PRINTED: 01/02/2024 FORM APPROVED OMB NO. 0938-0391

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | TE SURVEY |
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| STATEMENT C | F DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION | | MPLETED |
| AND PLAN OF | CORRECTION | IDENTITION TO THE TENT | A, BUILDIN | NG | | С |
| | | 495140 | B. WING _ | | | 2/13/2023 |
| NAME OF PE | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COI | DE | |
| | | | | 110 CHALMERS COURT | | |
| ROSE HIL | L HEALTH AND REHAB | | | BERRYVILLE, VA 22611 | | (45) |
| (X4) ID PREFIX TAG | (FACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 000 | INITIAL COMMENTS | | F | 000 | | |
| F 580 SS=E | standard survey was through 12/13/2023. compliance with 42 C Term Care requiremed (VA00060044-substainvestigated during the The census in this 12 108 at the time of the consisted of three clocurrent resident review Notify of Changes (In CFR(s): 483.10(g)(14 §483.10(g)(14) Notificity A facility must immore consult with the resident with his or representative(s) who (A) An accident involvesults in injury and aphysician intervention (B) A significant charmental, or psychosod deterioration in healt status in either life-the clinical complications (C) A need to alter the aneed to discontinual treatment due to advect commence a new for (D) A decision to transcribed the from the fact §483.15(c)(1)(ii). | ntiated with deficiency) was ne survey. 20 certified bed facility was a survey. The survey sample bed records reviews and 10 ews. 21 cation of changes. 22 cation of Changes. 23 cation of Changes. 24 cation of Changes. 25 cation of Changes. 26 cation of Changes. 27 cation of changes. 28 cation of changes. 29 cation of changes. 20 certified bed facility was 29 cation of changes and 10 20 cation of Changes. 20 certified bed facility was 29 cation of changes and 10 20 cation of Changes. 26 cation of Changes. 27 cation of changes. 28 cation of changes. 29 cation of changes. 20 certified bed facility was 20 cation of changes 20 certified bed facility was 21 certified bed facility was 22 certified bed facility was 23 certified bed facility was 24 certified bed facility was 25 certified bed facility was 26 certified bed facility was 27 certified bed facility was 28 certified bed facility was 29 certified bed facility was 20 certified bed facility 21 certified bed facility 21 certified bed facility 22 certified bed facility 23 certified bed facility 24 certified bed facility 25 certified bed facility 26 certified bed facility 26 certified bed f | F | Resident #1, Resident Resident # 11 physicin notified of medication available or administ current physician orderesident # 1, resident resident # 11 have befor medications available medication cart to be administrated. | an has been ons not ered. The ders for # 10 and en reviewed ability in the | 1/14/2024 |

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.

PRINTED: 01/02/2024 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A. BUILDING_ AND PLAN OF CORRECTION 12/13/2023 B. WING 495140 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 110 CHALMERS COURT **ROSE HILL HEALTH AND REHAB** BERRYVILLE, VA 22611 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 580 F 580 Continued From page 1 all pertinent information specified in §483.15(c)(2)

F 580 Continued From page 1 all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is(A) A change in room or roommate assignment as specified in §483.10(e)(6); or

- (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
- (iv) The facility must record and periodically 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, it was determined the facility staff failed to notify the physician/nurse practitioner when medications were not available or administered for three of 13 residents in the survey sample, Residents #1, #10, and #11.

The findings include:

1. For Resident #1, the facility staff failed to notify the physician/nurse practitioner (NP) when Toprol

DON/designee will review current residents in the facility physicians' orders for availability of medication in the medication cart. Current resident's physician orders will be reviewed for availability and documentation for any discrepancy identified by the nurse, upon discovery will be corrected.

The licensed nursing staff will be re-educated by DON/ADON / designee on obtaining and administering medications as directed by physician, to include notification of physician/ np and resident's representative of medication changes. No other residents on Toprol XL were identified for changes.

