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 ______	06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 06/27/2023 through 06/29/2023. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 6/27/2023 through 6/29/2023. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. No complaints were investigated during the survey. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 104 at the time of the survey. The survey sample consisted of 31 current resident reviews and four closed record reviews.	F 000		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.	F 552		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marc A. [illegible] TITLE: ADMINISTRATOR (X6) DATE: 7-25-2023

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 552	Continued From page 1 §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to inform a resident/resident representative of the risks and benefits of medication treatment for one of 35 residents in the survey sample, Resident #5. The findings include: For Resident #5 (R5), the facility staff failed to inform the resident/resident representative of the risks and benefits for the use of the anti-psychotic medication Seroquel (1). R5 was re-admitted to the facility on 12/27/22 with a diagnosis of schizoaffective disorder and a physician's order for Seroquel 50 mg (milligrams) in the morning and 25 mg in the evening. A review of R5's clinical record failed to reveal that the facility staff informed the resident or the resident's representative of the risks and benefits for the use of Seroquel. On 6/29/23 at 9:38 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated that any time anti-psychotic medication is initiated, the staff should ask the resident or resident representative to sign a consent form. RN #1 stated the form contains information such as the name of the medication, the reason the medication is prescribed, and the side effects that are associated with the medication.	F 552	F552 1) Resident #5 representative was informed of risk and benefits of anti-psychotic medication Seroquel 2) An audit of current residents on antipsychotic medications completed to ensure resident/resident representative was informed of risks and benefits of medication. 3) The DON/designee provided re-education to licensed nurses on ensuring resident/resident representative is informed of risks and benefits of anti-psychotic medications. 4) Anti-psychotic medications will be audited weekly for 2 months to ensure resident/resident representative was informed of risks and benefits of medication treatment. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5) Compliance Date: 7/27/2023	

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F 552	Continued From page 2 Further review of R5's clinical record revealed a consent to use antipsychotic medication form that documented consent for the use of Seroquel; however, the form did not evidence R5, or the resident's representative was made aware of the reason the medication was prescribed or the risks and benefits. The sections to document the reason for the medication and acknowledgment that R5 or the resident's representative was made aware of potential side effects of the medication were blank. On 6/29/23 at 11:43 a.m., ASM (administrative staff member) #1 (the Executive Director) and ASM #2 (the interim Director of Nursing) were made aware of the above concern. The facility policy titled, "Chemical Restraint" failed to document information regarding the above concern. Reference: (1) Seroquel is used to treat schizophrenia. Side effects include but are not limited to fainting, falling, seizures, uncontrollable movements, fast or irregular heartbeat, confusion, hives, blisters and difficulty breathing or swallowing. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a698019.html	F 552		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process,	F 553		

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F 553	Continued From page 3 including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on family interview, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to invite the responsible party to the care plan meeting for one of 35 residents in the survey sample, Resident #100. The findings include: For Resident #100 (R100) the facility staff failed	F 553	F553 1) Resident #100 care plan meeting was scheduled with responsible party on 6/28/23 and was held 7/6/23. 2) Audit of current residents scheduled to have a care plan meeting in the next 30 days completed to ensure responsible party was invited to the care plan meeting. 3) The DON/designee provided re-education to Social Services on participation requirements of care plan meetings. 4) Care plan meeting schedule will be audited weekly for 2 months to ensure responsible party was invited. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5) Compliance Date: 7/27/2023	

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F 553	Continued From page 4 to invite the family member/responsible party, to the care plan meeting held on 6/6/2023. On the most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 6/5/2023, the resident scored a three out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired for making daily decisions. An interview was conducted on 6/27/2023 at approximately 1:00 p.m. with the family member/responsible party of R100. The family member stated she was told she would have monthly meetings with the facility regarding her father's plan of care, but she hadn't had any and her father had been there since 5/26/2023. The progress note dated, 6/6/2023 at 1:15 p.m. documented, "Care plan meeting conducted with patient. There were no concerns addressed." An interview was conducted with OSM (other staff member) #3, the director of social services, on 6/28/2023 at 3:34 p.m. When asked who sends the invitations for the care plan meetings, OSM #3 stated initially they were sent through the mail but she felt that wasn't efficient, so she's been calling the families to invite them. When asked if she called R100's family member to invite them to the care plan meeting held on 6/6/2023, OSM #3 stated, she thought she did. A request was made for the documentation of the call. OSM #3 was asked if a care plan meeting should be held with a resident with a BIMS of three, OSM #3 stated, "Now that I think about it, I did the care plan with (R100). I should have had her with R100 for the care plan meeting."	F 553		

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F 553	Continued From page 5 The facility policy, "Family Notification," documented in part, "It is the policy of this facility to: 1. Keep families informed. 2. Keep families involved." ASM (administrative staff member) #1, the executive director, ASM #2, the interim director of nursing, ASM #4, the regional clinical consultant and ASM #5, regional vice president of operations, were made aware of the above findings on 6/28/2023 at 5:30 p.m. No further information was provided prior to exit.	F 553		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives	F 578		

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F 578	Continued From page 6 and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to conduct a periodic review of advance directives with residents and/or their RRs (resident representatives) to determine if they wished to make changes to their existing advance directives or maintain them as written, for two of 35 residents in the survey sample, Residents #36 and #2. The findings include: 1. For Resident #36 (R36), the facility staff failed to conduct a periodic review of the resident's advance directives (1). R36 was admitted to the facility on 6/25/20. A review of R36's clinical record revealed medical power of attorney and durable power of attorney	F 578	F578 1) Resident #36 and #2 had a periodic review of their advance directive completed. 2) Current residents audited to ensure a periodic review of advance directives was completed with resident and/or their representative. 3) The DON/designee provided re-education to Social Services on advance directive review requirements. 4) Random audits of residents advance directives will be completed to ensure a periodic review was completed with resident and/or their representative weekly for 2 months. Results will be presented to QAPI monthly. Any noted trends will be addressed immediately. 5) Compliance Date: 7/27/2023	

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F 578	Continued From page 7 documents dated 3/15/2015. Further review of R36's clinical record failed to reveal a periodic review of all aspects of advance directives was conducted with R36 or the resident's representative. On 6/28/23 at 3:41 p.m., an interview was conducted with OSM (other staff member) #3 (the director of social services). OSM #3 stated she holds an advance directive discussion with residents and/or their representatives upon admission and during quarterly care plan meetings. OSM #3 stated the discussion consists of if the residents want cardiopulmonary resuscitation, artificial means of nutrition/hydration and artificial respiration. OSM #3 stated she does not document the discussions held in quarterly care plan meetings unless there are changes. On 6/29/23 at 11:43 a.m., ASM (administrative staff member) #1 (the Executive Director) and ASM #2 (the interim Director of Nursing) were made aware of the above concern. The facility policy titled, "Advance Directive-Admissions/Social Services" documented, "5. Advanced Directives will be reviewed at least annually..." Reference: (1) "What kind of medical care would you want if you were too ill or hurt to express your wishes? Advance directives are legal documents that allow you to spell out your decisions about end-of-life care ahead of time. They give you a way to tell your wishes to family, friends, and health care professionals and to avoid confusion later on.	F 578		

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A living will tells which treatments you want if you are dying or permanently unconscious. You can accept or refuse medical care. You might want to include instructions on
·The use of dialysis and breathing machines
·If you want to be resuscitated if your breathing or heartbeat stops
·Tube feeding
·Organ or tissue donation
A durable power of attorney for health care is a document that names your health care proxy. Your proxy is someone you trust to make health decisions for you if you are unable to do so." This information was obtained from the website: https://medlineplus.gov/advancedirectives.html

2. For Resident #2 (R2), the facility staff failed to conduct a periodic review of the resident's advance directives (1).

R2 was admitted to the facility on 6/22/19. A review of R2's clinical record revealed an advance medical directive form dated 2013 (the day and month was illegible). Further review of R2's clinical record failed to reveal a periodic review of all aspects of advance directives was conducted with R2 or the resident's representative.

On 6/28/23 at 3:41 p.m., an interview was conducted with OSM (other staff member) #3 (the director of social services). OSM #3 stated she holds an advance directive discussion with residents and/or their representatives upon admission and during quarterly care plan meetings. OSM #3 stated the discussion consists of if the residents want cardiopulmonary resuscitation, artificial means of nutrition/hydration and artificial respiration. OSM

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F 578	Continued From page 9 #3 stated she does not document the discussions held in quarterly care plan meetings unless there are changes. On 6/29/23 at 11:43 a.m., ASM (administrative staff member) #1 (the Executive Director) and ASM #2 (the interim Director of Nursing) were made aware of the above concern.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (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). (ii) 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,	F 580		

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F 580	Continued From page 10 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 update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to notify the physician of a possible need to alter treatment for two of 35 residents in the survey sample, Residents #51 and #2. The findings include: 1. For Resident #51 (R51), the facility staff failed to notify the physician when the medication Pradaxa (1) was not administered on 6/12/23 and 6/13/23. A review of R51's clinical record revealed a physician's order dated 12/3/19 for Pradaxa 150 mg (milligrams) two times a day for atrial fibrillation. A review of R51's June 2023 MAR	F 580	F580 1) Resident #51 and #2 physician notified of dose of medication not administered with no new orders to alter treatment. 2) Current residents audited to ensure medication was administered and/or Physician notification in place. 3) The DON/designee provided re-education to Licensed Nurses on the process of notifying the physician for medications that are not available. 4) Residents medication administration record will be audited weekly for 2 months for notification of physician if not administered. Results will be presented to QAPI monthly. Any noted trends will be addressed immediately. 5) Compliance Date: 7/27/2023	

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(medication administration record) revealed the same physician's order for Pradaxa. On 6/12/23 and 6/13/23, the MAR documented the code, "7=Other/See Nurse Notes." Nurses' notes dated 6/12/23 and 6/13/23 documented, "Medication on order from pharmacy." Further review of nurses' notes and the June 2023 MAR failed to reveal documentation that Pradaxa was administered to R51 on 6/12/23 and 6/13/23, and failed to reveal documentation that R51's physician was notified.

On 6/28/23 at 4:18 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated the physician should absolutely be notified when a medication is not administered so the physician can adjust treatment.

On 6/29/23 at 11:43 a.m., ASM (administrative staff member) #1 (the Executive Director) and ASM #2 (the interim Director of Nursing) were made aware of the above concern. The facility staff did not provide a policy regarding physician notification.

Reference:
(1) "Dabigatran (Pradaxa) is also used to help prevent strokes or serious blood clots in adults who have atrial fibrillation (a condition in which the heart beats irregularly, increasing the chance of clots forming in the body, and possibly causing strokes) without heart valve disease. If you have atrial fibrillation and are taking dabigatran to help prevent strokes or serious blood clots, you are at a higher risk of having a stroke after you stop taking this medication. Do not stop taking dabigatran without talking to your doctor. Continue to take dabigatran even if you feel well. Be sure to refill your prescription before you run out of medication so that you will not miss any

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doses of dabigatran." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a610024.html

2. For Resident #2 (R2), the facility staff failed to notify the physician when the medication buspirone was not administered on 6/17/23.

