS (Minimum Data sessment Reference Date) are identically life decisions. The resident as severely make daily life decisions. The decisions are quiring total care for the assistance for all other daily living.	F6	500			
	behaviors."  As of this review on 3	/9/10, no physician or					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				_		، ا	c l
		495140	B. WING				10/2020
NAME OF P	ROVIDER OR SUPPLIER	1		S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	10/2020
				1	10 CHALMERS COURT		
ROSE HIL	L HEALTH AND REHAB			Е	BERRYVILLE, VA 22611		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 600	Continued From pag	e 60	F	600			
	· ·	tation had yet occurred.					
	A review of the comp. Resident #69 reveals have a hx (history) of which include following wheeling behind staft things, claiming I am member. I can becound believe that they going to take me hor sexual inappropriate being aggressive tow (residents) by grabbic arm, calling out where addressed, and reject refuses therapy print (refuse rest periods with the care plan includinterventions: "Aggraltercation, residents and revised 1/14/20.	orehensive care plan for ed one dated 6/24/15 for "I of the following behaviors ing and cursing at staff, of desk and packing up my going home with a staff me attached to certain staff or are my partner and are in e with them. I have a hx of behavior, I have a hx of behavior, I have a hx of vards staff/others rt's ing, hitting and squeezing in care needs have been ofting care when offered, (as needed), At times I will when encouraged/offered." ed the following essor of Resident to a separated" dated 10/17/19  "Ask me if I would like a cup					
	activities room and w	would like to go to the atch TV. Or if there is any enjoy" dated 6/26/19.					
	a path so that I can r hall way" dated 6/20/ "Attempt intervention	others out of the way to clear move freely up and down the /19 and revised 1/14/20.  Is before my behaviors					
	"Complete an activity not seat me around of as people who yell of 6/26/19. "Enc (enco	and revised 6/26/19.  y referral" dated 9/5/17. "Do others who disturb me such ut" dated 6/20/19 and revised urage) smaller groups to n" dated 6/20/19 and revised					
	has ordered" dated 2 my favorite place to	ny medications as my doctor 2/1/17. "Help me maintain sit" dated 2/1/17. "Help me people that are upsetting to					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG		SURVEY PLETED
		495140	B. WING _			C / <b>10/2020</b>
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	10/2020
ROSE HIL	L HEALTH AND REHAB			110 CHALMERS COURT BERRYVILLE, VA 22611		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		) BE	COMPLETION DATE
F 600	me separated from ot close to me" dated 6/2" "Let my physician know interfering with my date of 1/2" "Make sure I am not it dated 2/1/17. "Offer it diversion" dated 6/20, "Offer it (resident) his 2/1/17. "Please refer psychologist/psychiat psych for eval" dated 1/14/20. "Please tell before you begin" date me if I become upset/you want/need me to "Resident requires a gresidents. Feels crow close to his space" dated 6/26/19. "Speak to myoice" dated 6/26/19.  The comprehensive of also included one dath have behaviors which activities." This care interventions: "Assesset-up. Sit me where residents" dated 6/20, "Attempt interventions Offer me my favorite of 6/20//19 and revised 0 around others who dis and revised 10/20/19 as my doctor has order me maintain my favor 6/20/19 and revised 0	d revised 6/26/19. "Keep ther residents who are too 20/19 and revised 6/26/19. Ow if I (sic) my behaviors are illy living" dated 6/24/15. In pain or uncomfortable" me something I like as a /19 and revised 6/26/19. It own sugar packs" dated me to my rist as needed refer back to 6/24/15 and revised me what you are going to do ed 6/24/15. "Re-approach (combative, explain what do first" dated 12/30/19. It own properties are plan for Resident #69 ed 3/12/17 for "I sometimes a include hitting during plan included the following is dining room seating I am not too close to other /19 and revised 6/26/19. Is before my behavior begin. In drink (coffee) or food" dated 6/26/19. "Do not seat me sturb me" dated 8/1/18. "Help"	F	600		
		vised 6/26/19. "Make sure I				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G		TE SURVEY MPLETED
		495140	B. WING		,	C 03/10/2020
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611		10/2020
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 600	"Pharmacy medication "Please refer me to mas needed" dated 3/2 another (sic) resident within my space" date 6/26/19.  Resident #39:  A review of the clinical revealed a nurses not documented, "This resilverware of resident	comfortable" dated 8/1/18. on review" dated 3/13/17. ny psychologist/psychiatrist 12/17. "Separate me from ts if they sit to (sic) close ed 6/20/19 and revised al record for Resident #39	F 60	000		
	(complaints of) pain of (responsible party) practitioner) notified."  The comprehensive of revealed one dated on the shown behavior symplement of the shown behavior and picking not steady to steady voice - try alternative activity or 11/5/19. "Please help people that trigger in 11/5/19 and revised."  On 3/9/20 at 10:10 A	care plan for Resident #39 1/5/19 for "Sometimes I toms/risks, refusing personal e until it bleeds." This care owing interventions: s before my behavior 5/19. "During episodes of ors, please re-direct me by and speaking to me in a calm ying to redirect me to an topic of discuss" dated p me avoid situations and appropriate behaviors" dated 11/22/19.  M, ASM #1 and ASM #3 Members, the Executive				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495140	B. WING		C 03/10/2020
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	1 00/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 600 F 607 SS=E	incident. Additional i incident report was report of the resident (#69) grabbed pulled him out of his pulled him out of his pulled him out of his did not consider this did not conduct an instate agency.  On 3/10/20 at 2:30 P Staff Member, the Exaware of the concerninitial report had been agency. She stated facility's position that of the residents, it was information was proving Develop/Implement A CFR(s): 483.12(b)(1)	e aware of the identified information such as an equested.  facility provided a Assault of Another Resident in dated 3/6/20. This form ent (#39) reached for the sident's (#69) tray and this ed (#39) by the arm and chair."  M, ASM #1 stated that due is of the residents, the facility as abuse, or reportable, and itial report to the required  M, ASM #1 (Administrative executive Director) was made in Sent to the required state it had not been as it was the due to the cognitive status as not abuse. No further ided.  Abuse/Neglect Policies -(3)	F 60		
	§483.12(b)(1) Prohib neglect, and exploita misappropriation of re	it and procedures that: it and prevent abuse, tion of residents and esident property, ish policies and procedures			

			A. BUILDING	·	COMPLETED
		495140	B. WING		C 03/10/2020
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	1 00/10/2020
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 607	Continued From page	e 64	F 60	07	
	paragraph §483.95, This REQUIREMENT by: Based on staff intervand clinical record rethe facility staff failed abuse policy to report of abuse to the requires to residents in the suffer with t	e training as required at is not met as evidenced siew, facility document review view, it was determined that to implement the facility and investigate allegations red State agency for eight of prevey sample, (Residents 12, #39, #650, and #652). On 7 hit Resident #69, and then ident #67 back. On 3/18/19, ident #7 in the face. On 19 hit Resident #41 in the with a closed fist. The facility ent the facility abuse policy port the incident to the 19 and failed to notify and #41's physicians and 19 her the policy. On 10/17/19, ident #22 in the left arm with 19 hit Resident #69 pulled 19 hit Resident #69 pulled 19 hit Resident #650 in the 19 sident #69 grabbed Resident 19 hit Resident #650 in the 19 sident #650 in the 19 hit Resident #650 in the 19 hit Re			
	dated February 2017	/ policy, "Resident Abuse" and revised January 2020, It is inherent in the nature			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495140	B. WING			1	C
NAME OF D	DOVIDED OD CUDDUED	495140	B. WING		CTREET ADDRESS CITY STATE 71D CODE	03/	/10/2020
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ROSE HIL	L HEALTH AND REHA	3			110 CHALMERS COURT		
					BERRYVILLE, VA 22611		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 607	Continued From pag	ge 65	F	607			
		resident at Facility that he/she					
		uman rights, including the					
	right to be free from						
		r misappropriation of					
		agement of the facility					
		hts and hereby establishes					
	the following statem						
		ct these rights and to					
	establish a disciplina	ary policy, which results in the					
	·	ment of occurrences of					
		cedure:c. Questions may					
		ons constitute abuse of a					
		that may cause or causes					
		chological, or emotional harm,					
		by simple negligence,					
		Procedure for Reporting					
		ents of resident abuse are to					
		ately to the Licensed Nurse in Nursing, or the Administrator.					
		ie of those three officials, the					
	-	e to be completed and					
		se Coordinator or his/her					
		estigation. B. The facility					
	_	ate agency and one or more					
	-	tities any reasonable					
		against any individual who is					
		eceiving care from, the facility.					
	C. And if the events	s that caused the suspicion					
	resulted in serious b	odily injury the facility must					
	report within 2 hours	s after forming the suspicion.					
		used the suspicion did not					
		lily injury the facility shall					
		rsInvestigation: a. The					
		and/or Director of Nursing					
		atements from the victim, the					
		ossible witnesses including all					
		the vicinity of the alleged					
		l also secure all physical					
	evidence. Upon cor	mpletion of the investigation, a					

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)  F 607  Continued From page 66 detailed report shall be prepared"  A review of the facility policy, Resident Abuse - Resident to Resident" dated February 2017, no revision dates, documented, "Residents must not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends, or other individuals. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, or pain, or mental anguish, or deprivation by an individual, including	10/2020  (X5) COMPLETION DATE
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)  F 607  Continued From page 66 detailed report shall be prepared"  A review of the facility policy, Resident Abuse - Resident to Resident" dated February 2017, no revision dates, documented, "Residents must not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends, or other individuals. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, or pain, or mental anguish, or deprivation by an individual, including	(X5) COMPLETION
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 607  Continued From page 66 detailed report shall be prepared"  A review of the facility policy, Resident Abuse - Resident to Resident" dated February 2017, no revision dates, documented, "Residents must not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends, or other individuals. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, or pain, or mental anguish, or deprivation by an individual, including	COMPLETION
detailed report shall be prepared"  A review of the facility policy, Resident Abuse - Resident to Resident" dated February 2017, no revision dates, documented, "Residents must not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends, or other individuals. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, or pain, or mental anguish, or deprivation by an individual, including	
a caretaker, of goods and services that are necessary to attain or maintain physical, mental and psychosocial well-being. This includes verbal abuse, sexual abuse, physical abuse, mental abuse, involuntary seclusion, and misappropriation of resident property. Protocol: Resident to Resident Abuse: 1. Remove the residents from danger immediately4. Notification must be made to the following of all residents involved in the incident: a. attending physician. b. responsible party. 5. A documented investigation by the Administrator, Director of Nursing, or their designee must be initiated within twenty-four (24) hours of our knowledge of the alleged incident. This investigation includes talking with all involved (directly or indirectly), any family involved, all residents involved and any visitors or volunteers involved. Obtain written statements as deemed	
misappropriation of resident property. Protocol: Resident to Resident Abuse: 1. Remove the residents from danger immediately4. Notification must be made to the following of all residents involved in the incident: a. attending physician. b. responsible party. 5. A documented investigation by the Administrator, Director of Nursing, or their designee must be initiated within twenty-four (24) hours of our knowledge of the alleged incident. This investigation includes talking with all involved (directly or indirectly), any family involved, all residents involved and any visitors or volunteers	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495140	B. WING				0 10/2020
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB		•	1	STREET ADDRESS, CITY, STATE, ZIP CODE 10 CHALMERS COURT BERRYVILLE, VA 22611		
(X4) ID 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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	Department of Health Administrator, Director designee of the facility resident altercations in to the extent that phy transfer or discharge state specific protocol enforcement authoritial Administrator, Director designee of any instala mistreatment, neglector	ged incident9. The State is to be notified by the or of Nursing, or their y's knowledge of resident to n which a resident is injured sical intervention and/or to a hospital is required per ls. 10. The local law es are to be notified by the or of Nursing, or their nce of resident abuse, t, or misappropriation of ich is a "Criminal Act" and in	F	607			
	and then Resident #6 Punches were exchainstaff. The facility staff facility abuse policy to incident to the require notify Resident #67's party.	ent #67 hit Resident #69, 9 hit Resident #67 back. nged until separated by failed to implement the o investigate and report the ed state agency and failed to physician and responsible mitted to the facility on					
	1/17/13; diagnoses in stroke, dementia with hemiparesis, depress shoulder, dysphagia, epilepsy, and high blo MDS (Minimum Data (Assessment Referenthe resident as being to make daily life dec coded as requiring to	clude but are not limited to behaviors, hemiplegia and sion, pain in leg and adjustment disorder, bod pressure. The quarterly Set) with an ARD see Date) of 2/4/20 coded severely impaired in ability isions. The resident was tal care for bathing; nsfers, dressing, toileting					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495140	B. WING		C 03/10/2020	
	ROVIDER OR SUPPLIER	3	1	TREET ADDRESS, CITY, STATE, ZIP CODE  10 CHALMERS COURT  BERRYVILLE, VA 22611	· · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY 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 607	Resident #67 was at 11/21/12; diagnoses stroke, diabetes, her dementia with behavinsomnia, glaucoma pulmonary disease, blood pressure, and quarterly MDS (Minii (Assessment Refere the resident as being ability to make daily was coded as requir toileting; extensive a dressing, and hygier A review of the clinic revealed a nurse's n documented, "Resid another resident [#6] began swearing at h staff, the other reside [Resident #69] in the	dmitted to the facility on include but are not limited to miplegia, dysphagia, viors, adjustment disorder,	F 607	DEFICIENCY)		
	revealed a nurse's n documented, "Resid arguing with another swearing at the othe When approached b [Resident #67] puncture, when the other back, they began ex were separated." The	ral record for Resident #67 ote dated 1/22/19 that ent [Resident #67] was resident [Resident #69] r resident [Resident #69]. y staff, this resident hed the other resident in the resident [Resident #69] hit changing blows until they his note, and follow up				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495140	B. WING			C <b>3/10/2020</b>
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP C 110 CHALMERS COURT BERRYVILLE, VA 22611		•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 607		e 69 ent #67's responsible party notified of the incident.	F 60	7		
	(Administrative Staff Director and Regiona Services) were made incident. Additional i	M, ASM #1 and ASM #3 Members, the Executive al Director of Clinical e aware of the identified information such as an equested. None was				
	of the process is to not responsible party, and resident, identify if an needed, and the care and updated. ASM # cognitive status of the not consider this as a not complete an invested report it to the require					
	Staff Member, the Ex	M, ASM #1 (Administrative secutive Director) was made n. No further information was				
	the face. The facility facility abuse policy t incident to the require	dent #69 hit Resident #7 in staff failed to implement the o investigate and report the ed state agency and failed to ohysician and responsible policy.				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	, ,	MPLETED
		495140	B. WING			C 03/10/2020
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611		33/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 607	1/17/13; diagnoses stroke, dementia wi hemiparesis, depreshoulder, dysphagia epilepsy, and high I MDS (Minimum Dai (Assessment Referthe resident as beir to make daily life decoded as requiring extensive care for trand hygiene; super locomotion; and wabowel and bladder.  Resident #7 was ac 2/19/19; diagnoses stroke, hemiplegia, dysphagia, depress chronic obstructive quarterly MDS (Min (Assessment Referthe resident as beir make daily life decicoded as requiring extensive assistance toileting and hygien A review of the clini revealed a nurses redocumented, "Resident transive assistance at 1730 (5:30 PM). [#7] then [Resident [#6] ther [Resident #7] or injuries noted. Restaken to restorative	idmitted to the facility on include but are not limited to th behaviors, hemiplegia and ssion, pain in leg and a, adjustment disorder, blood pressure. The quarterly	F 60	7		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		ATE SURVEY OMPLETED
		495140	B. WING _			C <b>03/10/2020</b>
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	•	30.10.2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR  (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 607	Continued From pag	e 71	F	607		
		ursing, power of attorney, er] aware of incident. Care				
	revealed a nurses not documented, "Resident [#69] was resident [#69] was render the factor of the fa	al record for Resident #7 te dated 3/18/19 that ent [#7] was smacked by b) during dinner. The other emoved from the dining room. e.e. Resident [#7] was upset dining room and had supper ett [#7] was upset later but no ed." This note, and follow up rding this incident, did not et #7's responsible party or the ed of the incident.				
	(Administrative Staff and Regional Clinical	M, ASM #1 and ASM #3 Members, the Administrator I Nurse) were made aware of t and additional information				
	or Staff Member" for documented, "Reside face in dining room.	facility provided a Assault of Another Resident m dated 3/18/19. This form ent (#69) hit Resident (#7) on (Resident #69) was behind e backed into his w/c (wheel				
	of the process is to n responsible party, an resident, identify if an needed, and the care and updated. ASM #	M, ASM #1 stated that part otify the doctor and the d if psych is following the ny new interventions are e plan should be looked at 1 stated that due to the e residents, the facility did				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495140	B. WING _			C 03/10/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611	•	567 167 2025
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 607	not complete an inve	abuse, or reportable, and did estigation on the incident or	F€	507		
	Staff Member, the Ex	ed state agency.  PM, ASM #1 (Administrative xecutive Director) was made n. No further information was				
	the right side of her the facility staff failed to policy to investigate required state agence	dent #69 hit Resident #41 in face with a closed fist. The implement the facility abuse and report the incident to the cy, and failed to notify ician and responsible party.				
	1/17/13; diagnoses i stroke, dementia with hemiparesis, depres shoulder, dysphagia epilepsy, and high bl MDS (Minimum Data (Assessment Refere the resident as being to make daily life decoded as requiring to extensive care for training and hygiene; superv	, adjustment disorder, lood pressure. The quarterly a Set) with an ARD nce Date) of 2/4/20 coded g severely impaired in ability cisions. The resident was otal care for bathing; ansfers, dressing, toileting				
	4/21/18; diagnoses i	dmitted to the facility on nclude but are not limited to ure, dysphagia, depression, riors, and high blood				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495140	B. WING _			C <b>03/10/2020</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 110 CHALMERS COURT BERRYVILLE, VA 22611	E	00/10/2020
(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 CO  (EACH CORRECTIVE ACTION  CROSS-REFERENCED TO THE  DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 607	Set) with an ARD (As of 1/15/20 coded the moderately impaired it decisions. The reside total care for bathing; transfers, dressing, to supervision for eating.  A review of the clinical revealed a nurses not documented, "On 3-1 time. It was told this was sitting at the nurse chair. Staff/CNA was meal cart and resident was behind her (the skicking at the CNA whove out of her way, saw this take place he the right side of her [Resident #41] hollers right side of her face. made aware."  A review of the clinical revealed a nurses not documented, "Alert, so recipient in a res to realtercation. Denied papparent injuries not episode. OOB (out of tolerated. Needs to be time to her room and [resident] doorway' documentation regard.	rly MDS (Minimum Data sessment Reference Date) resident as being n ability to make daily life ent was coded as requiring extensive assistance for illeting, and hygiene; and .  Il record for Resident #69 re dated 1/12/20 that 1 shift 1/11/20 around dinner writer that, resident [#69] res station in his wheel passing by resident with the tin room [Resident #41] resident from the was in front of her to when this resident [#69] re landed his closed fist on Resident #41] face. The dout and was holding the NP [nurse practitioner] was all record for Resident #41 red dated 1/12/20 that he dated 1/12/20 that he (resident to resident) resident to resident he redirected from time to away from other resident did not not nsible party for Resident resident has incident did not nsible party for Resident	F	507		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
		495140	B. WING _			C 03/10/2020
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP 110 CHALMERS COURT BERRYVILLE, VA 22611	CODE	03/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C ( (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BI THE APPROPRIA	DATE
F 607	Continued From pag		F 6	607		
	(Administrative Staff and Regional Clinica	M, ASM #1 and ASM #3 Members, the Administrator I Nurse) were made aware of t and additional information				
	or Staff Member" for This form documents nurses station sitting this resident (#41) king that was pushing a for #69) right fist and con	Assault of Another Resident m dated 1/11/20 (misdated?). ed, "Resident (#69) in front of beside resident (#41). Saw cking at her (a staff member ood cart). Took his (Resident nnected with the other heekhe (Resident #69)				
	was a lady pushing to get down the hall to get down the hall to get down the hall to get down the lady from kit interceded to defend that part of the procest he responsible party resident, identify if an needed, and the care and updated. ASM # cognitive status of the not consider this as a not complete an invested to get a some complete and the some	M, ASM #1 stated, "There he meal cart, she was trying by the residents sitting in the preached out attempting to chen. (Resident #69) a staff member. She stated as is to notify the doctor and and if psych is following the property of the				
	Staff Member, the Ex	M, ASM #1 (Administrative secutive Director) was made n. No further information was				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		495140	B. WING		,	C 3/10/2020
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB	I		STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611		0/10/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 607	Continued From page provided.	e 75	F 60	07		
	the left arm with a clo failed to implement th	ident #69 hit Resident #22 in used fist. The facility staff he facility abuse policy to the incident to the required				
	1/17/13; diagnoses in stroke, dementia with hemiparesis, depress shoulder, dysphagia, epilepsy, and high blo MDS (Minimum Data (Assessment Referer the resident as being to make daily life decoded as requiring to extensive care for tra and hygiene; supervisiocomotion; and was bowel and bladder.	adjustment disorder, bod pressure. The quarterly Set) with an ARD noce Date) of 2/4/20 coded severely impaired in ability isions. The resident was tal care for bathing; nsfers, dressing, toileting sion for eating and frequently incontinent of mitted to the facility on aclude but are not limited to				
	hallucinations, and dy (Minimum Data Set) Reference Date) of 1 as being severely implife decisions. The re- requiring total care fo	yspnea. The quarterly MDS with an ARD (Assessment 2/10/19 coded the resident paired in ability to make daily esident was coded as or bathing; limited assistance oileting and hygiene; and				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		495140	B. WING _			C 03/10/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 110 CHALMERS COURT BERRYVILLE, VA 22611	DDE	1 03/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD B HE APPROPRIA	
F 607	revealed a nurses no documented, "This re [#22] were passing e resident punched res with a closed fist. Re	e 76 al record for Resident #69 ate dated 10/17/19 that esident [#69] and resident ach other in hall and this sident [#22] in the left arm esidents separated. NP and er and responsible party]	F6	507		
	revealed a nurse not documented, "This re near north nurses sta provocative manner. who, for no apparent [Resident #22] in upp residents were quick					
	(Administrative Staff Director and Regiona Services) were made	e aware of the identified nformation such as an				
	or Staff Member" for documented, "This re passing resident (#22	facility provided a Assault of Another Resident m dated 10/17/19. This form esident (Resident #69) was 2) in hall and this resident 2) in left arm with closed				
	On 3/09/20 at 3:20 P	M, ASM #1 stated that due				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED		
		495140	B. WING _			C <b>03/10/2020</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 110 CHALMERS COURT BERRYVILLE, VA 22611	<u>I</u>	03/10/2020
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	
F 607	did not consider this did not complete an i beyond the above ide was not a complete a report it to the require On 3/10/20 at 2:30 P Staff Member, the Exaware of the concern provided.  5. On 3/6/20, Reside	s of the residents, the facility as abuse, or reportable, and investigation on the incident entified incident report, which and thorough investigation or ed state agency.  M, ASM #1 (Administrative recutive Director) was made  No further information was	F 6	07		
	to implement the faci investigate and report state agency.  Resident #69 was ad 1/17/13; diagnoses in stroke, dementia with hemiparesis, depress shoulder, dysphagia, epilepsy, and high blom MDS (Minimum Data (Assessment Referent the resident as being to make daily life decoded as requiring to extensive care for trainand hygiene; supervillocomotion; and was bowel and bladder.  Resident #39 was additional report of the state of the supervillocomotion; and was bowel and bladder.	mitted to the facility on aclude but are not limited to a behaviors, hemiplegia and sion, pain in leg and adjustment disorder, bod pressure. The quarterly Set) with an ARD ace Date) of 2/4/20 coded severely impaired in ability isions. The resident was tal care for bathing; nsfers, dressing, toileting				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		495140	B. WING		C 03/10/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	03/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 607	alcohol dependence stress disorder, epil dystonia. The quart Set) with an ARD (A of 1/14/20 coded the impaired in ability to The resident was cobathing and extensi areas of activities of A review of the clinic revealed a nurses in documented, "Residents grabbed his arm an Residents separate.  A review of the clinic revealed a nurses in documented, "Residents grabbed his arm an Residents separate.  A review of the clinic revealed a nurses in documented, "This silverware of reside #69] grabbed this reto the floor. No inju (complaints of) pain (responsible party) practitioner) notified.  On 3/9/20 at 10:10 (Administrative Staf Director and Region Services) were madincident. Additional incident report was Per this request, the "Behavioral Outburs or Staff Member" for	nentia without behaviors, e, depression, post-traumatic epsy, high blood pressure and terly MDS (Minimum Data assessment Reference Date) e resident as being severely make daily life decisions. Oded as requiring total care for eve assistance for all other f daily living.  Cal record for Resident #69 one dated 3/6/20 that dent [#39] grabbed silverware meal tray. This resident [#69] d pulled him to the floor. d. No further behaviors."  Cal record for Resident #39 one dated 3/6/20 that resident [#39] grabbed ent [#69] tray and he [Resident esident's arm and pulled him ry noted. Offers no c/o or discomfort. RP present. NP (nurse"  AM, ASM #1 and ASM #3 of Members, the Executive enal Director of Clinical le aware of the identified information such as an requested.	F 60		

_ ` · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495140	B. WING				C 10/2020
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB		<u> </u>	1	STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	1 03/	10/2020
(X4) ID 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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	resident (#69) grabbe pulled him out of his of On 3/09/20 at 3:20 Pl to the cognitive status did not consider this add not conduct an inistate agency.  On 3/10/20 at 2:30 Pl Staff Member, the Exaware of the concern initial report had beer agency. She stated if facility's position that	ident's (#69) tray and this ed (#39) by the arm and chair."  M, ASM #1 stated that due is of the residents, the facility is abuse, or reportable, and tial report to the required  M, ASM #1 (Administrative ecutive Director) was made  ASM #1 was asked if an in sent to the required state it had not been as it was the due to the cognitive status is not abuse. No further	F	607			
	the face. The facility of facility abuse policy to incident to the require Resident #69 was ad 1/17/13; diagnoses in stroke, dementia with hemiparesis, depress shoulder, dysphagia, epilepsy, and high blo MDS (Minimum Data (Assessment Referer the resident as being to make daily life dec coded as requiring to	mitted to the facility on sclude but are not limited to behaviors, hemiplegia and scion, pain in leg and adjustment disorder, bod pressure. The quarterly Set) with an ARD sce Date) of 2/4/20 coded severely impaired in ability isions. The resident was tal care for bathing; insfers, dressing, toileting					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		495140	B. WING _			C 03/10/2020
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611		03/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 607	Resident #650 was a 3/14/18; diagnoses in femur fracture, depressive appnea, high bloatrial fibrillation, congrespiratory failure, ar resident expired at the time of survey. MDS (Minimum Data (Assessment Refere the resident as sever	dmitted to the facility on aclude but are not limited to assion, chronic obstructive and pressure, heart disease, gestive heart failure, acute and cardiac pacemaker. The are facility on 8/5/19 and current resident in the facility. The significant change	F 6	07		
	toileting, eating and dassistance for transfer assistance and the face. Resident [#69] was taken into restor staff LPN's (Licensed evening meal Resident [#69] cooper assistance for inappropriate behavior assistance for inappropriate behavior assistance for transfer	stal care for bathing, hygiene, dressing; and extensive ers.  al record for Resident #69 at dated 2/26/19 that ent to resident altercation at 1730 (5:30 PM). Staffing Assistant) alerted this ef50] bumped into residents dining room. Resident [#69] to resident [#650] twice in the separated from area and ative dining room with two departed Practical Nurse) to eat his ident alert times one. When departed are times one. When departed the end of the phase of the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	IPLE CONSTRUCTION  NG	(X3	(X3) DATE SURVEY COMPLETED	
		495140	B. WING			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	<b>I</b>	03/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 607	attorney] aware of in  A review of the clinic revealed a physician documented, "Called resident as she was room she was punch resident [#69]. She injuries. No bruising dorsum of the nose of the nose of the complete and the comp	al record for Resident #650 note dated 2/26/19 that I by the nurse to evaluate assaulted. At the dining and in to her nose by another was tearful and anxious. No but mild erythema on noted.  MM, ASM #1 and ASM #3 Members, the Executive al Director of Clinical a aware of the identified information such as an equested.  facility provided a t Assault of Another Resident m dated 2/26/19. This form ent (#69) hit Resident (#650) forehead in the dining 650) was close to his chair nair). Resident (#69) turned Resident #650)."  PM, ASM #1 stated that due as of the residents, the facility as abuse, or reportable, and investigation on the incident entified incident report, which and thorough investigation or	F	507		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		495140	B. WING _		03	C 3/10/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611	•	10/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 607	Continued From page provided.	÷ 82	F 6	07		
	#652 by the neck. Th implement the facility	ent #69 grabbed Resident e facility staff failed to abuse policy to investigate at to the required state				
	1/17/13; diagnoses in stroke, dementia with hemiparesis, depress shoulder, dysphagia, epilepsy, and high blo MDS (Minimum Data (Assessment Referer the resident as being to make daily life dec coded as requiring to extensive care for tra and hygiene; supervise	adjustment disorder, bod pressure. The quarterly Set) with an ARD ince Date) of 2/4/20 coded severely impaired in ability isions. The resident was tal care for bathing; insfers, dressing, toileting				
	Resident #652 was a 1/14/19; diagnoses in heart failure, insomnis behaviors, and high be expired on 2/19/19 ar in the facility at the tir admission MDS (Mini (Assessment Referer the resident as being to make daily life dec coded as requiring to	dmitted to the facility on clude but are not limited to a, dysphagia, dementia with clood pressure. The resident and was not a current resident are of the survey. The mum Data Set) with an ARD are Date) of 2/6/19 coded severely impaired in ability isions. The resident was tal care for bathing; nsfers, dressing, toileting				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495140	B. WING			C 03/10/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	I	03/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	BTATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 607	Continued From page	ge 83	F 60	07		
	revealed a nurses n documented, "Resid resident [#652] by the dining room. Remo room and kept him to Resident has remail Other resident [#65] Notified POA (Power	cal record for Resident #69 note dated 2/15/19 that dent [#69] grabbed another ne neck during supper in the ved resident [#69] from dining with nurse for supper. ned calm since removing. 2] has no apparent injuries. er of Attorney). Notified DON ). Notified NP (Nurse				
	revealed a nurses n also been crossed of Entry:On 2.15.19 (sic) by another resi Staff had been mon area. No further ab	cal record for Resident #652 ote dated 2/15/19, which had but, but documented, "Late [Resident #652] was chocked dent [#69] in a dining room. itoring her skin in a neck rasions had been noticed. No nd distress had been noted. d been notified."				
	(Administrative Staf Director and Region Services) were made	AM, ASM #1 and ASM #3  f Members, the Executive hal Director of Clinical le aware of the identified information such as an requested.				
	or Staff Member" fo documented, "(Resi resident (#652) whe	e facility provided a st Assault of Another Resident rm dated 2/15/19. This form dent #69) was at dinner table, seled and spoke past (Resident #69) reached out				