PRINTED: 01/02/2024 FORM APPROVED OMB NO. 0938-0391

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| AND PLAN OF | COMPLOTION | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | A, BUILDI | | | | |
| | | 495140 | B. WING | | | 12/ | 13/2023 |
| NAME OF PR | ROVIDER OR SUPPLIER | | | ı | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| POSE HIII | L HEALTH AND REHAB | | | | 10 CHALMERS COURT ERRYVILLE, VA 22611 | | |
| KOSE TILE | | | | Ь | PROVIDER'S PLAN OF CORRECTION | | (X5) |
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| F 580 | Continued From page | e 2 | F | 580 | | | |
| | XL and Meloxicam we | ere not available | | | | | |
| | administration. | | | | The DON/ designee will revie | w | |
| | mg (milligrams); give a day for pain. The November 2023 administration record order. On the followir dose, a "7" was docu other/see nurse note: 11/2/2023 11/3/2023 11/6/2023 11/7/2022 11/8/2023 The nurse's note for | (Meloxicam) Oral tablet 15 1 tablet by mouth one time MAR (medication) documented the above ng dates at the 9:00 a.m. mented, a "7" indicated, | | | the 24- hour report for documentation of medications missing, changes and/ or not available. Documentation will reviewed for notifications to physician / NP for further recommendations and residen representative for notification daily x14 days, and 5x week 60 days. The results of the medication 24-hour audit will reported to the monthly QAP committee for further recommendations. | t's , for | 1/16/2024 |
| | part, "Awaiting pharm box." | nacy delivery, not in back up 11/3/2023, documented in | | | | | yan can |
| | part, "Reordered - ph The nurse's note for nurse's note for this r | armacy notified." 11/6/2023, there was no | | | | | |
| | in part, "pharmacy wa delivered." | as notified of not being | | | | | |
| | The nurse's note date | ed, 11/8/2023, documented as notified several times - no | | | | | |
| | The physician order of documented in part, 'Give 1 tablet by mou pain." | dated, 11/15/2023, "Mobic Oral Tablet 15 mg; th one time a day for back | | | | | |
| | The November MAR | documented the above | | | | | |

Facility ID: VA0210

| CENTER | S FOR MEDICARE & I | MEDICAID SERVICES | | | | OMB NO. 0938-0391 | | |
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| STATEMENT O | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
| AND PLAN OF | CORRECTION | 100000000000000000000000000000000000000 | A BUILD | נייט | | C | | |
| | | 495140 | B. WING | _ | | 12/1 | 3/2023 | |
| NAME OF PR | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| DOSE UII I | L HEALTH AND REHAB | | | 1 | 110 CHALMERS COURT | | | |
| RUSE HILI | | | | L | BERRYVILLE, VA 22611 PROVIDER'S PLAN OF CORRECTION | | (X5) | |
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| F 580 | Continued From page order. On 11/16/2023 a.m. dose, a "7" was The nurse's note date in part, "Not available The nurse's note date in part, "Medication of Give 1 tablet by mout (high blood pressure). The November MAR order. On 11/2/2023, 11/17/2023, there was 9:00 a.m. doses of To The nurse's note date in part, "Awaiting phase in back up box." The nurse's note date in part, "Medication of | and 11/17/2023 for the 9:00 documented. ed, 11/16/2023, documented at this time." ed, 11/17/2023, documented n order from Pharmacy." dated, 4/19/2023, XL Oral Tablet Extended ng (Metoprolol Succinate); th one time a day for HTN orange." documented the above 11/14/2023, 11/16/2023, and as documented a "7" for the oprol XL. ted, 11/2/2023, documented armacy delivery, not available an order from Pharmacy." ed, 11/16/2023, documented an order from Pharmacy." ed, 11/16/2023, documented and in order from Pharmacy." | | 580 | | | | |
| | there, where extra m there, the nurse show not there the nurse s | t to see if the medication is edication is stored. If not all go to the backup box. If hould call the pharmacy to and the status of it. If you still | | | | | | |