A review of R2's clinical record revealed a physician's order dated 3/4/22 for buspirone 10 mg (milligrams) one time a day for anxiety disorder. A review of R2's June 2023 MAR (medication administration record) revealed the same physician's order for buspirone. On 6/17/23, the MAR documented the code, "7=Other/See Nurse Notes." A nurse's note dated 6/17/23 documented, "Medication on order." Further review of nurses' notes and the June 2023 MAR failed to reveal documentation that buspirone was administered to R2 on 6/17/23 and failed to reveal documentation that R2's physician was notified.

On 6/28/23 at 4:18 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated the physician should absolutely be notified when a medication is not administered so the physician can adjust treatment.

On 6/29/23 at 11:43 a.m., ASM (administrative staff member) #1 (the Executive Director) and ASM #2 (the interim Director of Nursing) were made aware of the above concern.

Reference:
(1) Buspirone is used to treat anxiety. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a688005.h

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F 580	Continued From page 13 tml	F 580		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1,	F 584		

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F 584	Continued From page 14 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to maintain a clean, comfortable, homelike environment for one of 35 residents in the survey sample, Resident #51. The findings include: For Resident #51 (R51), the facility staff failed to maintain the resident's room in a clean and homelike manner. Dirt and debris were observed on the resident's floor and bed frame on 6/27/23 and on 6/28/23. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/9/23, the resident scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact. On 6/27/23 at 11:39 a.m. and 6/28/23 at 9:12 a.m., observation of R51's room was conducted. The floor on the right side of the bed and under the bed contained dirt, multiple plastic medication cups, scraps of paper and a dried, brown, smeared substance. A dried brown substance, a dried orange substance and a macaroni noodle was observed on the bed frame. On 6/28/23 at 9:12 a.m., an interview was conducted with R51 who stated the facility staff does not clean the room and he couldn't remember the last time the	F 584	F584 1) Resident #51 room was cleaned. 2) An audit was conducted of resident rooms to ensure they are maintained in a clean, comfortable, homelike environment. 3) The DON/designee provided re-education to Housekeeping on ensuring residents rooms are maintained in a clean, comfortable, homelike environment. 4) Room rounds will be conducted 5 times a week to ensure Resident rooms are maintained in a clean, comfortable, homelike environment. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5) Compliance Date: 7/27/2023	

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F 584	Continued From page 15 room was cleaned. On 6/28/23 at 10:28 a.m., an interview was conducted with OSM (other staff member) #4 (the housekeeping account manager). OSM #4 stated every resident room should be cleaned daily, and the cleaning should consist of wiping down the bedside table, wiping down the nightstand, removing the trash, cleaning the sink, cleaning the mirror, cleaning the toilet, wiping down the bed frame, sweeping the floor, and mopping the floor. On 6/28/23 at 10:37 a.m., R51's room was observed with OSM #4 who stated the dirt and debris consisted of drinks, food and pill cups. OSM #4 stated R51's room was unacceptable and was not clean, comfortable, and homelike. On 6/29/23 at 11:43 a.m., ASM (administrative staff member) #1 (the Executive Director) and ASM #2 (the interim Director of Nursing) were made aware of the above concern. The facility did not have a policy regarding a clean, comfortable, homelike environment.	F 584		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the	F 622		

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F 622	Continued From page 16 services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care	F 622	F622 1) Resident #102 is no longer in the center. Residents #45, #43 and #89 remain safely in the facility. 2) Current residents in the facility that are transferred to the hospital have the potential to be affected. 3) The DON/designee provided re-education to licensed nurses of the documentation requirement of transfers to the hospital to licensed providers. 4) Transfers will be audited weekly for 2 months to ensure appropriate paperwork was provided to the receiving facility. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5) Compliance Date: 7/27/2023	

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F 622	Continued From page 17 institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to evidence the required documents were sent with residents upon	F 622		

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transfer to the hospital for four of 35 residents, Residents #45, #102, #43 and #89.

The findings include:

1. For Resident #45 (R45), the facility staff failed to evidence the required documents were sent with the resident upon transfer to the hospital on 3/11/2023 and 4/9/2023.

The nurse's note dated, 3/11/2023 at 9:45 p.m. documented, "Contacted (Name of Hospital) for an update on resident, admitted with PNE (pneumonia) and low H&H (hemoglobin and hematocrit) need transfusion."

There was no further documentation related to the 3/11/2023 transfer to the hospital.

The nurse's note dated 4/8/2023 at 6:41 p.m. documented in part, "FSBS (fingerstick blood sugar) is 516. Awaiting return call and orders from on call services."
The nurse's note dated 4/12/2023 at 3:54 p.m. documented in part, "Resident returned from (initials of hospital)."
There was no further documentation related to the 4/9/2023 transfer to the hospital.

On 6/28/2023 at 5:21 p.m. ASM (administrative staff member) #1, the executive director, and ASM #2, the interim director of nursing, stated the had no documentation of what was sent to the hospital on 3/11/2023 and 4/9/2023.

An interview was conducted with RN (registered nurse) #1 on 6/29/2023. When asked the process for when a resident goes to the hospital, RN #1 stated., the nurse should provide the transfer out

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packet, that includes the resident medication list, four or five pages of information regarding the resident, and a face sheet. RN #1 was asked if the care plan goals are sent with the resident, RN #1 stated she didn't believe that was in the packet. When asked where what is sent to the hospital is documented, RN #1 stated the only thing they were told to copy is the transfer out form.

The facility policy, "Transfer a Resident to a Hospital Policy: When the transfer of a resident is imminent, based on medical necessity, the primary nurse will report on the Nurse) to promote continuity of care. Procedure Emergency Transfer: 1. Call the physician and obtain an order to transfer the resident. 2. Call the ambulance 3. Complete the Interact Facility Transfer Form. 4. Print two copies of the resident's chart via PCC (see attached instructions) A. One copy for EMS and one for the hospital. 5. Place printed content into 2 transfer envelopes...13. Write discharge note. Include: A. Notification of family. B. Reason or transfer."

ASM #1, ASM #2, ASM #4, the regional clinical consultant and ASM #5, regional vice president of operations, were made aware of the above findings on 6/28/2023 at 5:30 p.m.

No further information was provided prior to exit.
2. For Resident #102 (R102), the facility staff failed to evidence required documentation was provided to the receiving facility for a transfer to the hospital on 05/26/2023.

The facility's nursing progress noted for (R102) dated 05/27/2023 documented, "Per Social Worker information, resident was admitted at

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F 622	Continued From page 20 (Name of Hospital)." Review of the EHR (electronic health record) failed to evidence documentation of required information provided to the hospital on 05/27/2023 for (R102). On 06/28/32 at approximately 5:00 p.m., an interview was conducted with ASM (administrative staff member) #2, the interim director of nursing. When asked to describe the procedure when a resident is transferred to the hospital ASM #2 stated that the resident's face sheet, care plan goals, medication list and transfer paperwork are sent to the hospital. When asked about the documentation for (R102's) transfer on 05/26/2023 she stated that she could not locate it. On 06/28/2023 at approximately 5:50 p.m., ASM #1, executive director and ASM #2, were made aware of the above findings. No further information was provided prior to exit. 3. For Resident #43, the facility staff failed to evidence required documentation was provided to the receiving facility upon a hospital transfer on 5/14/23 . A review of the clinical record revealed the following: A nurse's note dated 5/14/23 documented, "Nurse aide (name) reported resident has had two episodes of thick black liquid stool in large amounts. NP (Nurse Practitioner) (name) was notified, awaiting further instructions." A second nurse's note dated 5/14/23 documented, "(Name of) NP advised to send	F 622		

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resident out to ED (emergency department) for suspected GI (gastrointestinal) bleed."

A nurse's note dated 5/16/23 documented, "S/P (status post) return from ER (emergency room), dx (diagnosis) internal hemorrhoids. No c/o (complaints of) pain or discomfort. No acute distress. Resting in bed with eyes closed and call bell in reach."

A physician's progress note dated 5/16/23 documented, "Asked to see patient following recent ER visit. Patient was sent to the ER from this facility related to dark stools. Patient evaluated in the ER determined black stools related to iron supplementation. Stool was tested in ER and found to be negative for blood."

There was no documentation in the clinical record that evidenced documentation was sent to the hospital, including but not limited to:
(1) Contact information of the practitioner responsible for the care of the resident.
(2) Resident representative information including contact information.
(3) Advance Directive information.
(4) All special instructions or precautions for ongoing care, as appropriate.
(5) Comprehensive care plan goals.
(6) All other necessary information, including a copy of the resident's discharge summary.
(7) Any other documentation, as applicable, to ensure a safe and effective transition of care.

On 06/28/23 at approximately 5:00 p.m., an interview was conducted with ASM (Administrative Staff Member) #2, the interim Director of Nursing. When asked to describe the procedure when a resident is transferred to the

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hospital ASM #2 stated that the resident's face sheet, care plan goals, medication list and transfer paperwork are sent to the hospital. When asked about evidence of what documentation was sent for Resident #43, she stated, "We don't have it."

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

4. For Resident #89, the facility staff failed to evidence what required documentation was provided to the receiving facility upon hospital transfers on 4/5/23, 5/17/23 and 6/20/23.

A review of the clinical record revealed the following:

A. For the hospital transfer on 4/5/23:
A nurse's note dated 4/5/23 documented, "Critical labs value called to facility. NP (Nurse Practitioner) notified. gave verbal order to send to ER (emergency room) for further evaluation. Emergency contact notified. DON (Director of Nursing) notified, Admin (Administrator) notified. 911 called to transport resident to ER."

A nurse's note dated 4/5/23 documented, "Resident returned to facility on stretcher via Ambulance with 2 staff. Alert and awake. (Name of doctor) on call paged to be notified of resident return and new orders as well. (Name of doctor) called back and was made aware (name of family member), also notified of resident return."

B. For the hospital transfer on 5/17/23:
A nurse's note dated 5/17/23 documented, "CNA (Certified Nursing Assistant) reported that res had

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been reported to have vomited, then started with labored respirations....On call notified, O2 (oxygen) placed & (and) ordered to send to ED (emergency department), res (resident) (family member) also notified...."

C. For the hospital transfer on 6/20/23:
A nurse's note dated 6/20/23 documented, "Resident had a fall at 0415 (4:15 AM) this morning incurred multiple skin tears on right and left forearms. Hours later resident had complaint of hip pain. NP (nurse practitioner) notified , DON (Director of Nursing) notified and resident was sent vis (sic) 911 for evaluation and to rule out possible hip fracture. (Family member) notified and will be meeting resident there at (name of hospital)."

A nurse's note dated 6/20/23 documented, "Resident is returning to facility via (family member). No fractures and is doing well."

For all three hospital visits, there was no documentation to evidence required documentation was sent to the hospital, including but not limited to:
(1) Contact information of the practitioner responsible for the care of the resident.
(2) Resident representative information including contact information.
(3) Advance Directive information.
(4) All special instructions or precautions for ongoing care, as appropriate.
(5) Comprehensive care plan goals.
(6) All other necessary information, including a copy of the resident's discharge summary.
(7) Any other documentation, as applicable, to ensure a safe and effective transition of care.

