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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 06/02/2022

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

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E 000	Initial Comments An unannounced Emergency Preparedness COVID-19 Focused Survey was conducted 5/31/22 through 6/2/22. The facility was in substantial compliance with E0024 of 42 CFR Part 483.73, Requirement for Long Term Care Facilities. The census in this 120 certified bed facility was 105 at the time of the survey. The survey sample consisted of 6 current resident reviews and 3 closed record reviews.	E 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken, or is planning to take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been, or are to be corrected by the date or dates indicated.	
F 000	INITIAL COMMENTS An unannounced Medicare / Medicaid abbreviated survey was conducted 5/31/22 through 6/2/22. Two complaints was investigated during the survey (VA00055270-substantiated and VA00054128-unsubstantiated). Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The census in this 120 certified bed facility was 105 at the time of the survey. The survey sample consisted of 6 current resident reviews and 3 closed record reviews.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 684	1) Resident #3 no longer resides in the facility. 2) Current Residents in the facility had skin assessments completed by administrative nursing and any areas identified were addressed at the time of discovery. 3) DNS/Designee provided education to licensed nurses on providing care and services to wounds when they are identified on admission. 4) New admission charts will be reviewed in clinical start up by DNS/Designee to ensure any skin issue has a physician ordered treatment. Random skin audits will be performed on new admissions x4 weeks to ensure corresponding treatment order if indicated. All findings reported to QAPI committee monthly for further action if necessary.	6/21/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Luis Jimenez	Administrator	6/13/2022

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

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F 684	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review, and in the course of a complaint investigation, it was determined that the facility staff failed to provide care and services for wounds for 1 of 9 residents in the survey sample; Resident #3. For Resident #3 the facility staff failed to evidence that routine wound care and services were provided during the resident's 7 days at the facility. The wounds were documented as being assessed and treated only once and no orders were in place for treatments for the 7 days the resident was at the facility. The findings include: Resident #3 was admitted to the facility on 12/24/21 and discharged AMA (against medical advice) on 12/30/21. On the 5-day MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/28/21, Resident #3 scored a 15 out of 15 on the BIMS (Brief Interview for Mental Status exam) which indicated the resident was cognitively intact in ability to make daily life decisions. Resident #3 was coded as being independent for eating and required extensive to total care for all other areas of activities of daily living. A hospital summary dated 12/22/21 documented the resident was admitted to the hospital on 12/20/21 and had "Peripheral arterial disease, not able to palpate pedal pulses (chronic), chronic non healing stasis wounds..." The note did not identify the number of and location of wounds	F 684		

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F 684	Continued From page 2 other than being on bilateral lower extremities. A review of the facility admission documentation "Admission Data Collection" tool dated 12/24/21 documented a wound of the right inner ankle as "excoriated/reddened and open" and a wound of the left inner ankle "excoriated, reddened and open." No measurements or stages were documented. No other wound areas were documented. Resident #3's baseline care plan dated 12/24/21 included: "Your initial goals: Wound care, COVID (+)." Under "Resident goals on admission" was documented a quote by the resident as documented by facility staff, "Get stronger and my wounds better." Under "Skin Care Needs" was documented, "Other Skin Concerns: Vascular wounds to bil (bilateral) (down arrow for 'lower') legs." A review of the nurse's notes revealed one dated 12/28/21 that documented, "This nurse did skin assessment on this resident and [resident] has multiple open areas to BLE (bilateral lower extremities). Treatment implemented. Wound Consult. Drop foot bilateral. DX (diagnosis): Muscular dystrophy. Left lateral knee, L (left) posterior lower leg cluster of 2, Left lateral ankle and right lateral ankle. Right posterior lower leg cluster of 2. Dressings dry and intact." A review of the physician's orders revealed one dated 12/24/21 for weekly skin assessments. The assessment due on 12/29/21 was documented as being completed.	F 684		