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| STATEMENT C | F DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ,, · | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| AND PLAN OF | CORRECTION | PERTITIONION ROBBETS | A. BUILDI | ING . | | (| |
| | | 495140 | B. WING | _ | | 12/ | 13/2023 |
| NAME OF PE | ROVIDER OR SUPPLIER | | | 1 | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| BOSE UII | L HEALTH AND REHAB | | | | 110 CHALMERS COURT | | |
| ROSE HIL | L REALITH AND REHAD | | | | BERRYVILLE, VA 22611 | | (X5) |
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| | Continued From page can't administer the motify the doctor and responsible party. LP the steps they have to #2 stated, in the programmented in part, scheduled medication given at other than the example, the resident center at scheduled of antibiotic is needer front of the MAR for the initiated and circled. Entered on the revers provided for PRN (as two consecutive dose withheld or refuse, the ASM #1, the interimal interim director of nursing, we above findings on 12 No further information 2. For Resident #10, notify the physician/Not administered. The physician order documented, "Trulici Pen-injector (2) 1.5 Milliliter) (Dulaglutide subcutaneously one | nedication, the nurse should the resident and/or N #2 was asked where all aken are documented, LPN ress notes. dedication Administration" 2. If a dose of regularly is is withheld, refused, or it is not in the nursing care does time, or a starter dose d), the space provided on the that dosage administration is An explanatory note is se side of the record is needed) documentation. If it is not in the interior are the physician is notified." administrator, ASM #2, the regional as ASM #4 the interior assistant were made aware of the control | | 580 | DEFICIENCY) | | |
| | (Monday) for DM (dia | abetes mellitus)." | | | | | |

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | OMB NO. 0938-0391 | | |
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| STATEMENT C | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ` ' | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
| | | 495140 | B. WING | | | 12/· |) 13/2023 | |
| | ROVIDER OR SUPPLIER | | | 1 | STREET ADDRESS, CITY, STATE, ZIP CODE 10 CHALMERS COURT BERRYVILLE, VA 22611 | | | |
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| F 580 | On 10/16/2023 a "5" for the administration indicated, LOA (leaved Review of the nurse's documentation of the not given. Nor documentation of the not given. Nor documentation of the not given. Nor documentation wasn't given. The resident had a property of the property of the nurse was contained as the property of the nurse was contained as the property of the nurse of the nurse was the property of the nurse of the nur | ocumented the above order. was documented in the box of the Trulicity. A "5" e of absence). Is note failed to evidence e reason the medications was mentation of the physician oner being notified that is Thysician order dated, ted in part, "Resident has fri, pick up is 9:15 a.m." Inducted with RN #1 on I.m. When asked if a en due to the resident going weekly medication, what se take, RN #1 stated first I medication is if it can be by call the physician and follow I have been given once the m dialysis since it's only a RN #1 stated if she had seen I have called the physician und the resident's dialysis rese should have called the ractitioner and told them it staff member) #1, the interim #2, the interim director of the regional clinical director and assistant director of nursing, the above findings on i.m. | F | 580 | | | <i>a</i> / | |
| | No further information | n was provided prior to exit. | | | | | | |

PRINTED: 01/02/2024 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION

| STATEMENT O | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULT A, BUILDIN | | COMPLETED | | |
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| JIAD LEVIA OL | CONTROL | | ,, boilebii | | | | |
| | | 495140 | B. WING_ | | | 12/ | 13/2023 |
| | ROVIDER OR SUPPLIER L HEALTH AND REHAB | | | STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI REGULATORY OR LSC IDENTIFYING INFORMATION) TAG | | < | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| F 580 | 3. For Resident #11, notify the physician/N | the facility staff failed to NP when medications were | F | 580 | | | |
| | administration record following medications 10/27/2023 at 9:00 p -Hydrocortisone Exterior bilateral hands and le rash/itching for 7 day -Keflex Oral Capsule (milligram); give 1 caday for cellulitis lower-Lotrimin AF external of B. feet topically two (fungal rash) for 7 day -Tylenol Extra Streng 2 tablets by mouth two | er 2023 MAR (medication l) failed to evidence the swere administered on .m.: ernal gel 1%; apply to eg topically two time a day for ss. (antibiotic) 500 mg apsule by mouth two times a relegs for 5 days. I cream 1%; apply to plantar to times a day for tinea pedis ays. 19th Oral tablet - 500 mg; give we times day for pain. | | | | | |
| | above orders. The no and failed to evidence why the medications | cian orders documented the curse's notes were reviewed the any documentation as to were not administered or the sysician that the medications | | | | | |
| | practical nurse) #2 o LPN #2 was shown to what do the blanks of #2 stated it means the given. LPN #2 was a medications were not anything, LPN #2 statche physician that the | nducted with LPN (licensed in 12/12/2023 at 2:25 p.m. the above MAR. When asked in 10/27/2023 indicate, LPN in emedications were not asked if it was found that the of given, should the nurse do ated the nurse should notify it emedications were not given. | | | | | |