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F 622	Continued From page 24 On 06/28/23 at approximately 5:00 p.m., an interview was conducted with ASM (Administrative Staff Member) #2, the interim Director of Nursing. When asked to describe the procedure when a resident is transferred to the hospital ASM #2 stated that the resident's face sheet, care plan goals, medication list and transfer paperwork are sent to the hospital. When asked about evidence of what documentation was sent for Resident #89, she stated, "We don't have it." No further information was provided by the end of the survey.	F 622		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be	F 623		

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F 623	Continued From page 25 made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related	F 623	F623 1) Resident #102 is no longer in the center. Resident's #45, #43 and #89 remain safely in the center and evidence of written RP and ombudsman notification is available for current hospital transfers. 2) Current Residents in the facility that have been transferred to the hospital have the potential to be affected. 3) The DON/designee provided re-education to Social Services regarding the notification to the Ombudsman and written notification being sent to the Resident representative and/or Resident. Results of audits will be reviewed at the monthly QAPI meeting. Any discrepancies will be addressed immediately.	

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 ______	06/29/2023

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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F 623	Continued From page 26 disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review it was determined the facility staff failed to notify the Office of the State Long-Term Care Ombudsman and the resident and/or responsible party of a transfer to the	F 623	4) Transfers will be audited weekly for 2 months to ensure there is evidence of notification to the Ombudsman and written notification to the Resident representative and/or Resident. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5) Compliance Date: 7/27/2023	

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
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F 623	Continued From page 27 hospital for four of 35 residents in the survey sample, Residents #45, #102, #43, and #89. The findings include: 1. For Resident #45 (R45), the facility staff failed to notify the ombudsman of transfers to the hospital on 3/11/2023 and 4/12/2023. The nurse's note dated, 3/11/2023 at 9:45 p.m. documented, "Contacted (Name of Hospital) for an update on resident, admitted with PNE (pneumonia) and low H&H (hemoglobin and hematocrit) need transfusion." There was no further documentation related to the 3/11/2023 transfer to the hospital. The nurse's note dated 4/8/2023 at 6:41 p.m. documented in part, "FSBS (fingerstick blood sugar) is 516. Awaiting return call and orders from on call services." The nurse's note dated 4/12/2023 at 3:54 p.m. documented in part, "Resident returned from (initials of hospital)." There was no further documentation related to the 4/9/2023 transfer to the hospital. On 6/28/2023 a request was made for documentation that the ombudsman was notified of the transfer. On 6/28/2023 at 5:21 p.m. ASM (administrative staff member) #1, the executive director, and ASM #2, the interim director of nursing, stated they had no evidence of notification to the ombudsman. The facility policy, "Transfer a Resident to a	F 623		

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F 623 Continued From page 28

Hospital Policy" documented in part, "9. Send a copy of Bed Hold Policy and Involuntary Transfer form with the resident...Please note: Notification of Involuntary Transfers from the facility must be sent to the Ombudsman. Coordinate with local Ombudsman to determine communication frequency. (Must be at least monthly)."

ASM #1, ASM #2, ASM #4, the regional clinical consultant, and ASM #5, regional vice president of operations, were made aware of the above findings on 6/28/2023 at 5:30 p.m.

No further information was provided prior to exit.
2. For Resident #120 (R102), the facility staff failed to evidence the ombudsman, resident, or the resident's responsible party was notified of the transfer to the hospital on 05/26/2023.

The facility's nursing progress noted for (R102) dated 05/27/2023 documented, "Per Social Worker information, resident was admitted at (Name of Hospital)."

Review of the EHR (electronic health record) for (R102) failed to evidence written notification of transfer was provided to the ombudsman, (R102) or (R102's) representative for the transfer on 05/26/2023.

On 06/28/32 at approximately 5:00 p.m., an interview was conducted with ASM (administrative staff member) #2, the interim director of nursing. When asked to describe the procedure of notifying the resident, resident's representative and ombudsman when a resident is transferred to the hospital ASM #2 stated that she did not know what the facility's policy was.

F 623

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F 623	Continued From page 29 On 06/28/2023 at approximately 5:50 p.m., ASM #1, executive director and ASM #2, were made aware of the above findings. No further information was provided prior to exit. 3. For Resident #43, the facility staff failed to evidence that written notification was provided to Resident #43's responsible party and the ombudsman for a hospital transfer on 5/14/23. A review of the clinical record revealed the following: A nurse's note dated 5/14/23 documented, "(Name of) NP advised to send resident out to ED (emergency department) for suspected GI (gastrointestinal) bleed." A nurse's note dated 5/15/23 documented, "(Name of family member) was notified of resident's transport out to (name of hospital) for possible GI bleed last night on the 14th of May. He called this morning asking for an update on the resident. Update was given." There was no documentation to evidence that the resident's responsible party and the ombudsman was provided with written notification of the hospital transfer on 5/14/23. On 06/28/23 at approximately 5:00 p.m., an interview was conducted with ASM #2 (Administrative Staff Member), the interim Director of Nursing. When asked to describe the procedure of notifying the resident, resident's representative and ombudsman when a resident is transferred to the hospital ASM #2 stated that she did not know what the facility's policy was. When asked about evidence of a written notice to the resident's responsible party and the	F 623		

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F 623	Continued From page 30 ombudsman, she stated, "We don't have it." 4. For Resident #89, the facility staff failed to evidence that written notification was provided to Resident #89's responsible party and the ombudsman for hospital transfers on 4/5/23 and 5/17/23. A review of the clinical record revealed the following: A. For the hospital transfer on 4/5/23: A nurse's note dated 4/5/23 documented, "Critical labs value called to facility. NP (Nurse Practitioner) notified. gave verbal order to send to ER (emergency room) for further evaluation. Emergency contact notified. DON (Director of Nursing) notified, Admin (Administrator) notified. 911 called to transport resident to ER." A nurse's note dated 4/5/23 documented, "Residents family called about the 911 send out due to elevated and critical lab results." There was no documentation to evidence that the resident's responsible party and the ombudsman was provided with written notification of the hospital transfer on 4/5/23. On 06/28/23 at approximately 5:00 p.m., an interview was conducted with ASM #2 (Administrative Staff Member), the interim Director of Nursing. When asked to describe the procedure of notifying the resident, resident's representative and ombudsman when a resident is transferred to the hospital ASM #2 stated that she did not know what the facility's policy was. When asked about evidence of a written notice to	F 623		

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F 623	Continued From page 31 the resident's responsible party and the ombudsman, she stated, "We don't have it." No further information was provided by the end of the survey. B. For the hospital transfer on 5/17/23: A nurse's note dated 5/17/23 documented, "CNA (Certified Nursing Assistant) reported that res had been reported to have vomited, then started with labored respirations....On call notified, O2 (oxygen) placed & (and) ordered to send to ED (emergency department), res (resident) (family member) also notified...." There was no documentation to evidence that the resident's responsible party and the ombudsman was provided with written notification of the hospital transfer on 5/17/23. On 06/28/23 at approximately 5:00 p.m., an interview was conducted with ASM #2 (Administrative Staff Member), the interim Director of Nursing. When asked to describe the procedure of notifying the resident, resident's representative and ombudsman when a resident is transferred to the hospital ASM #2 stated that she did not know what the facility's policy was. When asked about evidence of a written notice to the resident's responsible party and the ombudsman, she stated, "We don't have it." No further information was provided by the end of the survey.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)	F 625		

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F 625	Continued From page 32 §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to provide a bed hold notice upon transfer to the hospital for two of 35 residents in the survey sample, Residents #45 and #89. The findings include:	F 625	F625 1) Residents #45 and #89 remain safely in the center and evidence of bed hold policy being sent for hospital transfers is available. 2) Current Residents that are transferred to the hospital have the potential to be affected. 3) The DON/designee provided re-education to Social Services and Business Office regarding the Transfer to Hospital policy related to bed holds. 4) Transfers will be audited weekly for 2 months to ensure evidence of bed hold policy was provided. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5) Compliance Date: 7/27/2023	

F 625 | Continued From page 33 | F 625

1. For Resident #45 (R45) the facility staff failed to provide a bed hold notice upon transfer on 3/11/2023 and 4/9/2023.

The nurse's note dated, 3/11/2023 at 9:45 p.m. documented, "Contacted (Name of Hospital) for an update on resident, admitted with PNE (pneumonia) and low H&H (hemoglobin and hematocrit) need transfusion."

There was no further documentation related to the 3/11/2023 transfer to the hospital.

The nurse's note dated 4/8/2023 at 6:41 p.m. documented in part, "FSBS (fingerstick blood sugar) is 516. Awaiting return call and orders from on call services."

The nurse's note dated 4/12/2023 at 3:54 p.m. documented in part, "Resident returned from (initials of hospital)."
There was no further documentation related to the 4/9/2023 transfer to the hospital.

On 6/28/23, a request was made for the bed hold documentation.

On 6/28/2023 at 5:21 p.m. ASM (administrative staff member) #1, the executive director, and ASM #2, the interim director of nursing, stated the had no documentation of what was sent to the hospital on 3/11/2023 and 4/9/2023.

An interview was conducted with RN (registered nurse) #1, on 6/29/2023 at 9:32 a.m. When asked if the nurses provide a bed hold notice to the resident and/or responsible party upon transfer to the hospital, RN #1 stated, many times

F 625 Continued From page 34 F 625

it's an emergency so it doesn't get given to the resident as it doesn't get filled in, in time. RN #1 was asked if they send it to the hospital with the resident, RN #1 stated, it should be going. When asked if she documents that the bed hold was sent with the resident or given to the responsible party, RN #1 stated, "No, not me personally."

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

On 6/28/2023 at 5:30 p.m. ASM #1, ASM #2, ASM #4, the regional clinical consultant, and ASM #5, regional vice president of operations, were made aware of the above findings.

No further information was provided prior to exit.
2. For Resident #89, the facility staff failed to evidence that a written bed hold notice was provided to the resident or Resident #89's responsible party at the time of a hospital transfer on 5/17/23.

A nurse's note dated 5/17/23 documented, "CNA (Certified Nursing Assistant) reported that res had been reported to have vomited, then started with labored respirations....On call notified, O2 (oxygen) placed & (and) ordered to send to ED (emergency department), res (resident) (family member) also notified...."

There was no documentation to evidence that the resident or the resident's responsible party was provided with written bed-hold notification at the time of the hospital transfer on 5/17/23.