NAME OF PROVIDER OR SUPPLIER  ROSE HILL HEALTH AND REHAB    CA   10		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	COME	
ROSE HILL HEALTH AND REHAB  SIMMARY STATEMENT OF DEFICIENCES  (EACH DEFICIENCY MIST BE PRECEDED BY FULL REQUIATORY OR LSC IDENTIFYING INFORMATION)  F 607  Continued From page 84 and grabbed her (Resident #652) by the neck"  On 3/09/20 at 3:20 PM, ASM #1 stated that due to the cognitive status of the residents, the facility did not consider this as abuse, or reportable, and did not complete an investigation on the incident beyond the above identified incident report, which was not a complete and thorough investigation or report it to the required state agency.  On 3/10/20 at 2:30 PM, ASM #1 (Administrative Staff Member, the Executive Director) was made aware of the concern. No further information was provided.  F 608  SS=C  CFR(s): 483.12(b)(5)(i)-(iii)  §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.  (i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements.			495140					-
PREFIX   REGULATORY OR LSC IDENTIFYING INFORMATION    PREFIX TAG   CROSS-REFERENCED TO THE APPROPRIATE   CROSS-REFERENCED TO THE APPROPRIATE   DEFICIENCY					1	10 CHALMERS COURT	1 001	10/2020
and grabbed her (Resident #652) by the neck"  On 3/09/20 at 3:20 PM, ASM #1 stated that due to the cognitive status of the residents, the facility did not consider this as abuse, or reportable, and did not complete an investigation on the incident beyond the above identified incident report, which was not a complete and thorough investigation or report it to the required state agency.  On 3/10/20 at 2:30 PM, ASM #1 (Administrative Staff Member, the Executive Director) was made aware of the concern. No further information was provided.  F 608 Reporting of Reasonable Suspicion of a Crime CFR(s): 483.12(b)(5)(i)-(iii)  §483.12(b) The facility must develop and implement written policies and procedures that:  §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.  (i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements.	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility.  (B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the	F 608	and grabbed her (Resonal Con 3/09/20 at 3:20 Pl to the cognitive status did not consider this add not complete an inbeyond the above ide was not a complete a report it to the require On 3/10/20 at 2:30 Pl Staff Member, the Exaware of the concern provided.  Reporting of Reasona CFR(s): 483.12(b)(5) Separate occurring in federally facilities in accordance Act. The policies and but are not limited to (i) Annually notifying defined at section 115 individual's obligation reporting requirement (A) Each covered ind State Agency and one entities for the politica facility is located any crime against any ind or is receiving care for (B) Each covered ind immediately, but not leave the status of the covered ind immediately, but not leave the considerate in the covered ind immediately, but not leave the covered ind immediately.	M, ASM #1 stated that due softhe residents, the facility as abuse, or reportable, and investigation on the incident entified incident report, which and thorough investigation or ed state agency.  M, ASM #1 (Administrative ecutive Director) was made.  No further information was able Suspicion of a Crime (i)-(iii)  y must develop and icies and procedures that:  reporting of crimes funded long-term care ewith section 1150B of the procedures must include the following elements. Ecovered individuals, as 50B(a)(3) of the Act, of that to comply with the following its.  ividual shall report to the erasonable suspicion of a ividual who is a resident of, orm, the facility.  ividual shall report ater than 2 hours after					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		TE SURVEY MPLETED
		495140	B. WING			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	0	3/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 608	later than 24 hours suspicion do not res (ii) Posting a consprights, as defined at Act. (iii) Prohibiting and defined at section 1 This REQUIREMEN by: Based on observat document review, it facility staff failed to rights regarding the crimes.  The findings include On 3/9/20 at 1:19 p halls, lobby and ememployee break roc conducted. No pos regarding the report observed. On 3/9/2 those same areas v (administrative staff director). ASM #1 stanotice had been on and state employmental but the notice in ASM #1 stated infor rights for the reporti reviewed during emtraining.  On 3/9/20 at 7:07 p	erious bodily injury, or not if the events that cause the sult in serious bodily injury. Sicuous notice of employee a section 1150B(d)(3) of the preventing retaliation, as 150B(d)(1) and (2) of the Act. It is not met as evidenced ion, staff interview and facility was determined that the post notice of employee reporting of suspicious	F 60			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7 50.25	_		(	
		495140	B. WING			03/	10/2020
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			11	TREET ADDRESS, CITY, STATE, ZIP CODE 10 CHALMERS COURT ERRYVILLE, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 608 F 609 SS=E	under the federal elde "Specifically, it is the notice in a conspicuor 'covered individuals' (their reporting obligation justice act) to report a SSA (state survey agenforcement; and their right to file a conagency if they feel the against an employee crime under this statute. No further information Reporting of Alleged CFR(s): 483.12(c)(1)(c)	reporting suspected crimes er justice act documented, Facility policy to: c. post a us location that informs all including staff) of tion under the EJA (elder a suspicion of a crime to the ency) and local law emplaint with the state survey a Facility has retaliated who reported a suspected te"		608			
	neglect, exploitation, must:  §483.12(c)(1) Ensure involving abuse, neglemistreatment, includir source and misappropare reported immedia hours after the allegat that cause the allegat serious bodily injury, the events that cause abuse and do not resithe administrator of the officials (including to tadult protective service)	that all alleged violations ect, exploitation or ng injuries of unknown priation of resident property, tely, but not later than 2 tion is made, if the events ion involve abuse or result in or not later than 24 hours if the allegation do not involve ult in serious bodily injury, to					

	OF DEFICIENCIES  CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S	ETED
		495140	B. WING		03/1	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	03/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 609	§483.12(c)(4) Repoinvestigations to the designated represe accordance with Stranger Agency, with incident, and if the appropriate correction This REQUIREMENT by:  Based on staff interest and clinical record in the facility staff failed abuse, for eight of sample, (Residents #650, and #652). Or Resident #69 and the facility staff failed abuse, for eight of sample, (Residents #650, and #652). Or Resident #69 and the foliation of the floor Resident #22 in the 3/6/20, Resident #650 in the floor Resident #6	ate law through established	F 60	9		
	dated February 201	e: ity policy, "Resident Abuse" 7 and revised January 2020, y: It is inherent in the nature				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILD			١,	2
		495140	B. WING				10/2020
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
BOSE UII	I HEALTH AND DEHAD			1	110 CHALMERS COURT		
KUSE HIL	L HEALTH AND REHAB			E	BERRYVILLE, VA 22611		
(X4) ID 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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 609	be afforded basic hur right to be free from a mistreatment, and/or property. The managerecognizes these right the following statemed procedures to protect establish a disciplinate fair and timely treatmeresident abuseProcedures to protect establish a disciplinate fair and timely treatmeresident abuseProcedures of the concession	esident at Facility that he/she man rights, including the abuse, neglect, misappropriation of gement of the facility at and hereby establishes ents, policies, and these rights and to ry policy, which results in the lent of occurrences of cedure for Reporting Abuse: sident abuse are to be to the Licensed Nurse in lursing, or the Administrator. The of those three officials, the to be completed and the Coordinator or his/her stigation. B. The facility at agency and one or more ties any reasonable against any individual who is ceiving care from, the facility that caused the suspicion odily injury the facility must after forming the suspicion. Sed the suspicion did not lay injury the facility shall seInvestigation: a. The ind/or Director of Nursing the ments from the victim, the sible witnesses including all the vicinity of the alleged also secure all physical apletion of the investigation, a per prepared"	F	609			
	Resident to Resident	" dated February 2017, no nented, "Residents must					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495140	B. WING			C 03/10/2020	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 110 CHALMERS COURT BERRYVILLE, VA 22611		33/10/2020	
(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 ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 609	but not limited to faci consultants or volunt serving the individual guardians, friends, or Incident/Accident Re by the nurse in charg Department of Health Administrator, Director designee of the facility resident altercations to the extent that phy transfer or discharge state specific protoco enforcement authority Administrator, Director designee of any insta- mistreatment, neglector	buse by anyone, including lity staff, other residents, eers, staff of other agencies I, family members or legal of other individuals6. An port form must be completed le9. The State in is to be notified by the or of Nursing, or their try's knowledge of resident to in which a resident is injured resical intervention and/or to a hospital is required per lols. 10. The local law ites are to be notified by the or of Nursing, or their ance of resident abuse, it, or misappropriation of inch is a "Criminal Act" and in	F 60	9			
	the required state ag for Residents #69 an #67 hit by Resident # hit Resident #67 back  Resident #69 was ad 1/17/13; diagnoses ir stroke, dementia with hemiparesis, depress shoulder, dysphagia, epilepsy, and high blomDS (Minimum Data (Assessment Referenthe resident as being	Imitted to the facility on include but are not limited to in behaviors, hemiplegia and sion, pain in leg and adjustment disorder, bood pressure. The quarterly Set) with an ARD ince Date) of 2/4/20 coded severely impaired in ability issions. The resident was					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	СОМ	E SURVEY PLETED
		495140	B. WING			C
	ROVIDER OR SUPPLIER  L HEALTH AND REHA			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	03	/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 609	and hygiene; super locomotion; and wa bowel and bladder.  Resident #67 was a 11/21/12; diagnoses stroke, diabetes, he dementia with beha insomnia, glaucoma pulmonary disease, blood pressure, and quarterly MDS (Min (Assessment Refer the resident as bein ability to make daily was coded as requi toileting; extensive a dressing, and hygie A review of the clini revealed a nurse's a documented, "Resident #69] in the punched back and a separated by staff."  A review of the clini revealed a nurse's a documented, "Resident #69] in the punched back and a separated by staff."  A review of the clini revealed a nurse's a documented, "Resident #69] in the punched back and a separated by staff."	ransfers, dressing, toileting vision for eating and s frequently incontinent of admitted to the facility on sinclude but are not limited to emiplegia, dysphagia, viors, adjustment disorder, a, chronic obstructive depression, convulsions, high dibipolar disorder. The imum Data Set) with an ARD ence Date) of 2/3/20 coded ag cognitively impaired in vife decisions. The resident ring total care for bathing and assistance for transfers, ane; and supervision for eating.  Cal record for Resident #69 mote dated 1/22/19 that dent [#69] was arguing with 67] when the other resident him. When approached by dent [#67] punched him e arm at which point he exchanged punches until cal record for Resident #67 mote dated 1/22/19 that dent [Resident #67] was er resident [Resident #69].	F 60	09		
	[Resident #67] pundarm, when the othe	by staff, this resident ched the other resident in the r resident [Resident #69] hit schanging blows until they				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		PLETED
		495140	B. WING			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	031	10/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 609	(Administrative Staf Director and Region Services) were madincident. Additional incident report was provided.  On 3/09/20 at 3:20 to the cognitive stat did not consider this did not complete an or report it to the reconstruction. No provided.  On 3/10/20 at 2:30 of the concern. No provided.  2. On 3/18/19, Rest the face and the faci immediately the aller #7 to the required services. Resident #69 was a 1/17/13; diagnoses stroke, dementia with hemiparesis, depressionalder, dysphagia epilepsy, and high the	AM, ASM #1 and ASM #3 If Members, the Executive hal Director of Clinical le aware of the identified information such as an requested. None was  PM, ASM #1 stated that due us of the residents, the facility is as abuse, or reportable, and investigation on the incident quired state agency.  PM, ASM #1 was made aware further information was  ident #69 hit Resident #7 in cility staff failed to report regation of abuse for Resident tate agency.  admitted to the facility on include but are not limited to th behaviors, hemiplegia and asion, pain in leg and a, adjustment disorder, blood pressure. The quarterly	F 60	09		
	the resident as bein to make daily life de coded as requiring t extensive care for tr	ence Date) of 2/4/20 coded g severely impaired in ability ecisions. The resident was total care for bathing; ransfers, dressing, toileting vision for eating and				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495140	B. WING		C 03/10/2020
	ROVIDER OR SUPPLIER  L HEALTH AND REHA	В	STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611		1 00/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 609	Resident #7 was ac 2/19/19; diagnoses stroke, hemiplegia, dysphagia, depress chronic obstructive quarterly MDS (Min (Assessment Refer the resident as beir make daily life decisoded as requiring extensive assistant toileting and hygien A review of the clini revealed a nurses redocumented, "Resident (#7) then [Resident #7] or injuries noted. Restaken to restorative Resident [#7] nurse and NP [director of and nurse practition plan updated."  A review of the clini revealed a nurses redocumented, "Resident [#7] nurse and NP [director of and nurse practition plan updated."  A review of the clini revealed a nurses redocumented, "Resident [#6] was in the feet of the	Imitted to the facility on include but are not limited to hemiparesis, diabetes, sion, high blood pressure, and pulmonary disease. The imum Data Set) with an ARD ence Date) of 12/6/19 coded ag cognitively intact in ability to sions. The resident was total care for bathing; se for transfers, dressing, e; and supervision for eating.  cal record for Resident #69 note dated 3/18/19 that dent [#69] was in dining room. He was going behind resident #7] back into his w/c (wheel 69] became agitated and hit in the side of the face. No idents separated and resident dining room to eat his meal. It was notified. DON, POA, nursing, power of attorney, her] aware of incident. Care cal record for Resident #7 note dated 3/18/19 that dent [#7] was smacked by 69] during dinner. The other removed from the dining room. In ace. Resident [#7] was upset dining room and had supper ent [#7] was upset later but no	F 609		

	OF DEFICIENCIES  CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495140	B. WING		03/10/2020
	ROVIDER OR SUPPLIER  L HEALTH AND REHA			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	03/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPROPRIES OF THE A	JLD BE COMPLETION
F 609	(Administrative State and Regional Clinic	age 93  AM, ASM #1 and ASM #3  Iff Members, the Administrator cal Nurse) were made aware of ent and additional information	F 60	9	
	or Staff Member" for documented, "Residence in dining room	e facility provided a st Assault of Another Resident orm dated 3/18/19. This form dent (#69) hit Resident (#7) on . (Resident #69) was behind she backed into his w/c (wheel			
	to the cognitive stat did not consider this did not complete ar beyond the above i	PM, ASM #1 stated that due tus of the residents, the facility is as abuse, or reportable, and in investigation on the incident dentified incident report, which is and thorough investigation or ired state agency.			
		PM, ASM #1 was made aware further information was			
	face with a closed f 1/12/20. The facility immediately the alle #41to the required: Resident #69 was a 1/17/13; diagnoses stroke, dementia wi hemiparesis, depre	as hit in the right side of her fist by Resident #69, on y staff failed to report egation of abuse for Resident state agency.  admitted to the facility on include but are not limited to ith behaviors, hemiplegia and ession, pain in leg and a, adjustment disorder,			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
		495140	B. WING _			C 03/10/2020
	ROVIDER OR SUPPLIER L HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, Z 110 CHALMERS COURT BERRYVILLE, VA 22611	ZIP CODE	33,10,2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTIVE CROSS-REFERENCED		DATE
F 609	MDS (Minimum Data (Assessment Refere the resident as being to make daily life decoded as requiring to extensive care for tra and hygiene; supervilocomotion; and was bowel and bladder.  Resident #41 was ac 4/21/18; diagnoses in congestive heart faile dementia with behave pressure. The quarte Set) with an ARD (As of 1/15/20 coded the moderately impaired decisions. The reside total care for bathing transfers, dressing, to supervision for eating.  A review of the clinic revealed a nurses not documented, "On 3-time. It was told this was sitting at the nur chair. Staff/CNA was meal cart and reside was behind her (the kicking at the CNA wow move out of her way saw this take place in the right side of her [Resident #41] holler	ood pressure. The quarterly a Set) with an ARD nce Date) of 2/4/20 coded a severely impaired in ability sisions. The resident was otal care for bathing; ansfers, dressing, toileting sion for eating and frequently incontinent of dimitted to the facility on include but are not limited to ure, dysphagia, depression, iors, and high blood erly MDS (Minimum Data assessment Reference Date) resident as being in ability to make daily life ent was coded as requiring; extensive assistance for oileting, and hygiene; and continued and sees station in his wheel is passing by resident #41] staff member) and tried ho was in front of her to when this resident [#69] te landed his closed fist on	Fé	609		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPL  A. BUILDING		1					
		495140	B. WING			C 03/10/2020	
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			1	STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611	1 03/	10/2020
(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 609	revealed a nurses not documented, "Alert, so recipient in a res to realtercation. Denied p apparent injuries note episode. OOB (out of tolerated. Needs to be time to her room and [resident] doorway	al record for Resident #41 te dated 1/12/20 that s/p (status post) being the es (resident to resident) ain or discomfort. No ed to right eye area s/p f bed) in w/c (wheelchair) as be re-directed from time to away from other res  M, ASM #1 and ASM #3 Members, the Administrator Nurse) were made aware of and additional information  facility provided a Assault of Another Resident in dated 1/11/20 (misdated?). d, "Resident (#69) in front of beside resident (#41). Saw eking at her (a staff member od cart). Took his (Resident innected with the other neekhe (Resident #69) honor."  M, ASM #1 stated, "There he meal cart, she was trying by the residents sitting in the reached out attempting to	F	609			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		(X3) DATE SURVEY COMPLETED	
		495140	B. WING		C 03/10/2020	
	ROVIDER OR SUPPLIER  L HEALTH AND REHA	В	STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611		03/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUNDER CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION	
F 609	complete and thoro the required state a On 3/10/20 at 2:30	eport, which was not a ugh investigation or report it to	F 60	9		
	closed fist by Resid	as hit in the left arm with a ent #69, on 10/17/19. The report immediately an for Resident #22 to the cy.				
	1/17/13; diagnoses stroke, dementia wi hemiparesis, depre shoulder, dysphagia epilepsy, and high MDS (Minimum Dai (Assessment Refer the resident as beir to make daily life decoded as requiring extensive care for trand hygiene; super	admitted to the facility on include but are not limited to the behaviors, hemiplegia and ssion, pain in leg and a, adjustment disorder, blood pressure. The quarterly ta Set) with an ARD ence Date) of 2/4/20 coded ag severely impaired in ability ecisions. The resident was total care for bathing; ransfers, dressing, toileting vision for eating and s frequently incontinent of				
	9/28/18; diagnoses dementia with beha hallucinations, and (Minimum Data Set Reference Date) of as being severely in	admitted to the facility on include but are not limited to viors, anxiety disorder, dyspnea. The quarterly MDS ) with an ARD (Assessment 12/10/19 coded the resident mpaired in ability to make daily resident was coded as				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION		OATE SURVEY OMPLETED
		495140	B. WING			C 03/10/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	<u> </u>	03/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 609	for dressing, eating, supervision for trans  A review of the clinic revealed a nurses in documented, "This [#22] were passing resident punched rewith a closed fist.	for bathing; limited assistance toileting and hygiene; and	F 60	9		
	revealed a nurse no documented, "This near north nurses s provocative manner who, for no apparer [Resident #22] in up residents were quic					
	(Administrative Staf Director and Region Services) were mad incident. Additional incident report was Per this request, the "Behavioral Outburs or Staff Member" fo documented, "This	•				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495140	B. WING			C <b>3/10/2020</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	<u> </u>	3/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHOL  CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 609	fist."  On 3/09/20 at 3:20 It to the cognitive state did not consider this did not complete an beyond the above it was not a complete report it to the requirement of the concern. No provided.  5. Resident #39 was floor by Resident #6 was a 1/17/13; diagnoses stroke, dementia with hemiparesis, depressionalder, dysphagia epilepsy, and high be MDS (Minimum Dat (Assessment Reference the resident as bein to make daily life de coded as requiring the extensive care for the resident and hygiene; supervolucion, and was bowel and bladder.  Resident #39 was a Resident	PM, ASM #1 stated that due us of the residents, the facility as abuse, or reportable, and investigation on the incident dentified incident report, which and thorough investigation or red state agency.  PM, ASM #1 was made aware further information was  s pulled out of his chair to the 9 on 3/6/20. The facility staff ediately an allegation of abuse the required state agency.  dmitted to the facility on include but are not limited to the behaviors, hemiplegia and asion, pain in leg and a dijustment disorder, alood pressure. The quarterly a Set) with an ARD ence Date) of 2/4/20 coded g severely impaired in ability cisions. The resident was otal care for bathing; ansfers, dressing, toileting	F 60				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		495140	B. WING _			C 03/10/2020	
	ROVIDER OR SUPPLIER	1	STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611			1 00/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BI THE APPROPRIA	DATE	
F 609	alcohol dependence stress disorder, epile dystonia. The quarte Set) with an ARD (Arof 1/14/20 coded the impaired in ability to The resident was cobathing and extensive areas of activities of A review of the clinic revealed a nurses not documented, "Residents regrabbed his arm and Residents separated A review of the clinic revealed a nurses not documented, "This residents regrabbed his arm and Residents separated A review of the clinic revealed a nurses not documented, "This resilverware of resider #69] grabbed this resilverware of resider #69] grabbed this resilverware of pain (complaints of) pain (responsible party) practitioner) notified.  On 3/9/20 at 10:10 A (Administrative Staff Director and Regions Services) were made incident. Additional incident report was resident report was resident for Staff Member" for Staff Member for Staff Member for staff Member for the staff pain and the staff Member for Staff Member for staff Member for staff Member for the staff pain and the staff Member for staff Member for staff Member for the staff pain and the staff pain a	depression, post-traumatic appy, high blood pressure and arly MDS (Minimum Data assessment Reference Date) aresident as being severely make daily life decisions. It ded as requiring total care for a seasistance for all other daily living.  The dated 3/6/20 that are all record for Resident [#69] are all read tray. This resident [#69] are pulled him to the floor.  The More and the season of the dated 3/6/20 that are all record for Resident #39 on t	F6	609			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION		ATE SURVEY DMPLETED
		495140	B. WING _			C 03/10/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611		567 167 2025
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 609	resident (#69) grabb pulled him out of his pulled him out of his On 3/09/20 at 3:20 Fto the cognitive statudid not consider this did not conduct an instate agency.  On 3/10/20 at 2:30 Fto the concern. ASM report had been sent agency. ASM #1 status of the resident further information with the facility's position status of the resident further information with the sent formation with the s	sident's (#69) tray and this ed (#39) by the arm and chair."  PM, ASM #1 stated that due as of the residents, the facility as abuse, or reportable, and nitial report it to the required  PM, ASM #1 was made aware at the ted it had not been as it was that due to the cognitive ts, it was not abuse. No ras provided.  The state of the face by Resident facility staff failed to report aution of abuse for Resident	F	509		
	Resident #69 was ac 1/17/13; diagnoses i stroke, dementia with hemiparesis, depres shoulder, dysphagia epilepsy, and high bl MDS (Minimum Data (Assessment Refere the resident as being to make daily life dec coded as requiring to extensive care for tra and hygiene; superv	dmitted to the facility on nclude but are not limited to hehaviors, hemiplegia and sion, pain in leg and, adjustment disorder, lood pressure. The quarterly a Set) with an ARD nce Date) of 2/4/20 coded g severely impaired in ability cisions. The resident was otal care for bathing; ansfers, dressing, toileting				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495140	B. WING				C <b>10/2020</b>
	ROVIDER OR SUPPLIER	3		11	TREET ADDRESS, CITY, STATE, ZIP CODE O CHALMERS COURT ERRYVILLE, VA 22611		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 609	3/14/18; diagnoses if femur fracture, depressive papnea, high blatrial fibrillation, congrespiratory failure, arresident expired at the time of survey MDS (Minimum Data (Assessment Refere the resident as sever make daily life decis coded as requiring to	admitted to the facility on nclude but are not limited to ession, chronic obstructive ood pressure, heart disease, gestive heart failure, acute nd cardiac pacemaker. The ne facility on 8/5/19 and current resident in the facility of The significant change a Set) with an ARD ence Date) of 6/28/19 coded rely impaired in ability to ions. The resident was otal care for bathing, hygiene, dressing; and extensive	F	809			
	revealed a nurses not documented, "Resid with resident [#650] CNA (Certified Nursi writer that resident [#650] w/c (wheel chair) in turned around and h face. Resident [#69] was taken into resto staff LPN's (License evening meal Resident [#69] coop residents. Resident for inappropriate bel [nurse practitioner, co	cal record for Resident #69 bete dated 2/26/19 that ent to resident altercation at 1730 (5:30 PM). Staff ing Assistant) alerted this #650] bumped into residents dining room. Resident [#69] it resident [#650] twice in the generated from area and rative dining room with two de Practical Nurse) to eat his sident alert times one. When de resident about incident he No further behaviors noted. erative with staff and other [#69] monitored frequently haviors. NP, DON and POA, director of nursing, power of ficident. Care plan updated."					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495140	B. WING				C 1 <b>10/2020</b>
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			110	EET ADDRESS, CITY, STATE, ZIP CODE  CHALMERS COURT  RRYVILLE, VA 22611	1 03/	10/2020
(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 SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 609	A review of the clinical revealed a physician documented, "Called resident as she was a room she was punched resident [#69]. She winjuries. No bruising light dorsum of the nose not on 3/9/20 at 10:10 All (Administrative Staff Ministrative Staff Member form documented, "Reside in face on nose and for room Resident (#60 and hit w/c (wheel charound and hit her (Richard Ministrative Staff M	Il record for Resident #650 note dated 2/26/19 that by the nurse to evaluate issaulted. At the dining ed in to her nose by another was tearful and anxious. No out mild erythema on oted.  M, ASM #1 and ASM #3 Members, the Executive Il Director of Clinical aware of the identified information such as an quested.  Acacility provided a Assault of Another Resident in dated 2/26/19. This form int (#69) hit Resident (#650) orehead in the dining 50) was close to his chair eair). Resident (#69) turned esident #650)."  M, ASM #1 stated that due is of the residents, the facility is abuse, or reportable, and investigation on the incident intified incident report, which and thorough investigation or distate agency.  M, ASM #1 was made aware	F	609			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		495140	B. WING			C
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CO 110 CHALMERS COURT BERRYVILLE, VA 22611		03/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 609	Resident #69 on 2/19 to report immediately Resident #652 to the Resident #69 was ac 1/17/13; diagnoses is stroke, dementia with hemiparesis, depress shoulder, dysphagia, epilepsy, and high bl MDS (Minimum Data (Assessment Refere the resident as being to make daily life decoded as requiring to extensive care for train and hygiene; supervilocomotion; and was bowel and bladder.  Resident #652 was a 1/14/19; diagnoses is heart failure, insomn behaviors, and high expired on 2/19/19 a in the facility at the tiadmission MDS (Min (Assessment Refere the resident as being the side of t	as grabbed by the neck by 5/19. The facility staff failed an allegation of abuse for a required state agency.  Idmitted to the facility on include but are not limited to in behaviors, hemiplegia and ision, pain in leg and ision for eating in ability cisions. The resident was obtained as the pain is in for eating and ision for eating and if requently incontinent of include but are not limited to italia, dysphagia, dementia with blood pressure. The resident ind was not a current resident me of the survey. The imum Data Set) with an ARD ince Date) of 2/6/19 coded is severely impaired in ability	F 60	09		
	coded as requiring to extensive care for tra and hygiene; and superside A review of the clinic revealed a nurses no	ansfers, dressing, toileting				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  NG	(X	3) DATE SURVEY COMPLETED
		495140	B. WING			C
	ROVIDER OR SUPPLIER	100140		STREET ADDRESS, CITY, STATE, ZIP CODI  110 CHALMERS COURT  BERRYVILLE, VA 22611	I	03/10/2020
(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 COI ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 609	resident [#652] by the dining room. Remov room and kept him w Resident has remain. Other resident [#652]	e neck during supper in the ed resident [#69] from dining ith nurse for supper. ed calm since removing.   has no apparent injuries. of Attorney). Notified DON	Fé	509		
	revealed a nurses no also been crossed of Entry:On 2.15.19 [F (sic) by another resid Staff had been monit area. No further abra	al record for Resident #652 te dated 2/15/19, which had ut, but documented, "Late Resident #652] was chocked ent [#69] in a dining room. oring her skin in a neck asions had been noticed. No d distress had been noted. been notified."				
	(Administrative Staff Director and Regiona Services) were made	e aware of the identified nformation such as an				
	or Staff Member" forn documented, "(Resid resident (#652) whee (Resident #69) and (I and grabbed her (Re On 3/09/20 at 3:20 P to the cognitive statu- did not consider this	Assault of Another Resident m dated 2/15/19. This form ent #69) was at dinner table,				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION	(	X3) DATE SURVEY COMPLETED
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		495140	B. WING			03/10/2020
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB		•	STREET ADDRESS, CITY, STATE, ZIP COD 110 CHALMERS COURT BERRYVILLE, VA 22611	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 609	was not a complete a report it to the require	ntified incident report, which nd thorough investigation or d state agency.  M, ASM #1 was made aware	F	609		
F 610 SS=E	Investigate/Prevent/CCFR(s): 483.12(c)(2)- §483.12(c) In responsion neglect, exploitation, must: §483.12(c)(2) Have eviolations are thoroug §483.12(c)(3) Prevent neglect, exploitation, investigation is in proceeding to the additional states of th	se to allegations of abuse, or mistreatment, the facility vidence that all alleged hly investigated.  It further potential abuse, or mistreatment while the gress.  It he results of all administrator or his or her ative and to other officials in the law, including to the State of 5 working days of the eged violation is verified a caction must be taken.  It is not met as evidenced siew, facility document review view, it was determined that to investigate allegations of 0 residents in the survey 19, #67, #7, #41, #22, #650,	F	610		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495140	B. WING _			C 03/10/2020	
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	<u> </u>	00/10/2020	
(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 CORRI ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 610	Resident #41 in the r closed fist. On 10/17/ Resident #22 in the le 2/26/19, Resident #6 face. On 2/15/19, Re #652 by the neck. Thinvestigate the allega Residents# 69, #67, if #652.  The findings include:  A review of the facility dated February 2017 documented, "Policy: and dignity of each rebe afforded basic hur right to be free from a mistreatment, and/or property. The management is to the side of the side o	I 2/20, Resident #69 hit ight side of her face with a 19, Resident #69 hit eft arm with a closed fist. On 9 hit Resident #650 in the sident #69 grabbed Resident e facility staff failed to tions of abuse for #7, #41, #22, #650 and  If policy, "Resident Abuse" and revised January 2020, It is inherent in the nature esident at Facility that he/she man rights, including the abuse, neglect, misappropriation of	F6	,			
	fair and timely treatm resident abuseProd A. All incidents of res reported immediately Charge, Director of N Once reported to one prescribed forms are delivered to the Abus designee for an inves shall report to the sta law enforcement enti- suspicion of a crime a	these rights and to ry policy, which results in the ent of occurrences of redure for Reporting Abuse: sident abuse are to be to the Licensed Nurse in lursing, or the Administrator. of those three officials, the to be completed and e Coordinator or his/her stigation. B. The facility te agency and one or more					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495140	B. WING			C <b>03/10/2020</b>
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB	33713		STREET ADDRESS, CITY, STAT 110 CHALMERS COURT BERRYVILLE, VA 22611	TE, ZIP CODE	03/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE DED TO THE APPROPRIA FICIENCY)	DATE.
F 610	C. And if the events to resulted in serious bo report within 2 hours at the events that caus result in serious bodily report within 24 hours. Abuse Coordinator are shall take written state suspect(s) and all post other employees in the abuse. He/she shall a evidence. Upon completailed report shall be a review of the facility. Resident to Resident' revision dates, document be subjected to at but not limited to facility consultants or volunted serving the individual, guardians, friends, or Incident/Accident Report the nurse in charge by the nurse in charge Department of Health Administrator, Director designee of the facility resident altercations in to the extent that phystomator or discharge state specific protocol enforcement authoritic Administrator, Director designee of any instal mistreatment, neglect	that caused the suspicion dily injury the facility must after forming the suspicion. Seed the suspicion did not by injury the facility shall seed the suspicion: a. The indoor Director of Nursing ements from the victim, the issible witnesses including all the vicinity of the alleged also secure all physical poletion of the investigation, a see prepared"  If policy, Resident Abuse - I dated February 2017, no mented, "Residents must buse by anyone, including ity staff, other residents, it staff, other residents, it staff, other agencies family members or legal other individuals	F	510		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		495140	B. WING _			C 03/10/2020
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611		03/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 610	Continued From pag	e 108	F 6	10		
	and then Resident #6	dent #67 hit by Resident #69 69 hit Resident #67 back. d to investigate the allegation ts #69 and #67.				
	1/17/13; diagnoses in stroke, dementia with hemiparesis, depress shoulder, dysphagia, epilepsy, and high bl MDS (Minimum Data (Assessment Refere the resident as being to make daily life decoded as requiring to extensive care for trained hygiene; supervisite strokes in the str	adjustment disorder, ood pressure. The quarterly Set) with an ARD nce Date) of 2/4/20 coded severely impaired in ability cisions. The resident was otal care for bathing; unsfers, dressing, toileting				
	11/21/12; diagnoses stroke, diabetes, hen dementia with behavinsomnia, glaucoma, pulmonary disease, oblood pressure, and quarterly MDS (Minir (Assessment Refere the resident as being ability to make daily lwas coded as requiritoileting; extensive adressing, and hygien	iors, adjustment disorder, chronic obstructive depression, convulsions, high bipolar disorder. The num Data Set) with an ARD nce Date) of 2/3/20 coded cognitively impaired in ife decisions. The resident ng total care for bathing and ssistance for transfers, e; and supervision for eating.				
	revealed a nurse's no	al record for Resident #69 ote dated 1/22/19 that ent [#69] was arguing with				