AND HUMAN SERVICES PRINTED: 01/02/2024

AND HUMAN SERVICES OMB NO. 0938-0391

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | (X3) DATE S | 0950-0591 |
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| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | COMPL | |
| ND PLAN OF | CORRECTION | IDENTIFICATION NOMBER. | A, BUILD | ING | | | |
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| D005 (III | L HEALTH AND REHAB | | | 1 | 10 CHALMERS COURT | | |
| ROSE HIL | L HEALTH AND REHAB | | | В | ERRYVILLE, VA 22611 | | (X5) |
| (X4) ID PREFIX TAG | (FACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | E ATE | COMPLETION DATE |
| F 580 | nursing, ASM #3, the ASM #4 the interim a | 2, the interim director of regional clinical director and ssistant director of nursing, the above findings on | F | 580 | | | |
| F 656 SS=D | Develop/Implement CCFR(s): 483.21(b)(1) §483.21(b) Comprehe §483.21(b)(1) The fair implement a comprehe care plan for each resident rights set for §483.10(c)(3), that in objectives and timefromedical, nursing, and needs that are identificated assessment. The cordescribe the following (i) The services that a or maintain the reside physical, mental, and required under §483. (ii) Any services that under §483.24, §483 provided due to the runder §483.10, include the following treatment under §483. (iii) Any specialized services provide as a result of recommendations. If findings of the PASA rationale in the reside | ensive Care Plans cility must develop and nensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable amental and psychosocial fied in the comprehensive mprehensive care plan must g- are to be furnished to attain ent's highest practicable I psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required .25 or §483.40 but are not esident's exercise of rights ding the right to refuse 3.10(c)(6). services or specialized is the nursing facility will FPASARR a facility disagrees with the RR, it must indicate its ent's medical record. th the resident and the | F | 656 | Resident #7 and #11 current physician orders have been reviewed for medication administration according to resident's plan of care. Reside # 10 Trulicity medication has been reviewed by physician and new order received on January 2024, to administer medication non dialysis every Thursday. Care plans were updated to reflamedication administration per physician order. | nd 4, n | 1/16/2024 |

| DEIMIN | | ALERICALD OF DVICES | | | | OWR NO | . 0938-0391 |
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| STATEMENT C | S FOR MEDICARE & DEFICIENCIES CORRECTION | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (· · · · / · · | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED C | |
| | | 495140 | B. WING | | | 1 | 13/2023 |
| | ROVIDER OR SUPPLIER | | | 11 | REET ADDRESS, CITY, STATE, ZIP CODE O CHALMERS COURT ERRYVILLE, VA 22611 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 656 | (A) The resident's go desired outcomes. (B) The resident's prefuture discharge. Fact whether the resident' community was asselecal contact agencial entities, for this purpower (C) Discharge plans plan, as appropriate, requirements set fort section. §483.21(b)(3) The set by the facility, as out care plan, mustified Be culturally-common This REQUIREMENT by: Based on staff interview, and clinical redetermined the facility the comprehensive or residents in the survey #11, and #10. The findings include: 1. For Resident #7, it implement the compadministering medical orders. The comprehensive part, the following: Focus: Resident at repisodes due to diagonellitus). Insulin definition in the survey part, the following: Focus: Resident at repisodes due to diagonellitus). Insulin definition in the survey part, the following: Focus: Resident at repisodes due to diagonellitus). Insulin definition in the survey part, the following: Focus: Resident at repisodes due to diagonellitus). Insulin definition in the survey part, the following: Focus: Resident at repisodes due to diagonellitus). Insulin definition in the survey part the following: Focus: Resident at repisodes due to diagonellitus). Insulin definition in the survey part the following: Focus: Resident at repisodes due to diagonellitus). Insulin definition in the survey part the following: Focus: Resident at repisodes due to diagonellitus). Insulin definition in the survey part the following: | als for admission and eference and potential for cilities must document s desire to return to the essed and any referrals to es and/or other appropriate ose. in the comprehensive care in accordance with the h in paragraph (c) of this ervices provided or arranged lined by the comprehensive expetent and trauma-informed. T is not met as evidenced eview, facility document ecord review, it was ty staff failed to implement eare plan for three of 13 ey sample, Residents #7, the facility staff failed to rehensive care plan for ations per the physician care plan documented, in isk for hyper/hypoglycemic gnosis of DM (diabetes | F | 656 | Care plans will be reviewed wischeduled RAI quarterly assessments for following medication administration per orders/recommendations. DON/IDT team will review car plans and revise with review of 24-hour report to include any network physician orders-recommendations upon discovery. The Dialysis resides were reviewed for any other medication identified for change with none identified, no other residents noted for Trulicity. | re f ew nts | |