On 6/29/23 at 9:32 AM, an interview was

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F 625	Continued From page 35 conducted with RN #1 (Registered Nurse). When asked when a resident goes to the hospital, do you provide a bed-hold notice, she stated that it is in a packet and when the nurses send someone out they need to be completing the form and provide it to the resident. When asked where is it documented that one was provided, she stated that it is not documented that the bed-hold was provided. When asked if it is given to the resident's responsible party, she stated that it probably was not if it wasn't given to them on the way out the door. On 6/29/23 at 9:42 AM, ASM #4 (Administrative Staff Member) the Regional Clinical Consultant, provided a copy of a bed-hold notice dated 2/16/23, from time of admission but none was provided at the time of the hospital transfer on 5/17/23. No further information was provided by the end of the survey.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to maintain a complete and accurate MDS (minimum data set) assessment for one of 35 residents in the survey sample, Resident #5. The findings include:	F 641		

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F 641	Continued From page 36 For Resident #5 (R5), the facility staff failed to code the resident's significant weight loss on the quarterly MDS assessment with an ARD (assessment reference date) of 4/28/23. A review of R5's clinical record revealed the resident weighed 163.8 pounds on 10/4/22 and weighed 138 pounds on 4/12/23. A note signed by the registered dietitian on 4/18/23 documented R5 presented with a weight loss of 15.9 percent in the last 180 days. Section K of R5's quarterly MDS with an ARD of 4/28/23 documented no weight loss of ten percent or more in the last six months. On 6/29/23 at 9:09 a.m., an interview was conducted with RN (registered nurse) #3 (the MDS coordinator). RN #3 stated R5 clearly had a weight loss, and this should have been coded on the 4/18/23 MDS assessment. RN #3 stated she references the CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) manual when completing MDS assessments. The CMS RAI manual documented, "K0300 Weight Loss: Code 0, no or unknown: if the resident has not experienced weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days or if information about prior weight is not available. ·Code 1, yes on physician-prescribed weight-loss regimen: if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was planned and pursuant to a physician's order. ·Code 2, yes, not on physician-prescribed weight-loss regimen: if the resident has experienced a weight loss of 5% or more in the	F 641	F641 1) Resident #5 quarterly MDS for 4/28/23 was modified to reflect significant weight loss. 2) Audit of current residents quarterly MDS completed to ensure significant weight loss was coded appropriately if indicated. 3) Administrator/Designee re-educated MDS department on properly coding weight loss per the RAI manual. 4) Quarterly MDS assessments audited weekly for 2 months to ensure accurate coding for weight loss. Results of audits will be reviewed at the monthly QAPI meeting. Any discrepancies will be addressed immediately. 5) Compliance Date: 7/27/2023	

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F 641	Continued From page 37 past 30 days or 10% or more in the last 180 days, and the weight loss was not planned and prescribed by a physician." On 6/29/23 at 11:43 a.m., ASM (administrative staff member) #1 (the Executive Director) and ASM #2 (the interim Director of Nursing) were made aware of the above concern.	F 641		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656		

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ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

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F 656	Continued From page 38 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to develop and/or implement the comprehensive care plan for 7 of 35 residents in the survey sample; Residents #67, #40, 76, #45, #54, #51, and #2. The findings include: 1. For Resident #67, the facility staff failed to develop a comprehensive care plan related to smoking. On 6/26/23 at approximately 11:30 AM, the facility staff provided a list of residents who smoked. Resident #67 was on the list. On 6/27/23 at 4:45 PM in an interview conducted with Resident #67, he stated that he smokes about one small sized cigar a week. He stated	F 656	F656 1) Resident #67, #40, #76, #45, #54, #51 and #2 care plans have been developed and/or are being implemented. 2 Current residents have the potential to be affected if their needs are not care planned and the care plan is not followed. 3) The DON/designee provided re-education to licensed staff on implementing and developing care plans. 4) Random audits of 10 residents conducted weekly for 2 months to ensure comprehensive care plans are being implemented and developed. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5) Compliance Date: 7/27/2023	

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	495140	A. BUILDING ______ B. WING ______	06/29/2023

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that staff are to store his cigars and lighter and that he is to obtain them from the staff and then he walks up to the store about two blocks away to get a cup of coffee and sits on a bench drinking his coffee and smoking his cigar off campus.

The clinical record documented the resident as not being a smoker as follows:
1. The most recent "Quarterly Data Collection Tool" dated 11/21/22 documented, "Does the resident smoke?" The box for "No" was marked.
2. A physician's progress note dated 4/21/23 documented, "(-) (negative) smoker..."

A review of the comprehensive care plan failed to reveal any evidence that Resident #67 was care planned for smoking related concerns and interventions.

On 6/28/23 at 4:18 PM, an interview was conducted with RN #1 (Registered Nurse). When asked what was the purpose of the care plan, she stated that it is what the staff go by to provide resident preferences, resident needs, etc. When asked if a resident who goes off property to smoke should have a care plan, she stated that they should have a care plan for smokers even though it is a non-smoking facility, they should be care planned that they leave to smoke. She stated there should be a care plan for residents who freely leaves the facility frequently.

The facility policy, Care Plan Preparation" was reviewed. This policy documented, "A care plan direct's the patient's nursing care from admission to discharge. This written action plan is based on nursing diagnoses that have been formulated after reviewing assessment findings, and it embodies the components of the nursing

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process: assessment, diagnosis, planning, implementation and evaluation..."

On 6/29/23 at 9:20 AM, ASM #1 (Administrative Staff Member) the Executive Director, and ASM #4 the Regional Clinical Consultant, were made aware of the findings. No further information was provided by the end of the survey.

2. For Resident #40, the facility staff failed to develop a comprehensive care plan for the use of siderails.

On 6/28/23 at 8:35 AM, Resident #40 was observed in bed, with the head of his bed elevated and the siderails were up on both sides.

A review of the clinical record revealed that on 4/14/23, the therapy department had assessed Resident #40 for the use of siderails and determined that they were necessary for the resident for increased safety and independence for bed mobility.

A review of the clinical record revealed the comprehensive care plan. The care plan did not address the use of the siderails.

On 6/28/23 at 4:18 PM, an interview was conducted with RN #1 (Registered Nurse). When asked what was the purpose of the care plan, she stated that it is what the staff go by to provide resident preferences, resident needs, etc. When asked if a resident had siderails, should they be on the care plan, she stated, "Definitely." She stated the siderails are to help residents assist themselves with positioning, like rolling over, to help them not roll off the bed. When asked why

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should they be on the care plan, she stated that staff need to know the resident is needing the assistance of siderails and they need to be used.

The facility policy, Care Plan Preparation" was reviewed. This policy documented, "A care plan direct's the patient's nursing care from admission to discharge. This written action plan is based on nursing diagnoses that have been formulated after reviewing assessment findings, and it embodies the components of the nursing process: assessment, diagnosis, planning, implementation and evaluation..."

On 6/29/23 at 9:20 AM, ASM #1 (Administrative Staff Member) the Executive Director, and ASM #4 the Regional Clinical Consultant, were made aware of the findings. No further information was provided by the end of the survey.

3. For Resident #76 (R76), the facility staff failed to develop a care plan to address the resident's smoking.

On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date (ARD) of 5/3/2023, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. In Section G - Functional Status, the resident was coded as only requiring supervision after set up assistance if needed.

An interview was conducted with R76 on 6/27/2023 at approximately 1:30 p.m. When asked if he goes out to smoke, R76 stated he goes out about three times a day for smoking and does go out other times just to walk. R76 was

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asked who keeps his cigarettes, R76 stated they are kept in the social workers office during the week, but the nurses have them on the weekends and after the social worker goes home. When asked where he smokes since this is a non-smoking facility, R76 stated he walks to the end of the building and goes across the road where the telephone poles are, that's not the facility property. R76 also stated he walks up behind the building, through the path in the woods to an open field just to get away from the facility. R76 stated he also walks in the town and goes to the store a few blocks away. When asked if he signs out if he is going smoking outside, R76 stated that he doesn't bother to sign out now because they give me my cigarettes, so they know where I'm going.

The comprehensive care plan, revised on 11/22/2022, failed to evidence a care plan for being a smoker.

An interview was conducted with RN (registered nurse) #1, a unit manager, on 6/28/2023 at 4:30 p.m. When asked the purpose of the care plan, RN #1 stated it's a disciplinary team effort to see what is good for the resident. That's what the staff go by to care for the resident. It should contain the resident's preferences, likes and dislikes, and how to care for them. RN #1 was asked if a resident should be care planned if they independently goes off the property, RN #1 stated, yes, if they are going out frequently. When asked if they had knowledge the resident is smoking and going off property to do so, even though the facility is a non-smoking facility, should that be care planned, RN #1 stated, "The residents even sign a paper that says they can't smoke. I would want it care planned."

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ASM (administrative staff member) #1, the executive director, ASM #2, the interim director of nursing, ASM #4, regional clinical consultant, and ASM #5, the regional vice president of operations, were made aware of the above concern on 6/28/2023 at 5:30 p.m.

No further information was provided prior to exit.

4. For Resident #45, the facility staff failed to implement the comprehensive care plan for communicating with the dialysis center each time the resident went to dialysis.

The comprehensive care plan dated, 12/12/2022, documented in part, "Focus: Alteration in Kidney Function due to end stage renal disease (ESRD) with dialysis on M - W - F." The "Interventions" documented in part, "Written communication form with review of weights and any change of condition between dialysis provider and living center."

The physician order dated, 5/17/2023 documented, "Dialysis (name, address and phone number of dialysis center) MWF (Monday/Wednesday/Friday) one tine a day every Mon, Wed, Fri related to end stage renal disease. Chair time 12:45 p.m. until 17:00 p.m. (5:00 p.m.).

The review of the clinical record failed to evidence communication with the dialysis center on the following dates:
May 2023: 5/17/2023, 5/19/2023, 5/26/2023, 5/29/2023 and 5/31/2023.
June 2023: 6/2/2023, 6/5/2023, 6/7/2023, 6/9/2023, 6/12/2023, 6/14/2023, 6/16/2023,

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F 656	Continued From page 44 6/19/2023, 6/23/2023, and 6/26/2023. An interview was conducted with LPN (licensed practical nurse) #5 on 6/28/2023 at 5:32 p.m. When asked the process for resident going to dialysis, LPN #5 stated a paper goes with the resident, it is filled out by the nurse here [at the facility] and then dialysis fills it out, sometimes, and sends it back. When asked how the paper is taken to the dialysis center, LPN #5 stated, it is put in an envelope and sent with the resident. An interview was conducted with RN (registered nurse) #1, a unit manager, on 6/28/2023 at 4:30 p.m. When asked the purpose of the care plan, RN #1 stated it's a disciplinary team effort to see what is good for the resident. That's what the staff go by to care for the resident. It should contain the resident's preferences, likes and dislikes, and how to care for them. ASM (administrative staff member) #1, the executive director, ASM #2, the interim director of nursing, ASM #4, regional clinical consultant, and ASM #5, the regional vice president of operations, were made aware of the above concern on 6/29/2023 at 11:43 a.m. No further information was provided prior to exit. 5. For Resident #54 (R54), the facility staff failed to develop a care plan for the resident's diagnosis of PTSD (post-traumatic stress disorder). R54 was admitted to the facility on 1/20/22 with a diagnosis of PTSD. A review of R54's comprehensive care plan dated 2/2/22 failed to reveal a care plan to address PTSD. On 6/28/23 at 4:18 p.m., an interview was	F 656		

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F 656	Continued From page 45 conducted with RN (registered nurse) #1 who stated a care plan for PTSD should be developed, reflect the resident's behaviors, and document interventions to address the behaviors. On 6/29/23 at 11:43 a.m., ASM (administrative staff member) #1 (the Executive Director) and ASM #2 (the interim Director of Nursing) were made aware of the above concern. 6. For Resident #51 (R51), the facility staff failed to implement the resident's comprehensive care plan for cardiovascular medication administration on 6/12/23 and 6/13/23. R51's comprehensive care plan dated 4/22/19 documented, "Impaired Cardiovascular status related to: Hypertension, Peripheral Vascular Disease (PVD), HLD (hyperlipidemia), A-fib (atrial fibrillation), hx (history) of cva (cerebrovascular accident) and hemiplegia (paralysis). Interventions: medications as ordered by physician..." A review of R51's clinical record revealed a physician's order dated 12/3/19 for Pradaxa (1) 150 mg (milligrams) two times a day for atrial fibrillation. A review of R51's June 2023 MAR (medication administration record) revealed the same physician's order for Pradaxa. On 6/12/23 and 6/13/23, the MAR documented the code, "7=Other/See Nurse Notes." Nurses' notes dated 6/12/23 and 6/13/23 documented, "Medication on order from pharmacy." Further review of nurses' notes and the June 2023 MAR failed to reveal documentation that Pradaxa was administered to R51 on 6/12/23 and 6/13/23. On 6/28/23 at 4:18 p.m., an interview was	F 656		