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	-		C 03/10/2020	
	NAME OF PROVIDER OR SUPPLIER  ROSE HILL HEALTH AND REHAB			1	TREET ADDRESS, CITY, STATE, ZIP CODE  10 CHALMERS COURT  BERRYVILLE, VA 22611	1 03/	10/2020
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610	began swearing at his staff, the other reside [Resident #69] in the punched back and ex separated by staff."  A review of the clinical revealed a nurse's not documented, "Reside arguing with another swearing at the other When approached by [Resident #67] punch arm, when the other reports, they began except were separated."  On 3/9/20 at 10:10 Al (Administrative Staff I Director and Regional Services) were made incident. Additional in incident report was reprovided.  On 3/09/20 at 3:20 Pl to the cognitive status did not complete an in or report it to the requirement. No furnished.	when the other resident m. When approached by int [#67] punched him arm at which point he schanged punches until all record for Resident #67 be dated 1/22/19 that ent [Resident #69] resident [Resident #69] resident [Resident #69]. It staff, this resident in the resident [Resident #69] hit shanging blows until they when the series of the identified aware of the identified information such as an equested. None was when the series of the residents, the facility as abuse, or reportable, and investigation on the incident	F	610			
		staff failed to investigate the					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495140	B. WING		C 03/10/2020	
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611	1 00/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION	
F 610	1/17/13; diagnoses in stroke, dementia with hemiparesis, depress shoulder, dysphagia, epilepsy, and high bl MDS (Minimum Data (Assessment Refere the resident as being to make daily life decoded as requiring to extensive care for tra and hygiene; supervi locomotion; and was bowel and bladder.  Resident #7 was adr 2/19/19; diagnoses in stroke, hemiplegia, h dysphagia, depressic chronic obstructive p quarterly MDS (Minir (Assessment Refere the resident as being make daily life decisi coded as requiring to extensive assistance toileting and hygiene  A review of the clinic revealed a nurses no documented, "Resider	Imitted to the facility on include but are not limited to in behaviors, hemiplegia and sion, pain in leg and adjustment disorder, cood pressure. The quarterly in Set) with an ARD ince Date) of 2/4/20 coded in severely impaired in ability sisions. The resident was otal care for bathing; insfers, dressing, toileting sion for eating and frequently incontinent of initted to the facility on include but are not limited to emiparesis, diabetes, on, high blood pressure, and ulmonary disease. The inum Data Set) with an ARD ince Date) of 12/6/19 coded in cognitively intact in ability to ons. The resident was	F 610			
	chair). Resident [#69 her [Resident #7] on	7] back into his w/c (wheel b] became agitated and hit the side of the face. No lents separated and resident				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  G	(X3	(X3) DATE SURVEY COMPLETED	
		495140	B. WING _			C <b>03/10/2020</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611		03/10/2020
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 610	taken to restorative of Resident [#7] nurse wand NP [director of nand nurse practitione plan updated."  A review of the clinicarevealed a nurses not documented, "Reside another resident [#69] was re No injuries on the fact but remained in the owith others. Resident redness or injury note.  On 3/9/20 at 10:10 A (Administrative Staff and Regional Clinicathe identified incident was requested.  Per this request, the "Behavioral Outburst or Staff Member" for documented, "Reside face in dining room. (Resident #7) and shochair)."  On 3/09/20 at 3:20 P to the cognitive statudid not consider this did not complete an ibeyond the above ide was not a complete a report it to the require	ining room to eat his meal. It was notified. DON, POA, It was power of attorney, It was ent [#7] was smacked by It during dinner. The other It moved from the dining room. It was upset later but no	F 6	10		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		495140	B. WING _				C <b>10/2020</b>	
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB		1	110	REET ADDRESS, CITY, STATE, ZIP CODE O CHALMERS COURT ERRYVILLE, VA 22611	, 00.	10/2020	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 610	Continued From page of the concern. No fur provided.  3. Resident #41 was face with a closed fist 1/12/20. The facility sallegation of abuse for Resident #69 was add 1/17/13; diagnoses in stroke, dementia with hemiparesis, depress shoulder, dysphagia, epilepsy, and high blo MDS (Minimum Data (Assessment Referenthe resident as being to make daily life decicoded as requiring to extensive care for trainand hygiene; supervisiocomotion; and was bowel and bladder.  Resident #41 was add 4/21/18; diagnoses in congestive heart failu dementia with behavi pressure. The quarter	hit in the right side of her by Resident #69, on taff failed to investigate the r Resident #41.  mitted to the facility on clude but are not limited to behaviors, hemiplegia and ion, pain in leg and adjustment disorder, bod pressure. The quarterly Set) with an ARD face Date) of 2/4/20 coded severely impaired in ability isions. The resident was tal care for bathing; insfers, dressing, toileting sion for eating and frequently incontinent of mitted to the facility on clude but are not limited to re, dysphagia, depression,	Fé	510	DEFICIENCY)			
	of 1/15/20 coded the moderately impaired decisions. The reside total care for bathing; transfers, dressing, to supervision for eating	resident as being in ability to make daily life ent was coded as requiring extensive assistance for bileting, and hygiene; and						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE (	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495140	B. WING		C 03/10/2020	
	ROVIDER OR SUPPLIER	3	11	REET ADDRESS, CITY, STATE, ZIP CODE 0 CHALMERS COURT ERRYVILLE, VA 22611	1 00/10/2020	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFINE DEFICIENCY)	D BE COMPLETION	
F 610	documented, "On 3-time. It was told this was sitting at the nurchair. Staff/CNA wa meal cart and reside was behind her (the kicking at the CNA was move out of her way saw this take place if the right side of her [Resident #41] holler right side of her face made aware."  A review of the clinic revealed a nurses not documented, "Alert, recipient in a res to raltercation. Denied apparent injuries not episode. OOB (out tolerated. Needs to time to her room and [resident] doorway  On 3/9/20 at 10:10 A (Administrative Staff and Regional Clinicate identified incider was requested.  Per this request, the "Behavioral Outburs or Staff Member" for This form document nurses station sitting this resident (#41) kit	the dated 1/12/20 that 11 shift 1/11/20 around dinner writer that, resident [#69] reses station in his wheel s passing by resident with that in room [Resident #41] staff member) and tried who was in front of her to . When this resident [#69] the landed his closed fist on [Resident #41] face. The dout and was holding the the NP [nurse practitioner] was that record for Resident #41 tote dated 1/12/20 that the syp (status post) being the the resident to resident) pain or discomfort. No the determinant of the syp of bed) in w/c (wheelchair) as the re-directed from time to the daway from other res the MM, ASM #1 and ASM #3 Members, the Administrator all Nurse) were made aware of the and additional information	F 610			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		495140	B. WING			C
	ROVIDER OR SUPPLIER  L HEALTH AND REHAE			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	l	03/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 610	resident (#41) right of was defending aide's was defending aide's On 3/09/20 at 3:20 F was a lady pushing to get down the hall area. (Resident #41 kick the lady from kit interceded to defend also stated that due residents, the facility abuse, or reportable investigation on the identified incident recomplete and thorouthe required state ago On 3/10/20 at 2:30 F of the concern. No fiprovided.  4. Resident #22 was closed fist by Reside facility staff failed to abuse for Resident #8 Resident #69 was ad 1/17/13; diagnoses i stroke, dementia with hemiparesis, depressionalder, dysphagia epilepsy, and high bit MDS (Minimum Data (Assessment Referenthe resident as being	nnected with the other cheekhe (Resident #69) is honor."  PM, ASM #1 stated, "There he meal cart, she was trying by the residents sitting in the ) reached out attempting to chen. (Resident #69) is a staff member. ASM #1 to the cognitive status of the did not consider this as and did not complete an incident beyond the above port, which was not a gh investigation or report it to pency.  PM, ASM #1 was made aware further information was  shit in the left arm with a sent #69, on 10/17/19. The investigate the allegation of #22.  dmitted to the facility on include but are not limited to in behaviors, hemiplegia and sion, pain in leg and adjustment disorder, lood pressure. The quarterly a Set) with an ARD ince Date) of 2/4/20 coded g severely impaired in ability cisions. The resident was	F6	10		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		495140	B. WING			C 03/10/2020
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP  110 CHALMERS COURT  BERRYVILLE, VA 22611	CODE	03/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O ( (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 610	extensive care for train and hygiene; supervisiocomotion; and was bowel and bladder.  Resident #22 was add	nsfers, dressing, toileting sion for eating and frequently incontinent of mitted to the facility on	F6	310		
	dementia with behavior hallucinations, and dy (Minimum Data Set) was Reference Date) of 12 as being severely implife decisions. The rerequiring total care for	rspnea. The quarterly MDS with an ARD (Assessment 2/10/19 coded the resident paired in ability to make daily sident was coded as a bathing; limited assistance bileting and hygiene; and				
	revealed a nurses not documented, "This re [#22] were passing ea resident punched resi with a closed fist. Re	Il record for Resident #69 re dated 10/17/19 that sident [#69] and resident ach other in hall and this dent [#22] in the left arm sidents separated. NP and r and responsible party]				
	revealed a nurse note documented, "This re near north nurses sta provocative manner. who, for no apparent [Resident #22] in upp residents were quickly	sident walking in hallway tion. Not behaving in a Encountered resident [#69] reason, punched her er right arm. The two y separated and no further resident suffered no injuries dent. Appropriate				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION  G	١ , ,	(X3) DATE SURVEY COMPLETED		
		495140	B. WING			C 03/10/2020	
	ROVIDER OR SUPPLIER  L HEALTH AND REHAE	}		STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	<b>,</b>	00/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 610	Continued From pag	e 116	F 6	10			
	(Administrative Staff Director and Regional Services) were made	e aware of the identified information such as an					
	or Staff Member" for documented, "This re passing resident (#2	facility provided a t Assault of Another Resident m dated 10/17/19. This form esident (Resident #69) was 2) in hall and this resident 22) in left arm with closed					
	to the cognitive statu did not consider this did not complete an beyond the above id	PM, ASM #1 stated that due is of the residents, the facility as abuse, or reportable, and investigation on the incident entified incident report, which and thorough investigation or ed state agency.					
		PM, ASM #1 was made aware urther information was					
	#69 on 2/26/19. The	as hit in the face by Resident facility staff failed to ion of abuse for Resident					
	1/17/13; diagnoses i stroke, dementia with hemiparesis, depres	dmitted to the facility on nclude but are not limited to n behaviors, hemiplegia and sion, pain in leg and , adjustment disorder,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495140	B. WING _			C 03/10/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	·	03/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 610	MDS (Minimum Data (Assessment Refere the resident as being to make daily life de coded as requiring to extensive care for trand hygiene; supervlocomotion; and was bowel and bladder.  Resident #650 was a 3/14/18; diagnoses if femur fracture, deprosleep apnea, high blatrial fibrillation, conrespiratory failure, a resident expired at the time of survey MDS (Minimum Data (Assessment Refere the resident as seve make daily life decisicoded as requiring to	lood pressure. The quarterly a Set) with an ARD ence Date) of 2/4/20 coded g severely impaired in ability cisions. The resident was otal care for bathing; ansfers, dressing, toileting rision for eating and a frequently incontinent of admitted to the facility on include but are not limited to ression, chronic obstructive ood pressure, heart disease, gestive heart failure, acute and cardiac pacemaker. The facility on 8/5/19 and current resident in the facility of the facility of the significant change a Set) with an ARD ence Date) of 6/28/19 coded rely impaired in ability to ions. The resident was otal care for bathing, hygiene, dressing; and extensive	F 6	10		
	revealed a nurses not documented, "Resid with resident [#650] CNA (Certified Nursi writer that resident [in w/c (wheel chair) in turned around and h face. Resident [#69	cal record for Resident #69 one dated 2/26/19 that ent to resident altercation at 1730 (5:30 PM). Staffing Assistant) alerted this #650] bumped into residents dining room. Resident [#69] it resident [#650] twice in the ] separated from area and rative dining room with two				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN		(X3) DATE SURVEY COMPLETED	
		495140	B. WING _			C <b>03/10/2020</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 110 CHALMERS COURT BERRYVILLE, VA 22611	<b>I</b> ;E	03/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	DATE
F 610	staff LPN's (License evening meal Res this writer questione denied allegations. Resident [#69] coop residents. Resident for inappropriate bel [nurse practitioner, cattorney] aware of in A review of the clinic revealed a physiciar documented, "Called resident as she was room she was punch resident [#69]. She	d Practical Nurse) to eat his sident alert times one. When d resident about incident he No further behaviors noted. erative with staff and other [#69] monitored frequently naviors. NP, DON and POA, director of nursing, power of incident. Care plan updated." et al record for Resident #650 in note dated 2/26/19 that d by the nurse to evaluate assaulted. At the dining ned in to her nose by another was tearful and anxious. No just mild erythema on	F6	310		
	(Administrative Staff Director and Region Services) were madincident. Additional incident report was report was reported by the "Behavioral Outburs or Staff Member" for documented, "Residin face on nose and room Resident (# and hit w/c (wheel charound and hit her (I On 3/09/20 at 3:20 Fto the cognitive status	facility provided a t Assault of Another Resident m dated 2/26/19. This form lent (#69) hit Resident (#650) forehead in the dining 650) was close to his chair hair). Resident (#69) turned				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		495140	B. WING _			C 03/10/2020	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	<u>'</u>	33, 13, 2323	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 610		investigation on the incident	F 6	10			
	•	entified incident report, which and thorough investigation or ed state agency.					
		M, ASM #1 was made aware urther information was					
	Resident #69 on 2/1	as grabbed by the neck by 5/19. The facility staff failed egation of abuse for Resident					
	1/17/13; diagnoses in stroke, dementia with hemiparesis, depress shoulder, dysphagia, epilepsy, and high bl MDS (Minimum Data (Assessment Refere the resident as being to make daily life decoded as requiring to extensive care for trained hygiene; superv	adjustment disorder, ood pressure. The quarterly a Set) with an ARD nce Date) of 2/4/20 coded g severely impaired in ability cisions. The resident was otal care for bathing; ansfers, dressing, toileting					
	1/14/19; diagnoses in heart failure, insomn behaviors, and high expired on 2/19/19 a in the facility at the ti admission MDS (Min	admitted to the facility on include but are not limited to ia, dysphagia, dementia with blood pressure. The resident ind was not a current resident me of the survey. The imum Data Set) with an ARD ince Date) of 2/6/19 coded					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495140	B. WING			C <b>03/10/2020</b>
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	<u> </u>	03/10/2020
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 610	the resident as being to make daily life dec coded as requiring to	severely impaired in ability isions. The resident was tal care for bathing; nsfers, dressing, toileting	F 61	0		
	revealed a nurses no documented, "Reside resident [#652] by the dining room. Removeroom and kept him we Resident has remained Other resident [#652]	ent [#69] grabbed another eneck during supper in the ed resident [#69] from dining ith nurse for supper. ed calm since removing. has no apparent injuries. of Attorney). Notified DON				
	revealed a nurses no also been crossed ou Entry:On 2.15.19 [F (sic) by another resid Staff had been monitarea. No further abra	al record for Resident #652 te dated 2/15/19, which had it, but documented, "Late Resident #652] was chocked ent [#69] in a dining room. oring her skin in a neck asions had been noticed. No d distress had been noted. been notified."				
	(Administrative Staff Director and Regiona Services) were made	aware of the identified nformation such as an equested.				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDI	_		(	c
		495140	B. WING			03/	10/2020
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			11	TREET ADDRESS, CITY, STATE, ZIP CODE 10 CHALMERS COURT ERRYVILLE, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610	or Staff Member" form documented, "(Resident resident (#652) wheel (Resident #69) and (Fland grabbed her (Resident #69) and (Fland grabbed her (Resident #69) and (Fland grabbed her (Resident #69) and grabbed her (Resident #69) at 3:20 Pl to the cognitive status did not complete an in beyond the above ide was not a complete a report it to the require.  On 3/10/20 at 2:30 Pl of the concern. No further form the fland form of the concern. No further fland for the fland form of the concern. No further fland for the fland form of the fland	Assault of Another Resident in dated 2/15/19. This form ent #69) was at dinner table, led and spoke past Resident #69) reached out sident #652) by the neck"  M, ASM #1 stated that due is of the residents, the facility is abuse, or reportable, and investigation on the incident entified incident report, which and thorough investigation or indivestigation or individuals in the facility unlessessed individuals in the facility would individ		610			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495140	B. WING			C 03/10/2020	
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP COI 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 PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 622	under Medicare or Me Nonpayment applies submit the necessary payment or after the the Medicare or Medicaic resident refuses to pay resident who become admission to a facility resident only allowab or (F) The facility cease: (ii) The facility may not resident while the application of the facility may not resident while the application of the facility may not resident while the application of the facility may not resident while the application of the facility may not resident while the application of the facility may not discharge or transfer or safety of the reside facility. The facility may that failure to transfer when the facility transfer sedent under any of in paragraphs (c)(1)(i section, the facility more discharge is documedical record and a communicated to the institution or provider (i) Documentation in the facility may not discharge is documedical record and a communicated to the institution or provider (i) Documentation in the facility may not discharge is documedical record and a communicated to the institution or provider (ii) Documentation in the facility may not discharge is documentation in the facility may not discharge in the facility may not d	pay for (or to have paid edicaid) a stay at the facility. if the resident does not paperwork for third party hird party, including the deficient does not paperwork for third party hird party, including the deficient deficient deficient deficient and the stay for his or her stay. For a seligible for Medicaid after the facility may charge a decharges under Medicaid; as to operate. So transfer or discharge the deal is pending, pursuant to deter, when a resident ght to appeal a transfer or the facility pursuant to sect the deal in the danger or discharge would pose.  The facility pursuant to sect the fa	F 62	22			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495140	B. WING				C 10/2020
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			1	TREET ADDRESS, CITY, STATE, ZIP CODE 10 CHALMERS COURT BERRYVILLE, VA 22611		10,2020
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 622	needs, and the service facility to meet the nee (ii) The documentatio (2)(i) of this section of (A) The resident's phydischarge is necessar (A) or (B) of this section (B) A physician when necessary under parathis section.  (iii) Information provice must include a minim (A) Contact information responsible for the car (B) Resident represent contact information (C) Advance Directive (D) All special instruction ongoing care, as app (E) Comprehensive of (F) All other necessar copy of the resident's consistent with §483. any other documental a safe and effective to this REQUIREMENT by:  Based on staff intervice of the required information that the fact the required information that the fact the required information that the survey with the survey	the teresident be available at the receiving sed(s). In required by paragraph (c) must be made bysysician when transfer or rry under paragraph (c) (1) on; and transfer or discharge is agraph (c)(1)(i)(C) or (D) of ded to the receiving provider um of the following: on of the practitioner are of the resident. Intative information including a discharge summary, and it information, including a discharge summary, and it information including a discharge summary, and it in a applicable, and it in a applicable, to ensure ransition of care.  The is not met as evidenced it is in a paragraph (c) and it in a paragraph (c) and it in a paragraph (c) and it in a paragraph (c) (1) in a paragraph (c) (1) or (D) of and it in a paragraph (c) (1) or (D) of and it in a paragraph (c) (1) or (D) of and it in a paragraph (c) (1) or (D) of and it in a paragraph (c) (1) or (D) of and it in a paragraph (c) (1) or (D) of and it in a paragraph (c) (1) or (D) of and it in a paragraph (c) (1) or (D) of and it in a paragraph (c) (1) or (D) or (D) of and it in a paragraph (c) (1) or (D) o	F	622			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495140	B. WING			C 03/10/2020	
	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	TY, STATE, ZIP CODE JRT		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY 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)	IOULD BE	(X5) COMPLETION DATE	
F 622	Resident #7's transfer #59's hospital transfer Resident #40's hospital transfer Resident #40's hospital transfer Resident #40's hospital transfer Resident #40's hospital transfer Resident #114 with diagnoses that including holood pressure, mellitus [2]. Resident set], was not due at facility's "Admission 114 dated 01/03/202 "Moderately impaired The nurse's note for 01/03/2020 document [resident] was noted on left side and was practitioner] was not hip via [by] [Name of appropriate parties minmediately. At 185 Radiology Company At 2030 [8:30 p.m.] mand demanded she is department] now be received order to set [evaluation]. Called ED."  The physician's order "1/3/2020 1910 [7:10 ED for left hip eval."  Review of the EHR [the paper clinical received order received order to set [evaluation]. The physician's order "1/3/2020 1910 [7:10 ED for left hip eval."	erred on 01/09/2020. For er on 1/3/2020, for Resident er on 1/13/20 and for ital transfer on 12/29/19.  Tas admitted to the facility with ded but were not limited to: sepsis [1], and diabetes t # 114's MDS [minimum data the time of survey. The Assessment" for Resident # 10 documented in part, d for daily decision making."  Resident # 114 dated nted, "At 1835 [6:45 p.m.] res to be on the floor in her room in severe pain. NP [nurse iffed and ordered XRAY of left f Radiology Company]. All	F 62				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495140	B. WING		C 03/10/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	1 33/10/2020
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION
F 622	of Resident # 114's h  On 03/09/20 at 4:38 p conducted with LPN p regarding transfers of describe the paperwore receiving facility, LPN demographic informationsheet, nurse's notes, Background, Assessimedication list, and a done. When asked if comprehensive care summary, LPN # 5 st  On 03/09/2020 at app [administrative staff in director, ASM # 2, dir 3, regional director of made aware of the fir  No further information  References: [1] An illness in which inflammatory responst germs. The symptom by the germs themse body releases cause information was obtain https://medlineplus.go  [2]A chronic disease information was obtain information was obtain	e receiving facility at the time ospital transfer.  o.m., an interview was dicensed practical nurse] # 5 for residents. When asked to work that is sent to the life # 5 stated that they send tion, a copy of the face SBAR [Situation, ment, Response form], my blood work that was set they send the resident's plan goals or care plan facted no.  oroximately 6:55 p.m. ASM member] # 1, executive ector of nursing, and ASM # 1 clinical services, were addings.  In was provided prior to exit.  In the body has a severe, see to bacteria or other has of sepsis are not caused lives. Instead, chemicals the	F 622		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	, ,	OATE SURVEY COMPLETED	
		495140	B. WING _			C 03/10/2020	
	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611		1 00/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CORRESTIVE ACTION C	SHOULD BE	(X5) COMPLETION DATE	
F 622	2. Resident # 60 wadiagnoses that incluipain, muscle weaking 60's most recent ME quarterly assessmer reference date) of 0'60 as scoring a 13 or mental status (BIMS being cognitively into The nurse's note for 02/27/2020 documental and AMS [altered p.m.]. Bruise to top Background: Reside upcoming apt [appoing [catheter] next month [ninety-two over fifty [temperature], 93% [respiration]. Respoundated with new or emergent transfer. [called and updated of "2/27/20 1910 [7:10] ER [emergency roor tx [treatment] due to status]."  Review of the EHR [the paper clinical rector evidence that the goals were sent to the Gresident # 60's far on 03/09/20 at 4:38 conducted with LPN	as admitted to the facility with ded but were not limited to: less and low iron. Resident # los [minimum data set], a not with an ARD (assessment of the facility of the facil	F 6	22			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495140	B. WING				C 10/2020
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB		•	11	TREET ADDRESS, CITY, STATE, ZIP CODE 10 CHALMERS COURT ERRYVILLE, VA 22611		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 622	sent to the receiving transfer, LPN # 5 staft demographic informal sheet, nurse's notes, Background, Assessing medication list, and a done. When asked if comprehensive care summary, LPN # 5state On 03/09/2020 at app [administrative staff in director, ASM # 2, dir 3, regional director of made aware of the firm. No further information 3. Resident # 36 was diagnoses that including holood pressure, cholesterol. Resident [minimum data set], a an ARD (assessment 01/08/2020, coded Roon the brief interview a score of 0 - 15, 14 making daily decision. The nurse's note for 101/09/2020 documen resident found on the Background: resident Surroundings free of not on. His [sic] not we resident alert/oriented BP [blood pressure] was stated to the state of the state	ribe the paperwork that is facility for a facility initiated ted that they send ation, a copy of the face SBAR [Situation, ment, Response form], any blood work that was a they send the resident's plan goals or care plan ated no.  Proximately 6:55 p.m. ASM member] # 1, executive rector of nursing, and ASM # a clinical services, were redings.  In was provided prior to exit.  It is admitted to the facility with led but were not limited to: muscle weakness, and high a # 36's most recent MDS a quarterly assessment with a reference date) of resident # 36 as scoring a 14 for mental status (BIMS) of being cognitively intact for as.  Resident # 36 dated ated in part, "Situation: a floor in the bathroom.	F	622			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	, ,	OMPLETED	
		495140	B. WING			C 03/10/2020	
	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611		1 00/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 622	stabled the neck untimedical service] arridepressed today and NP [nurse practitions send him to the hosp Review of the EHR I the paper clinical rector evidence that the goals were sent to the of Resident # 36's factor of Resident # 5's factor of Resident # 7's fa	omplain [sic] neck pain, il the EMS [emergency wed, he mentioned he was d yesterday. Called on call er] and [sic] get the order to bital."  Gelectronic health record] and cord for Resident # 36 failed comprehensive care plan he receiving facility at the time acility initiated transfer.  p.m., an interview was [licensed practical nurse] # 5 intended that they send facility for a facility initiated atted that they send facton, a copy of the face attended, SBAR [Situation, sment, Response form], any blood work that was if they send the resident's aplan goals or care plan stated no.  sproximately 6:55 p.m. ASM member] # 1, executive irector of nursing, and ASM # of clinical services, were	F 62	22			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495140	B. WING				10/2020
	ROVIDER OR SUPPLIER		-	11	TREET ADDRESS, CITY, STATE, ZIP CODE  O CHALMERS COURT  ERRYVILLE, VA 22611	03/	10/2020
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 622	coded Resident #7 as interview for mental s - 15, 13 - being cognidecisions.  The "Progress Notes' (4:18 p.m.)" for Resid "Resident had low O2 and put on 2L (two litsigns) have been stal seem like herself. Fa noticed that she was (director of nursing) a resident. Need to spemessage, NP (nurse notified her of concerchanged as residents. Decision was made to further evaluation"  The "Progress Notes' (1:11 a.m.)" for Resid admitted to [Name of pneumonia."  Review of the clinical (electronic health received a cocumental provided to the received facility-initiated transformation of the complex staff in director for evidence and interest of the complex staff in director for evidence and interest of the complex staff in director for evidence and interest of the complex staff in director for evidence and interest of the complex staff in director for evidence and interest of the complex staff in director for evidence and interest of the complex staff in director for evidence and interest of the complex staff in director for evidence and interest of the complex staff in director for evidence and interest of the complex staff in director for evidence and interest of the complex staff in director for evidence and interest of the complex staff in director for evidence and interest of the complex staff in director for evidence and interest of the complex staff in the complex staff i	sesment with an ARD the date) of 12/06/2019, as scoring a 13 on the brief tatus (BIMS) of a score of 0 tively intact for making daily  I dated "1/3/2020 16:18 tent #7 documented, 2 (oxygen) sat (saturation) ters) of oxygen. VS (vital tole, but resident did not tamily came in and also had not herself. Spoke to DON thout my concerns about teak to Doctor. Left practitioner) called and the condition worsened. To send her to hospital for  I dated "1/4/2020 01:11 tent #7 documented, "Patient Hospital] with diagnosis of  Trecord and the EHR tord) for Resident #7 failed to tion of the information ring provider for the ter on 1/3/2020.  The date of the executive  The date of the executive  The date of 1/3/2020.  The date of 1/3/2020.  The date of 1/3/2020.	F	622			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING (X3) DATE COMF			
		495140	B. WING			C 03/10/2020
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	I	03/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 622	transfer of Resident # On 3/9/20 at approxin provided the bed hold #7's representative ar sent to the ombudsmatransfer on 1/3/2020. to evidence any residithe receiving provider transfer on 1/3/2020. On 3/9/20 at 4:38 p.m conducted with LPN (regarding facility-initia LPN #5 stated that the information, a copy of information document information), nurse's representation list, and an with the resident for a LPN #5 stated that the or care plan summary resident to the receiving of cadministrative staff indirector of clinical sernot have any addition the required information receiving provider for Resident #7 on 1/3/20 On 3/9/20 at approxing the executive director nursing, and ASM #3,	nately 9:00 a.m., ASM #1 notice provided to Resident and the notice of discharge an for the facility-initiated The documentation failed ent information provided to for the facility-initiated , an interview was licensed practical nurse) #5 ted transfers of residents. e facility sends demographic the face sheet (an with basic resident notes, SBAR ment containing situation, ent and recommendation), hy blood work that was done facility-initiated transfer. e resident's care plan goals are not sent with the ng facility.  eximately 6:55 p.m., ASM nember) #3, the regional vices, stated that they did all evidence to provide for on being provided to the a facility-initiated transfer of	F6	522		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495140	B. WING		C 03/10/2020	
	ROVIDER OR SUPPLIER	В		STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	1 33/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION	
F 622	Continued From particles No further information References:  1. Cerebrovascular accident: A stroke. The brain stops. A subrain attack." If bloth than a few seconds nutrients and oxygel asting damage. The from the website: https://medlineplus.  2. Pneumonia: An lungs. Many germs and fungi, can cause get pneumonia by in This information was https://medlineplus.  5. Resident #59 was 12/6/19; diagnoses congestive heart fa atrial fibrillation, per anxiety disorder, die blood pressure, der		F 62	DEFICIENCY)		
	the resident as beir make daily life decimake daily life decimate and a review of the clininote dated 1/13/20 laying (Sic.) in bed God please help mastomachResiden right upper quad (q	ence Date) of 1/24/20 coded ng mildly impaired in ability to sions.  Ical record revealed a nurses that documented, "Resident crying "please help me, oh e" while holding her t has slow bowel sounds to uadrant) and no bowel sounds sNP notified and gave N.O,				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		DATE SURVEY COMPLETED
		495140	B. WING			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611		03/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY 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)	IOULD BE	(X5) COMPLETION DATE
F 622	(new order) to send eval (evaluation). R notified."  Further review reveat 1/13/20 that docume (complaints of) seve crying and asking fo pain. Stated she did yesterday, denies natike eating. On 1/11 discomfort and constime with good bowevery mild. Bowel reg (1) was given and not large past bowel moderned (non-tender), bowel upper quadrants, reshypoactive bowel so rigid or board like  Further review of the reveal any evidence documentation was transfer.  On 3/09/20 at 4:38 producted with LPN regarding facility init. When asked to describe sent to the receiving transfer of a resident send demographic in sheet, nurse's notes any blood work that they send the resident send demographic in sheet, nurse's notes any blood work that they send the resident send demographic in sheet, nurse's notes any blood work that they send the resident send demographic in the send d	to ER (emergency room) for P (responsible party)  aled a Physician's note dated ented, "Nurse reported c/o re abdominal pain. She is r help with her abdominal I had a bowel movement ausea but stated does not feel /20 she did c/o abdominal tipation for two days. At the el sounds and pain level was giment started and MiraLax urses reported her having a vementabdomen soft, NT sounds positive on right of three abdomen very unds. None distended. Not Send to ER for evaluation"  It clinical record failed to of what, if any, required provided to the hospital upon on, an interview was (licensed practical nurse) #5 fated transfers of residents. The paperwork that is facility for a facility initiated to the paperwork that is facility for a facility initiated the paperwork that is facility for a facility initiated the paperwork that is facility for a facility initiated the paperwork that is facility for a facility initiated the paperwork that is facility for a facility initiated the paperwork that is facility for a facility initiated the paperwork that is facility for a facility initiated the paperwork that is facility for a facility initiated the paperwork that is facility for a facility initiated the paperwork that is facility for a facility initiated the paperwork that is facility for a facility initiated the paperwork that is facility for a facility initiated the paperwork that is facility for a facility initiated the paperwork that is facility for a facility initiated the paperwork that is facility for a facility initiated the paperwork that is facility for a facility initiated the paperwork that is facility for a facility initiated the paperwork that is facility for a facility for a facility for a facility initiated the paperwork that is facility for a faci	F6	522		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		PLETED
		495140	B. WING		1	C / <b>10/2020</b>
	ROVIDER OR SUPPLIER	3	STREET ADDRESS, CITY, STATE, ZIP CODI  110 CHALMERS COURT  BERRYVILLE, VA 22611			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 622	envelopes that has copy of this informat Resident #59's hosp was informed today that (make copies). to retain the copies the transfer packet of from LPN #5. None On 3/10/20 at 2:30 l Staff Member, the E aware of the concerprovided.  (1) MiraLax - is used constipation. Information obtained https://medlineplus.stml  6. Resident #40 wa 11/4/11; diagnoses is stroke, dysphagia, he depression, high blocontractures. The se (Minimum Data Set)	what information to send. A tion was requested for bital transfer. LPN stated, "I that we are supposed to do I was never told that we had of what was sent." A copy of was requested at this time was provided.  PM, ASM #1 (Administrative executive Director) was made in. No further information was do to treat occasional defrom gov/druginfo/meds/a603032.h  s admitted to the facility on include but are not limited to be include but are not limited to be included ignificant change MDS with an ARD (Assessment)	F 62	22		
	being severely impa decisions.  A review of the clinic note dated 12/29/19 resident room for pa (history of) stroke at with AMS (altered mafter sternum rub co	1/14/20 coded the resident as aired in ability to make daily life cal record revealed a nurses that documented, "Called to attent not respondingHx and has dementiaResident mental status) responsive only ampleted, non-verbal to staff, ainful stimuliSend to ER				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495140	B. WING _				C <b>10/2020</b>
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			11	REET ADDRESS, CITY, STATE, ZIP CODE  O CHALMERS COURT  ERRYVILLE, 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 SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 622	(treatment)."  Further review reveal 12/30/19 that docume (complaint of) acute of was sent out to ER lathest x-ray completed facilitythere is define status from his base I status from his base I Further review of the reveal any evidence of documentation was putransfer.  On 3/09/20 at 4:38 putconducted with LPN (regarding facility initial When asked to describe sent to the receiving futransfer LPN #5 state demographic informatisheet, nurse's notes, any blood work that we they send the resident plan summary LPN #5 where staff document sent to the hospital, Leading has envelopes that the form that has envelopes that has enveloped the ha	ed a physician's note dated ented, "Reason for visit: c/o change in mental statushe st nightblood work and d and send him back to litely change in his mental ine"  clinical record failed to of what, if any, required rovided to the hospital upon entertied transfers of residents. It is acility for a facility initiated d that they send tion, a copy of the face SBAR, medication list, and was done. When asked if t's care plan goals or care as stated no. When asked end what information was PN #5 stated that the facility ave what to information information was requested spital transfer. LPN #5 and today that we are make copies). I was never tain the copies of what was	F	522			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		E SURVEY IPLETED
						С
		495140	B. WING _		0:	3/10/2020
	ROVIDER OR SUPPLIER  L 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 SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 622	On 3/10/20 at 2:30 PI Staff Member, the Ex aware of the concern provided.	M, ASM #1 (Administrative ecutive Director) was made  No further information was	F6			
	S483.15(c)(3) Notice Before a facility transinesident, the facility in (i) Notify the resident representative(s) of the the reasons for the manguage and manne facility must send a corepresentative of the Long-Term Care Omberon (ii) Record the reason discharge in the residuaccordance with paral and (iii) Include in the noting paragraph (c)(5) of the \$483.15(c)(4) Timing (i) Except as specified (c)(8) of this section, discharge required unmade by the facility a resident is transferred (ii) Notice must be made before transfer or discontinuous dischargered under this section; (B) The health of individual control of the section; (B) The health of individual control of the section; (B) The health of individual control of the section; (B) The health of individual control of the section; (B) The health of individual control of the section; (B) The health of individual control of the section; (B) The health of individual control of the section; (B) The health of individual control of the section of the se	before transfer. fers or discharges a hust- and the resident's he transfer or discharge and ove in writing and in a r they understand. The hopy of the notice to a Office of the State hudsman. his for the transfer or ent's medical record in graph (c)(2) of this section;  ce the items described in his section.  of the notice. If in paragraphs (c)(4)(ii) and he notice of transfer or hider this section must be to least 30 days before the he or discharged. he de as soon as practicable	F 6	523		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495140	B. WING _			C <b>03/10/2020</b>
	OVIDER OR SUPPLIER  - HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	<b>'</b>	33/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 623	allow a more immediunder paragraph (c)(D) An immediate trarequired by the residunder paragraph (c)(E) A resident has not days.  §483.15(c)(5) Contention of the contice specified in paragraph (c)(i) The reason for trace in the contice specified in paragraph (cii) The effective date (iii) The location to with transferred or dischala (iv) A statement of the including the name, and telephone number of completing the form hearing request; (v) The name, addretelephone number of Long-Term Care Om (vi) For nursing faciliand developmental disabilities, the mailing telephone number of the protection and acceptable developmental disabilities, the mailing telephone number of the protection and acceptable disabilities, the mailing telephone number of the protection and acceptable disabilities, the mailing telephone number of the protection and acceptable disabilities, the mailing telephone number of the protection and acceptable disabilities, the mailing telephone number of the protection and acceptable disabilities, the mailing telephone number of the protection and acceptable disabilities, the mailing telephone number of the protection and acceptable disabilities.	ealth improves sufficiently to ate transfer or discharge, 1)(i)(B) of this section; insfer or discharge is ent's urgent medical needs, 1)(i)(A) of this section; or of resided in the facility for 30 on the soft the notice. The written aragraph (c)(3) of this section owing: ansfer or discharge; e of transfer or discharge; hich the resident is rged; e resident's appeal rights, address (mailing and email), er of the entity which ets; and information on how orm and assistance in and submitting the appeal ses (mailing and email) and the Office of the State budsman; ty residents with intellectual disabilities or related and email address and the agency responsible for dvocacy of individuals with illities established under Part and Disabilities Assistance of 2000 (Pub. L. 106-402,	F 6	23		