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

| CENTERS FOR MEDICARE & I | | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTI | IPLE (| CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | CORRECTION | IDENTIFICATION NUMBER: | A. BUILDIN | 1G | | | |
| | | 495140 | B. WNG _ | | | C 12/13/2023 | |
| | ROVIDER OR SUPPLIER | 490140 | | 110 | REET ADDRESS, CITY, STATE, ZIP CODE DICHALMERS COURT ERRYVILLE, VA 22611 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | ; | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | E ATE | (X5) COMPLETION DATE |
| F 656 | Focus: Resident is ta at risk for side effects Interventions: Admini Focus: Resident is ta depression and anti-r Interventions: Admini per order observing eantidepressant per or Medicate for pain as Focus: Resident is ta medication placing reeffects. Interventions: Admini observing effect. Focus: Resident is at to ASHD (arterioscler blood pressure Taki medications daily. Interventions: Admini medications per order deview of the Octobe administration record following medications 10/27/2023 at 9:00 p-Donepezil HCL Oral by mouth at bedtime -Melatonin Oral Tables Give 1 tablet by mouth two times a darbeat or a darbeat or a darbeat or a disease)Memantine HCL Oral disease)Memantine HCL Oral definition or a darbeat or a d | king two anticoagulant and //complications ster medication per order. king an antidepressant for manic for Chronic pain. ster anti manic medication effect. Administer der observing effect. order observing effect. king an antipsychotic esident at risk for side ster medications per order erisk for cardiac disease due extic heart disease), high ang antihypertensive effect. Ster antihypertensive effect. The cardiac disease due extic heart disease due extic heart disease), high ang antihypertensive effect. The cardiac disease due extic heart disease of the external for antihypertensive effect. The cardiac disease due extic heart disease of the external for antihypertensive effect. The cardiac disease due extic heart disease of the external for antihypertensive effect. The cardiac disease due extinct the external for antihypertensive effect. The cardiac disease due external for antihypertensive effect. | F6 | 356 | DON/designee will re educate to licensed nurses and IDT team revision of care plans after reviewing 24-hour report and/physician summary for documentation of medication changes per physician orders and/or recommendations/changes for revision of current care plant designee will review physicial orders and 24-hour report, day 14 days, and 5x week for 60 cfor documentation accuracy care plan revision. The result will be reported to QAPI more x3 for further recommendations. | on for ges an illy x lays and ts athly | 1/10/2024 |

FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING_ C 12/13/2023 B. WING 495140 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 110 CHALMERS COURT **ROSE HILL HEALTH AND REHAB** BERRYVILLE, VA 22611 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 656 Continued From page 10 -Olanzapine Oral Tablet 2.5 mg; Give 1 tablet by mouth two times a day related to anxiety. -Tramadol HCL Oral Tablet 50 mg; Give 1 tablet by mouth every 12 hours for pain. -Gabapentin Oral Capsule 300 mg; Give 1 capsule by mouth three times a day for chronic pain. -Trazadone HCL Oral Tablet 50 mg; Give 1 tablet by mouth three times a day for anxiety and dementia. An interview was conducted with RN (registered nurse) #1, on 12/12/2023 at 3:19 p.m. When asked the purpose of the care plan, RN #1 stated it so that everyone know how to take care of that resident, what special utensils, devices needed and why residents are on medications. RN #1 was asked if medications were not given, per the physician order, and it's written on the care plan, is that following the care plan, RN #1 stated, no. The facility policy, "Care Plan" documented in part, "All staff must be familiar with each resident's Care Plan and all approaches must be implemented." ASM #1, the interim administrator, ASM #2, the interim director of nursing, ASM #3, the regional clinical director and ASM #4 the interim assistant director of nursing, were made aware of the above findings on 12/12/2023 at 4:45 p.m. No further information was provided prior to exit. 2. For Resident #11, the facility staff failed to

orders.