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F 656	Continued From page 46 conducted with RN (registered nurse) #1 who stated the purpose of the care plan is to direct staff how to care for residents. RN #1 stated medications should be ordered from the pharmacy when there are seven pills remaining. RN #1 stated if a medication is not available for administration, then she checks the bottom of medication cart, where extra medications are stored, and if the medication is not there, then she checks the backup medication supply box and calls the pharmacy. On 6/29/23 at 9:38 a.m., another interview was conducted with RN #1. RN #1 stated nurses need to give medications as ordered, and nurses have access to residents' care plans. On 6/29/23 at 11:43 a.m., ASM (administrative staff member) #1 (the Executive Director) and ASM #2 (the interim Director of Nursing) were made aware of the above concern. Reference: (1) "Dabigatran (Pradaxa) is also used to help prevent strokes or serious blood clots in adults who have atrial fibrillation (a condition in which the heart beats irregularly, increasing the chance of clots forming in the body, and possibly causing strokes) without heart valve disease. If you have atrial fibrillation and are taking dabigatran to help prevent strokes or serious blood clots, you are at a higher risk of having a stroke after you stop taking this medication. Do not stop taking dabigatran without talking to your doctor. Continue to take dabigatran even if you feel well. Be sure to refill your prescription before you run out of medication so that you will not miss any doses of dabigatran." This information was obtained from the website:	F 656		

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https://medlineplus.gov/druginfo/meds/a610024.html

7. For Resident #2 (R2), the facility staff failed to implement the resident's comprehensive care plan for anti-anxiety medication administration on 6/17/23.

R2's comprehensive care plan dated 7/10/19 documented, "Potential for drug related complications associated with use of psychotropic medications related to: prescribed Anti-Depressant medication, anti-anxiety medication. Interventions: provide medications as ordered by physician..."

A review of R2's clinical record revealed a physician's order dated 3/4/22 for buspirone (1) 10 mg (milligrams) one time a day for anxiety disorder. A review of R2's June 2023 MAR (medication administration record) revealed the same physician's order for buspirone. On 6/17/23, the MAR documented the code, "7=Other/See Nurse Notes." A nurse's note dated 6/17/23 documented, "Medication on order." Further review of nurses' notes and the June 2023 MAR failed to reveal documentation that buspirone was administered to R2 on 6/17/23.

On 6/28/23 at 4:18 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated the purpose of the care plan is to direct staff how to care for residents. RN #1 stated medications should be ordered from the pharmacy when there are seven pills remaining. RN #1 stated if a medication is not available for administration, then she checks the bottom of medication cart, where extra medications are

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F 656	Continued From page 48 stored and if the medication is not there, then she checks the backup medication supply box and calls the pharmacy. On 6/29/23 at 9:38 a.m., another interview was conducted with RN #1. RN #1 stated nurses need to give medications as ordered, and nurses have access to residents' care plans. On 6/29/23 at 11:43 a.m., ASM (administrative staff member) #1 (the Executive Director) and ASM #2 (the interim Director of Nursing) were made aware of the above concern. Reference: (1) Buspirone is used to treat anxiety. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a688005.html	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to clarify a physician order for the diagnosis for the use of Seroquel, for one of 35 residents in the survey sample, Resident #157. The findings include:	F 658		

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F 658	Continued From page 49 For Resident #157 (R157) the facility staff failed to clarify the diagnosis in a physician order for Seroquel, an antipsychotic medication. The physician order dated, 6/23/2023, documented, "Seroquel (1) 25 mg (milligrams) po (by mouth) TID (three times a day) 8 am, 2 pm, 8 pm. DX (diagnosis): 0.3.90." An interview was conducted with RN (registered nurse) #2, on 6/29/2023. When asked what Seroquel is used for, RN #2 stated, "It's used to calm people down. Off label, it's used for sleep. It's an antipsychotic medication." The above order was reviewed with RN #2. RN #2 was asked if they knew the diagnosis for the use of the Seroquel, RN #2 stated they didn't know what that meant. When asked if this order should be clarified, RN #2 stated, yes. Review of the electronic and paper medical record, failed to evidence any psychiatry notes. On 06/29/23 at 9:57 a.m., a conversation was held with ASM (administrative staff member) #4, the regional clinical consultant. The above order was shared with ASM #4 that there were no notes for psychiatry in the record. ASM #4 stated she would investigate it. On 6/29/2023 at 10:30 a.m. ASM #4 presented the psychiatrist nurse practitioner notes. When asked if the order containing the diagnosis of DX: 0.3.90 needed to be clarified, ASM #4 stated, yes. The psychiatric nurse practitioner notes dated 6/23/2023, documented in part, "Primary Diagnosis: Adjustment Disorder with Disturbance of Emotions & Conduct. Dementia in other	F 658	F658 1) Resident #157 diagnosis of Seroquel was clarified and Professional Standards of Practice are being followed. 2) Residents currently on antipsychotic medications were audited to ensure diagnosis follows Professional Standards of Practice. 3) DON/Designee re-educated Licensed nurses on professional standards of practice for clarifying diagnosis for antipsychotic medications. 4) Audits of residents on antipsychotic medications will be conducted weekly for 2 months to ensure diagnosis meets professional standards of practice. Results of audits will be reviewed at the monthly QAPI meeting. Any discrepancies will be addressed immediately. 5) Compliance Date: 7/27/2023	

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F 658	Continued From page 50 diseases classified elsewhere, mild with other behavioral disturbance." A policy was requested for the clarification of physician orders, however none was provided. On 6/29/2023 at 11:43 a.m., ASM #1, the executive director, ASM #2, the interim director of nursing, ASM #4, and ASM #5, the regional vice president of operations, were made aware of the above concern. No further information was provided prior to exit. (1) Seroquel is also used along with other medications to treat depression. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a698019.html.	F 658		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...	F 676		

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ROSE HILL HEALTH AND REHAB	**110 CHALMERS COURT BERRYVILLE, VA 22611**

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F 676	Continued From page 51 §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on family interview, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to consistently provide ADL (activities of daily living) care for one of 35 residents in the survey sample, Resident #100. The findings include: For Resident #100 (R100), the facility staff failed to provide bathing/showers twice a week from 5/26/2023 through 6/28/2023. On the most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 6/5/2023, the resident scored a three out of 15 on the BIMS	F 676	F676 1) Resident #100 is receiving ADL bathing assistance. 2) Current residents have the potential to be affected. 3) The DON/designee will re-educate certified nursing assistance regarding documentation of showers, shower schedule and how to give a shower. 4) Nursing Administration will review shower documentation weekly for 2 months for accuracy to ensure that the residents are receiving regular showers and it is being documented. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5) Compliance Date: 7/27/2023	

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F 676	Continued From page 52 (brief interview for mental status) score, indicating the resident was severely impaired for making daily decisions. In Section G - Functional Status, R100 was coded as not received any bathing during the look back period. The resident was coded as requiring extensive assistance of two to three staff members for toileting and limited assistance of one staff member for personal hygiene. An interview was conducted on 6/27/2023 at approximately 1:00 p.m. with the family member/responsible party of R100. The family member stated she doesn't think her father has had a shower since he's been there. She stated he smelled all the time. The ADL (activities of daily living) documentation for May 2023, failed to document any bathing from 5/26/2023 through 5/31/2023. The ADL documentation for June 2023, documented the resident received a bed bath on 6/9/2023, and received a shower on 6/20/2023 and 6/23/2023. It was documented on 6/27/2023, that R100 refused a shower/bath. The review of the nurse's notes from 5/26/2023 through 6/27/2023 failed to evidence documentation of the resident refusing any other showers/baths. An interview was conducted with RN (registered nurse) #1, on 6/28/2023 at approximately 4:15 p.m. When asked how often the resident receive showers, RN #1 stated they are to get one twice a week. RN #1 was asked where the baths/showers are given is documented, RN #1 stated, the aides document in the ADL documentation. When asked where it is	F 676		

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F 676	Continued From page 53 documented if a resident refuses a shower, RN #1 stated if a resident refuses, then the nurse goes in to encourage a shower, if they still refuse the nurse must write a nurses note that the resident refused their shower. An interview was conducted with CNA (certified nursing assistant) #16 on 6/29/2023 at 9:00 a.m. When asked how often showers are given, CNA #1 stated they should be given twice a week. CNA #16 was asked if a resident refuses a shower, what happens, CNA #1 stated the aides reapproach and offer again later. If the resident still refuses the aide reports it to the nurse and the nurse has to go in and talk to the resident. When asked where the aides document what type of bath/shower was given or the resident refused the shower, CNA #1 stated in the computer (ADL documentation record). A request was made for the policy on showers/bathing on 6/28/2023, however none was provided. On 6/29/23 at 11:43 a.m., ASM (administrative staff member) #1, the executive director, ASM #2, the interim director of nursing, ASM #4, the regional clinical consultant, and ASM #5, the regional vice president of operations, were made aware of the above concern. No further information was provided prior to exit.	F 676		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		

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F 689	Continued From page 54 as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to complete smoking assessments for four of 35 residents in the survey sample, Residents #76, #38, #67, and #307. The findings include: 1. For Resident #76 (R76), the facility staff failed to complete a safe smoking assessment. During the entrance conference on 6/27/2023 at approximately 10:20 a.m. a request was made for the list of smokers. ASM (administrative staff member) #1, the executive director, presented a list of residents that smoke but stated they are a non-smoking facility. ASM #1 stated when he came, he found out that residents were going outside to smoke. He then asked where the residents keep their cigarettes and lighters and found out the residents were keeping them in their rooms. He immediately removed them from the resident rooms, and they are kept by the staff, locked up. ASM #1 stated they were in the process of assessing the residents to see if they were capable of navigating outside to smoke. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date (ARD) of 5/3/2023, the resident scored a 15 out of 15 on the BIMS	F 689	F689 1) Resident #76, #38, #67 and #307 have smoking assessment completed. 2) Audit of current residents that smoke off property completed to ensure smoking assessment completed. 3) The DON/designee provided re-education to Licensed staff on ensuring smoking assessment is completed on residents that smoke off property. 4) Audits of residents that smoke off of property will be completed weekly for 2 months to ensure smoking assessment was completed. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5) Compliance Date: 7/27/2023	

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F 689	Continued From page 55	F 689		

(brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. In Section G - Functional Status, the resident was coded as only requiring supervision after set up assistance if needed.