	OF DEFICIENCIES  CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	NG	STRUCTION		LETED
		495140	B. WING				C
	ROVIDER OR SUPPLIER	433140	] B. Wille	STREET	T ADDRESS, CITY, STATE, ZIP CODE  ALMERS COURT  YVILLE, VA 22611	03/	10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	agency responsible for advocacy of individual established under the for Mentally III Individual established under the feeting the transfer must update the recipas practicable once the becomes available.  §483.15(c)(8) Notice In the case of facility the administrator of the written notification provided to the State Survey A State Long-Term Carthe facility, and the rewell as the plan for the relocation of the residual established in the residual established in the survey and clinical resident and the residual established in the survey 460, #36, #7, #59 and to evidence that writter transfer was provided in the survey 460, #36, #7, #59 and to evidence that writter transfer was provided in the survey 460, #36, #7, #59 and to evidence that writter transfer was provided in the survey 460, #36, #7, #59 and the survey 460, #36, #7, #59	or the protection and als with a mental disorder e Protection and Advocacy uals Act.  es to the notice. The notice changes prior to or discharge, the facility bients of the notice as soon the updated information  in advance of facility closure closure, the individual who is the facility must provide for to the impending closure gency, the Office of the e Ombudsman, residents of esident representatives, as the transfer and adequate dents, as required at §  This not met as evidenced are in the cord review, it was the cord review, it was the cord review, it was the dent's representative of a feet transfer for six of 50 by sample, Residents #114, and the consible party for the	F	523			
	Resident # 60, Resid and /or the ombudsm	sfer on 01/03/2020. To ent # 60's representative han for the facility-initiated # 60 on 02/27/2020, and to					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION  IG	1, ,	COMPLETED
		495140	B. WING _			C 03/10/2020
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	<u> </u>	03/10/2020
(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 CORRECT ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPLICATION OF THE APPLICAT	OULD BE	(X5) COMPLETION DATE
F 623	and the ombudsman transfer of Resident a facility staff failed to was provided to the resident #59's responsible failed to evidence a hospital transfer was #40's representative residents hospital transfer was #40's representative residents hospital transfer was findings included a hospital transfer was failed to evidence a hospital transfer was #40's representative residents hospital transfer was findings included and the findings included and the findings included and pressure, mellitus [2]. Resident # 114 was gractilitus [2]. Resident # 114 was not due at the facility's "Admission was 114 dated 01/03/202 "Moderately impaired The nurse's note for 01/03/2020 document [resident] was noted on left side and was practitioner] now so appropriate parties noted appr	ent # 36's representative for the facility-initiated # 36 on 01/09/2020. The evidence written notification responsible party for a fer of Resident #7, and to ensible party for Resident er on 1/13/20. The facility re that written notification of as provided to the Resident and the Ombudsman for the ensfer on 12/29/19.  Eas admitted to the facility with led but were not limited to: sepsis [1], and diabetes # 114's MDS [minimum data he time of survey. The Assessment" for Resident # 0 documented in part, If for daily decision making."  Resident # 114 dated red, "At 1835 [6:45 p.m.] res to be on the floor in her room in severe pain. NP [nurse fied and ordered XRAY of left Radiology Company]. All rotified of incident for [6:55 p.m.] [Name of arrived and obtained xray. Resident was taking to long.	F6			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	COMPLETED
		495140	B. WING		C 03/10/2020
	ROVIDER OR SUPPLIER	В		STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	1 33/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 623	Continued From pa	ge 139	F 62	3	
		er for Resident # 114 dated umented, "Sent to ED for left			
	the paper clinical re to evidence written	[electronic health record] and cord for Resident # 114 failed notification of the transfer on dent # 114 and Resident #			
	conducted with LPN regarding transfers describe the proced contact the responsions know the resident is When asked how the contacted, LPN # 5 RP by phone. Whe resident are provide	B p.m., an interview was I [licensed practical nurse] # 5 of residents. When asked to lure LPN # 5 stated that they sible party [RP] to let them so being sent to the hospital. he responsible party is stated that they contact the he asked if the RP and the he with a written notification of fer, LPN # 5 stated no.			
	[administrative staff director, ASM # 2, c	pproximately 6:55 p.m. ASM member] # 1, executive director of nursing, and ASM # of clinical services, were findings.			
	No further informati	on was provided prior to exit.			
	inflammatory responderms. The symptom by the germs thems body releases caus information was obt	ch the body has a severe, nse to bacteria or other oms of sepsis are not caused selves. Instead, chemicals the e the response. This ained from the website: gov/ency/article/000666.htm.			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495140	B. WING		C 03/10/2020
	ROVIDER OR SUPPLIER	В		STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611	03/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 623	Continued From pa	ge 140	F 623		
	regulate the amoun information was obt	e in which the body cannot t of sugar in the blood. This tained from the website: a.gov/medlineplus/ency/article/			
	diagnoses that inclupain, muscle weakr 60's most recent Mi quarterly assessme reference date) of 0 60 as scoring a 13 mental status (BIMS	as admitted to the facility with uded but were not limited to: ness and low iron. Resident # DS [minimum data set], a ent with an ARD (assessment 01/27/2020, coded Resident # on the brief interview for S) of a score of 0 - 15, 13 - tact for making daily decisions.			
	02/27/2020, docum with fall and AMS [a [6:30 p.m.]. Bruise forehead. Backgrooriented, has upcor cardiac cath [cathel 92/56 [ninety-two or 97.5 [temperature], 20 [respiration]. Repractitioner] update non emergent trans Party] called and up	d with new orders to send out fer. [Name of Responsible odated of pending transfer."			
	p.m.] documented, room] for eval [eval due to fall + AMS [a Review of the EHR	er dated "2/27/20 1910 [7:10 "Sent to ER [emergency uation] + [and] tx [treatment] altered mental status]."  [electronic health record] and ecord for Resident # 60 failed			

		(X3) DATE COMP	SURVEY PLETED				
		495140	B. WING _			1	C <b>10/2020</b>
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			STREET ADDR 110 CHALMEI BERRYVILL		1 00/	10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	,	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD E OSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	/or the ombudsman v notification of a facilit 02/27/2020 for Resid On 03/09/20 at 4:38 p conducted with LPN regarding facility initia When asked to describe to let them know the hospital. When aske contacted, LPN # 5 s RP by phone. When and the resident a wr transfer, LPN # 5 star On 03/09/2020 at 5:5 conducted with OSM the director of social notification to the resident and the resident with OSM the director of social notification to the resident or the or the or the order of their name appears of ombudsman is notification. OSM # 4's further their name appears of the procedure, OSM # 4's further their name appears of their name appears of the procedure of the procedur	# 60's representative and vere provided written y-initiated transfer on ent # 60.  D.m., an interview was dicensed practical nurse] # 5 ated transfers of residents, ibe the procedure LPN # 5 ated the responsible party [RP] resident is being sent to the down the responsible part is tated that they contact the asked if the send the RP itten notification of the red no.  5 p.m., an interview was [other staff member] # 4, services, regarding written dent's responsible party and then asked to describe the stated that when a resident red for more than 24 hours, an a discharge report and the red of the names on the other stated that if the	F	523			
	name would not app therefore the ombuds their transfer. When transfer and notificati # 4 stated that they w hours so notification sent.  On 03/09/2020 at app [administrative staff n	e more than 24 hours their ear on the report and man would not be notified of asked about Resident # 60's on to the ombudsman, OSM were not gone more than 24 to the ombudsman was not  proximately 6:55 p.m. ASM member] # 1, executive sector of nursing, and ASM #					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		PLETED
		495140	B. WING _			C 10/2020
	ROVIDER OR SUPPLIER	3	STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611		1 03/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 623	No further information  3. Resident # 36 was diagnoses that include	of clinical services, were indings.  In was provided prior to exit.  It is admitted to the facility with ded but were not limited to:	F 6.	23		
	cholesterol. Residen [minimum data set], an ARD (assessmer 01/08/2020, coded F on the brief interview	Resident # 36 as scoring a 14  for mental status (BIMS) of  being cognitively intact for				
	01/09/2020 documer resident found on the Background: resider Surroundings free of not on. His [sic] not resident alert/oriente BP [blood pressure] five over thirty-eight] 15 min [minutes]. C stabled the neck unt medical service] arridepressed today and	Resident # 36 dated inted in part, "Situation: e floor in the bathroom. It slept in the evening. It hazard material, call light is witnessed. Assessment: ed and diaphoresis diastolic was low 105/38 [one hundred then went up to 120/78 after complain [sic] neck pain, ill the EMS [emergency wed, he mentioned he was digesterday. Called on call er] and [sic] get the order to bital."				
	the paper clinical red to evidence that Re representative and the provided with a written	electronic health record] and cord for Resident # 36 failed sident # 36, Resident # 36's he ombudsman were en notification of the reason ed transfer on 01/09/2020.				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		495140	B. WING _			C 03/10/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 110 CHALMERS COURT BERRYVILLE, VA 22611		03/10/2020
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 623	conducted with LPN [ regarding facility initial When asked to descript to let them know the relative to let them know the resident at the letter than the resident at the letter than the letter to letter them. The letter than the let	o.m., an interview was licensed practical nurse] # 5 ated transfers of residents. ibe the procedure LPN # 5 act the responsible party [RP] resident is being sent to the d how the responsible party a stated that they contact the asked if the staff send the a written notification of the PN # 5 stated no.  5 p.m., an interview was [other staff member] # 4, services, regarding written dent's responsible party and en asked to describe the stated that when a resident tred for more than 24 hours, in a discharge report and the d of the names on the ther stated that if the emore than 24 hours their ear on the report and man would not be notified of asked about Resident # 36's and notification to the 4 stated that they were not ours so notification to the sent.  Proximately 6:55 p.m. ASM member] # 1, executive ector of nursing, and ASM # clinical services, were	F 6	23		
	No further information	n was provided prior to exit.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED		
		495140	B. WING _			C 03/10/2020	
	ROVIDER OR SUPPLIER  L HEALTH AND REHAE	3		STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611		33,13,232	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 623	Continued From pag	ne 144	F 6	23			
	02/19/2019, with a re with diagnoses that it to cerebral infarction Resident #7's most r set), a quarterly asse (assessment referenceded Resident #7 a interview for mental - 15, 13 - being cogredecisions.  The "Progress Notes (4:18 p.m.)" for Resilem Resident had low O and put on 2L (two lisigns) have been staseem like herself. F noticed that she was (director of nursing) resident. Need to specified her of conce changed as resident Decision was made further evaluation'  The "Progress Notes (1:11 a.m.)" for Resident in Interview of the clinical (electronic health recevidence documents.	e practitioner) called and rns. Orders were given, then s condition worsened. to send her to hospital for '  "" dated "1/4/2020 01:11 dent #7 documented, "Patient f Hospital] with diagnosis of all record and the EHR cord) for Resident #7 failed to ation of written notice of the was provided to Resident #7 onsible party, for the					

	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		495140	B. WING			C 03/10/2020	
	ROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE  10 CHALMERS COURT  BERRYVILLE, VA 22611	1 03/	10/2020
(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 SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	was made via a list provided to the reside party for the facility-in #7 on 1/3/2020.  On 3/9/20 at approximate provided the bed hold #7's representative at sent to the ombudsmatransfer on 1/3/2020. to evidence a written #7 and or the responsiacility-initiated transfer On 3/9/20 at 4:38 p.m. conducted with LPN (regarding facility-initiated that the party by telephone to is being sent to the howritten notification to sent by nursing.  On 3/9/20 at 5:55 p.m. conducted with OSM director of social serv notification to the residence in the service of the notification to the residence of the service of the	nately 4:30 p.m., a request rovided to ASM nember) #1, the executive that written notification was ent and or the responsible itiated transfer of Resident nately 9:00 a.m., ASM #1 I notice provided to Resident and the notice of discharge an for the facility-initiated. The documentation failed notification to the Resident sible party for the er on 1/3/2020.  In., an interview was dicensed practical nurse) #5 ated transfers of residents. ey contact the responsible let them know the resident ospital. LPN #5 stated that a the responsible party is not not., an interview was (other staff member) #4, the ices, regarding written dent and or resident's SM #4 stated that she does cation to the responsible graff notifies them.  Eximately 6:55 p.m., ASM nember) #3, the regional	F	623			
		vices, stated that they did al evidence to provide for a					

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				0 10/2020
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB		•	1	TREET ADDRESS, CITY, STATE, ZIP CODE 10 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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	provided to Resident party for a facility-initi On 3/9/20 at approxir the executive director nursing, and ASM #3 clinical services were No further information References:  1. Cerebrovascular caccident: A stroke. We the brain stops. A strown brain attack." If blood than a few seconds, the nutrients and oxygen lasting damage. This from the website: https://medlineplus.go.  2. Pneumonia: An influngs. Many germs, sand fungi, can cause get pneumonia by inhold This information was https://medlineplus.go.  5. Resident #59 was 12/6/19; diagnoses in congestive heart failuatrial fibrillation, peripanxiety disorder, diabblood pressure, demequarterly MDS (Minim (Assessment Reference).	the reason for transfer being #7 and or the responsible ated transfer on 1/3/2020.  Inately 7:00 p.m., ASM #1, r., ASM #2, the director of the regional director of made aware of the findings.  It was presented prior to exit.  It is ease, infarction or //hen blood flow to a part of oke is sometimes called a d flow is cut off for longer he brain cannot get  Brain cells can die, causing information was obtained ov/ency/article/000726.htm.  Fection in one or both of the uch as bacteria, viruses, pneumonia. You can also haling a liquid or chemical, obtained from the website: ov/pneumonia.html.  admitted to the facility on clude but are not limited to re, chronic kidney disease, heral vascular disease, etes, sleep apnea, high entia, and dyspnea. The num Data Set) with an ARD note Date) of 1/24/20 coded mildly impaired in ability to	F	623			

1, 7		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		495140	B. WING		C		
	ROVIDER OR SUPPLIER  L HEALTH AND REHA			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	03/10/2020		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION		
F 623	Continued From pa	ge 147	F 62	23			
	note dated 1/13/20 laying (Sic.) in bed God please help me stomachResiden right upper quad (qt to the other 3 quads (new order) to send eval (evaluation). Further review reve 1/13/20 that docum for evaluation"  Further review of the reveal any evidence reason for transfer responsible party.  On 3/09/20 at 4:38 conducted with LPN regarding facility ini When asked to des stated that they cor (RP) to let them known to the hospital. When party is contacted, I contact the RP by pend the RP a writte LPN #5 stated no.	thas slow bowel sounds to uadrant) and no bowel sounds sNP notified and gave N.O, to ER (emergency room) for RP (responsible party)  aled a Physician's note dated ented in part "Send to ER  e clinical record failed to e that written notification of the was provided to the  p.m., an interview was I (licensed practical nurse) #5 tiated transfers of residents. oribe the procedure, LPN #5 stated the responsible party ow the resident is being sent en asked how the responsible LPN #5 stated that they shone. When asked if the en notification of the transfer,					
	conducted with OSI (Social Services Din notification to the re When asked if they	:55 p.m., an interview was M (other staff member) #4 rector) regarding written esident's responsible party. notify the responsible party in ited no, nursing notifies them.					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495140	B. WING			l	0 10/2020	
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB		•	1	STREET ADDRESS, CITY, STATE, ZIP CODE 10 CHALMERS COURT BERRYVILLE, 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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 623	Staff Member, the Exaware of the concern provided.  (1) MiraLax - is used constipation. Information obtained https://medlineplus.gotml  6. Resident #40 was 11/4/11; diagnoses in stroke, dysphagia, he depression, high bloocontractures. The sig (Minimum Data Set) of Reference Date) of 1/2 severely impaired in a decisions.  A review of the clinical note dated 12/29/19 to resident room for patif (history of) stroke and with AMS (altered meafter sternum rub connot responding to pai (emergency room) for (treatment)."	M, ASM #1 (Administrative ecutive Director) was made . No further information was to treat occasional from ov/druginfo/meds/a603032.h admitted to the facility on clude but are not limited to miplegia, diabetes,	F	623	,			
	12/30/19 that docume	ed a physician's note dated ented, "Reason for visit: c/o tal statushe was sent out						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495140	B. WING _			C 03/10/2020		
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			11	TREET ADDRESS, CITY, STATE, ZIP CODE 10 CHALMERS COURT ERRYVILLE, VA 22611	1 00	10/2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE	
F 623	_	e 149 d work and chest x-ray nim back to facilitythere is	F	523				
		is mental status from his						
	regarding facility initia When asked to descr	m., an interview was licensed practical nurse) #5 ated transfers of residents. libe the procedure LPN #5 act the responsible party						
	(RP) to let them know to the hospital. Wher party is notified, LPN the RP by phone. Wi	the resident is being sent asked how the responsible #5 stated that they contact nen asked if the send the RP of the transfer, LPN #5						
	conducted with OSM (Social Services Direct notification to the resi the ombudsman. Wh procedure, OSM #4 s	5 p.m., an interview was (other staff member) #4 ctor) regarding written dent's responsible party and en asked to describe the tated that when a resident is d for more than 24 hours,						
	their name appears o she notifies the ombu report. OSM #4 furth was not gone more th	n a discharge report and dsman of the names on the er stated that if the resident nan 24 hours their name the report and therefore the						
	transfer. When asked transfer and notification stated that they were	d about Resident # 40's on to the ombudsman, OSM not gone more than 24 o the ombudsman was not						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495140	B. WING _			03/	10/2020	
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			STREET ADDRESS, CITY, ST 110 CHALMERS COURT BERRYVILLE, VA 2261				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 623	party in writing, OSM notifies them.  On 3/10/20 at 2:30 Pt Staff Member, the Exaware of the concern.	they notify the responsible #4 stated no, nursing  M, ASM #1 (Administrative ecutive Director) was made . No further information was	F	523				
F 656 SS=E	provided. Develop/Implement C CFR(s): 483.21(b)(1)	Comprehensive Care Plan	F	556				
	implement a compreh care plan for each respectives and timefra medical, nursing, and needs that are identificant assessment. The condescribe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that under §483.210, including treatment under §483.3 (iii) Any specialized services provide as a result of recommendations. If a findings of the PASAF rationale in the reside	cility must develop and nensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial ied in the comprehensive aprehensive care plan must g-are to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required .25 or §483.40 but are not esident's exercise of rights ding the right to refuse 8.10(c)(6).  ervices or specialized as the nursing facility will PASARR a facility disagrees with the RR, it must indicate its						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		495140	B. WING_			C	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	<u> </u>	03/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 656	desired outcomes.  (B) The resident's pr future discharge. Fa whether the resident community was asselecal contact agencie entities, for this purp (C) Discharge plans plan, as appropriate requirements set for section.  This REQUIREMEN by:  Based on observation record review and fadetermined that the and/or implement the for five of 50 resident (Residents #313, 18 staff failed to develo comprehensive care #313's fall risk. The implement Resident plan for medication a implement Resident plan for oxygen admimplement Resident plan for the use of oxto develop a comprehensive camplement #61's use Positive Airway President # 61's use Positive Airway President 1. The facility staff for	ative(s)- pals for admission and  eference and potential for cilities must document 's desire to return to the essed and any referrals to es and/or other appropriate ose. in the comprehensive care in accordance with the th in paragraph (c) of this  T is not met as evidenced  on, staff interview, clinical cility document review it was facility staff failed to develop to comprehensive care plan ts in the survey sample, ts in the survey sample, and implement a plan to address Resident facility staff failed to #18's comprehensive care administration, failed to #11's comprehensive care inistration, and failed to #87's comprehensive care inistration, and failed to #87's comprehensive care exygen. The facility staff failed hensive care plan to address of a C-PAP [Continuous sure].	F 6	56			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		495140	B. WING _			C 03/10/	2020
	ROVIDER OR SUPPLIER L HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CO 110 CHALMERS COURT BERRYVILLE, VA 22611	DE	1 00/10/	1020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BI HE APPROPRIA		(X5) OMPLETION DATE
F 656	3/2/2020 with diagnor not limited to myocar (2) and muscle weak (minimum data set), due at the time of the nursing admission as coded Resident #313 (person, place and times of the second servation was conher room. Resident #313 the lowest position to reach.  Review of the "Admisted dated "03/02/2020 14 #313 documented the non-ambulatory (not mobility or difficulty in the side of the bed, if or poor trunk control would require safety Section O document decision-making skill Resident #313 was a and bladder. Section documented Resider at all times, ambulate adequate vision. Do gait/balance, systolic medications, predisp	admitted to the facility sees that included but were dial infarction (1), dementia mess. The most recent MDS for Resident #313 was not excessment dated 3/2/2020 as being "disoriented x 3 me) at all times."  mately 1:00 p.m., an ducted of Resident #313 in #313 was observed asleep in 313's bed was observed in the floor with the call bell in sesion Data Collection Form" 400 (2:00 p.m.)" for Resident eresident was walking), having poor bed noving to a sitting position on having difficulty with balance and on medication that precautions in Section N. ed Resident #313 had poor s. Section I documented always incontinent of bowel in "L. Risk for Falls" in #313 was disoriented x 3 bry and continent and having cumentation areas for	F6	556			
	The "Baseline Care F	Plan Summary" dated					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495140	B. WING				0 10/2020
	ROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 10 CHALMERS COURT BERRYVILLE, VA 22611	1 03/	10/2020
(X4) ID 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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	"This is a written sum Plan developed on ac 3/2/20. This temporary your needs, preference used until your overal and a comprehensive reflect your ongoing regoals. This facility with any changes to this Beaseline care plan fare documentation of risk fall precautions.  The comprehensive of dated "3/4/2020" failed documentation for a few progress Notes" (2:35 a.m.)" document and oriented with perwas yelling out and unassistant) entering the half on the bed with keen in the lowest position just sitting there and sout of the bed. VSS (c/o (complaints of) parts anything when sitting assessment and no in provided to the resident trying to get out or reassurance that we with call bell. Upon Not (to check level of confound to be sleeping out. Upon waking resident and the call bell. Upon Not (to check level of confound to be sleeping out. Upon waking resident and provided to the resident trying to get out or reassurance that we with a call bell. Upon Not (to check level of confound to be sleeping out. Upon waking resident and the provided to the resident trying to get out or reassurance that we with a call bell. Upon Not (to check level of confound to be sleeping out. Upon waking resident and the provided to the resident trying to get out or reassurance that we with a call bell. Upon Not (to check level of confound to be sleeping out. Upon waking resident and the provided to the resident trying to get out or reassurance that we with the call bell. Upon Waking resident trying to get out or the provided to the resident trying to get out or the provided to the resident trying to get out or the provided to the resident trying to get out or the provided to the resident trying to get out or the provided to the resident trying to get out or the provided to the resident trying to get out or the provided to the resident trying to get out or the provided to the resident trying to get out or the provided to the resident trying to get out or the provided to the resident trying to get out or the provided trying trying trying trying t	#313 documented in part mary of the Baseline Care dmission for [Blank Line] on ry care plan is based on ces and goals. It will be a lassessment is completed a care plan is developed to needs, preferences and all also notify you in writing of caseline Care Plan." The ailed to evidence a of falls for Resident #313 or care plan for Resident pon CNA (certified nursing er room found resident on nees on the floor. Bed was a Resident stated she was she had not fallen or rolled (vital signs stable) with no can have the importance of fed on her own and would assist her if she used euro (neurological) checks sciousness) resident was quietly and no longer yelling sident up she voiced she mat she wanted to sleep but	F	656			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULT		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495140	B. WING			C 03/10/2020		
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			11	TREET ADDRESS, CITY, STATE, ZIP CODE O CHALMERS COURT ERRYVILLE, VA 22611	1 03/	10/2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE	
F 656	Continued From page	e 154	F	656				
	Resident sleeping at incidents."	this time with no other						
	"3/9/2020 09:51 (9:51 She is not lethargic conversant. She den she still not sleep [sic and at times crying. I awake and talking to legs dangling down from her due to deme On 3/10/20 at 8:05 a. conducted with LPN (regarding care plannifalling. LPN #6 stated care plan was to accoresident. LPN #6 stated were used in assession orientation status, trafalling and diagnosis. resident is at risk for finto place such as purposition and placing aplan was put into place care plan would be put in hours after admission assessed as a fall risk after a fall and the cathen. When asked at stated that she had be admission and had fa LPN #6 stated that Reevery two hours and position at all times. #6 should have had a stated that have had a stated that have had a stated that have had a should have had a stated that have had a should have had a stated that have had a should have had a stated that have had a should have had a stated that have had a should have had a stated that have had a should have had	m., an interview was (licensed practical nurse) #6 ing residents at risk for d that the purpose of the commodate the care of the ted that multiple factors ing residents including insfer status and history of LPN #6 stated that if a falls, interventions were put titing the bed in the lowest a star on the door and a care ise. When asked when the jut into place, LPN #6 stated to place within the first 24 a, if the resident was not k, they would be reassessed free plan would be updated bout Resident #313, LPN #6						