implement the comprehensive care plan for administering medications per the physician PRINTED: 01/02/2024

PRINTED: 01/02/2024 FORM APPROVED OMB NO. 0938-0391

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | 0/0 1411 | TIDI | E CONSTRUCTION | (X3) DATE S | | |
|--------------------------|---|---|-------------------|------|---|-------------|--------------------|--|
| STATEMENT C | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | COMPLETED | | |
| MAD LIDAM OF | OS. WEGITOT | | 1, , , , , , , | | | | | |
| | | 495140 | B. WING | _ | | 12/1 | 3/2023 | |
| NAME OF PR | ROVIDER OR SUPPLIER | | | 1 | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| DOSE UII | L HEALTH AND REHAB | | | | 110 CHALMERS COURT BERRYVILLE, VA 22611 | | | |
| KOSE NIE | | | | L | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| (X4) ID PREFIX TAG | (FACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | 3E | COMPLETION DATE | |
| F 656 | The comprehensive of part, the following: Focus: Altered skin in to: per family my skir history of skin tears. Interventions: Treatm Focus: I have increased uring therapy. Interventions: Medica physician and follow Review of the Octobra administration record | ntegrity non pressure related is fragile and I have a ments as ordered. Seed pain in my right knee ate for pain as ordered by up for effectiveness. er 2023 MAR (medication is failed to evidence the swere administered on | F | 656 | 6 | | | |
| | -Hydrocortisone Extendilateral hands and learn rash/itching for 7 day -Keflex Oral Capsule (milligram); give 1 can day for cellulitis lower -Lotrimin AF externation of B. feet topically two (fungal rash) for 7 day -Tylenol Extra Streng 2 tablets by mouth the An interview was concurse) #1, on 12/12/ | ernal gel 1%; apply to eg topically two time a day for ys. e (antibiotic) 500 mg apsule by mouth two times a er legs for 5 days. I cream 1%; apply to plantar yo times a day for tinea pedis ays. eth Oral tablet - 500 mg; give wo times day for pain. Inducted with RN (registered 2023 at 3:19 p.m. When | | | | | | |
| | asked the purpose of it so that everyone k resident, what specia and why residents a was asked if medica physician order, and is that following the order. | of the care plan, RN #1 stated now how to take care of that all utensils, devices needed are on medications. RN #1 titions were not given, per the lit's written on the care plan, care plan, RN #1 stated, no. | | | * | | | |

interim director of nursing, ASM #3, the regional

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

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | CNICTON | (X3) DA | TE SURVEY | | |
|--------------------------|---|---|---------------------|--|--------------------------------|--------------------|--|--|
| STATEMENT C | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE C | | | COMPLETED | | |
| AND PLAN OF | CORRECTION | (DENTIFICATION NOWBER. | A. BUILDING | | | С | | |
| | | 405440 | B, WING | | 1 | 2/13/2023 | | |
| | | 495140 | | REET ADDRESS, CITY, STATE, ZIP CO | DE | | | |
| NAME OF P | ROVIDER OR SUPPLIER | | 1 | CHALMERS COURT | | | | |
| ROSE HIL | L HEALTH AND REHAB | | | RRYVILLE, VA 22611 | | | | |
| (1002-1112 | | | | PROVIDER'S PLAN OF C | ORRECTION | (X5) | | |
| (X4) ID PREFIX TAG | (FACH DEFICIENC | TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE IE APPROPRIATE | COMPLETION DATE | | |
| F 656 | clinical director and | ASM #4 the interim assistant | F 656 | | | | | |
| | above findings on 12 | vere made aware of the 1/12/2023 at 4:45 p.m. | | | | | | |
| | | n was provided prior to exit. | | | | | | |
| | implement the comp | , the facility staff failed to rehensive care plan for ations per the physician | | | | | | |
| | part, the following: Focus: I am a diabet hypo/hyperglycemia receiving insulin and | care plan documented in tic placing resident at risk for episodes. Resident is I diet as treatment. tic medications as ordered by | | | | | | |
| | Pen-injector (2) 1.5 milliliter) (Dulaglutide | ity Subcutaneous Solution MG/0.5ML (milligrams per e); inject 0.5 ml time a day every Mon | | | | | | |
| | On 10/16/2023 a "5" | locumented the above order. "was documented in the box n of the Trulicity. A "5" ve of absence). | | | | | | |
| | documentation of th | e's note failed to evidence be reason the medications was mentation of the physician tioner being notified that is | | | | | | |
| | An interview was conurse) #1, on 12/12 | onducted with RN (registered /2023 at 3:19 p.m. When | | | lé gentinuntion | sheet Page 13 of | | |
| | | Event ID: R | PF11 Fac | cility ID: VA0210 | II continuation | ander age to o | | |

FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (XI) THOUSE TOUR TOUR | | EGONSTRUCTION | COMPLETED | | | |
|---|--|--|---------------------|---|------------------------|--|--|--|
| AND PLAN OF | CORRECTION | 1,52,11,11,11 | A. BOILDING | | С | | | |
| | | 495140 | B. WNG | | 12/13/2023 | | | |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611 | | | | |
| (X4) ID PREFIX TAG | (FACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETION | | | |
| F 656 | asked the purpose of it so that everyone known resident, what special and why residents are was asked if medicate physician order, and is that following the control of the | the care plan, RN #1 stated now how to take care of that all utensils, devices needed e on medications. RN #1 ions were not given, per the it's written on the care plan, are plan, RN #1 stated, no. administrator, ASM #2, the raing, ASM #3, the regional ASM #4 the interim assistant were made aware of the /12/2023 at 4:45 p.m. In was provided prior to exit. If Revision (i)-(iii) ensive Care Plans prehensive care plan must redisciplinary team, that interdisciplinary team, tha | F 655 | | etor of and A | | | |

PRINTED: 01/02/2024

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

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | T CONSTRUCTION | (X3) DATE SURVEY |
|--------------------------|---|--|---------------------|--|------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | COMPLETED |
| AND PLAN OF | CORRECTION | IDENTIFICATION OF THE PROPERTY | A. BUILDING | | С |
| | | 495140 | B. WING | | 12/13/2023 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| | LUCALTU AND DEUAD | | | 110 CHALMERS COURT | |
| ROSE HIL | L HEALTH AND REHAB | | | BERRYVILLE, VA 22611 | 10N (X5) |
| (X4) ID PREFIX TAG | (FACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE COMPLETION |
| F 657 | (F) Other appropriate disciplines as determ or as requested by the (iii)Reviewed and revited team after each assessments. This REQUIREMENT by: Based on observation interview, and clinical determined the facility revise the care plant survey sample, Resident #12, the the care plan for a plant resident when the resident when the resident when the resident scored a 15 interview for mental resident was not conditionally decisions. Resident was not conditionally decisions. Resident was not conditionally decisions. Resident to self-propel his can walk 150 feet. The comprehensive and last revised on | e staff or professionals in nined by the resident's needs he resident. Vised by the interdisciplinary essment, including both the quarterly review To is not met as evidenced on, resident interview, staff all record review, it was by staff failed to review and for one of 13 residents in the dent #12. | F 65 | DON/designee reviewed current residents in the fact with physician orders for have been reviewed with changes as indicated at discovery. No other resident were identified with issue with LOA orders. Care provere reviewed for revision applicable. The facility's medical direction will provide re - education medical practitioner staff regarding LOA orders an supporting documentation. | ents s lans n as |
| | to: history of falls, us | se of medication, complicated | | | |