An interview was conducted with R76 on 6/27/2023 at approximately 1:30 p.m. When asked if he goes out to smoke, R76 stated he goes out about three times a day for smoking. He does go out other times just to walk. R76 was asked who keeps his cigarettes, R76 stated they are kept in the social workers office during the week, but the nurses have them on the weekends and after the social worker goes home. When asked where he smokes as this is a non-smoking facility, R76 stated he walks to the end of the building and goes across the road where the telephone poles are, that's not the facility property. R76 also stated he walks up behind the building, through the path in the woods to an open field just to get away from the facility. R76 stated he also walks in the town and goes to the store a few blocks away. When asked if he signs out if he is going smoking outside, R76 stated that he doesn't bother to sign out now because they give me my cigarettes, so they know where I'm going.

An interview was conducted with ASM #1 on 6/27/2023 at 4:11 p.m. When asked if residents were assessed for safe smoking, ASM #1 stated he didn't believe so.

Review of the clinical record failed to evidence a smoking assessment for R76. The comprehensive care plan dated, revised on 11/22/2022 failed to evidence a care plan for being a smoker. There was no evidence that R76

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F 689	Continued From page 56 had any accidents, burns, etc. while smoking. A document in the admission packet, "Non-Smoking Policy" documented, "Smoking (including the use of e-cigarettes) is prohibited for everyone on the property operated by the Center, including residents, employees, visitors, volunteers, consultants, contractors, and government representatives. This policy applies to: All areas of the interior of the Facility and any outbuildings on the property. Parking lots and common outdoor areas within the boundaries of the facility. The facility may have specific Residents who are allowed to smoke because there were admitted prior to the implementation of this non-smoking policy. Violations of the Facility's smoking policy may result in your involuntary discharge from the facility. THIS NON-SMOKING POLICY EFFECTIVE MAY 9, 2017." Resident #76 signed this document on 1/26/2022. The "South Resident Sign Out" documents contained 15 pages, that were not labeled with a date. The sheets for May 2023 did not have any sheets prior to 5/3/2023. R76 signed out on 5/3/2023 six times, 5/4/2023 seven times, 5/8/2023 two times. Unable to tell dates until 5/11/2023 when the resident signed out three times. May 12, 2023 the resident signed out four times. There were no papers dated 5/13/2023. On 5/14/2023 R76 signed out two times. On 5/15/2023, the resident signed out three times. There was nothing for 5/16/2023. On 5/17/2023 R76 signed out five times. Nothing documented for 5/18/2023. A sheet dated 5/6/2023 through 5/22/2023 failed to evidence documentation of R76 signing out. R76 signed out twice on 5/19/2023. R76 signed out once on 5/20/2023,	F 689		

F 689 Continued From page 57 F 689

5/21/2023 and 5/22/2023. Then the papers jump to 5/26/2023 where R76 signed out twice. Documentation on 5/27/2023, R76 signed out twice. On 5/28/2023, the resident signed out once. There was no documentation for 5/29/2023, that R76 signed out. R76 signed out once on 5/30/2023. On 5/31/2023 the resident signed out once.

For the month of June 2023, R76 signed out once on 6/1/2023 and 6/2/2023. There was no dated documentation of R76 signing out until 6/7/2023 when he signed out once. On June 8, 2023, R76 did not sign out. There was no dated documentation for 6/9/2023. R76 signed out twice on 6/10/2023. There is no documentation for 6/11/2023. On 6/12/2023, R76 signed out once. There was no documentation for 6/13/2023. On 6/14/2023, the resident signed out once. There was no documentation for 6/15/2023 or 6/16/2023. There was no further documentation in the book.

An interview was conducted with LPN (licensed practical nurse) #2 on 6/28/2023 at 1:35 p.m. When asked if there were any residents that smoke, LPN #2 stated, "I don't know about this, but they sneak across the road. The nurses took everything away from them. They (nurses) locked them up in a cart that is not used." When asked who gives them their cigarettes, LPN #2 stated, "They have to asked up for them." LPN #2 was asked who watches them go off the property, LPN #2 stated an aide is supposed to. The residents are supposed to be alert and oriented and sign out in the book. LPN #2 stated there is a book up front the resident have to sign out in. LPN #2 stated this has only been recently. The residents had already signed the no smoking

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policy, it needs to be stopped all together. LPN #2 stated, "We weren't aware of it." When asked if she had any cigarettes for R76, LPN #2 stated she had not be asked by them for any cigarettes from her today. LPN #2 was asked for the residents that do smoke, has a smoking assessment been completed, LPN #2 stated she had never done a smoking assessment. When asked the purpose of the smoking assessment, LPN #2 stated it's to review their medications, if the resident has COPD (chronic obstructive pulmonary disease), if they are on oxygen, it is a danger. LPN #2 was asked if the smoking assessment reviewed the ability of the resident to light a cigarette, if they have ashes or burn holes in their clothing, LPN #2 stated she hadn't done one.

An interview was conducted with ASM #1, and ASM #5, the regional vice president of operations, on 6/28/2023 at 2:08 p.m. When asked what prompted taking the cigarettes away from residents, ASM #1 stated he was told about it when he was updating the survey readiness book. ASM #1 was asked what he was told, ASM #1 stated he was told the residents were going off property to smoke. This is a smoke-building. ASM #1 stated last Friday, 6/23/2023, he asked where the cigarettes and lighters were kept and was told the residents had them in their rooms. ASM #1 stated he immediately took them away. They are stored in social services Monday through Friday and nursing has them locked up on the weekend, holidays and after social services goes home. When asked if the residents have been assessed for safe smoking, ASM #1 stated, a smoking assessment in not done, there is nothing in (name of computer program).

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F 689	Continued From page 59 An interview was conducted with ASM #4, the regional clinical consultant, and ASM #5, on 6/28/2023 at 2:54 p.m. ASM #5 stated that the residents are signing out, and going off property, they are responsible for their safety. They are on LOA (leave of absence). There would be no need to do a smoking assessment or care plan it. When asked if a resident doesn't sign out, ASM #5 stated he didn't know. At 4:11 p.m. ASM #5 stated that if a resident doesn't sign out then the resident will be educated on the process. Then if they still don't sign out, we would have to take each individual case and work through the process of education and if needed transfer out. The facility policy, "FACILITY NON-SMOKING POLICY" documented in part, "It is the policy of the facility to promote a healthier environment by becoming a non-smoking facility. The facility will have smoking residents that will be "grandfathered in" but new admission will be made aware upon admission that the facility is a non-smoking facility. This policy applies to all smoking and tobacco related products including but not limited to: Cigarettes, cigars, E-Cigarettes, Vaporizers (aka "Vapes"), hookahs and pipes...While the facility leadership will attempt to accommodate those current residents who desire to smoke, the primary obligation is to the safety of the facility population as a whole. Therefore, any resident or visitor who does not comply with rules regarding smoking will be asked to restrict or forfeit smoking or visiting privileges. IF the smoking infraction or lack of compliance is serious enough, it will warrant discharge in accordance with state and federal law. Anytime the administrator or designee determines there is a reasonable suspicion of a violation of the smoking policy, such as a resident retaining their	F 689		

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smoking materials or having others bring in smoking materials that are not retained according to policy, a room search may be conducted of all involved persons and areas...All residents must be supervised while smoking by a facility staff member...Smoking is prohibited to ALL staff while on facility property."

ASM #1, ASM #2, the interim director of nursing, ASM #4 and ASM #5 were made aware of the above concern on 6/28/2023 at 5:30 p.m.

No further information was provided prior to exit.

2. For Resident #38 (R38), the facility staff failed to complete a safe smoking assessment.

On the most recent MDS assessment, a quarterly assessment, with an ARD of 5/10/2023, the resident scored a 15 out of 15 on the BIMS score, indicating the resident was not cognitively impaired for making daily decisions. In Section G - Functional Status, the resident was coded as requiring supervision with set up help only for transfers, walking in the room and moving on and off the unit. R38 was discharged from the facility on 6/14/2023 and readmitted on 6/22/2023.

During the entrance conference on 6/27/2023 at approximately 10:20 a.m. a request was made for the list of smokers. ASM (administrative staff member) #1, the executive director, presented a list of residents that smoke but stated they are a non-smoking facility. ASM #1 stated when he came, he found out that residents were going outside to smoke. He then asked where the residents keep their cigarettes and lighters and found out the residents were keeping them in their rooms. He immediately removed them from

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F 689	Continued From page 61 the resident rooms and they are kept by the staff, locked up. ASM #1 stated they were in the process of assessing the residents to see if they were capable of navigating outside to smoke. Review of the clinical record failed to evidence a smoking assessment for R38. The care plan dated 6/28/2023 failed to evidence documentation related to smoking. There was no evidence that R38 had any accidents, burns, etc. while smoking. A document in the admission packet, "Non-Smoking Policy" documented, "Smoking (including the use of e-cigarettes) is prohibited for everyone on the property operated by the Center, including residents, employees, visitors, volunteers, consultants, contractors, and government representatives. This policy applies to: All areas of the interior of the Facility and any outbuildings on the property. Parking lots and common outdoor areas within the boundaries of the facility. The facility may have specific Residents who are allowed to smoke because there were admitted prior to the implementation of this non-smoking policy. Violations of the Facility's smoking policy may result in your involuntary discharge from the facility. THIS NON-SMOKING POLICY EFFECTIVE MAY 9, 2017." Resident #38 signed this document on 6/23/2023. An interview was conducted with ASM #1 on 6/27/2023 at 4:11 p.m. When asked if residents were assessed for safe smoking, ASM #1 stated he didn't believe so. An interview was conducted with LPN (licensed practical nurse) #2 on 6/28/2023 at 1:35 p.m.	F 689		

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When asked if there were any residents that smoke, LPN #2 stated, "I don't know about this, but they sneak across the road. The nurses took everything away from the. They (nurses) locked them up in a cart that is not used." When asked who gives them their cigarettes, LPN #2 stated, "They have to asked up for them." LPN #2 was asked who watches them go off the property, LPN #2 stated an aide is supposed to. The residents are supposed to be alert and oriented and sign out in the book. LPN #2 stated there is a book up front the resident have to sign out in. LPN #2 stated this has only been recently. The residents had already signed the no smoking policy, it needs to be stopped all together. LPN #2 stated, "We weren't aware of it." When asked if she had any cigarettes for R38, LPN #2 stated she had not been asked by them for any cigarettes from her today. LPN #2 was asked for the residents that do smoke, has a smoking assessment been completed, LPN #2 stated she had never done a smoking assessment. When asked the purpose of the smoking assessment, LPN #2 stated it's to review their medications, if the resident has COPD (chronic obstructive pulmonary disease), if they are on oxygen, it is a danger. LPN #2 was asked if the smoking assessment reviewed the ability of the resident to light a cigarette, if they have ashes or burn holes in their clothing, LPN #2 stated she hadn't done one.