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			(X3) DATE SURVEY COMPLETED		
		495140	B. WING _			C <b>03/10/2020</b>		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 110 CHALMERS COURT BERRYVILLE, VA 22611	E	03/10/2020		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	DATE		
F 656	dated 3/6/2020, and consider the incident #313 did not comple LPN #6 stated that it fall and interventions observed closely after incidents. LPN #6 recomprehensive care stated that there was addressed Resident.  On 3/9/20 at approxi was made by written staff member) #1, the facility policy on dever comprehensive care.  On 3/10/20 at 10:40 director of clinical sed did not have a policy the care plan, and the their standard of practopy of the documer Procedures, 8th Edit 130-132 Care Plan Forcedures, 8th Edit 130-132 Care Plan Forcedures of admission. Patient's primary nur the patient. If the care one nursing diagnos diagnosis and impler priority to each diagrowith the highest priority to each diagrowith the plan throughout the plan throu	stated that they did not a fall because Resident tely come out of the bed. would be considered a near that Resident #313 was er the incident for any further eviewed the baseline and plans for Resident #313 and a not a care plan that #313's risk of falls.  mately 6:55 p.m., a request list to ASM (administrative e executive director for the eloping and implementing the plan.  a.m., ASM #3, the regional rvices stated that the facility on developing, implementing at they follow Lippincott as etice. ASM #3 provided a tt "Lippincott Nursing ion, Wolters Kluwer; pages Preparation."	F6	556				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7t. BOILDI	_		(	
		495140	B. WING			03/	10/2020
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			1	TREET ADDRESS, CITY, STATE, ZIP CODE  10 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	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	diagnosis contains two risk and the risk factor assessing the patient' diagnostic label from create a specific label describes the condition riskRisk factors- For no etiological (cause) patient's vulnerability the problem isn't yet put that predispose the parameter of clinical sent the findings.  No further information Reference:  1. Myocardial infarction heart attacks are cause blocks one of the cord arteries bring blood at blood flow is blocked, oxygen and heart cell obtained from the well https://medlineplus.go.  2. Dementia- A loss of with certain diseases language, judgment, a information was obtain https://medlineplus.go.  2. The facility staff fail	osis; a risk-related nursing to components: the identified rs. Identified risk- After rs. Identified risk- After rs condition, choose a a facility-approved list, or a for the patient that the patient that the patient is at the raisk diagnosis there are a factors. You're identifying a for a potential problem, so present. List the risk factors attent to the identified risk rimately 1:25 p.m., ASM #1, and ASM #3, the regional vices were made aware of the was provided prior to exit.  On - Heart attack. Most seed by a blood clot that conary arteries. The coronary and oxygen to the heart. If the the heart is starved of s die. This information was besite:  Ov/ency/article/000195.htm.	F	656			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION  NG	(2	COMPLETED		
		495140	B. WING _			C <b>03/10/2020</b>		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP  110 CHALMERS COURT  BERRYVILLE, VA 22611	CODE	03/10/2020		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIAT	(X5) COMPLETION DATE		
F 656	administration.  Resident #18 was ad 12/14/18. Resident; were not limited to do major depressive disannual MDS (minimulation with an ARD (assess 12/10/19, coded the daily decision-making.)  Resident #18's comp 12/18/19 and 12/19/12 Cardiovascular statudensity lipoproteins [ordered by physician documented, "Impair related to: Demential physicianPotential complications associated and the side of th	dmitted to the facility on #18's diagnoses included but ementia, high cholesterol and order. Resident #18's arm data set), assessment ement reference date) of resident's cognitive skills for g as moderately impaired.  The care plan dated 18 documented, "Impaired is related to: HDL (high cholesterol])Medications as a medication as ordered by for drug related ated with use of psychotropic	F	656				
	a physician's order d (1) 40 mg (milligrams physician's order dat 10 mg by mouth onc order dated 11/7/19 (milligrams) by mout medications were so Resident #18's Dece administration record On 12/31/19, LPN (life failed to document site	heduled for 8:00 p.m., on mber 2019 MAR (medication						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		495140	B. WING			C		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611		03/10/2020		
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F 656	Other/ See Nurse Nemedication adminissimvastatin dated 1 "Waiting to be sent note regarding done documented, "Waiting trazodone documented, "Waiting trazodone documented, "Waiting trazodone documented, "Waiting There was no further the administration of trazodone to Reside On 3/9/20 at 4:38 producted with LPN regarding comprehensated the purpose able to make all nemerical the nurses on. To know reside implement what it is this." In regards to ensuring medication administration, LPN medications from the are left available for stated if a medication and smedication, she corpossible, obtains the up" box (a box in the medications available stated if the needed the "back up" box the pharmacy and asks immediately sent or call in an order to the stated that after she in the second of the stated that after she in the second of the stated that after she in the second of the second	lotes." An eMAR (electronic tration record) note regarding 2/31/19, documented, from pharmacy." An eMAR epezil dated 12/31/19, ng for pharmacy." An eMAR on administration record) note e dated 12/31/19, ng to be sent from pharmacy." er documentation regarding of simvastatin, donepezil or ent #18 on 12/31/19.  I.m., an interview was I (licensed practical nurse) #5 ensive care plans. LPN #5 of the care plan was, "To be eds known, to be able to make see it and know what's going ents' needs and we have to easy; how are we going to do the facility process for the sare available for a #5 stated she re-orders e pharmacy when ten tablets on is scheduled for	F 65	56				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495140	B. WING		C 03/10/2020
	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	1 00/10/2020
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F 656	conducted with LPN #18's medication and LPN #11 stated it has 12/31/19 and he couthe pharmacy or if h donepezil or trazodo date.  On 3/9/20 at 7:07 p. member) #1 (the exterior of nursing) director of clinical set the above concern.  No further information was https://medlineplus.stml  (2) "Donepezil is used disorder that affects clearly, communicate and may cause chapersonality)." This is the website: https://medlineplus.stml  (3) Trazodone is used information was obtine some condition and the set of	m., a telephone interview was #11 regarding Resident ministration on 12/31/19. In the deep a while since add not recall if he contacted e administered simvastatin, one to Resident #18 on that m., ASM (administrative staff ecutive director), ASM #2 (the and ASM #3 (the regional ervices) were made aware of the on was presented prior to exit. The sed to treat high cholesterol. It is sobtained from the website: gov/druginfo/meds/a692030.h	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495140	B. WING _				C <b>10/2020</b>		
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F 656	#11's comprehensive administration.  Resident #11 was ad 12/22/16. Resident # were not limited to di high blood pressure. MDS (minimum data ARD (assessment recoded the resident's impaired. Section G requiring extensive a staff with bed mobility coded the resident as therapy.  Resident #11's comp 1/11/17 documented status related to Con Hypertension (high b 3L/NC (three liters vionally sorted of the control oxygen at two liters probserved lying in bed nasal cannula conneconcentrator that was concentrator was set half and three liters as	ailed to implement Resident e plan of care for oxygen  mitted to the facility on #11's diagnoses included but abetes, heart failure and Resident #11's quarterly set) assessment with an ference date) of 12/10/19, cognition as moderately coded Resident #11 as ssistance of two or more y and transfers. Section O s having received oxygen  rehensive care plan dated , "Impaired Cardiovascular gestive Heart Failure (CHF), lood pressure)Oxygen a nasal cannula)"  #11's clinical record revealed ated 2/5/20 for continuous per minute.  m., Resident #11 was d receiving oxygen via a	F	656	DEFICIENCY)				
	between the two and	a half and three-liter lines. ne flow meter was conducted							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	}		STREET ADDRESS, CITY, ST 110 CHALMERS COURT BERRYVILLE, VA 22611		03/10/2020	
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F 656	regarding care plans of the care plan was needs known, to be nurses see it and kn residents' needs and it says; how are we gasked to describe who concentrator flow me has a physician's ord stated the two-liter limiddle of the ball at was important to set because if too low, thypoxic (an inadequingh, the resident co and experience bad hallucinations.  On 3/9/20 at 7:07 p.1 member) #1 (the exedirector of nursing) addirector of clinical set the above concern.  No further information.  A. The facility staff for the facility staff for the staff fo	(licensed practical nurse) #5 LPN #5 stated the purpose , "To be able to make all able to make sure all the ow what's going on. To know I we have to implement what going to do this." LPN #5 was here the ball in an oxygen eter should be if a resident der for two liters. LPN #5 he should pass through the eye level. LPN #5 stated it oxygen at the correct rate he resident could become ate oxygen level) and if too uld become over oxygenated side effects including  m., ASM (administrative staff ecutive director), ASM #2 (the and ASM #3 (the regional rvices) were made aware of  m was presented prior to exit.  ailed to implement Resident # care plan for the use of  dmitted to the facility with ded but were not limited to bulmonary disease [1].  t recent MDS (minimum data essment with an ARD ce date) of 02/13/2020, as scoring a 12 on the staff	F	556			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			110	REET ADDRESS, CITY, STATE, ZIP CODE O CHALMERS COURT ERRYVILLE, VA 22611	1 00	10/2020	
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F 656	of 0 - 15, 12- being mognition for making of "Special Treatments, Resident # 87 was considered to the	al status (BIMS) of a score loderately impaired of daily decisions. In Section O Procedures and Programs" oded for the use of oxygen.  o.m., an observation of ed they were sitting in their om watching television hasal cannula. Observation deen one-and -a half and two ones. And they were sitting in their om watching television hasal cannula. Observation deen one-and -a half and two ones. And they were sitting in their om watching television hasal cannula. Observation deen one-and -a half and two ones. And they were sitting in their om watching television hasal cannula. Observation deen one-and -a half and two ones. Observation deen one-and -a half and two ones. And they were sitting in their om watching television hasal cannula. Observation deen one-and -a half and two	F	356	DETICITION 1			
	for Resident # 87 doc	o] liters NC [nasal cannula]						
	dated of 11/20/2019 of alteration in Respirate	care plan for Resident # 87 documented, "Focus: I have ory Status Due to Chronic ry Disease, Congestive						

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 656	"Interventions", it doc medications as order to medication and tre 11/20/2019."	e 163 nitiated 11/20/2019." Under umented in part, "Administer ed. Observe labs, response atments. Date Initiated	F	656					
	conducted with LPN [ regarding how to read resident's oxygen cor that the liter line on the	licensed practical nurse] # 5 If the flow rate on a Incentrator. LPN # 5 stated It is flow meter of the oxygen It is a stated of							
	observation of Reside oxygen concentrator 5. When asked to ob oxygen flow rate LPN was set between one per minute. When as oxygen the physician LPN # 5 stated, "Two immediately adjusted Resident # 87. When purpose of a resident (the care plan) was to needs known and to i When asked if Reside implemented for two based on the observation of the conducted with ASM member] # 3, regional	ordered for Resident #87, liters per minute." LPN # 5 the oxygen flow rate for a sked to describe the 's care plan, LPN # 5 stated o make all the resident care implement what it says. ent # 87's care plan was liters of oxygen per minute ations, LPN # 5 stated no.  7 p.m., an interview was [administrative staff I director of clinical services. and and the nursing staff I, "Our policies and							

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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	ROVIDER OR SUPPLIER  L HEALTH AND REHAB	100110		1	TREET ADDRESS, CITY, STATE, ZIP CODE 10 CHALMERS COURT SERRYVILLE, VA 22611	<u>  U3/</u>	10/2020	
(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 656	Williams and Wilkins documented, "A writte communication tool a members that helps e careThe nursing ca information about the and goals. It contains achieving the goals e and is used to direct or revise and update the there are changes in with new orders" Fulippincott Williams & Company Philadelphi  On 03/09/2020 at app [administrative staff indirector, ASM # 2, dir 3, regional director of made aware of the firm.  No further information.  References: [1] Disease that make can lead to shortness was obtained from the https://www.nlm.nih.g.  5. The facility staff fa comprehensive care pof a C-PAP [Continuo [1]].  Resident # 61 was act diagnoses that including a care	entals of Nursing Lippincott 2007 pages 65-77 en care plan serves as a mong health care team ensure continuity of re plan is a vital source of patient's problems, needs, a detailed instructions for stablished for the patient careexpect to review, a care plan regularly, when condition, treatments, and undamentals of Nursing Wilkins 2007 Lippincott a pages 65-77.  Proximately 6:55 p.m. ASM member] # 1, executive ector of nursing, and ASM # clinical services, were adings.  In was provided prior to exit.  This information is website:  Ov/medlineplus/copd.html.	F	656				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611		03/10/2020		
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F 656	recent comprehens an admission asses (assessment refere coded Resident # 6 assessment for mer of 0 - 15, 15- being daily decisions. In 3 Treatments, Proced # 61 was coded as On 03/08/20 at 3:20 observations of Res C-PAP mask lying of uncovered.  On 03/09/20 at 8:25 Resident # 61's roo lying on top of the base of the C-PAP machine On 03/09/2020 at a interview was conducted of 11/26/2015 the C-PAP machine On 03/09/2020 at a interview was conducted with LPN regarding the storage of the conducted with LPN regarding the storage of the code of the conducted with LPN regarding the storage of the code of the conducted with LPN regarding the storage of the code of th	ive MDS (minimum data set), issment with an ARD noce date) of 09/10/2019, 1 as scoring a 15 on the staff ntal status (BIMS) of a score cognitively intact for making Section O "Special dures and Programs" Resident having a C-PAP.  1) p.m., and 4:44 p.m., sident # 61's room revealed a on top of the bedside table  2) a.m., an observation of m revealed a C-PAP mask redside table uncovered.  3) sorder sheet] dated 03/2020 illed to evidence an order for P machine.	F 65	6			

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	495140	B. WING		03/10/2020	
	3		STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	1 00/10/2020	
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should be covered to When asked to descresident's comprehe stated was to make known and to impler On 03/10/2020 at 10 conducted with LPN order for Resident # reviewing all of Resident was not an order for On 03/10/2020 at 10 conducted with LPN regarding the missir Resident # 61's use that a respiratory/Con 03/09/2020. Whethe care plan when physician's order for stated, "I knew she on 03/09/2020 at application of the control of the contro	o prevent bacteria on it."  cribe the purpose of a chasive care plan, LPN # 5 all the resident care needs ment what it says.  0:05 a.m., an interview was # 2 regarding a physician's 61's use of a C-PAP. After dent # 61's discontinued and ters, LPN # 2 stated that there is the use of a C-PAP.  0:05 a.m., an interview was # 3, MDS coordinator of a C-PAP. LPN # 3 stated PAP care plan was developed the asked how they developed there was no evidence of a the use of a C-PAP, LPN # 3 used one."	F 65	,		
No further information References: [1] Positive airway pa machine to pumpairway of the lungs. open during sleep. To CPAP (continuous particular information)	on was provided prior to exit.  Tressure (PAP) treatment uses air under pressure into the This helps keep the windpipe The forced air delivered by positive airway pressure)				
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB  SUMMARY S (EACH DEFICIEN REGULATORY OF REGULA	ROVIDER OR SUPPLIER  L HEALTH AND REHAB  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 166 should be covered to prevent bacteria on it." When asked to describe the purpose of a resident's comprehensive care plan, LPN # 5 stated was to make all the resident care needs known and to implement what it says.  On 03/10/2020 at 10:05 a.m., an interview was conducted with LPN # 2 regarding a physician's order for Resident # 61's use of a C-PAP. After reviewing all of Resident # 61's discontinued and active physician orders, LPN # 2 stated that there was not an order for the use of a C-PAP.  On 03/10/2020 at 10:05 a.m., an interview was conducted with LPN # 3, MDS coordinator regarding the missing documentation for Resident # 61's use of a C-PAP. LPN # 3 stated that a respiratory/C-PAP care plan was developed on 03/09/2020. When asked how they developed the care plan when there was no evidence of a physician's order for the use of a C-PAP, LPN # 3 stated, "I knew she used one."  On 03/09/2020 at approximately 6:55 p.m. ASM [administrative staff member] # 1, executive director, ASM # 2, director of nursing, and ASM # 3, regional director of clinical services, were made aware of the findings.  No further information was provided prior to exit.	ROVIDER OR SUPPLIER  L HEALTH AND REHAB  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 166 should be covered to prevent bacteria on it." When asked to describe the purpose of a resident's comprehensive care plan, LPN # 5 stated was to make all the resident care needs known and to implement what it says.  On 03/10/2020 at 10:05 a.m., an interview was conducted with LPN # 2 regarding a physician's order for Resident # 61's use of a C-PAP. After reviewing all of Resident # 61's discontinued and active physician orders, LPN # 2 stated that there was not an order for the use of a C-PAP.  On 03/10/2020 at 10:05 a.m., an interview was conducted with LPN # 3, MDS coordinator regarding the missing documentation for Resident # 61's use of a C-PAP. LPN # 3 stated that a respiratory/C-PAP care plan was developed on 03/09/2020. When asked how they developed the care plan when there was no evidence of a physician's order for the use of a C-PAP, LPN # 3 stated, "I knew she used one."  On 03/09/2020 at approximately 6:55 p.m. ASM [administrative staff member] # 1, executive director, ASM # 2, director of nursing, and ASM # 3, regional director of clinical services, were made aware of the findings.  No further information was provided prior to exit.  References: [1] Positive airway pressure (PAP) treatment uses a machine to pump air under pressure into the airway of the lungs. This helps keep the windpipe open during sleep. The forced air delivered by CPAP (continuous positive airway pressure)	ROVIDER OR SUPPLIER  L HEALTH AND REHAB  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 166 should be covered to prevent bacteria on it." When asked to describe the purpose of a resident's comprehensive care plan, LPN # 5 stated was to make all the resident care needs known and to implement what it says.  On 03/10/2020 at 10:05 a.m., an interview was conducted with LPN # 2 regarding a physician's order for Resident # 61's use of a C-PAP. After reviewing all of Resident # 61's use of a C-PAP.  On 03/10/2020 at 10:05 a.m., an interview was conducted with LPN # 3, MDS coordinator regarding the missing documentation for Resident # 61's use of a C-PAP.  On 03/10/2020 at 10:05 a.m., an interview was conducted with LPN # 3, MDS coordinator regarding the missing documentation for Resident # 61's use of a C-PAP, LPN # 3 stated that a respiratory/C-PAP care plan was developed on 03/09/2020. When asked how they developed the care plan when there was no evidence of a physician's order for the use of a C-PAP, LPN # 3 stated, "I knew she used one."  On 03/09/2020 at approximately 6:55 p.m. ASM [administrative staff member] # 1, executive director, ASM # 2, director of nursing, and ASM # 3, regional director of clinical services, were made aware of the findings.  No further information was provided prior to exit.  References:  [1] Positive airway pressure (PAP) treatment uses a machine to pump air under pressure into the airway of the lungs. This helps keep the windpipe open during sleep. The forced air delivered by CPAP (continuous positive airway pressure)	

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 656	[2] Sleep apnea is a causes your breathing Breathing pauses car minutes. They may or hour. This informatio website: https://medlii	thing problems. This ned from the website: ov/ency/article/001916.htm. common disorder that g to stop or get very shallow. I last from a few seconds to occur 30 times or more an was obtained from the neplus.gov/sleepapnea.html.		656			
F 657 SS=E	be- (i) Developed within 7 the comprehensive as (ii) Prepared by an intincludes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent practice the resident and their An explanation must medical record if the pand their resident rep not practicable for the resident's care plan. (F) Other appropriate disciplines as determined or as requested by the (iii)Reviewed and reviews.	ensive Care Plans brehensive care plan must  I days after completion of essessment. For disciplinary team, that end ited to-resician.  I with responsibility for the essential end of the participation of esident's representative(s).  I de included in a resident's participation of the resentative is determined endevelopment of the estaff or professionals in need by the resident's needs	F	657			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 110 CHALMERS COURT BERRYVILLE, VA 22611	•	
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F 657	by: Based on staff intervine review, and clinical redetermined that the far and revise the comprof 50 residents in the #69, #7, #41, #22, #6 facility staff failed to reare plans to address Resident #69, #67, #3 staff failed to review a and Resident # 43's caddress the use of hat facility staff failed to redeterministration of physical Resident #99.  The findings include:  1. The facility staff facomprehensive care Resident #69 to addrincident on 1/22/19, vincident on 1/22/19, vincident #69 and the #67 back.  Resident #69 was ad 1/17/13; diagnoses in stroke, dementia with hemiparesis, depress shoulder, dysphagia,	iew, facility document acord review, it was acility staff failed to review and revise the comprehensive care plans to allo assist bar bed rails. The eview and revise Resident care plan to address the sician ordered oxygen to a resident #69 and assist bar bed rails. The eview and revise Resident care plans to address the sician ordered oxygen to a resident #69 and the resident #69 and the resident #69 and the resident #69 hit Resident when Resident #69 hit Resident #69 and the resident #69 hit R	F 68	57		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
	495140	B. WING			C <b>03/10/2020</b>		
NAME OF PROVIDER OR SUPPLIER  ROSE HILL HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611		00/10/2020		
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	5.475		
blood pressure, and bipo quarterly MDS (Minimum (Assessment Reference the resident as being cog ability to make daily life of was coded as requiring to toileting; extensive assist dressing, and hygiene; and A review of the clinical reference documented, "Resident we resident when the other that him. When approaches	Date) of 2/4/20 coded verely impaired in ability ins. The resident was care for bathing; ers, dressing, toileting in for eating and quently incontinent of ude but are not limited to egia, dysphagia, adjustment disorder, onic obstructive ession, convulsions, high olar disorder. The in Data Set) with an ARD Date) of 2/3/20 coded gritively impaired in decisions. The resident otal care for bathing and stance for transfers, and supervision for eating.  Scord for Resident #69 dated 1/22/19 that was arguing with another resident began swearing ed by staff, the other the arm at which point he anged punches until ensive care plan for the dated 6/24/15 for "I efollowing behaviors"	F 65	57				

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 _			03/1	;  0/2020	
	ROVIDER OR SUPPLIER  L HEALTH AND REHA	В	•	STREET ADDRESS, CITY, STATE, ZIP C 110 CHALMERS COURT BERRYVILLE, VA 22611	CODE			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIA	I	(X5) COMPLETION DATE	
F 657	member. I can bec and believe that the going to take me he sexual inappropriate being aggressive to (residents) by grabbarm, calling out whe addressed, and rejerefuses therapy properties and revised 1/14/20 of coffee and see if activities room and other activity I would "Assist with moving a path so that I can hall way" dated 6/20/1 "Complete an activi not seat me around as people who yell 6/26/19. "Enc (encayoid over stimulati 6/26/19. "Give me has ordered" dated my favorite place to to avoid situations of me" dated 6/20/19 ame separated from close to me" dated interfering with my of "Make sure I am no	m going home with a staff ome attached to certain staff by are my partner and are ome with them. I have a hx of the behavior, I have a hx of the wards staff/others rt's oing, hitting and squeezing ten care needs have been the behavior, I have a hx of the behavior of the beha	F6	357				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495140	B. WING _			C 03/10/2020	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 110 CHALMERS COURT BERRYVILLE, VA 22611	DE	1 03/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BI HE APPROPRIA	DATE	
F 657	"Offer rt (resident) his 2/1/17. "Please refer psychologist/psychia psych for eval" dated 1/14/20. "Please tell before you begin" da me if I become upset you want/need me to "Resident requires a residents. Feels croc close to his space" d 6/26/19. "Speak to n voice" dated 6/26/19  The comprehensive also included one da have behaviors which activities." This care interventions: "Assesset-up. Sit me where residents" dated 6/20/19 and revised around others who dand revised 10/20/19 as my doctor has ord me maintain my favo 6/20/19 and revised situations or people to dated 6/20/19 and re am not in pain or und "Pharmacy medication" residents" dated 3/2 another (sic) residents	b/19 and revised 6/26/19. s own sugar packs" dated r me to my trist as needed refer back to 1 6/24/15 and revised me what you are going to do ted 6/24/15. "Re-approach c/combative, explain what do first" dated 12/30/19. great distance from other wded when people get too ated 6/20/19 and revised ne unhurriedly and in a calm	F	357			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495140	B. WING			C <b>03/10/2020</b>		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611	<u>I</u> _	03/10/2020		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 657		e 172 orehensive care plan for o reveal any revisions to	F 6	57				
	A review of the clinic revealed a nurse's not documented, "Resident swearing at approached by staff, other resident in the hit back, they began were separated."  Further review of the #67 revealed a social that documented, "C IDT (Interdisciplinary Responsible party in attendResident has resident on 1/22/19 addistress from incident and appropriate." A review of the comp Resident #67 failed that any revision after this have a care plan, da (diagnoses) of Bipola Disorder." This care interventions: "Encolactivities related to me "Help me to keep in friends" dated 6/11/1 with similar interests me my medications to	al record for Resident #67 be dated 1/22/19 that ent was arguing with another the other resident. When this resident punched the arm, when the other resident exchanging blows until they  clinical record for Resident Il services note dated 1/23/19 are plan meeting held with team) and resident. vited but did not d an altercation with another and has no emotional tPlan of care reviewed  orehensive care plan for oreveal any for behaviors or is incident. The resident did ted 6/11/15, for "I have dxs ar Disorder and Adjustment plan included the following urage me to get involved in ny interests" dated 6/24/19. contact with family and 5. "Introduce me to others ' dated 6/24/19. "Please give						
		my doctor if my symptoms see if I need a change in my						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G	' '	(X3) DATE SURVEY COMPLETED		
		495140	B. WING			C <b>03/10/2020</b>	
	ROVIDER OR SUPPLIER	В		STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	<b>,</b>	00/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 657	discuss my feelings 6/24/19.	6/11/15. "Take the time to s when I'm feeling sad" dated	F 65	57			
	(Administrative Star Director and Region Services) were mad incident. Additiona	AM, ASM #1 and ASM #3  If Members, the Executive  Inal Director of Clinical  Ide aware of the identified  I information such as an  requested. None was					
	of the process is to responsible party, a resident, identify if a	PM, ASM #1 stated that part notify the doctor and the and if psych is following the any new interventions are re plan should be looked at					
	excerpt from Lippin Edition documented PREPARATION- A nursing care from a dischargeUpdate	care plan directs the patient's dmission to and revise the plan ent's stay, based on the					
		PM, ASM #1 was made aware further information was					
	comprehensive car address an allegation	failed to review and revise the e plan for Resident #7 to on of abuse on 3/18/19, when esident #7 in the face.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		495140	B. WING _			C 03/10/2020
	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611		33,13,2323
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 657	Continued From pag	ge 174	F 6	557		
	2/19/19; diagnoses is stroke, hemiplegia, led dysphagia, depression chronic obstructive properties of the resident as being make daily life decise coded as requiring the extensive assistance to	e for transfers, dressing, e; and supervision for eating, or bathing; extensive care for toileting and hygiene; g and locomotion; and was not of bowel and bladder.  dmitted to the facility on include but are not limited to the behaviors, hemiplegia and esion, pain in leg and eating, adjustment disorder, lood pressure. The quarterly a Set) with an ARD ence Date) of 2/4/20 coded g severely impaired in ability cisions. The resident was otal care for bathing; ansfers, dressing, toileting				
	revealed a nurses no documented, "Resid	cal record for Resident #7 ote dated 3/18/19 that lent was smacked by another er. The other resident was				

L' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495140	B. WING _			C 03/10/2020		
	ROVIDER OR SUPPLIER	}		STREET ADDRESS, CITY, STATE, ZIP CO 110 CHALMERS COURT BERRYVILLE, VA 22611	DE	00/10/2020		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD B	DATE		
F 657	face. Resident was dining room and had Resident was upset noted."  A review of the compresident #7 failed to result of this incident A review of the clinic revealed a nurses not documented, "Resident and (5:30 PM). He (#7) then (Resident and chair). Resident become separated and reside room to eat his meal notified. DON, POA	ning room. No injuries on the upset but remained in the supper with others. later but no redness or injury orehensive care plan for reveal any revisions as a substitute of a supper with others. In the supper with others or injury orehensive care plan for reveal any revisions as a substitute of supper with other was a substitute of supper with other was in dining room at was going behind resident was going	F6	957				
	(Administrative Staff and Regional Clinica the identified inciden was requested.  Per this request, the "Behavioral Outburs or Staff Member" for documented, "Resid face in dining room. (Resident #7) and sh chair)." This form was	MM, ASM #1 and ASM #3 Members, the Administrator all Nurse) were made aware of and additional information  facility provided a transparent Assault of Another Resident and ated 3/18/19. This form the ent (#69) hit Resident (#7) on (Resident #69) was behind the backed into his w/c (wheel has specific to Resident #69) any care plan reviews for						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		495140	D. WING			03/	10/2020
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			1	STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611		
			1		THE TOTAL PROPERTY OF		
(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 SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	Continued From page	± 176	F	657			
	of the process is to no responsible party, and following the resident	ded, and the care plan					
	excerpt from Lippinco	re plan directs the patient's nission to nd revise the plan					
	On 3/10/20 at 2:30 Pt of the concern. No fu provided.	M, ASM #1 was made aware rther information was					
	#41's comprehensive revised to address an when on 1/12/20, Res	iled to ensure that Resident care plan was reviewed, incident of alleged abuse sident #69 hit Resident #41 face with a closed fist.					
	4/21/18; diagnoses in congestive heart failu dementia with behavior pressure. The quarte Set) with an ARD (Assof 1/15/20 coded the moderately impaired in decisions. The resident total care for bathing;	rly MDS (Minimum Data sessment Reference Date)					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495140	B. WING		C 03/10/2020
	ROVIDER OR SUPPLIER	В		STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	1 03/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 657	1/17/13; diagnoses stroke, dementia with hemiparesis, depres shoulder, dysphagite pilepsy, and high IMDS (Minimum Da (Assessment Referthe resident as being to make daily life decoded as requiring extensive care for the tand hygiene; supersident and stroke stroke in the stroke in th	admitted to the facility on include but are not limited to the behaviors, hemiplegia and ssion, pain in leg and a, adjustment disorder, blood pressure. The quarterly ta Set) with an ARD ence Date) of 2/4/20 coded and severely impaired in ability ecisions. The resident was total care for bathing; ransfers, dressing, toileting vision for eating and is frequently incontinent of	F 65	7	
	revealed a nurses redocumented, "Alert recipient in a res to altercation. Denied apparent injuries not episode. OOB (out tolerated. Needs to time to her room and doorway"  A review of the comes identified activities, ye hitting others and a belong to others, wincluded the followinterventions before	ical record for Resident #41 note dated 1/12/20 that , s/p (status post) being the res (resident to resident) I pain or discomfort. No oted to right eye area s/p of bed) in w/c (wheelchair) as to be re-directed from time to ad away from other res  Inprehensive care plan for alled one dated 5/22/18 for "I shaviors which include yelling Illing during care, cursing, ttempting to take things that andering." This care plan ng interventions: "Attempt e my behaviors begin. I to be separated from other			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED		
		495140	B. WING _			C <b>03/10/2020</b>		
	ROVIDER OR SUPPLIER	}		STREET ADDRESS, CITY, STATE, ZIP COE 110 CHALMERS COURT BERRYVILLE, VA 22611	I )E	33/10/2020		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIA	5.475		
F 657	dated 7/4/19 and reverse around others will "Help me maintain in 5/22/18. "Help me to that are upsetting to revised 9/19/19. "Stiviolent outburst behade-escalate me beformanifested" dated 1/4 A review of the compartment of	nen her behavior escalates" rised 12/18/19. "Do not seat no disturb me" dated 7/4/19. ny favorite place to sit" dated of avoid situations or people me" dated 7/4/19 and aff will key into precursors to aviors and attempt to re any adverse behaviors are 15/20.  The precipitation of the precursion of the precipitation of the	F 6	57				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
		495140	<b>495140</b> B. WING		C 03/10/2020		
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP COL 110 CHALMERS COURT BERRYVILLE, VA 22611		3/10/2020	
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 657	nurses station sitting this resident (#41) kid that was pushing a for #69) right fist and corresident (#41) right of was defending aide's On 3/09/20 at 3:20 P was a lady pushing the to get down the hall that area. (Resident #41) kick the lady from kitch interceded to defend was specific to Resid any care plan reviews On 3/09/20 at 3:20 P of the process is to not responsible party, and resident, identify if an eneded, and the care and updated.  The facility documented, PREPARATION- A can ursing care from addischarge Update a throughout the patient patient's response"	d, "Resident (#69) in front of beside resident (#41). Saw sking at her (a staff member lood cart). Took his (Resident lanceted with the other neekhe (Resident #69) honor."  M, ASM #1 stated, "There ne meal cart, she was trying by the residents sitting in the reached out attempting to chen. (Resident #69) a staff member. This form lent #69 and did not address is for Resident #41.  M, ASM #1 stated that part lotify the doctor and the diff psych is following the lay new interventions are le plan should be looked at lateral regarding care plans, an lott Nursing Procedures Eight lateral regarding care plans, an lott Nursing Procedures Eight lateral regarding care plans, an lateral regarding care plans, and lateral regarding care plans, a	F 6	57			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
		495140	B. WING _			C 03/10/2020	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 110 CHALMERS COURT BERRYVILLE, VA 22611	)E	03/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD		DATE	
F 657	#22's comprehensive revised to address a incident, on 10/17/18 Resident #69, in the Resident #22 was as 9/28/18; diagnoses i dementia with behave hallucinations, and of (Minimum Data Set) Reference Date) of as being severely im life decisions. The requiring total care for	ailed to ensure that Resident e care plan was reviewed and n allegation of abuse 0, Resident #22 was hit by left arm with a closed fist.  dmitted to the facility on nclude but are not limited to viors, anxiety disorder, lyspnea. The quarterly MDS with an ARD (Assessment 12/10/19 coded the resident paired in ability to make daily esident was coded as or bathing; limited assistance toileting and hygiene; and	F 6	557			
	1/17/13; diagnoses i stroke, dementia with hemiparesis, depresshoulder, dysphagia epilepsy, and high bind MDS (Minimum Data (Assessment Refere the resident as being to make daily life decoded as requiring to extensive care for train and hygiene; supervolucomotion; and was bowel and bladder.  A review of the clinic revealed a nurse not documented, "This rear north nurses states."	, adjustment disorder, lood pressure. The quarterly a Set) with an ARD nce Date) of 2/4/20 coded g severely impaired in ability cisions. The resident was otal care for bathing; ansfers, dressing, toileting					

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				C <b>10/2020</b>
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB		1	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	upper right arm. The separated and no furt resident suffered no i incident. Appropriate timely manner."  A review of the comp. Resident #22 reveale sometimes have behave and auditory hallucing seeing and hearing facare, easily agitated. The floor intentionally but has no injuries the with male rt's (resident husband, altercation walker at different plaself and takes off brief the following intervent before my behaviors revised 6/18/19. "Do who disturb me" date maintain my favorite mainta	reason, punched her in two residents were quickly ther conflict ensued. The njuries as a result of this enotifications done in a rehensive care plan for ed one dated 10/5/18 for "I avior which include visual ations, esp (especially) about amily members, refuses Resident places herself on and is acting out behavior ese falls. Will get into bed hits) thinks they are her with another rt. She leaves aces and at times undresses ef." This care plan included tions: "Attempt interventions begin" dated 10/5/18 and not seat me around others d 10/5/18. "Help me place to sit" dated 10/5/18. Lations or people that are ed 10/5/18 and revised eparated from people that d from my behaviors" dated 10/20/19.  Tehensive care plan for or reveal any revisions to	F	657			

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED		
		495140	B. WING			C 03/10/2020		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611		03/10/2020		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 657	notified."  On 3/9/20 at 10:10 at (Administrative Staf Director and Region Services) were madincident. Additional incident report was  Per this request, the "Behavioral Outburs or Staff Member" for documented, "This passing resident (#2 punched resident (#5st." This form was did not address any Resident #22.  On 3/09/20 at 3:20 of the process is to responsible party, a resident, identify if a needed, and the call and updated.  The facility documented excerpt from Lipping Edition documented PREPARATION- A conversion of the process. Update throughout the patient's response  On 3/10/20 at 2:30 in the call and the call and the call and updated.	AM, ASM #1 and ASM #3 If Members, the Executive that Director of Clinical the aware of the identified information such as an arequested.  If facility provided a set Assault of Another Resident and the aware of the identified information such as an arequested.  If facility provided a set Assault of Another Resident are dated 10/17/19. This form aresident (Resident #69) was 22) in hall and this resident #22) in left arm with closed as specific to Resident #69 and care plan reviews for  If PM, ASM #1 stated that part anotify the doctor and the and if psych is following the any new interventions are are plan should be looked at a cott Nursing Procedures Eight I, "CARE PLAN care plan directs the patient's dmission to and revise the plan ent's stay, based on the	F 63	57				

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 _				C 10/2020
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611			10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE			(X5) COMPLETION DATE
F 657	Continued From page	e 183	F 6	657			
	comprehensive care an allegation of abuse Resident #650, when was hit in the face by Resident #650 was a 3/14/18; diagnoses in femur fracture, depresleep apnea, high bloatrial fibrillation, congrespiratory failure, an resident expired at the therefore was not a cat the time of survey. MDS (Minimum Data (Assessment Referenthe resident as sever make daily life decision was highly and the survey.	dmitted to the facility on aclude but are not limited to ssion, chronic obstructive and pressure, heart disease, estive heart failure, acute d cardiac pacemaker. The e facility on 8/5/19 and urrent resident in the facility The significant change					
	toileting, eating and d assistance for transfe	lressing; and extensive					
	stroke, dementia with hemiparesis, depress shoulder, dysphagia, epilepsy, and high blo MDS (Minimum Data (Assessment Referer the resident as being	adjustment disorder, ood pressure. The quarterly					
	coded as requiring to extensive care for tra and hygiene; supervis	tal care for bathing; nsfers, dressing, toileting					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		4054.40	B WING			l	c
		495140	B. WING			03/	10/2020
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			1	STREET ADDRESS, CITY, STATE, ZIP CODE I10 CHALMERS COURT BERRYVILLE, VA 22611		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	revealed a physician documented, "Called resident as she was a room she was punched resident. She was tea injuries. No brusing the dorsum of the nose not she was punched to the weak of the should be should	all record for Resident #650 mote dated 2/26/19 that by the nurse to evaluate assaulted. At the dining ed in to her nose by another arful and anxious. No out mild erythema on oted.  clinical record for Resident e's note dated 2/26/19 that ted by another resident lining hall. No injuries ful and upset. Slight ally. Resident calmed down ttaff. NP (Nurse ower of Attorney), DON notified. Resident remained ough the rest of the e to monitor."	F	657			

l' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495140	B. WING		C 03/10/2020
	ROVIDER OR SUPPLIER	В		STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	1 00/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION
F 657	denied allegations. Resident cooperatives residents. Resident inappropriate behave [nurse practitioner, of attorney], aware updated."  Further review of the #69 revealed a physthat documented, "can incident. Residence twice at the diby the staff. Found in the hall way look to him self and denied he does have a teneous 2/7/19 blood work velectrolytes WNL (veresident closely. We evaluation of his medical modern and Region Services) were made incident. Additional incident report was per this request, the "Behavioral Outbursor Staff Member" for documented, "Resident face on nose and roomResident (# and hit w/c (wheel caround and hit her cattering the staff of	No further behaviors noted.  We with staff and other to monitored frequently for Wiors. NP, DON and POA director of nursing, and power of incident. Care plan  e clinical record for Resident sician's note dated 2/26/19 Called by the nurse to report ent had hit a resident in her ning room and was witnessed resident sitting in wheelchair and out the window. He is alert ed the episode. As per staff dency to get violant (sic).  with Valproic acid level 23.0, within normal limits). Monitor fill refer to the psych for edications."  AM, ASM #1 and ASM #3 of Members, the Executive hal Director of Clinical de aware of the identified information such as an requested.	F 65	7	

_ ` · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:		DING		
		495140	B. WING _			C 03/10/2020	
	ROVIDER OR SUPPLIER  L HEALTH AND REHAE			STREET ADDRESS, CITY, STATE, ZIP C 110 CHALMERS COURT BERRYVILLE, VA 22611	CODE	1 00/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD B THE APPROPRIA	DATE.	
F 657	of the process is to responsible party, ar resident, identify if an needed, and the card and updated.  The facility document excerpt from Lippino Edition documented, PREPARATION- A conursing care from addischarge Update at throughout the patient's response On 3/10/20 at 2:30 Fof the concern. No fiprovided.  6. The facility staff fare Resident #39's compuse of halo assist bath Resident #39 was ac 6/15/18.	Is for Resident #650.  If M, ASM #1 stated that part notify the doctor and the aid if psych is following the my new interventions are explan should be looked at a tregarding care plans, an nott Nursing Procedures Eight "CARE PLAN are plan directs the patient's mission to and revise the plan not's stay, based on the and the intervention was a lied to review and revise orehensive care plan for the repair bed rails.  If it is a lied to review and revise orehensive care plan for the residual to the facility on an another with a lied to the facility on an another with another with an another with anothe	F	557			
		ument information regarding halo assist bar bed rails.					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			ATE SURVEY DMPLETED
		495140	B. WING			C <b>03/10/2020</b>
	ROVIDER OR SUPPLIER	В		STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	·	50/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 657	Continued From pa	ge 187	F 65	7		
		.m., Resident #39 was h bilateral halo assist bars up.				
	conducted with LPN regarding comprehe halo assist bars. LF a recommendation residents who need physician's order for residents' care plan the use of halo assion 3/9/20 at 7:07 pmember) #1 (the exdirector of nursing)	.m., ASM (administrative staff recutive director), ASM #2 (the and ASM #3 (the regional ervices) were made aware of				
	excerpt from Lippine Edition documented PREPARATION- A nursing care from a dischargeUpdate	care plan directs the patient's dmission to and revise the plan ent's stay, based on the				
	No further informati	on was presented prior to exit.				
	1	failed to revise Resident # e care plan to address the use				
	diagnoses that inclumuscle weakness,	admitted to the facility with uded but were not limited to: swallowing difficulties and 's most recent MDS (minimum				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED		
		495140	B. WING			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	<u> </u>	03/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 657	(assessment reference coded Resident # 43 interview for mental - 15, six - being sever making daily decision Resident # 43 as recof two staff members on 03/08/20 at 3:15 revealed Resident # left upper bed rails/Hon 03/09/20 at 8:05 revealed Resident # left upper bed rails/Hon 03/09/20 at 8:05 revealed Resident # left upper bed rails/Hon 03/09/20 at 5:20 purconducted with LPN regarding compreheraddress the use of his stated the nurses ob the therapy staff for assist bars, obtain a assist bars, then the reviewed and then reassist bars.  On 03/09/2020 at application of the first part	assessment with an ARD ace date) of 01/15/2020, as scoring a six on the brief status (BIMS) of a score of 0 erely impaired of cognition for as. Section G coded quiring extensive assistance as for bed mobility.  p.m., an observation 43 lying in bed with right and dalos raised.  a.m., an observation 43 lying in bed with right and dalos raised.  care plan for Resident # 43 filed to address the use of bed  m., an interview was (licensed practical nurse) #1 asive care plan revisions to alo assist bars. LPN #1 tain a recommendation from residents who need halo physician's order for the halo residents' care plans are evised for the use of halo  approximately 6:55 p.m. ASM member] # 1, executive rector of nursing, and ASM # of clinical services, were	F	357		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495140	B. WING				C / <b>10/2020</b>	
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611			10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 657	Continued From page	e 189	F	657				
	Resident #99's comp	iled to review and revise rehensive care plan to artion of physician orderd 99.						
	diagnoses that includ history of pulmonary of 99's most recent MDS quarterly assessment reference date) of 02/99 as scoring a 13 or mental status (BIMS) being cognitively intac Section O "Special Tr	dmitted to the facility with ed but were not limited to: embolism [1]. Resident # 5 (minimum data set), a with an ARD (assessment /19/2020, coded Resident # 10 the staff assessment for of a score of 0 - 15, 13-ct for making daily decisions. The eatments, Procedures and sident # 99 for the use of						
	Resident # 99 revealed wheelchair in their root receiving oxygen by rany oxygen concentrated Observation of the oxygen with the oxygen concentration of the oxygen concentration	ygen flow rate revealed the n was between three-and-a						
	Resident # 99 revealed wheelchair in their root receiving oxygen by rany oxygen concentrate Observation of the ox	ygen flow rate revealed the n was between three-and-a						
	The POS [physician's	order sheet] dated 03/2020						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I	IPLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED		
		495140	B. WING _			C <b>03/10/2020</b>	
	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP COE 110 CHALMERS COURT BERRYVILLE, VA 22611	)E	33/10/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA	DATE	
F 657	nasal cannula 2L/m Order Date 12/08/20 The comprehensive dated of 11/26/2019 documentation for readministration of oxy On 03/09/20 at 4:38 conducted with LPN regarding how to rearesident's oxygen contact the liter line on the concentrator should the float ball at the ainformed of the above 99 oxygen flow rate, set incorrectly and the oxygen flow rate was minute. When aske a resident's compresident's compresident's compresident's compresident's compresident's compresident's company of the conducted with LPN 3, MDS coordinator documentation of Reafter reviewing Resident plan dated 11/2 the care plan was not conducted with second conducted with the care plan was not conducted to the conducted to the care plan was not conducted to the conducted	care plan for Resident # 99 failed to evidence espiratory care or the //gen.  p.m., an interview was [licensed practical nurse] # 5 and the flow rate on a procentrator. LPN # 5 stated the flow meter of the oxygen pass through the middle of propriate flow rate. When //e observations of Resident # LPN # 5 stated that it was nat the physician ordered is to be set at two liters per d to describe the purpose of mensive care plan, LPN # 5 all the resident care needs ment what it says.  05 a.m., an interview was [licensed practical nurse] # regarding the missing esident # 99's use of oxygen. dent # 99's comprehensive 16/2019, LPN # 3 stated that of updated for Resident # 99's	F 6				
	nursing should have that they, MDS, wou On 03/09/2020 at ap [administrative staff	# 3 further stated that updated the care plan and lld have revised the care plan.  oproximately 6:55 p.m. ASM member] # 1, executive irector of nursing, and ASM #					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				_			C
		495140	B. WING			03/	10/2020
NAME OF PF	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ROSE HIL	L HEALTH AND REHAB				10 CHALMERS COURT BERRYVILLE, VA 22611		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	×	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 657	Continued From page	<del>2</del> 191	F	657			
		clinical services, were					
	No further information	n was provided prior to exit.					
	References: [1] A blockage of an a	artery in the lungs.This					
	information was obtai	ned from the website:					
F 658	https://medlineplus.gov/ency/article/000132.htm. F 658 Services Provided Meet Professional Standards		F	658			
SS=E	CFR(s): 483.21(b)(3)						
	§483.21(b)(3) Compre						
	as outlined by the cor	d or arranged by the facility, mprehensive care plan,					
	must- (i) Meet professional						
	this REQUIREMENT by:	is not met as evidenced					
	Based on observatio	n, staff interview and clinical					
		letermined facility staff failed standards of practice for					
	two of 50 residents in	the survey sample,					
	Resident #99 and Re failed to follow medical	sident #61. The facility staff					
		during the administration of					
	Protonix delayed rele	ase tablet on 3/9/20. RN					
	,	crushed, opened and mixed 0 mg (milligram) Protonix					
	delayed release caps	ule with pudding and					
		lication to Resident #99. I to obtain an order for					
	Resident #61 use of a	a CPAP [continuous positive					
	airway pressure].						
	The findings include:						
	1. Resident #99 was	admitted to the facility on					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495140	B. WING	B. WING			C 03/10/2020		
	ROVIDER OR SUPPLIER		1	11	REET ADDRESS, CITY, STATE, ZIP CODE  0 CHALMERS COURT  ERRYVILLE, VA 22611	1 00	10/2020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SHOULD BE C			
F 658	not limited to pulmona depressive disorder (recent MDS (minimur assessment with an A Reference Date) of 2, #99 as scoring an 13 mental status (BIMS) being cognitively intak On 3/9/20 at approximobservation of medica Resident #99 was conurse) #1. RN #1 preadminister to Resider mg (milligram) one ta of the Protonix tablet sleeve and pill crushe empty the contents in then mixed the medica RN #1 then proceeded other capsules and mudding. RN #1 was tablet intact and place asked about the table Resident #99 takes a crushed or opened up Xarelto (blood thinner placed in the pudding medications to Resider "Mar (March) 9, 2020 "Protonix Tablet Delay (Pantoprazole Sodiur Protonix) Give 1 (one	noses that included but were ary embolism (2) and major 3). Resident #99's most in data set), a quarterly ARD (Assessment /19/2020 coded Resident on the staff assessment for of a score of 0 - 15, 13-ct for making daily decisions.  Intelly 8:20 a.m., an attion administration for inducted with RN (registered epared medications to int #99 including Protonix 40 blet. Prior to administration RN #1 used the plastic er to crush the tablet and it to a medication cup. RN #1 station contents with pudding. In the public day of the pill contents with observed leaving one single end it in pudding. When eat, RN #1 stated that all of her medications into pudding except for the residual pudding except for the	F	658					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED		
		495140	B. WING _			C 03/10/2020	
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB	1		STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611		03/10/2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 658	Continued From pag	e 193	F6	58			
		care plan failed to evidence a administering medications as					
	"3/1/2020-3/31/2020 receiving the Protoni	ninistration Record" dated " documented Resident #99 x Tablet delayed release as each day at 9:00 a.m.					
	On 3/9/20 at approximately 4:45 p.m., a request was made to LPN (licensed practical nurse) #2, to interview RN #1. LPN #2 stated that RN #1 had already left for the day and RN #1 was not scheduled to work on 3/10/20.						
	interview was condu- stated that delayed r not be crushed or op- delayed released me released over an ext #1 stated that they n something that they	mately 5:00 p.m., an cted with LPN #1. LPN #1 release medications should bened. LPN #1 stated that reans the medication is to be rended period of time. LPN reeded to get an order for could crush or a liquid rent #99 if she could not release medication.					
	was made by written staff member) #1, the	mately 6:55 p.m., a request list to ASM (administrative e executive director for the lication administration.					
	director of clinical se followed their policie Lippincott as their sta provided a copy of th Nursing Procedures,	a.m., ASM #3, the regional rvices stated that the facility s, the regulations and andard of practice. ASM #3 ne document "Lippincott 8th Edition, Wolters Kluwer; e Medication Administration					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  G	L COM		
		495140	B. WING _			C <b>03/10/2020</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	I	03/10/2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 658	Edition, Wolters Klumedication administ failed to evidence groof delayed release root delayed release root delayed release root delayed release root documented in part, administered as premanufacturers' specific principles and practilegally authorized to administer medical have familiarized the consideration of the crushed or capsuresident has difficult using the following gorder from prescribe release or enteric-codissolving in the stongenerally not be crushed."  "PROTONIX Delayer swallowed whole, we stomach should no crushed." [4]	cott Nursing Procedures, 8th wer; pages 678-680, Safe ration practices, general" uidance in the administration nedications.  Idedication Administration 2/12 (December 2012)" "Medications are scribed in accordance with iffications, good nursing ces and only by persons do so. Personnel authorized ations do so only after they emselves with the medication of so, medication tablets may also emptied out when a y swallowing or is tube-fed, puidelines and with a specific erb. Long-acting, extended to bated (coating to prevent mach) dosage forms should shed; an alternative should be defended to the split, chewed, or	F 6	58			
	director of nursing a	ecutive director, ASM #2, the nd ASM #3, the regional ervices were made aware of					
	No further information	on was presented prior to exit.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495140	B. WING			C <b>3/10/2020</b>	
	ROVIDER OR SUPPLIER		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)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 658	Continued From pag	e 195	F 65	8			
	inhibitor that decreas produced in the storm treat erosive esophal esophagus from stor gastroesophageal reladults and children when the pantoprazole is usual a time while your esolinformation was obtainttps://www.drugs.co.  2. Pulmonary emboliblockage in a lung arl when a when a blood travels through the bis a serious condition damage to the lungs blood, Damage to othe lungs blood, Damage to	nach acid caused by flux disease, or GERD) in yho are at least 5 years old. ally given for up to 8 weeks at ophagus heals. This ined from the website: om/protonix.html  us- (PE) is a sudden tery. It usually happens d clot breaks loose and loodstream to the lungs. PE of that can cause: Permanent the Low oxygen levels in your her organs in your body from the cially if a clot is large, or if this information was					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495140	B. WING		C 03/10/2020		
	ROVIDER OR SUPPLIER	В	1	STREET ADDRESS, CITY, STATE, ZIP CODE  10 CHALMERS COURT  BERRYVILLE, VA 22611	03/10/2020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION		
F 658	m?setid=cfeacb5c-4  2. Resident # 61 w diagnoses that incluobstructive sleep al recent comprehens an admission asses (assessment refere coded Resident # 6 assessment for me of 0 - 15, 15- being daily decisions. In Treatments, Proced # 61 was coded as positive airway president was referenced to a servations of Resident # 61 servations of Resident # 61's roo laying on top of the The POS [physicial for Resident # 61 fathe use of the C-PAT The comprehensive	as admitted to the facility with uded but were not limited to: onea [2]. Resident # 61's most ive MDS (minimum data set), sement with an ARD nce date) of 09/10/2019, it as scoring a 15 on the staff intal status (BIMS) of a score cognitively intact for making Section O "Special dures and Programs" Resident having a C-PAP [continuous issure] [1].  D p.m., and at 4:44 p.m., sident # 61's room revealed a on top of the bedside table  D a.m., an observation of im revealed a C-PAP mask bedside table uncovered.  D's order sheet] dated 03/2020 ailed to evidence an order for in machine.	F 658				
	interview was cond When asked how o mask, Resident #6	pproximately 8:30 a.m., an ucted with Resident # 61. ften they use the C-PAP 1 stated every night. When by had been using the C-PAP,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495140	B. WING		C 03/10/2020		
	ROVIDER OR SUPPLIER	В		STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611	1 00/10/2020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	O BE COMPLETION		
F 658	past 15 years."  On 03/10/2020 at 1 conducted with LPN order for Resident # reviewing, all of Reactive physician order so asked to describe the C-PAP, LPN # 2 stafor a physician's order according to the set no order, they need and a respiratory or and notify the reside When asked if there outcomes for the recorrect settings, LP would not get the phave respiratory discoxygen]." When as receiving respirator physician's order, LOn 03/09/2020 at a [administrative staff director, ASM # 2, 03, regional director made aware of the No further informatic References:  [1] Positive airway is a machine to pump airway of the lungs open during sleep."	d, "I've been using it for the  0:05 a.m., an interview was  I # 2 regarding a physician's f 61's use of a C-PAP. After sident # 61's discontinued and lers LPN # 2 stated that there or the use of a C-PAP. When the procedure for the use of a sited, "Nursing should check der, and set the machine ting on the order. If there is to notify the nurse practitioner tompany to verify the settings to notify the nurse practitioner tompany to verify the settings to notify the nurse practitioner tompany to verify the settings to notify the nurse practitioner tompany to verify the settings to notify the nurse practitioner tompany to verify the settings to notify the nurse practitioner tompany to verify the settings to notify the nurse practitioner tompany to verify the settings to notify the nurse practitioner tompany to verify the settings to notify the nurse practitioner tompany to verify the settings to notify the nurse practitioner tompany to verify the settings to notify the nurse practitioner to notify the settings to notify the nurse practitioner to notif	F 658				