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F 684	Continued From page 3 None of the above wounds other than the ankles were identified at admission. There was no identification of wound types, measurements, staging (if applicable) or descriptions of each wound documented. There was no evidence of treatment orders or a wound consult located in the clinical record. Other than the above note and the above weekly assessment, there was no evidence that at any other time during the resident's 7 days at the facility of any other wound evaluations, treatments, or orders for any wound care. The weekly assessment was documented as initials on the Treatment Administration Record, and there was no note that documented what, if any, wound areas were identified or any treatments. On 6/2/22 at 11:54 AM an interview was conducted with LPN #2 (Licensed Practical Nurse) who was the wound care nurse that wrote the above note dated 12/28/21. They stated that they could not recall anything regarding the type, size, staging, or appearance of the wounds. LPN #2 stated that the resident was admitted on a Friday (12/24/21) on the evening shift after LPN #2 had left for the day, and that LPN #2 did not get to see the resident until returning to work on "Monday or Tuesday" (12/27/21 to 12/28/21). LPN #2 stated that on the day they evaluated the resident's wounds, that afterwards, before they were able to enter any orders or anything else into the medical record about the wounds, for any assessments and treatments, other than the above note, that LPN #2 started feeling bad, and was immediately tested and shown to be positive for COVID-19 and had to leave the facility. LPN #2 stated that they turned the chart over to the Assistant Director of Nursing to complete the orders and paperwork (who was no longer at the	F 684		

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facility), but that it was never done. LPN #2 stated that by the time they returned to work after quarantine for COVID-19, the resident had already left. The one note on 12/28/21 was the only time LPN #2 had assessed the resident's wounds, and without the orders being entered, no one else was doing any assessments and treatments of the wounds.

Further review of the clinical record revealed a social services note dated 12/30/21 that documented, "Received phone call from resident [family member], that [family member] was currently on the way to pick [resident] up to take [resident] home. When arrived we sat down with nursing staff so we could explain the risk of leaving against medical advice (AMA). Family member agreed it was not safe for [resident] to return home, which would to be to live by [them]self. I explained this to resident as well. Resident stated [resident] is still going home regardless. Resident signed AMA form."

On 6/2/22 at 1:03 PM an interview was conducted with OSM #2 (Other Staff Member) the social services assistant that wrote the above note. OSM #2 stated that Resident #3 stated that everything they were getting at facility they could have gotten at home and that they were very upset about some bandages on their legs. OSM #2 stated that the resident's concern was the facility was not doing the dressing changes properly. OSM #2 stated they explained to the resident that the staff date the dressings every time they clean and change them and the resident said no one had been in to change the ones on their legs. OSM #2 stated that they saw the dressings and recalled one of the dressings being 2 days old and the other 2 dressings did not

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have dates on them. OSM #2 stated that they went and got 2 of the nurses to remove them and clean them because the resident was leaving AMA and said that at the least the facility could do was change them before the resident left. OSM #2 stated that was the only thing the resident was really upset about.

On 6/2/22 at 1:10 PM an interview was conducted with LPN #3 who was involved in the wound care on the day of discharge. LPN #3 stated that there was a second nurse that actually did the dressing change (who was no longer at the facility), so LPN #3 did not see the dressing that was removed and if it was dated. LPN #3 stated their part was to hold the resident's leg up to assist with the dressing changes. LPN #3 was not able to state anything regarding the condition of the old dressing or if the old dressing was dated.

The facility "Wound Prevention Program" was reviewed. This policy documented under "Skin Program" on page 3, "...A licensed nurse will complete a total body assessment on each resident on admission and weekly...All open areas will be identified and documented on the appropriate forms...Resident(s) with wounds will have appropriate treatment..."

On 6/2/22 at 4:00 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2, the Director of Nursing, ASM #3 the Regional Director of Clinical Services, and ASM #4, the Regional Vice President were made aware of the findings. No further information was provided.

COMPLAINT DEFICIENCY