An interview was conducted with ASM #1, and ASM #5, the regional vice president of operations, on 6/28/2023 at 2:08 p.m. When asked what prompted taking the cigarettes away from residents, ASM #1 stated he was told about it when he was updating the survey readiness book. ASM #1 was asked what he was told, ASM

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F 689	Continued From page 63 #1 stated he was told the residents were going off property to smoke. This is a smoke-building. ASM #1 stated last Friday, 6/23/2023, he asked where the cigarettes and lighters were kept and was told the residents had them in their rooms. ASM #1 stated he immediately took them away. They are stored in social services Monday through Friday and nursing has them locked up on the weekend, holidays and after social services goes home. When asked if the residents have been assessed for safe smoking, ASM #1 stated, a smoking assessment in not done, there is nothing in (name of computer program). An interview was conducted with ASM #4, the regional clinical consultant, and ASM #5, on 6/28/2023 at 2:54 p.m. ASM #5 stated that the residents are signing out, and going off property, they are responsible for their safety. They are on LOA (leave of absence). There would be no need to do a smoking assessment or care plan it. ASM #1, ASM #2, the interim director of nursing, ASM #4 and ASM #5 were made aware of the above concern on 6/28/2023 at 5:30 p.m. No further information was provided prior to exit. 3. For Resident #67, the facility staff failed to complete a safe smoking assessment. On 6/26/23 at approximately 11:30 AM, the facility staff provided a list of residents who smoked. Resident #67 was on the list. On 6/27/23 at 4:45 PM in an interview conducted with Resident #67, he stated that he smokes about one small sized cigar a week. He stated that staff are to store his cigars and lighter and that he is to obtain them from the staff and then	F 689		

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F 689	Continued From page 64 he walks up to the store about two blocks away to get a cup of coffee and sits on a bench drinking his coffee and smoking his cigar off campus. A review of the clinical record failed to reveal any evidence that a safe smoking assessment was completed for Resident #67. There was no evidence that Resident #67 had any accidents, burns, etc. while smoking. On 6/28/23 at 1:35 PM, an interview was conducted with LPN #2 (Licensed Practical Nurse). When asked if any of the residents on her unit smokes, she stated, "Yes. I didn't know about it but apparently they sneak across the road (off campus but in eyesight of the facility) and smoke. She stated that the Administration confiscated everything from the residents that they could find (smoking materials) because the residents had signed a no smoking policy. She stated that the smoking materials are locked up in a cart and that residents will ask for the smoking materials but they have to leave the property to smoke. When asked if, for the residents who do smoke, has smoking assessments been completed on them, she stated. "No." When asked what was the purpose of a smoking assessment, she stated that some residents may have medication related issues, be on oxygen, have COPD (chronic obstructive pulmonary disease), and to ensure they can light their own cigarette and put it out. On 6/28/23 at 2:08 PM an interview was conducted with ASM #1 (Administrative Staff Member) the Executive Director. He stated that he was new to the facility as of the week prior to this survey, and on "Friday" (6/23/23) he had	F 689		

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F 689	Continued From page 65 identified that this was a concern and started addressing it. He stated that so far, he had addressed the accessibility of the smoking materials by having them locked up and residents have to ask for them, go off campus to smoke, and return the materials upon return to the facility. He stated that the concern would be residents who were not cognitively intact potentially getting access to a lighter or cigarette. When asked about residents being assessed for safe smoking, he stated that they were not because 1) there is no smoking assessment form in the electronic health record system that could be utilized because the facility was supposed to be a smoke-free facility, and 2) that when the residents leave the facility property to smoke and are cognitively intact, they are responsible for their own safety offsite. A review of the comprehensive care plan failed to reveal any evidence that Resident #67 was care planned for smoking related concerns and interventions. No further information was provided by the end of the survey. 4. For Resident #307 (R307), the facility staff failed to complete a safe smoking assessment. On 6/27/23 at approximately 10:30 a.m., an interview was conducted with ASM (administrative staff member) #1 (the executive director). ASM #1 stated the facility was a non-smoking facility but there were some residents who walked off the property to smoke. ASM #1 stated these residents were deemed physically safe to walk off the property and were required to sign themselves out, but smoking assessments had not been completed. ASM #1 further stated these	F 689		

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	495140	A. BUILDING ______ B. WING ______	06/29/2023

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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F 689	Continued From page 66 residents had to obtain their cigarettes and lighters from the nurses or social services employees. ASM #1 provided a list of the residents who went off the property to smoke and R307's name was on the list. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 1/19/23, the resident scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact. On 6/27/23 at 4:45 p.m., an interview was conducted with R307. R307 stated he obtains his smoking materials at the nurses' station, signs himself out, and walks off the property once or twice a day to smoke. A review of R307's clinical record failed to reveal a safe smoking assessment to ensure the resident could safely, independently smoke. On 6/28/23 at 418 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated a smoking assessment should be completed for residents who leave the property to smoke. RN #1 stated this should be done for the residents' safety and to ensure the residents can safely hold a cigarette, light a cigarette, and to ensure the residents know to not wear oxygen while smoking. On 6/29/23 at 11:43 a.m., ASM #1 and ASM #2 (the interim Director of Nursing) were made aware of the above concern.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)	F 692		

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F 692	Continued From page 67 §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to monitor a resident's weight for one of 35 residents in the survey sample, Resident #12. The findings include: For Resident #12 (R12), the facility staff failed to obtain physician ordered weekly weights. The weekly weights were ordered due to a significant weight loss. Review of R12's clinical record revealed a note signed by the registered dietician on 3/7/23 that documented, "Summary: Significant wt (weight)	F 692	F692 1) Resident #12 has been receiving weekly weights per physician order. 2) Current residents with weekly weights ordered were audited to ensure they were being obtained. 3) The DON/designee provided re-education to UM/RD/Designee on weight policy for obtaining weekly weights. 4) Residents on weekly weights will be audited weekly for 2 months to ensure they were obtained per physician order. Results of audits will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5) Compliance Date: 7/27/2023	

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F 692	Continued From page 68	F 692		

loss -5% x 30 days and-9% x 90 days. PO (By mouth) intake is sufficient to meet EEN at this time. BMI (Body Mass Index) is WNL (Within Normal Limits), but on the lower end of normal (18.9-24.9 is normal). Interventions in place for wt loss. Recommend increasing fortified foods to TID (three times a day) with all meals and weekly wt x 1 month. RD (Registered Dietician) will continue to monitor."

Further review of R12's clinical record revealed a physician's order dated 3/13/23 for weekly weights for one month due to significant weight loss. A review of R12's weights for 3/13/23 through 4/13/23 revealed only one weight was obtained on 4/12/23. R12 weighed 100 lbs on 3/1/23 and 103 lbs on 4/12/23.

On 6/29/23 at 9:38 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated residents who are losing weight, gaining weight, on a fluid restriction, or who aren't eating well are monitored for weekly weights. RN #1 stated a physician's order for weekly weights should be entered under the weights section in the computer system so the CNA (certified nursing assistant) who obtains weekly weights will see the order and obtain the weights.

On 6/29/23 at 11:43 a.m., ASM (administrative staff member) #1 (the Executive Director) and ASM #2 (the interim Director of Nursing) were made aware of the above concern.

The facility policy titled, "Weight Loss Prevention Program" documented, "Obtain weights-monthly by the 5th of each month-ensure accurate weights and reweighs are timely. Consistent staff to weigh residents weekly and monthly at

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F 692	Continued From page 69 consistent times. Document-monthly and weekly weights on the Monthly/Weekly Weight Record..."	F 692		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to provide evidence of communication to the dialysis center for one of 35 residents in the survey sample, Resident #45. The findings include: For Resident #45, the facility staff failed to evidence communication with the dialysis center every time the resident went to dialysis. The physician order dated, 5/17/2023 documented, "Dialysis (name, address and phone number of dialysis center) MWF (Monday/Wednesday/Friday) one tine a day every Mon, Wed, Fri related to end stage renal disease. Chair time 12:45 p.m. until 17:00 p.m. (5:00 p.m.). The review of the clinical record failed to evidence communication with the dialysis center on the following dates: May 2023: 5/17/2023, 5/19/2023, 5/26/2023,	F 698		

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F 698	Continued From page 70 5/29/2023 and 5/31/2023. June 2023: 6/2/2023, 6/5/2023, 6/7/2023, 6/9/2023, 6/12/2023, 6/14/2023, 6/16/2023, 6/19/2023, 6/23/2023, and 6/26/2023. The comprehensive care plan dated, 12/12/2022, documented in part, "Focus: Alteration in Kidney Function due to end stage renal disease (ESRD) with dialysis on M - W - F." The "Interventions" documented in part, "Written communication form with review of weights and any change of condition between dialysis provider and living center." An interview was conducted with LPN (licensed practical nurse) #5 on 6/28/2023 at 5:32 p.m. When asked the process for resident going to dialysis, LPN #5 stated a paper goes with the resident, it is filled out by the nurse here (at the facility) and then dialysis fills it out, sometimes, and sends it back. When asked how the paper is taken to the dialysis center, LPN #5 stated, it is put in an envelope and sent with the resident. A request was made on 6/28/2023 at approximately 6:00 p.m. for the missing dialysis communication forms. On 6/29/2023 at 8:30 a.m., ASM (administrative staff member) #4, the regional clinical consultant, presented some missing communication forms. When asked if there were any other forms, ASM #4 stated that is all they could find. ASM #4 was asked if there should be a communication form for each time the resident goes to dialysis, ASM #4 stated, yes. The facility policy, "Coordination of Hemodialysis," documented in part, "Procedure: 1. A	F 698	F698 1) Resident #45 has evidence of ongoing communication with the dialysis center. 2) Current residents that receive dialysis were audited to ensure evidence of ongoing communication with the dialysis center. 3) DON/Designee re-educated Licensed nurses on dialysis policy. 4) Weekly audits for 2 months will be conducted on dialysis residents to ensure evidence of ongoing communication with the dialysis center. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5) Compliance Date: 7/27/2023	

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F 698	Continued From page 71 communication format will be initiated by the facility for any resident going to an ESRD facility for hemodialysis...2. Nursing will collect information regarding the resident to send to the ESRD facility with the resident - information recommended but not limited to: A. Resident information - face sheet. B. Copy of current physician orders. C. Copy of plan of care. D. Blank Progress Note. E. Blank ESRD Communication form. 3. Nursing will send the resident information with the resident to the designated appointments at the ESRD facility. Nursing will give a brief summary of the resident's physical, mental, and emotional condition, oral intake, activity tolerance and change in physician orders since the last appointment. 4. The ESRD facility it to review and complete the ESRD communication form at each visit. 5. Upon the resident's return to the facility, nursing will review the ESRD communication form and communicate with the resident's physician and of the ancillary departments as needed. 6. The facility will notify the ESRD facility of scheduled resident care conferences through the communication forms. 7. The completed ESRD form must be maintained as part of the medical record." ASM (administrative staff member) #1, the executive director, ASM #2, the interim director of nursing, ASM #4, the regional clinical consultant, and ASM #5, the regional vice president of operations, were made aware of the above concern on 6/29/2023 at 11:43 a.m. No further information was provided prior to exit.	F 698		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4)	F 700		

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F 700	Continued From page 72 §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to ensure residents were assessed for, informed of risk and benefits of, and signed a consent for the use of siderails/bedrails for two of 35 residents in the survey sample; Residents #40 and #96. The findings include: 1. For Resident #40, the facility staff failed to ensure that the resident was informed of the risk and benefits of, and signed a consent for the use of siderails prior to using them.	F 700	F700 1) Resident #40 and #96 have necessary bedrail requirements implemented. 2) Audits of current residents with bed rails were conducted to ensure implementation of assessment, risk and benefits reviewed and informed consent signed. 3) The DON/designee provided re-education to Licensed nurses, rehab services and maintenance on ensuring assessment is completed, risk and benefits reviewed and informed consents have been obtained for side rails. 4) The DON/Designee will audit new orders for side rails to ensure assessment was completed, risk and benefits were reviewed and informed consent was obtained weekly for 2 months. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5) Compliance Date: 7/27/2023	