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		495140	B. WING _			C <b>03/10/2020</b>	
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	<u> </u>	03/10/2020	
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 658	the breathing in peop apnea and other breatinformation was obtain https://medlineplus.go/ [2] Sleep apnea is a causes your breathin Breathing pauses carminutes. They may o hour. This information website: https://medlinguality of Care CFR(s): 483.25  § 483.25 Quality of care is a furth applies to all treatment facility residents. Base assessment of a resident residents received accordance with profest practice, the comprehencation of the comprehencation of the facility staff failed in accordance with profest practice and the computation of the facility staff failed in accordance with profest practice and the computation of the facility staff failed in accordance with profest practice and the computation of the facility staff failed in accordance with profest practice and the computation of the facility staff failed in accordance with profest practice and the computation of the facility staff failed in accordance with profest practice and the computation of the facility staff failed in accordance with profest practice and the computation of the facility staff failed in accordance with profest practice and the computation of the facility staff failed in accordance with profest practice and the computation of the facility staff failed in accordance with profest practice and the computation of the facility staff failed in accordance with profest practice and the computation of the facility staff failed in accordance with profest practice.	airway collapse that block le with obstructive sleep athing problems. This ined from the website: by/ency/article/001916.htm.  common disorder that g to stop or get very shallow. In last from a few seconds to ccur 30 times or more an in was obtained from the neplus.gov/sleepapnea.html.  are Indamental principle that int and care provided to led on the comprehensive dent, the facility must ensure extreatment and care in lessional standards of nensive person-centered sidents' choices.  To is not met as evidenced liew, facility document review liew, it was determined that to provide care and services rofessional standards of prehensive plan of care for in the survey sample, f40). The facility staff failed an prescribed medications to saff19. The facility staff failed physician's order for	F 6				
	services.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	TIPLE CONSTRUCTION  NG	(X:	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	430140		STREET ADDRESS, CITY, STATE, ZIP COI 110 CHALMERS COURT BERRYVILLE, VA 22611	DE	03/10/2020	
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F 684	Continued From page	e 199	F	684			
	12/14/18. Resident # were not limited to de major depressive disc annual MDS (minimu with an ARD (assess 12/10/19, coded the r daily decision making Review of Resident # a physician's order da (1) 40 mg (milligrams physician's order date 10 mg by mouth once The medications were	admitted to the facility on fals's diagnoses included but ementia, high cholesterol and order. Resident #18's m data set), assessment ment reference date) of resident's cognitive skills for g as moderately impaired.  E18's clinical record revealed ated 12/14/18 for simvastatin by by mouth at bedtime and a led 1/3/19 for donepezil (2) e a day.  E scheduled for 8:00 p.m. on mber 2019 MAR (medication					
	administration record (licensed practical nu simvastatin and done Resident #18 on the the code, "7= Other/eMAR (electronic me record) note regardin 12/31/19 documented pharmacy." An eMAI and dated 12/31/19 dopharmacy." There we regarding the administ donepezil on 12/31/1 Resident #18's comp 12/19/18 documented status related to: HDI [cholesterol])Medical	). On 12/31/19, LPN rse) #11 failed to document repezil was administered to MAR. LPN #11 documented See Nurse Notes." An dication administration g simvastatin and dated d, "Waiting to be sent from R note regarding donepezil locumented, "Waiting for as no further documentation stration of simvastatin or 9.  rehensive care plan dated d, "Impaired Cardiovascular L (high density lipoproteins					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495140	B. WING			C 03/10/2020	
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CO 110 CHALMERS COURT BERRYVILLE, VA 22611			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 684	Review of a pharmace revealed a quantity of simvastatin and a quadonepezil for Resider facility on that date. I medication "back up" various medications to resist tablets of simvastatin.  On 3/9/20 at 4:38 p.m. conducted with LPN is process for ensuring, medications are avail #5 stated she re-order pharmacy when ten that administration. LPN is scheduled for administ the medication, she of possible, obtains the up" box. LPN #5 stated administers the medication up note that the Con 3/9/20 at 5:57 p.m. conducted with LPN is #18's medication administers the medication and LPN #11 stated it had 12/31/19 and he could the pharmacy or if he donepezil to Residen.  On 3/9/20 at 7:07 p.m. member) #1 (the executive of nursing) at	al status related to: In as ordered by physician"  By manifest dated 12/5/19 If 30- 40 mg tablets of In an an antity of 30- 10 mg tablets of In antity of the facility In an interview of the facility In an interview was If a telephone interview was I	F 68	34			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 110 CHALMERS COURT BERRYVILLE, VA 22611	DDE	00/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 684	Continued From page the above concern. The facility staff follow the facility standard of the facility standard of the facility pharmacy. Administration- General Medications are a with written orders of the facility document administration practic Lippincott Nursing Producemented, "Follow an order entered into system"  No further information References:  (1) Simvastatin is us This information was https://medlineplus.gtml  (2) "Donepezil is used disorder that affects	e 201  ASM #2 and ASM #3 stated vs Lippincott and policies as of practice.  y policy titled, "Medication eral Guidelines" documented, administered in accordance the prescriber"  t regarding safe medication ces, an excerpt from rocedures Eight Edition a written or typed order or a computer order-entry  n was presented prior to exit.  ed to treat high cholesterol. obtained from the website: ov/druginfo/meds/a692030.h  d to treat dementia (a brain the ability to remember, think e, and perform daily activities					
	the website: https://medlineplus.g tml 2. Resident #40 was 11/4/11; diagnoses ir stroke, dysphagia, h depression, high bloc contractures. The si	. •					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 684	being severely impaidecisions. The reside total care for bathing extensive assistance toileting; and was incolled bladder.  A review of the clinical physician's order data consult.  Further review reveated discontinued in the esponsive on 1/20/20.  A review of the mont Sheets) printed on 1/20/20.  A review of the mont Sheets) printed on 2/27/20 are Practitioner on	/14/20 coded the resident as red in ability to make daily life ent was coded as requiring transfers, and hygiene; for dressing, eating, and continent of bowel and continent of continent con	F 68	4		

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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		495140	B. WING			03/	10/2020
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			11	TREET ADDRESS, CITY, STATE, ZIP CODE 10 CHALMERS COURT ERRYVILLE, VA 22611		
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F 690 SS=D	some reason the order shouldn't have been. order is needed for how was currently receiving from 1/20/20 up to the notified that there was on 3/9/20 at 7:07 PM.  On 3/10/20 at 12:50 Fithere wasn't a policy from the wasn't	PM, an interview was #3. She stated that for er was discontinued when it ASM #3 stated that an espice and that the resident ag hospice without an order et time when the facility was anot an order for hospice,  PM, ASM #3 stated that for hospice. No further ded. inence, Catheter, UTI (3)  Ince. Sility must ensure that then of bladder and bowel on ervices and assistance to unless his or her clinical es such that continence is ain.  PSIGNATE OF THE PROPERTY OF		684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 690	receives appropriate prevent urinary tract is continence to the extreme \$483.25(e)(3) For a mincontinence, based of comprehensive assessmented that a residen receives appropriate restore as much norm possible.  This REQUIREMENT by:	incontinent of bladder treatment and services to infections and to restore ent possible.  esident with fecal on the resident's esment, the facility must t who is incontinent of bowel treatment and services to hal bowel function as	F	690			
	review, it was determ failed to provide treat maintain and/or resto function for one of 50 sample, Resident #78 identify and address urinary continence be (minimum data set) a (assessment reference	iew and clinical record ined that the facility staff ment and services to re a resident's bladder residents in the survey 8. The facility staff failed to Resident #8's decline in a tween a quarterly MDS ssessment with an ARD be date) of 12/9/19 and a sment with an ARD of					
	10/15/19. Resident # were not limited to dia and high blood press quarterly MDS assess 12/9/19 coded the resintact, scoring a 14 of for mental status. Se	sment with an ARD of sident as being cognitively ut of 15 on the brief interview ction H coded Resident #78 tinent of urine (less than					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
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	ROVIDER OR SUPPLIER  L HEALTH AND REHAB		•	1	TREET ADDRESS, CITY, STATE, ZIP CODE  10 CHALMERS COURT  BERRYVILLE, VA 22611		
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F 690	quarterly MDS asses 2/12/20 coded the remoderately impaired, brief interview for me Resident #78 as freq (seven or more episoduring the seven-day Review of Resident #living) records reveal with four episodes of 12/3/19 through 12/9 urinary incontinence.  Resident #78's comp 11/11/19 documented bowel and bladder Simedications with phy contributing to incont medications which murination; use of brief protection"  Review of Resident # including nurses' note notes, failed to reveal staff identified and according to the resident # including nurses' note notes, failed to reveal staff identified and according to the resident # including nurses' note notes, failed to reveal staff identified and according to the resident # including nurses' note notes, failed to reveal staff identified and according to the resident # including nurses' note notes, failed to reveal staff identified and according to the resident # including nurses' note notes, failed to reveal staff identified and according to the resident # including nurses' note notes, failed to reveal staff identified and according to the resident # including nurses' notes.	period). Resident #78's sment with an ARD of sident's cognition as a scoring 12 out of 15 on the ntal status. Section H coded uently incontinent of urine ides of urinary incontinence ides of urinary incontinence ides and presented urinary incontinence from 1/19 and seven episodes of from 2/6/20 through 2/12/20.  The ensive care plan dated in the incomplete incontinenceDiscuss sician which may be inence; evaluate timing of any cause increased is/pads for incontinence  The ensive care plan dated in the incomplete in the incomplete in the incomplete in the intinence between the 12/9/19	F	690			
	(MDS coordinator) ar regarding the decline continence from the and the 2/12/20 MDS	m., an interview was (licensed practical nurse) #1 ad LPN #3 (unit manager), in Resident #78's urinary 12/9/19 MDS assessment assessment. LPN #1 at urinary changes including					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495140	B. WING		C 03/10/2020		
	ROVIDER OR SUPPLIER	3	1	TREET ADDRESS, CITY, STATE, ZIP CODE 10 CHALMERS COURT EERRYVILLE, VA 22611	, 03.10.2020		
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F 690	assessments but sh when Resident #78's completed because MDS assessments of LPN #1 stated she regions oxygen level and he "frequently incontine oxygen level and he "frequently incontine occasionally incontine occasionally incontine occasionally incontine incomplete in the ide #78's continence be stated therapy refer physician notification when a resident's confucted the exident #78's continence to the exident #78's continence of the exident #78's continence of the exident #78's continence implemented to the exident #78's continence implemented to the exident #78's continence in February or activity into distance in February not evaluated or treation of the exident #78 received in the exident #78 received in the exident #78 received in February of the exident #78 (Centers for Services) RAI (Resident #78) (	declines when coding MDS e probably did not do so s MDS assessments were she (LPN #1) was new. The were reviewed with LPN #1. how knows that Resident #78 on what is going on with her r anxiety. When asked if ent" is a decline from inent," LPN #1 stated, "Yeah, I stated she did not ntified the decline in Resident cause she was new. LPN #1 rals, toileting programs and in should be implemented ontinence level declines. LPN e asked if any interventions of address the decline in inence level. LPN #1 and "No."  D.m., an interview was of (other staff member) #10 rector). OSM #10 stated ed physical therapy for olerance and walking of 2020, but the resident was atted for bladder incontinence.  D.m., ASM (administrative the executive director) and all director of clinical services) of the above concern.  To Medicare and Medicaid dent Assessment Instrument) ding MDS assessments	F 690				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		495140	B. WING			03/10/2020	
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			11	TREET ADDRESS, CITY, STATE, ZIP CODE 10 CHALMERS COURT ERRYVILLE, VA 22611		
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F 695 SS=E	gather information on bladder appliances, the urinary toileting progration continence, bowel tra- patterns. Each residerisk of developing inco- identified, assessed, a individualized treatment non-medicinal treatments services to achieve of elimination function as	the items in this section is to the use of bowel and the use of and response to ams, urinary and bowel ining programs, and bowel int who is incontinent or at continence should be and provided with ent (medications, ents and/or devices) and remaintain as normal		690 695			
	The facility must ensure needs respiratory care and tracheal succare, consistent with practice, the compreherand 483.65 of this sufficient that the sufficient facility and the sufficient facility staff failed to sufficient facility facil	d tracheal suctioning.  Ire that a resident who e, including tracheostomy tioning, is provided such professional standards of lensive person-centered tts' goals and preferences,					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		1, ,	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CO 110 CHALMERS COURT BERRYVILLE, VA 22611		3/10/2020	
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F 695	Resident #11 at the ptwo liters per minute.  Resident #11 was ad 12/22/16. Resident # were not limited to dishigh blood pressure.  MDS (minimum data ARD (assessment recoded the resident's impaired. Section G requiring extensive a staff with bed mobility coded the resident as therapy.  Resident #11's comp 1/11/17 documented, status related to Con Hypertension (high b 3L/NC (three liters via Review of Resident # a physician's order doxygen at two liters ponsal cannula conneconcentrator that was	illed to administer oxygen to obysician prescribed rate of mitted to the facility on #11's diagnoses included but abetes, heart failure and Resident #11's quarterly set) assessment with an ference date) of 12/10/19, cognition as moderately coded Resident #11 as ssistance of two or more y and transfers. Section O is having received oxygen rehensive care plan dated "Impaired Cardiovascular gestive Heart Failure (CHF), lood pressure)Oxygen a nasal cannula)"	F 69	95			
	the concentrator flow	s evidenced by the ball in meter positioned between d three-liter lines. This					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	•	03/10/2020	
(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 CORI ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 695	observation of the flow eye level.  On 3/9/20 at 4:38 p.m conducted with LPN (LPN #5 was asked to an oxygen concentrative resident has a physic LPN #5 stated the two through the middle of #5 stated it was impocorrect rate because become hypoxic (an if and if too high, the refoxygenated and experimely and including hallucination on 3/9/20 at 7:07 p.m member) #1 (the executive director of nursing) and director of clinical service the above concern.  The oxygen concentrations documents instructions documents with the service of the concentrations	a., an interview was licensed practical nurse) #5. describe where the ball in or flow meter should be if a fan's order for two liters. Deliter line should pass the ball at eye level. LPN retant to set oxygen at the if too low, the resident could madequate oxygen level) sident could become over rience bad side effects ins.  a., ASM (administrative staff cutive director), ASM #2 (the ind ASM #3 (the regional vices) were made aware of	F6	,			
	ball rises to the line. L/min (liter per minute) The facility document excerpt from Lippinco Edition documented, helps relieve hypoxer maintain adequate ox vital organsVerify the	regarding oxygen, an tt Nursing Procedures Eight 'Oxygen administration nia (low level of oxygen) and ygenation of tissues and e practitioner's order for the use oxygen is considered a					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION  NG			LETED
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	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CO 110 CHALMERS COURT BERRYVILLE, VA 22611	DDE	, , ,	
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F 695	Continued From page	e 210	F 6	395			
		n was presented prior to exit. iled to administer Resident #					
		g to the physician's orders.					
	diagnoses that includ chronic obstructive pure Resident # 87's most set), a quarterly asse (assessment reference coded Resident # 87 assessment for ments of 0 - 15, 12- being macognition for making of "Special Treatments, Resident # 87 was coold on 03/08/20 at 1:35 prevealed Resident # 8 wheelchair watching oxygen by nasal cannoxygen concentrator observation of the oxygen half and two liters per set of the oxygen and the oxygen and two liters per set of the oxygen and the oxygen and two liters per set of the oxygen and the ox	recent MDS (minimum data ssment with an ARD ce date) of 02/13/2020, as scoring a 12 on the staff al status (BIMS) of a score rederately impaired of daily decisions. In Section O Procedures and Programs" ded for the use of oxygen.  b.m., an observation of stiting in their room in a television and receiving roula connected to any that was running.  cygen flow rate revealed the mass between one-and -a minute.					
	revealed Resident # 8 in their room watching by nasal cannula con concentrator that was the oxygen flow rate	o.m., an observation of 37 sitting in their wheelchair g television receiving oxygen nected to an oxygen s running. Observation of revealed the flow rate of the one-and -a half and two					
		a.m., an observation of ed they were sitting in their					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	03/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
F 695	wheelchair in their receiving oxygen by of the oxygen flow responsible to the oxygen was bet liters per minute.  The POS [physician for Resident # 87 dc Concentrator at 2 [trevery shift. Order Interventions of the comprehensive dated of 11/20/2019 alteration in Respira Obstructive Pulmon Heart Failure. Date "Interventions", it do medications as orde [laboratory tests], retreatments. Date Interventions of the conducted with LPN regarding how to reresident's oxygen concentrator should the float ball at the accomposition of Resident's oxygen concentrator should the float ball at the accomposition of Resident's oxygen flow rate, LF was set between or per minute. When a prescribed oxygen flow rate, LF was set between or per minute. When a prescribed oxygen flow rate, LF was set between or per minute. When a prescribed oxygen flow rate, LF was set between or per minute. When a prescribed oxygen flow rate, LF was set between or per minute. When a prescribed oxygen flow rate, LF was set between or per minute. When a prescribed oxygen flow rate, LF was set between or per minute. When a prescribed oxygen flow rate, LF was set between or per minute. When a prescribed oxygen flow rate, LF was set between or per minute. When a prescribed oxygen flow rate, LF was set between or per minute. When a prescribed oxygen flow rate, LF was set between or per minute. When a prescribed oxygen flow rate, LF was set between or per minute. When a prescribed oxygen flow rate, LF was set between or per minute. When a prescribed oxygen flow rate, LF was set between or per minute. When a prescribed oxygen flow rate, LF was set between or per minute. When a prescribed oxygen flow rate, LF was set between or per minute. When a prescribed oxygen flow rate, LF was set between or per minute. When a prescribed oxygen flow rate, LF was set between or per minute.	oom watching television on ansal cannula. Observation ate revealed the flow rate of ween one-and -a half and two observation of sorder sheet] dated 03/2020 occumented, "Oxygen wo] liters NC [nasal cannula] oute 10/25/2019."  The care plan for Resident # 87 of documented, "Focus: I have atory Status Due to Chronic ary Disease, Congestive of Initiated 11/20/2019." Under occumented in part, "Administer ordered. Observe labs esponse to medication and	F 69	5	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	COMPLETED
		495140	B. WING		C 03/10/2020
	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	1 00/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES (CROSS-REFERENCE)	D BE COMPLETION
F 695	Resident # 87's oxygin part, "6.3.4 Flowrater, locate the the flowmeter, locate the the flowmeter. Next ball rises to the line. L/min [liter per minu.  On 03/09/2020 at 5: conducted with ASM member] # 3, region When asked what stollows, ASM # 3 staprocedures and Lipp According to Lipping "Nursing Assessment Administer oxygen in concentration.  On 03/09/2020 at application of the flow of	ufacturer] User Manual" for gen concentrator documented ate. To properly read the exprescribed flowrate line on the transport of the exprescribed."  Of p.m., an interview was a fladministrative staff and director of clinical services. It that and practice the facility ated, "Our policies and bincott."  Cott, page 242, read in part: International interventions: 3. In the appropriate  Opproximately 6:55 p.m. ASM member] # 1, executive irector of nursing, and ASM # of clinical services, were indings.  On was provided prior to exit.	F 69	5	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		495140	B. WING			C 03/10/2020	
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			11	TREET ADDRESS, CITY, STATE, ZIP CODE 10 CHALMERS COURT ERRYVILLE, VA 22611	03/	10/2020
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695	diagnoses that includ history of pulmonary of pulmonary of pulmonary of set), a quarterly asse (assessment reference coded Resident # 99 assessment for ments of 0 - 15, 13- being codaily decisions. In Set Treatments, Procedur # 99 was coded for the On 03/08/20 at 1:48 prevealed Resident # 9 in their room watching oxygen by nasal cannocentrator that was the oxygen flow rate oxygen was between liters per minute.  On 03/08/20 at 4:43 prevealed Resident # 9 in their room watching oxygen by nasal cannocentrator that was the oxygen by nasal cannocentrator that was the oxygen flow rate oxygen by nasal cannocentrator that was the oxygen flow rate oxygen was between liters per minute.  The POS [physician's for Resident # 99 door nasal cannula 2L/min Order Date 12/08/20	dmitted to the facility with ed but were not limited to: embolism [1].  recent MDS (minimum data assment with an ARD be date) of 02/19/2020, as scoring a 13 on the staff al status (BIMS) of a score organitively intact for making ection O "Special res and Programs" Resident are use of oxygen.  D.m., an observation of severaled the flow rate of the three-and-a half and four onested to an oxygen of running. Observation of revealed the flow rate of the three-and-a half and four of severaled the flow rate of the three-and-a half and four order sheet] dated 03/2020 cumented, "O2 [oxygen] via [two liters per minute].  Eare plan for Resident # 99	F	695			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		ATE SURVEY DMPLETED
		495140	B. WING _			C <b>03/10/2020</b>
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP COD 110 CHALMERS COURT BERRYVILLE, VA 22611		00/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 695	conducted with LPN regarding how to rea resident's oxygen co that the liter line on the concentrator should the float ball at the all informed of the above # 99's oxygen flow rewas set incorrectly at	spiratory care or the gen. p.m., an interview was [licensed practical nurse] # 5	Fé	95		
	Resident # 87's oxyg in part, "6.3.4 Flowraflowmeter, locate the the flowmeter. Next, ball rises to the line. L/min [liter per minute. On 03/09/2020 at 5:0 conducted with ASM member] # 3, regiona When asked what stafollows, ASM # 3 star procedures and Lipp According to Lippince "Nursing Assessmen Administer oxygen in concentration.	27 p.m., an interview was [administrative staff al director of clinical services. andard of practice the facility ted, "Our policies and incott."  20tt, page 242, read in part: t and Interventions: 3. the appropriate  proximately 6:55 p.m. ASM				
	[administrative staff r	proximately 6:55 p.m. ASM nember] # 1, executive rector of nursing, and ASM #				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	` '	ATE SURVEY DMPLETED
		495140	B. WING			C 03/10/2020
	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	<u> </u>	00/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 695	3, regional director of made aware of the fill No further information References: [1] A blockage of an information was obtainttps://medlineplus.gd.  4. The facility staff f. C-PAP [Continuous mask in a sanitary mask in a s	of clinical services, were indings.  In was provided prior to exit.  In was provided prior to	F 69	5		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495140	B. WING		0:	C 3/ <b>10/2020</b>
	NAME OF PROVIDER OR SUPPLIER  ROSE HILL HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611	1 0.	3/10/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 695	Continued From page for Resident # 61 faithe use of the C-PAF.  The comprehensive dated of 11/26/2019 for the use of the C-On 03/09/2020 at apinterview was conducted with asked how long they Resident # 61 stated past 15 years."  On 03/09/20 at 4:38 conducted with LPN regarding the storagin use. LPN # 5 stat should be covered to On 03/09/2020 at appart [administrative staff director, ASM # 2, di 3, regional director of made aware of the file.	Je 216  Jed to evidence an order for P machine.  Care plan for Resident # 61 failed to evidence an order PAP machine.  Proximately 8:30 a.m., an octed with Resident # 61. Jen they use the C-PAP stated every night. When we had been using the C-PAP, dr., "I've been using it for the p.m., an interview was [licensed practical nurse] # 5 Jen of a C-PAP mask when not be dred, "It has to be cleaned to prevent bacteria on it."  Deproximately 6:55 p.m. ASM member] # 1, executive irector of nursing, and ASM # of clinical services, were	F 695	DEFICIENCY)	ROPKIALE	
	a machine to pump a airway of the lungs. open during sleep. T CPAP (continuous prevents episodes of the breathing in peolapnea and other bre	ressure (PAP) treatment uses air under pressure into the This helps keep the windpipe The forced air delivered by ositive airway pressure) f airway collapse that block ple with obstructive sleep athing problems. This ained from the website:				

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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		495140	B. WING			03/	10/2020
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			1	TREET ADDRESS, CITY, STATE, ZIP CODE  10 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	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 700 SS=D	[2] Sleep apnea is a causes your breathing Breathing pauses car minutes. They may or hour. This informatio website: https://medlingedrails CFR(s): 483.25(n)(1)-\$483.25(n) Bed Rails The facility must atternatives prior to in a bed or side rail is us correct installation, us rails, including but not elements.  \$483.25(n)(1) Assess entrapment from bed \$483.25(n)(2) Review bed rails with the resirrepresentative and obto installation.  \$483.25(n)(3) Ensure are appropriate for the \$483.25(n)(4) Follow recommendations and and maintaining bed in This REQUIREMENT by: Based on observation document review and	common disorder that g to stop or get very shallow. I last from a few seconds to ccur 30 times or more an In was obtained from the Ineplus.gov/sleepapnea.html.  (4)  In the facility must ensure ise, and maintenance of bed it limited to the following  I the resident for risk of I rails prior to installation.  I that the bed's dimensions ise resident's size and weight.  I the manufacturers' I d specifications for installing		700			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495140	B. WING		C 03/10/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	03/10/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE COMPLETION
F 700	residents in the surversidents in the surversident #39, #107 assist bar bed rails, benefits with the resident with the resident for the use. The findings included 1. Resident #39 was 6/15/18. Resident #were not limited to sand muscle weakned MDS (minimum data ARD (assessment recoded the resident's impaired. Section Grequiring extensive staff with bed mobility Review of Resident a quarterly data collection documented, "Side indicated at this Tim Resident #39's clinic facility staff assesses halo assist bar bed in documentation that benefits for the use (or the resident's repthere was evidence obtained.  Resident #39's communication that Resident #39's communication that benefits for the use (or the resident's repthere was evidence obtained.	requirements for three of 50 rey sample, (Residents #39, facility staff failed to assess and #43 for the use of halo failed to review risks and idents (or the resident's failed to obtain informed of halo assist bar bed rails.  Se admitted to the facility on the facility of the facility of the facility on the facility of the facility	F 70		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		495140	B. WING		C	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	03/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 700	On 3/9/20 at 8:21 a observed in bed with the risk was provided and a Resident #39 was read ASM (administrative executive director).  On 3/9/20 at 4:59 producted with LPN regarding bed rails. "no rail" facility with residents who have stated the therapy sand recommendation halo assist bars to the LPN #1 stated side completed by nurse and as needed but longer side rails and stated the side rails and stated the side rails and stated the side rail awas not an assessinand that is why the rails were not indicate benefits of the halo explained to resider documented but color signed by resider On 3/9/20 at 7:07 prodirector of rursing) director of clinical so the above concern.  The facility policy tit	ge 219  Im., Resident #39 was h bilateral halo assist bars up.  Im., bed rail assessments, sks and benefits for bed rails bed rail informed consent for equested via a list provided to e staff member) #1 (the  Im., an interview was I (licensed practical nurse) #1  LPN #1 stated the facility is a the exception of a few halo assist bars. LPN #1 staff completes assessments ons for residents who need turn and maneuver in bed. The resident who need turn and maneuver in bed. The resident #39 the resident #30 the resid	F 70			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495140	B. WING _			C 03/10/2020		
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CO 110 CHALMERS COURT BERRYVILLE, VA 22611	DE	1 00/10/2020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BI E APPROPRIA	DATE		
F 700	vs. restraint." The poinformation regarding.  No further informatio 2. Resident # 107 w. with diagnoses that it to: muscle weakness history of falls. Resid MDS (minimum data assessment with an date) of 02/25/2020, scoring an 13 on the status (BIMS) of a socognitively intact for Section G coded Resextensive assistance bed mobility.  On 03/08/20 at 1:32 revealed Resident # and left upper bed ra  On 03/09/20 at 8:04 revealed Resident # and left upper bed ra  The comprehensive of dated 02/21/2020 do risk for falls related to Fell in the past 31-18 New environment. Dunder "Interventions" "Halo to assist resided due to CVA [cerebral (stroke)]/Hemi [hemi] Initiated: 02/21/2020.	of side rails as an enabler olicy did not document ghalo assist bar bed rails.  In was presented prior to exit. as admitted to the facility included but were not limited to, high blood pressure and ent # 107's most recent set), an admission ARD (assessment reference coded Resident # 107 as brief interview for mental fore of 0 - 15, 13 - being making daily decisions. Sident # 107 as requiring of two staff members for p.m., an observation 107 lying in bed with right ils/Halos raised.  a.m., an observation 107 lying in bed with right ils/Halos raised.  care plan for Resident # 107 cumented in part, "Focus. At possible in the past 30 days, and days. History of falls. The past 30 days are initiated: 02/21/2020."  "It documented in part, "It documented in part, and with turning/repositioning vascular accident paresis] left side. Date	F 7	700				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		495140	B. WING _			C 03/10/2020
	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611		00,10,2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 700	device evaluation. If (electronic health refailed to evidence in obtained, the risks, it was provided.  On 3/9/20 at 4:59 p. conducted with LPN regarding bed rails. "no rail" facility with residents who have stated the therapy stand recommendation halo assist bars to tu LPN #1 stated side in completed by nurses and as needed but to longer side rails and stated the side rails were not in and benefits of the hexplained to resident documented but conor signed by resident On 03/09/2020 at application [administrative staff director, ASM # 2, d 3, regional director of made aware of the fill No further information.	d to evidence a physical further review of EHR cord) for Resident # 107 formed consent was benefits, and for bed rail use  m., an interview was (licensed practical nurse) #1 LPN #1 stated the facility is a the exception for a few halo assist bars. LPN #1 staff completes assessments are for residents who need arn and maneuver in bed. The resident was assessments are for not halo assist bars. LPN #1 sessment for Resident # sessment for the halo assist the assessment documented adicated. LPN #1 stated risks halo assist bars should be the sand this should be sent forms are not provided the or their representatives.  Deproximately 6:55 p.m. ASM member] # 1, executive frector of nursing, and ASM # of clinical services, were indings.	F 7	700		
		es admitted to the facility with ded but were not limited to:				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
			A. BOILD	_		, ا	С	
		495140	B. WING		<del></del>		10/2020	
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB		•	1	STREET ADDRESS, CITY, STATE, ZIP CODE 10 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)			X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
F 700	pain. Resident # 43's data set), a quarterly (assessment reference coded Resident # 43 interview for mental set - 15, six - being seven making daily decision Resident # 43 as requof two staff members  On 03/08/20 at 3:15 prevealed Resident # 42 left upper bed rails/History and the comprehensive of dated 09/10/2019 fail bed rails.  Review of the EHR (experience informed corrisks, benefits, and for the conducted with LPN (regarding bed rails.)  In or rail facility with the residents who have he stated the therapy stated and recommendation.	vallowing difficulties and most recent MDS (minimum assessment with an ARD ce date) of 01/15/2020, as scoring a six on the brief status (BIMS) of a score of 0 rely impaired of cognition for as. Section G coded uiring extensive assistance for bed mobility.  o.m., an observation 43 lying in bed with right and alos raised.  a.m., an observation 43 lying in bed with right and alos raised.  care plan for Resident # 43 ed to evidence the use of  electronic health record) for to evidence a physical device eview of EHR (electronic sident # 107 failed to consent was obtained, the or bed rail use was provided.  n., an interview was (licensed practical nurse) #1  LPN #1 stated the facility is a ne exception for a few railo assist bars. LPN #1  aff completes assessments as for residents who need an and maneuver in bed.	F	700				

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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		495140	B. WING		03/1	10/2020
	ROVIDER OR SUPPLIER  L 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 .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD E  CROSS-REFERENCED TO THE APPROPRI  DEFICIENCY)	<b>I</b>	(X5) COMPLETION DATE
F 732 SS=C	and as needed but th longer side rails and r stated the side rail as was not an assessme and that is why the as rails were not indicate benefits of the halo as explained to residents documented but consor signed by residents.  On 03/09/2020 at app [administrative staff rr director, ASM # 2, dir 3, regional director of made aware of the fir was provided prior to Posted Nurse Staffing CFR(s): 483.35(g)(1).  §483.35(g) Nurse Staffing CFR(s): 483.35(g)(1) Data remust post the followir basis:  (i) Facility name.  (ii) The current date.  (iii) The total number by the following category unlicensed nursing st resident care per shift (A) Registered nurses (B) Licensed practical	upon admission, quarterly ese assessments are for not halo assist bars. LPN #1 sessment for Resident # 43 ent for the halo assist bars esessment documented side ed. LPN #1 stated risks and esist bars should be es and this should be eent forms are not provided es or their representatives.  Proximately 6:55 p.m. ASM nember] # 1, executive ector of nursing, and ASM # clinical services, were edings.No further information exit. Information equirements. The facility equirements. The facility equirements. The facility equirements on a daily  and the actual hours worked pories of licensed and aff directly responsible for t: E. I nurses or licensed defined under State law). des.		732		