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F 700	Continued From page 73 On 6/28/23 at 8:35 AM, Resident #40 was observed in bed, with the head of his bed elevated and the siderails were up on both sides. A review of the clinical record revealed that on 4/14/23, the therapy department had assessed Resident #40 for the use of siderails and determined that they were necessary for the resident for increased safety and independence for bed mobility. Further review of the clinical record failed to reveal any evidence of risk and benefits of the use of siderails (i.e., entrapment) was provided to Resident #40, and there was no evidence of a signed consent. On 6/28/23 at 4:18, an interview was conducted with RN #1 (Registered Nurse), the unit manager. When asked what was the process if residents are to have siderails, she stated that nursing can make a suggestion for it, and the therapy department evaluates the resident and determines if the resident would benefit from siderails and then maintenance should be notified to add them onto the bed. She stated that siderails are there to assist the resident and if the resident cannot use them then they shouldn't have them. She stated that residents should be assessed for the use of siderails. When asked if anyone explains the risk and benefits and obtain an informed consent for the use of siderails, she stated that the resident is educated if they are cognitively intact, and are explained the risk of entrapment. She stated that she had never seen a paper consent form at the facility for siderails. A review of the clinical record revealed the comprehensive care plan. The care plan did not	F 700		

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F 700	Continued From page 74 address the use of the siderails. On 6/29/23 at 9:20 AM, ASM #1 (Administrative Staff Member) the Executive Director, and ASM #4 the Regional Clinical Consultant, were made aware of the findings. No further information was provided by the end of the survey. No further information was provided by the end of the survey. 2. For Resident #96 (R96), the facility staff implemented bed rails without a documented recommended clinical need, failed to review the risks and benefits of bed rails, and failed to obtain informed consent for the use of bed rails. On 6/27/23 at 11:27 a.m., R96 was observed lying in bed with bilateral bed rails (grab bars) in the upright position. A review of R96's clinical record failed to reveal a physician's order for bed rails, failed to reveal evidence that the risks and benefits of bed rails were explained to the resident (or resident representative), and failed to reveal evidence that informed consent for the use of bed rails was obtained. The side rail assessment section of an admission data collection form dated 4/27/23 documented, "14. Recommendations: None. 15. Does not have Ambulatory Ability..." On 6/28/23 at 4:18 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated the need for bed rails is more so assessed by the therapy staff, to see if the resident has the strength to turn. RN #1 stated if a resident does not have the strength to turn then there is no reason for bed rails to be on the bed. RN #1 stated that if a resident uses bed rails, then the	F 700		

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F 700	Continued From page 75 nurses explain the need and risks to the resident, but she had never seen a physical form where informed consent is documented. Further review of R96's clinical record failed to reveal documentation that the therapy staff decided R96 needed bed rails. On 6/29/23 at 11:43 a.m., ASM (administrative staff member) #1 (the Executive Director) and ASM #2 (the interim Director of Nursing) were made aware of the above concern.	F 700		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		

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ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

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F 755	Continued From page 76 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to ensure medications were available for administration for two of 35 residents in the survey sample, Residents #51 and #2. The findings include: 1. For Resident #51 (R51), the facility staff failed to administer the physician ordered medication Pradaxa (1) on 6/12/23 and 6/13/23. A review of R51's clinical record revealed a physician's order dated 12/3/19 for Pradaxa 150 mg (milligrams) two times a day for atrial fibrillation. A review of R51's June 2023 MAR (medication administration record) revealed the same physician's order for Pradaxa. On 6/12/23 and 6/13/23, the MAR documented the code, "7=Other/See Nurse Notes." Nurses' notes dated 6/12/23 and 6/13/23 documented, "Medication on order from pharmacy." Further review of nurses' notes and the June 2023 MAR failed to reveal documentation that Pradaxa was administered to R51 on 6/12/23 and 6/13/23. A review of the facility backup medication supply list revealed Pradaxa was not stocked in the supply.	F 755	F755 1) Resident #51 Pradaxa and Resident #2 Buspirone are available for administration. 2) Current residents receiving medications have the potential to be affected if medications are not available. 3) The DON/designee provided re-education to Licensed nursing staff on pharmacy services to include ensuring medication is available for administration. 4) Random audits of residents receiving medications will be conducted weekly for 2 months to ensure medication is available for administration. Results of audits will be reviewed at the monthly QAPI meeting. Any discrepancies will be addressed immediately. 5) Compliance Date: 7/27/2023	

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 ______	06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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On 6/28/23 at 4:18 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated medications should be ordered from the pharmacy when there are seven pills remaining. RN #1 stated if a medication is not available for administration, then she checks the bottom of medication cart, where extra medications are stored, and if the medication is not there, then she checks the backup medication supply box and calls the pharmacy.

On 6/29/23 at 11:43 a.m., ASM (administrative staff member) #1 (the Executive Director) and ASM #2 (the interim Director of Nursing) were made aware of the above concern. The facility staff did not provide a policy regarding the administration of medications per physician's orders.

Reference:
(1) "Dabigatran (Pradaxa) is also used to help prevent strokes or serious blood clots in adults who have atrial fibrillation (a condition in which the heart beats irregularly, increasing the chance of clots forming in the body, and possibly causing strokes) without heart valve disease. If you have atrial fibrillation and are taking dabigatran to help prevent strokes or serious blood clots, you are at a higher risk of having a stroke after you stop taking this medication. Do not stop taking dabigatran without talking to your doctor. Continue to take dabigatran even if you feel well. Be sure to refill your prescription before you run out of medication so that you will not miss any doses of dabigatran." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a610024.html

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F 755	Continued From page 78	F 755		

2. For Resident #2 (R2), the facility staff failed to administer the physician ordered medication buspirone (1) on 6/17/23.

A review of R2's clinical record revealed a physician's order dated 3/4/22 for buspirone 10 mg (milligrams) one time a day for anxiety disorder. A review of R2's June 2023 MAR (medication administration record) revealed the same physician's order for buspirone. On 6/17/23, the MAR documented the code, "7=Other/See Nurse Notes." A nurse's note dated 6/17/23 documented, "Medication on order." Further review of nurses' notes and the June 2023 MAR failed to reveal documentation that buspirone was administered to R2 on 6/17/23.

A review of the facility backup medication supply list revealed buspirone was not stocked in the supply.

On 6/28/23 at 4:18 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated medications should be ordered from the pharmacy when there are seven pills remaining. RN #1 stated if a medication is not available for administration, then she checks the bottom of medication cart, where extra medications are stored and if the medication is not there, then she checks the backup medication supply box and calls the pharmacy.

On 6/29/23 at 11:43 a.m., ASM (administrative staff member) #1 (the Executive Director) and ASM #2 (the interim Director of Nursing) were made aware of the above concern.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 755	Continued From page 79 Reference: (1) Buspirone is used to treat anxiety. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a688005.html	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to ensure one of 35 residents in the survey sample was free from a significant medication error; Resident #51. The findings include: For Resident #51 (R51), the facility staff failed to administer the physician ordered medication Pradaxa (1) on 6/12/23 and 6/13/23 used for the treatment of atrial fibrillation. A review of R51's clinical record revealed a physician's order dated 12/3/19 for Pradaxa 150 mg (milligrams) two times a day for atrial fibrillation. A review of R51's June 2023 MAR (medication administration record) revealed the same physician's order for Pradaxa. On 6/12/23 and 6/13/23, the MAR documented the code, "7=Other/See Nurse Notes." Nurses' notes dated 6/12/23 and 6/13/23 documented, "Medication on order from pharmacy." Further review of nurses' notes and the June 2023 MAR failed to reveal documentation that Pradaxa was administered to	F 760		

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F 760	Continued From page 80 R51 on 6/12/23 and 6/13/23. A review of the facility backup medication supply list revealed Pradaxa was not stocked in the supply. On 6/28/23 at 4:18 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated medications should be ordered from the pharmacy when there are seven pills remaining. RN #1 stated if a medication is not available for administration, then she checks the bottom of medication cart, where extra medications are stored, and if the medication is not there, then she checks the backup medication supply box and calls the pharmacy. On 6/29/23 at 11:43 a.m., ASM (administrative staff member) #1 (the Executive Director) and ASM #2 (the interim Director of Nursing) were made aware of the above concern. The facility staff did not provide a policy regarding the administration of medications per physician's orders. Reference: (1) "Dabigatran (Pradaxa) is also used to help prevent strokes or serious blood clots in adults who have atrial fibrillation (a condition in which the heart beats irregularly, increasing the chance of clots forming in the body, and possibly causing strokes) without heart valve disease. If you have atrial fibrillation and are taking dabigatran to help prevent strokes or serious blood clots, you are at a higher risk of having a stroke after you stop taking this medication. Do not stop taking dabigatran without talking to your doctor. Continue to take dabigatran even if you feel well. Be sure to refill your prescription before you run	F 760	F760 1) Resident #51 is free from significant medication errors and had no adverse reactions. 2) Medication pass observation audits were completed on Licensed Nurses. 3) The DON/designee provided re-education to Licensed Nurses on medication administration. 4) Random medication observation audits will be conducted weekly for 2 months to ensure residents are free from significant medication errors. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5) Compliance Date: 7/27/2023	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 760	Continued From page 81 out of medication so that you will not miss any doses of dabigatran." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a610024.html	F 760		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to serve food in a sanitary manner in one of one resident dining rooms. The findings include: The facility staff assembled a resident's hamburger and cut it in half using their bare	F 812		

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F 812	Continued From page 82 hands. On 06/27/2023 at approximately 12:40 p.m., an observation of the facility's dining room during the lunch meal was conducted. CNA (certified nursing assistant) #1 was observed with bare hands, to place the top of a hamburger roll on a hamburger, then held the hamburger together and cut it in half with a knife. On 06/27/23 at approximately 2:23 p.m., an interview was conducted with CNA #1. After being informed of the observation, CNA #1 stated that recalled the incident and that she should have been wearing gloves. When asked why it was important to wear gloves when handling a resident's food CNA #1 stated that it would prevent cross contamination. The facility policy titled, "Meal Distribution" documented, "6. Proper food handling techniques to prevent contamination and temperature maintenance controls will be used for point-of-service dining." On 06/28/2023 at approximately 5:50 p.m., ASM #1, executive director and ASM #2, were made aware of the above findings. No further information was provided prior to exit.	F 812	F812 1) Food is being served in a sanitary manner in the dining room according to professional standards for food service safety. 2) Audit of dining room to ensure food is being served in a sanitary manner according to professional standards for food service safety. 3) The Dietary Manger/Designee re-educated staff on serving food in a sanitary manner according to professional standards for food service safety. 4) Weekly audits for 2 months will be conducted to ensure staff are serving food in a sanitary manner according to professional standards for food service safety. Results of audits will be reviewed at the monthly QAPI meeting. Any discrepancies will be addressed immediately. 5) Compliance Date: 7/27/2023	