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	COMPLETED	
		495140	B. WING		C 03/10/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	1 03/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 732	(i) The facility must p specified in paragraph daily basis at the begon (ii) Data must be positive (ii) Data must be positive (iii) Data must be publicated that available to the publicated that community (iii) Paragraph (iii) Data Market (i	cost the nurse staffing data on (g)(1) of this section on a ginning of each shift. Sted as follows: ole format. Cost access to posted nurse cicility must, upon oral or enurse staffing data ic for review at a cost not to ity standard.  By data retention acility must maintain the taffing data for a minimum of quired by State law, whichever on and staff interview, it was facility staff failed to post the ginformation. Nurse staffing the was not posted on 3/8/20. The information for 3/7/20 was on the maintain of the control of th	F 73		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· '	PLE CONSTRUCTION  3	, ,	(X3) DATE SURVEY COMPLETED		
		495140	B. WING			C 03/10/2020	
	ROVIDER OR SUPPLIER L HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611		00/10/2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL		HOULD BE	(X5) COMPLETION DATE	
F 732	staffing coordinator), information posting. present in the facility sometimes on weeke generates the staffininformation in the lob the morning. OSM # places nurse staffing days in the posting someone to post the in the facility. OSM # who was responsible when she was not probut she assumed the On 3/9/20 at 5:38 p.r conducted with OSM works from 5:00 p.m weekdays and 9:00 a weekend). OSM #8	(other staff member) #7 (the regarding the nurse staffing OSM #7 stated she is Monday through Friday and ends. OSM #7 stated she greport and posts the oby as soon as she arrives in error stated on Fridays, she information for weekend leeve, in the lobby for current date when she is not error to the information esent during the weekends erreceptionist did.  m., an interview was #8 (the receptionist who it o 8:00 p.m. during a.m. to 3:00 p.m. every other	F 73	32			
	member) #1 (the exe director of nursing) a director of clinical se the above concern.	m., ASM (administrative staff ecutive director), ASM #2 (the nd ASM #3 (the regional rvices) were made aware of					
	stated the facility did	a.m., ASM #1 and ASM #3 not have a policy regarding ormation posting and staff ns.					
F 755 SS=D		n was presented prior to exit. cedures/Pharmacist/Records i(1)-(3)	F 7	55			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		495140	B. WING _			C 03/10/2020
	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	•	30.10.2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 755	Continued From pag	ge 226	F 7	55		
	drugs and biological them under an agree §483.70(g). The fact personnel to administ permits, but only und a licensed nurse.  §483.45(a) Procedur pharmaceutical serve that assure the accurdispensing, and adhibiologicals) to meet §483.45(b) Service of must employ or obtain pharmacist who-	vide routine and emergency s to its residents, or obtain				
		lishes a system of records of on of all controlled drugs in nable an accurate				
	order and that an acis maintained and portion of this REQUIREMENT by:  Based on staff inter and clinical record rethe facility staff failed prescribed medication.	mines that drug records are in acount of all controlled drugs eriodically reconciled.  T is not met as evidenced view, facility document review eview, it was determined that do to ensure physician on were available for dered for one of 50 residents				

		l ` ′		, ,	(X3) DATE SURVEY COMPLETED	
	495140	B. WING			C 03/10/2020	
			STREET ADDRESS, CITY, STATE, ZIP COD 110 CHALMERS COURT BERRYVILLE, VA 22611		3/10/2020	
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION	I SHOULD BE	(X5) COMPLETION DATE	
in the survey sample, 12/31/19, the facility semedication trazadone because the medication pharmacy.  The findings include:  Resident #18 was ad 12/14/18. Resident # were not limited to de major depressive discannual MDS (minimu with an ARD (assessi 12/10/19, coded the redaily decision-making).  Review of Resident # a physician's order da 25 mg (milligrams) by medication was scheated administration record (licensed practical nutrazodone was administration administration administration administration administration further documental administration of trazeroscient #18's comp 12/18/18 documented complications associal	Resident #18. On staff failed to administer the e (1) to Resident #18 ion was on order from the e (1) to Resident #18 ion was on order from the e (1) to Resident #18 ion was on order from the e (1) to Resident #18 ion was on order from the e (1) to Resident #18 ion was ender the ended to the end ended to the end ended to the end end end end end end end end end en	F 75	55			
	CORRECTION  ROVIDER OR SUPPLIER  L HEALTH AND REHAB  SUMMARY ST. (EACH DEFICIENC REGULATORY OR I)  Continued From page in the survey sample, 12/31/19, the facility smedication trazadone because the medicati pharmacy.  The findings include:  Resident #18 was ad 12/14/18. Resident # were not limited to de major depressive discannual MDS (minimu with an ARD (assessi 12/10/19, coded the redaily decision-making)  Review of Resident # a physician's order da 25 mg (milligrams) by medication was schered administration record (licensed practical nutrazodone was administration record (licensed practical nutrazodone was administration administration administration administration administration administration administration of trazeromplications associated in the MAR. LPN #11 double Complication administration of trazeromplications associated in the material decomplications related to the complications related to the complication related to the complications related to the complication related t	A95140  ROVIDER OR SUPPLIER  L HEALTH AND REHAB  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 227  in the survey sample, Resident #18. On 12/31/19, the facility staff failed to administer the medication trazadone (1) to Resident #18 because the medication was on order from the pharmacy.  The findings include:  Resident #18 was admitted to the facility on 12/14/18. Resident #18's diagnoses included but were not limited to dementia, high cholesterol and major depressive disorder. Resident #18's annual MDS (minimum data set), assessment with an ARD (assessment reference date) of 12/10/19, coded the resident's cognitive skills for daily decision-making as moderately impaired.  Review of Resident #18's clinical record revealed a physician's order dated 11/7/19 for trazodone 25 mg (milligrams) by mouth at bedtime. The medication was scheduled for 8:00 p.m. on Resident #18's December 2019 MAR (medication administration record). On 12/31/19, LPN (licensed practical nurse) #11 failed to document trazodone was administered to Resident #18 on the MAR. LPN #11 documented the code, "7= Other/ See Nurse Notes." An eMAR (electronic medication administration record) note regarding trazodone and dated 12/31/19 documented, "Waiting to be sent from pharmacy." There was no further documentation regarding the administration of trazodone on 12/31/19.  Resident #18's comprehensive care plan dated 12/18/18 documented, "Potential for drug related complications associated with use of psychotropic medicationProvide medications as ordered by	A BUILDING  A SOVIDER OR SUPPLIER  L HEALTH AND REHAB  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 227  In the survey sample, Resident #18. On 12/31/19, the facility staff failed to administer the medication trazadone (1) to Resident #18 because the medication was on order from the pharmacy.  The findings include:  Resident #18 was admitted to the facility on 12/14/18. Resident #18's diagnoses included but were not limited to dementia, high cholesterol and major depressive disorder. Resident #18's annual MDS (minimum data set), assessment with an ARD (assessment reference date) of 12/10/19, coded the resident's cognitive skills for daily decision-making as moderately impaired.  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Resident #18's comprehensive care plan dated 12/18/18 documented, "Potential for drug related complications associated with use of psychotropic medicationProvide medications as ordered by	ROUNDER OR SUPPLIER  L HEALTH AND REHAB  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  COntinued From page 227  In the survey sample, Resident #18. On 12/31/19, the facility staff failed to administer the medication trazadone (1) to Resident #18 because the medication trazadone (1) to Resident #18 because the medication was on order from the pharmacy.  The findings include:  Resident #18 was admitted to the facility on 12/14/18. Resident #18's diagnoses included but were not limited to demential, high cholesterol and major depressive disorder. Resident #18's annual MDS (minimum data set), assessment with an ARD (assessment reference date) of 12/10/19, coded the resident's cognitive skills for daily decision-making as moderately impaired.  Review of Resident #18's clinical record revealed a physician's order dated 11/7/19 for trazodone 25 mg (milligrams) by mouth at bedtime. The medication was scheduled for 8:00 p.m. on Resident #18's December 2019 MAR (medication administration record). On 12/31/19, LPN (licensed practical nurse) #11 failed to document trazodone was administration record) note regarding trazodone and dated 12/31/19 documented, "Wating to be sent from pharmacy." There was no further documentation regarding the administration of trazodone on 12/31/19.  Resident #18's comprehensive care plan dated 12/18/18 documented, "Voltaniia for drug related complications associated with use of psychotropic medicationProvide medications as ordered by	A BUILDING  A BUILDING  B. WIND  STREET ADDRESS, CITY, STATE 2IP CODE  10 CHALMERS COURT BERRYVILLE, VA 22611  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY IFUL REGULATORY OR LSC IDENTIFYING INFORMATION)  COntinued From page 227  In the survey sample, Resident #18. On 12/31/19, the facility staff failed to administer the medication trazadone (1) to Resident #18 because the medication was on order from the pharmacy.  The findings include:  Resident #18 was admitted to the facility on 12/14/18. Resident #18's diagnoses included but were not limited to dementia, high cholesterol and major depressive disorder. Resident #18's annual MDS (minimum data set), assessment with an ARD (assessment reference date) of 12/10/19, coded the resident's cognitive skills for daily decision-making as moderately impaired.  Review of Resident #18's clinical record revealed a physician's order dated 11/7/19 for trazodone 25 mg (milligrams) by mouth at bedtime. 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		495140	B. WING _			C 03/10/2020
	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	'	33/13/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 755	Continued From pag	e 228	F 7	55		
	(a box containing value available for administration and some conducted with LPN process for ensuring administration as progre-orders medication ten tablets are left at LPN #5 stated if a madministration and some dication, she compossible, obtains the up" box. LPN #5 stated is not available in the contacts the pharma medication to be immore practitioner to pharmacy. LPN #5 and administers the follow up note that the Con 3/9/20 at 5:57 p. conducted with LPN #18's medication ad LPN #11 stated it had 12/31/19 and he couthe pharmacy or if he Resident #18 on thad	#5 regarding the facility medication is available for escribed. LPN #5 stated she is from the pharmacy when vailable for administration. edication is scheduled for the cannot find the tacts the pharmacy and if emedication from the "back sted if the needed medication the "back up" box then she cy and asks for the mediately sent or asks the call in an order to the local stated that after she obtains medication, she documents a the medication was given.  m., a telephone interview was #11 regarding Resident ministration on 12/31/19. d been a while since alld not recall if he contacted the administered trazodone to t date.				
	member) #1 (the exedirector of nursing) a	m., ASM (administrative staff ecutive director), ASM #2 (the and ASM #3 (the regional ervices) were made aware of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		495140	B. WING			03/	10/2020
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			11	TREET ADDRESS, CITY, STATE, ZIP CODE 10 CHALMERS COURT ERRYVILLE, VA 22611		
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F 755	Continued From page The facility pharmacy Administration- Gene "1. Medications are awith written orders of The facility pharmacy RECEIVING NON-COMEDICATIONS" docurelated products are repharmacy on a timely No further information Reference: (1) Trazodone is used information was obtain https://medlineplus.got.label/Store Drugs and CFR(s): 483.45(g)(h)(s) §483.45(g) Labeling of Drugs and biologicals labeled in accordance professional principles appropriate accessory instructions, and the eapplicable. §483.45(h) Storage of	policy titled, "Medication ral Guidelines" documented, dministered in accordance the prescriber"  policy titled, "ORDER AND DNTROLLED imented, "Medications and eceived from the provider basis"  It to treat depression. This ned from the website: by/ency/article/002559.htm d Biologicals (1)(2)  of Drugs and Biologicals aused in the facility must be a with currently accepted s, and include the y and cautionary expiration date when	F	755		ΤΕ	DATE
	Federal laws, the faci biologicals in locked of	ordance with State and lity must store all drugs and compartments under proper and permit only authorized cess to the keys.					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			' '	(X3) DATE SURVEY COMPLETED	
		495140	B. WING _			C 03/10/2020		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		03/10/2020	
					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 CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 761	Continued From page		F7	761	1			
	, , , ,	cility must provide separately						
		affixed compartments for						
		drugs listed in Schedule II of						
		Orug Abuse Prevention and						
		nd other drugs subject to he facility uses single unit						
		ition systems in which the						
		imal and a missing dose can						
	be readily detected.							
		is not met as evidenced						
	by:							
		n and staff interview it was						
		aff failed to ensure expired						
		ogical's were not available						
		medication carts observed,						
		d North Unit one medication						
	cart), and one of one	t medication rooms. On the						
		dication cart 2 bottles of						
		ere observed available for						
		ulfate (mineral supplement)						
		th "Best by 12/19" labeled on						
	_ , _ ,	en) oz. (ounce) bottle of						
	Geri-mucil fiber laxati	ve and dietary supplement						
	•	n the bottle. On the North						
		I (one) eleven plastic vials of						
		alation solution 0.083%						
	(percent) 2.5mg (milli							
		: Sep 2019, were available e medication room located						
		he facility, nine containers of						
		arb steady 1.8cal (calorie)						
		eeding) with "use before 1						
		ed on the top shelf of the						
	storage cabinet.	•						
	The findings include:							

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		495140	B. WING			C 03/10/2020	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 110 CHALMERS COURT BERRYVILLE, VA 22611		33,10,2023	
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 761	with LPN (licensed predication room local facility. Observation revealed 9 (nine) 100 Nepro with Carb steath hang tube feeding) lostorage cabinet. The contain "use before 1 the bottle. When ask bottle meant, LPN #1 feeding expired on 12 been discarded. LPN have any residents uhad been overlooked available for use in the central supply stocks double checks all suppull out prior to taking ensure they are in dated on 3/9/20 at 4:35 p.n with LPN (license premedication carts local facility. Observation revealed a bottle of 1 (mineral supplement) labeled on the bottle on the bottle meant, I tablets expired in Dechave been thrown awaintained the suppl LPN #7 stated that the p.m 7:00 a.m.) shift and she checked it exhave been overlooke the yellow medication (ounce) bottle of Geri	n., an observation was made ractical nurse) #1 of the sted on the South Unit of the of the medication room 10 ml (milliliter) containers of dy 1.8cal (calorie) (ready to cated on the top shelf of the e package was observed to Dec 2019" on the neck of sed what the date on the stated that it meant that the 2/1/2019 and should have W #1 stated that they do not sing this type of feeding so it LPN #1 stated that it was see medication room and that the room and nursing oplies and medications they gother with the room to	F 76	51			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G	· ,	(X3) DATE SURVEY COMPLETED	
		495140	B. WING			C 3/40/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 110 CHALMERS COURT BERRYVILLE, VA 22611		3/10/2020
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F 761	hand written dated of the bottle. When ask stated that the "11-2-been opened by the 2019 and that the "03 expiration date which had expired on Septe that it had been over checks.  On 3/9/20 at 4:45 p.r medication carts local facility were conducted of the medication cart (eleven) plastic vials liquid medication) in Sulfate inhalation solincrease air flow to lu 2.5mg (milligram)/3m observed to be labeled asked what the date meant that the medic of 2019 and should held #7 stated that it must during the cart check.  On 3/9/20 at approximal was made by written staff member) #1, the facility policy on main medication carts and on 3/10/20 at 10:40 director of clinical sed did not have a policy the medication carts.	is observed to contain a  f "11-2-19" on the top lid of feed about the dates, LPN #7 19" meant that the bottle had facility staff on November 2, 19/19" was the manufacturer's meant that the medication ember 2019. LPN #7 stated looked in the medication cart  In. further observation of the sted on the North Unit of the ed with LPN #7. Observation to 1 (one) revealed 11 (small container holding a box labeled "Albuterol ution (medication used to lungs) 0.083% (percent) fill (milliliter)." The box was fied "Exp: Sep 2019." When meant, LPN #7 stated that it faction expired in September lave been discarded. LPN to have been overlooked first.  mately 6:55 p.m., a request list to ASM (administrative first executive director for the intaining and stocking	F 76	51		

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		495140	B. WING _			03/	10/2020
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			1	TREET ADDRESS, CITY, STATE, ZIP CODE 10 CHALMERS COURT ERRYVILLE, VA 22611		
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F 761	Williams and Wilkins and page 174, "Always not the date after which it potency. Never admit drugdiscard any druexpiration date"  On 3/9/20 at approximation of the second s	entals of Nursing Lippincott 2007, Lippincot Company, ote a drug's expiration date - loses some amount of nister an outdated ag that has reached its	F	761			
F 812 SS=E	, , , ,		F	312			
	§483.60(i)(2) - Store, serve food in accorda	prepare, distribute and nce with professional					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 812	by: Based on observation document review it we failed to prepare food sanitary manner and manner in two of two The findings include: On 03/08/2020 at 11: the facility's kitchen we [other staff member] at the following results: An observation of OS they were preparing rekitchen without their real than the facility's changing their gloves Observation on 03/08 nutritional room with coordinator at 4:00p. It container containing the refrigerator. Furth slices of cheesecake on top of the cheese of these food items fadate on the items. Of food is placed in the rethat it should be dated	rvice safety.  Is not met as evidenced  In, staff interview, and facility as determined facility staff in the facility's kitchen in a store food in a sanitary nutritional rooms.  45 a.m., an observation of vas conducted with OSM # 1, dietary manager with  IM # 3, dietary aide, revealed resident lunch trays in the mustache covered.  IM # 2, cook, revealed they rolls with gloved hands after salad dressings that had dry storage room without  IN # 1, fine dining m., revealed a plastic reight slices of cheesecake in the observation revealed two wrapped in a napkin sitting take container. Observation siled to evidence a name or SM # 1 stated that when nutritional room refrigerators d and have a name on it. In removed the cheesecake	F	812			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED		
		495140	B. WING	B. WING		03/10/2020	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 110 CHALMERS COURT BERRYVILLE, VA 22611		33,13,2323	
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 812	nutritional room with a coordinator at 4:05 p. a 15 ounce can, without refrigerator. Observations ix flavored ice-pops name or date on the state when food is place refrigerators that it shows name on it. OSM #1 six flavored ice-pops in a trashcan.  On 03/08/2020 at 2:4 conducted with OSM and OSM #2, cook. 3's mustache not beint that all facial hair shows asked why gloves we residents' food, OSM prevent cross contains #1 was informed of the handling the dinner row handling the packets stated that they show to serve the rolls or how wrapped.  The facility's policy "Spart, "1. All staff mem the shoulders, confined facial hair properly retails of the facility policy, "For the facility policy," "For the facili	B/2020 of the north unit's OSM # 1, fine dining m., revealed sliced peaches out a name or date in the ation of the freezer revealed and a popsicle without a food items. OSM # 1 stated are did in the nutritional room ould be dated and have a immediately removed the and a popsicle and placed it  O p.m., an interview was # 1, fine dining coordinator When asked about OSM # ng covered OSM # 1 stated and be covered. When are worn when plating the # 2 stated that it was to be initiation. At this time, OSM he observation of OSM # 2 olls with their hands after of salad dressing OSM # 2 olls with their hands after of salad dressing OSM # 2 old have used a pair of tong and them individually  Staff Attire" documented in the swill have their hair off and in a hair net or cap, and strained."	F 81				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		E SURVEY IPLETED
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		495140	B. WING _	<del>-</del>	o:	3/10/2020
	ROVIDER OR SUPPLIER  L 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 SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 812	The facility policy "Sn "3. Snacks will be as in accordance with the each resident and the patient care areas in a On 03/09/2020 at app [administrative staff m director, ASM # 2, dir 3, clinical services sp the findings.  No further information Infection Prevention 8	acks" documented in part, sembled, labeled, and dated e individual plan or care for ose items will be delivered to a timely manner."  proximately 6:55 p.m., ASM nember] # 1, the executive ector of nursing, and ASM # ecialist were made aware of a was provided prior to exit.	F 8			
SS=E	development and trar diseases and infection §483.80(a) Infection program. The facility must esta and control program (a minimum, the follow §483.80(a)(1) A systereporting, investigatin and communicable distaff, volunteers, visitiproviding services un arrangement based u	ntrol blish and maintain an and control program a safe, sanitary and ment and to help prevent the asmission of communicable ans.  prevention and control blish an infection prevention (IPCP) that must include, at ving elements:  em for preventing, identifying, and controlling infections seases for all residents, ors, and other individuals der a contractual upon the facility assessment to §483.70(e) and following				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING	COMPLETED
495140 B. WING	C <b>03/10/2020</b>
NAME OF PROVIDER OR SUPPLIER  ROSE HILL HEALTH AND REHAB  STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	03/10/2020
(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 TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIES OF THE PROPRIES OF TH	D BE COMPLETION
\$483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:  (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;  (ii) When and to whom possible incidents of communicable disease or infections should be reported;  (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;  (iv)When and how isolation should be used for a resident; including but not limited to:  (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and  (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.  (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and  (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.  §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.  §483.80(e) Linens.  Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495140	B. WING		C 03/10/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	03/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 880	IPCP and update the This REQUIREMENT by:  Based on observate document review are was determined that implement infection storage of a C-PAP in the survey sample laundry room and infacility's main dining to store Resident #6 positive airway preseprevent infection. To maintain the clean I sanitary manner. Dobserved on the movents and support be service in the main approximately 12:10 assistant) #1 was of food items, without worn while touching serving trays, and serving trays, and serving trays, and serving trays	duct an annual review of its duct an annual review, facility and clinical record review, it duct facility staff failed to control practices for the mask for one of 50 residents e, Residents # 61; in the none of two dining rooms, (the groom). The facility staff failed 61's CPAP [continuous assure] mask in a manner to the facility staff failed to aundry area in a clean and bust, dirt and lint were etal overhead conduit piping, beams. During the lunch meal dining room on 3/8/20 at 0 p.m., CNA (certified nursing bserved touching resident changing gloves that were ground the stands.	F 88		

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495140	B. WING		C 03/10/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	03/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 880	Treatments, Proced # 61 was coded as  On 03/08/20 at 3:20 Resident # 61's rool laying on top of the  On 03/08/20 at 4:44 Resident # 61's rool laying on top of the  On 03/09/20 at 8:29 Resident # 61's rool laying on top of the  The POS [physician for Resident # 61 fathe use of the C-PA  The comprehensive dated of 11/26/2019 for the use of the C-  On 03/09/2020 at a interview was conducted with EPA Resident # 61 state past 15 years."  On 03/09/20 at 4:38 conducted with LPA regarding the storag in use. LPN # 5 state should be covered to the conducted with LPA regarding the storag in use. LPN # 5 state should be covered to the conducted with LPA regarding the storag in use. LPN # 5 state should be covered to the conducted with LPA regarding the storag in use. LPN # 5 state should be covered to the conducted with LPA regarding the storag in use. LPN # 5 state should be covered to the conducted with LPA regarding the storag in use. LPN # 5 state should be covered to the conducted with LPA regarding the storag in use. LPN # 5 states and the covered to the conducted with LPA regarding the storag in use. LPN # 5 states and the covered to the conducted with LPA regarding the storag in use. LPN # 5 states and the covered to the conducted with LPA regarding the storag in use. LPN # 5 states and the covered to the conducted with LPA regarding the storag in use.	ures and Programs" Resident having a C-PAP.  p.m., an observation of m revealed a C-PAP mask bedside table uncovered.  p.m., an observation of m revealed a C-PAP mask bedside table uncovered.  a.m., an observation of m revealed a C-PAP mask bedside table uncovered.  a.m., an observation of m revealed a C-PAP mask bedside table uncovered.  's order sheet] dated 03/2020 iled to evidence an order for P machine.  care plan for Resident # 61 failed to evidence an order	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION  B		(X3) DATE SURVEY COMPLETED	
		495140	B. WING			C	
NAME OF PROVIDER OR SUPPLIER  ROSE HILL HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611		03/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 880	conducted with LPN [CPAP mask] should On 03/09/2020 at a [administrative staff director, ASM # 2, 0 3, regional director made aware of the staff director and aware of the staff director of made aware of the staff of the staff director of made aware of the staff of the staff member of t	# 5. LPN #5 stated that it d have been placed in a bag.  pproximately 6:55 p.m. ASM member] # 1, executive lirector of nursing, and ASM # of clinical services, were	F 88				

1 1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COMPLETED	
		495140	B. WING		03/10/2020	
	ROVIDER OR SUPPLIER	В		STREET ADDRESS, CITY, STATE, ZIP CODE I10 CHALMERS COURT BERRYVILLE, VA 22611	7 33/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 880	and lint was really to On 3/9/20 at 7:07 p member) #1 (the extended director of nursing) director of clinical signs the above concern.  On 3/10/20 at 10:40 stated the facility director of clinical signs the above concern.  On 3/10/20 at 10:40 stated the facility director of clinical signs the clean laundry at the conducted in the maximum transfer of the dining room. Challed the consisting of the dining room. Challed the clean laundry at the dining room. Challed the containing the plate stand and served the containing the plate stand and served the containing open the gloved fingers at plate, including open the gloved fingers at the containing service of the containing open the gloved fingers at the containing open the gloved fingers at the containing open the gloved fingers at the containing the plate stand and served the gloved fingers at the containing open the gloved fingers at the containing open the gloved fingers at the containing the plate stand and served the gloved fingers at the containing open the gloved fingers at the containing the gloved fingers at the contain	ated the amount of dust, dirt oad.  .m., ASM (administrative staff eccutive director), ASM #2 (the and ASM #3 (the regional ervices) were made aware of  0 a.m., ASM #1 and ASM #3 d not have a policy regarding	F 880			

` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	MULTIPLE CONSTRUCTION  JILDING		(X3) DATE SURVEY COMPLETED	
		495140	B. WING _			C 03/10/2020	
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611		03/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 880	Continued From pag	e 242	F 8	80			
	applying the butter we picked up the empty hands, and carried it door and returned the member.  CNA #1 then moved to the next table to be retrieved a second seplates of food with the on the folding serving continued to serve the table using her general rolls and butter them picked up the empty hands and carried it	g her gloved fingers and with a knife. CNA #1 then serving tray with the gloved back to the kitchen service e tray to a kitchen staff  the folding serving tray stand e served. CNA #1 then erving tray containing three e gloved hands and placed it g tray stand. CNA #1 the three residents seated at loved fingers to open the with a knife. CNA #1 then serving tray with the gloved back to the kitchen service he tray to a kitchen staff					
	to the next table to be retrieved a third serve of food with the glove folding serving tray is serve the two resides her gloved fingers to them with a knife. On the serving tray with the back to the kitchen is tray to a kitchen staff.  The last resident was p.m. CNA #1 did not after serving residen serving trays, folded stand and touched metals.	the folding serving tray stand e served. CNA #1 then ing tray containing two plates ed hands and placed it on the tand. CNA #1 continued to ints seated at the table using open the rolls and butter NA #1 then picked up the gloved hands, and carried it ervice door and returned the finember.  It is served their lunch at 12:49 it change the gloves donned it drinks. CNA #1 touched and moved the serving tray nultiple resident food items, wearing the same pair of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
		495140	B. WING _		0	C <b>3/10/2020</b>
	ROVIDER OR SUPPLIER  L HEALTH AND REHAE		,	STREET ADDRESS, CITY, STATE 110 CHALMERS COURT BERRYVILLE, VA 22611		9.10.2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTI' CROSS-REFERENCE	LAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 880	observation in the diresident food is hand gloves are worn when When asked what el prior to touching the gloves have touched holder. CNA #1 stattaught to use gloves had never thought at then touching the role contaminated from the kitchen cleans the uses but she would upon the rolls and apusing her fingers to coross contamination.  On 3/9/20 at approximas made by written staff member) #1, the facility policy on service.  On 3/10/20 at 10:40 director of clinical sedid not have a policy room and that the faserving food to resid.  On 3/9/20 at approximate the executive director of clinical services were clinical ser	m., an interview was #1 regarding the lunch ning room. When asked how lled, CNA #1 stated that In handling things like rolls. Is the gloves have touched rolls, CNA #1 stated that the It the plates, trays and tray led that they have been when serving food and she boout touching the trays and lis but that they would be the trays. CNA #1 stated that the trays on the inside between use a fork in the future to oply the butter rather than open the rolls to prevent any	F	380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		PLE CONSTRUCTION  B	· ,	COMPLETED	
		495140	B. WING		,	C 03/10/2020	
NAME OF PROVIDER OR SUPPLIER  ROSE HILL HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611		03/10/2020		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 883 F 883 SS=D	CFR(s): 483.80(d)(1 §483.80(d) Influenza immunizations §483.80(d)(1) Influe policies and procedu (i) Before offering the each resident or the receives education repotential side effects (ii) Each resident is immunization Octobe annually, unless the contraindicated or the immunized during the (iii) The resident or thas the opportunity (iv) The resident or that following:  (A) That the resident was provided educated and potential side edimmunization; and (B) That the residen immunization or did immunization or did immunization due to refusal.  §483.80(d)(2) Pneumust develop policie that- (i) Before offering the immunization, each	mococcal Immunizations )(2) a and pneumococcal mza. The facility must develop ures to ensure that- e influenza immunization, resident's representative regarding the benefits and s of the immunization; offered an influenza er 1 through March 31 immunization is medically re resident has already been resident has already been resident's representative refuse immunization; and redical record includes redical contraindication or redical contraindications or receive the influenza redical contraindications or record disease. The facility resident or the resident's resident or the resident's rese education regarding the	F 88				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495140	B. WING		C 03/10/2020	
	ROVIDER OR SUPPLIER	В		STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611	1 00/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION	
F 883	immunization, unless medically contraind already been immu (iii) The resident or has the opportunity (iv)The resident's medicumentation that following:  (A) That the resider was provided education and potential side eximmunization; and (B) That the resider pneumococcal immunication or This REQUIREMENT by:  Based on staff intered and clinical record in the facility staff failed pneumococcal immunifluenza and pneumococcal in the pneumococcal immunifluenza and pneumococcal in the pneumococcal immunifluenza and pneumococcal i	offered a pneumococcal as the immunization is icated or the resident has nized; the resident's representative to refuse immunization; and redical record includes indicates, at a minimum, the action regarding the benefits affects of pneumococcal and retitle received the unization or did not receive mmunization due to medical refusal.  In it is not met as evidenced arview, facility document review review, it was determined that and to administer the unization for one of five mococcal resident #7 to receive mmunization was obtained on illity staff failed to administer	F 883			

I ' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		495140	B. WING			C 03/10/2020
	OVIDER OR SUPPLIER . HEALTH AND REHAE	3		STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611	l	00/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	pneumococcal vacci 10/5/19, that was sign documented Resided pneumococcal vacci. Further review of Resident review of Resident failed to reveal evide immunization was possible of the immunization was possible of the immunization, resident does wish the nurses make sure to the immunization, admin documents the immunization, immunization, admin documents the immunization and in effects.  Review of Resident Resident #7's only of penicillin (antibiotics) on 3/9/20 at 7:07 p. member) #1 (the exident penicided penici	#7's clinical record revealed a ine consent form dated gned by two nurses and ent #7 did wish to receive the ine (immunization).  Resident #7's clinical record, er 2019 medication d, October 2019 nurses' #7's immunization record ence that the pneumococcal rovided to the resident.  m., an interview was a (licensed practical nurse) #5, or process for administering the unization. LPN #5 stated idents are provided a consent zation. LPN #5 stated if a or receive the immunization, are the resident is not allergic to obtains an order for the inisters the immunization, unization administration in the monitors the resident for side  #7's clinical record revealed locumented allergies was	F 88	33		

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 _			C
	ROVIDER OR SUPPLIER  L HEALTH AND REHAB	450140		STREET ADDRESS, CITY, STATE, ZIP CODE  110 CHALMERS COURT  BERRYVILLE, VA 22611		03/10/2020
(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 COR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 883	On 3/10/20 at 9:47 a. conducted with LPN # signed Resident #7's consent form on 10/5 could not provide any Resident #7 and the pimmunization.  The facility policy title Vaccinations" docume admitted to the facility opportunity to receive pneumococcal vaccin The vaccine should b (medication administr	m., an interview was #1, one of the nurses who pneumococcal vaccine /19. LPN #1 stated she information regarding oneumococcal  d, "Pneumococcal ented, "All residents / will be given the to receive the e per physician's order9. e documented on the MAR	F8	383		