| | | I SERVICES | CV2V MUIL | TIDI E (| CONSTRUCTION | (X3) DATE | SURVEY |
|--------------------------|--|--|--------------------|----------|---|-----------------------------|----------------------------|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | | LETED |
| AIAD EDAIA OF | CONNECTION | | A. BUILDI | | • | | c |
| | | 495140 | B. WING | | | 12/ | 13/2023 |
| NAME OF D | ROVIDER OR SUPPLIER | | | ST | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | KOVIDER OR SOLVEIER | | | 110 | CHALMERS COURT | | 1 |
| ROSE HIL | L HEALTH AND REHAB | | | ВЕ | ERRYVILLE, VA 22611 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | 3E | (X5) COMPLETION DATE |
| F 657 | by seizure disorder, rindependent ambulat documented in part, resident of the dange downtown alone and The physician order of documented, "For passupervision at all time of the building." A request was made for October, Novembrathe only logs present November. ASM (ac #1 stated they could for December. The Conly documented R1 month. An interview was consured parking lot. ASM #5 expected person to go member? ASM #5 st responsible person. another resident, AS that is responsible. An interview was consumented to the parking lot. ASM #5 st responsible person. another resident, AS that is responsible. An interview was consumented to the parking lot. ASM #5 st responsible to the parking lot. ASM #5 st responsible to the passage outside to the passage outside to the passage outside with him, R1 stated he still goes outside with him, R1 | required walked for ion." The "Interventions" 12/4/2023: Re-educate of signing out to go to drinking." | F | 657 | The DON/ designee will review the 24- hour report for documentation for new admissions with LOA orders. Data obtained from audit for documentation will be reviewed for further recommendations for LOA orders and notification, daily x14 days, and 5x week for 6 days. The results of the LOA review, physician orders, and 24-hour audit will be reported to the monthly QAPI committee for further recommendations. | 5, r 7 0 A d | 1 116 2024 |

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | _ | _ | | CIVID IVE | |
|---------------|------------------------------|---|------------|-------|--|-------------|--------------------|
| STATEMENT C | F DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MUL | TIPLE | CONSTRUCTION | (X3) DATE : | SURVEY LETED |
| AND PLAN OF | CORRECTION | IDENTIFICATION NUMBER: | A. BUILD | ING_ | | | , |
| | | | D MANO | | | 1 | 13/2023 |
| | | 495140 | B. WING | | TREET ADDRESS, CITY, STATE, ZIP CODE | 121 | 13/2023 |
| NAME OF PE | ROVIDER OR SUPPLIER | | | | 10 CHALMERS COURT | | |
| ROSE HILI | L HEALTH AND REHAB | | | | ERRYVILLE, VA 22611 | | |
| | | | | ۳ | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL | ID PREF | IX | (EACH CORRECTIVE ACTION SHOULD B) | E | COMPLÉTION DATE |
| PREFIX TAG | REGULATORY OR I | LSC IDENTIFYING INFORMATION) | TAG | | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | VIE | |
| | | | - | _ | | | |
| - 0 | | - 40 | _ | 657 | | | |
| F 657 | Continued From page | | | 037 | | | |
| | didn't because it was | too cold now. | | | | | |
| | An interview was con | ducted with RN (registered | | | | | |
| | nurse) #1, on 12/12/2 | 2023 at 3:19 p.m. When | | | | | |
| | asked the purpose of | the care plan, RN #1 stated | | | | | |
| | | now how to take care of that | | | | | |
| | | I utensils, devices needed e on medications. RN #1 | | | | | |
| | was asked if the phys | sician wrote an order for | | | | | |
| | supervision of a resid | | | | | | |
| | | building, should that be on | | | | | |
| | the care plan, RN #1 | stated, yes. | | | | | |
| | The facility policy "C | are Plan" documented in | | | | | |
| | part. "An interdiscipling | nary plan of care will be | | | | - | |
| | established for every | resident and updated in | | | | | |
| | accordance with state | e and federal regulatory | | | | | |
| | requirements and on | an as needed basis. | | | | | |
| | ASM #1, the interim a | administrator, ASM #2, the | | | | | |
| | interim director of nur | rsing, ASM #3, the regional | | | | | |
| | | SM #4 the interim assistant | | | | | |
| | | ere made aware of the | | | | | |
| | above findings on 12 | /12/2023 at 4:45 p.m. | | | | | |
| | | n was obtained prior to exit. | | | | | |
| F 658 | Services Provided Me | eet Professional Standards | F | 658 | | | |
| SS=E | CFR(s): 483.21(b)(3) | (i) | | | D :1 # 11 Posident # | 2 | 1/1/2024 |
| | §483.21(b)(3) Compr | ehensive Care Plans | | | Resident # 11, Resident # | ۷, | - Jugara |
| | The services provide | d or arranged by the facility, | | | and Resident #7 current | _ | 8 |
| | as outlined by the cor | mprehensive care plan, | | | physician orders have been | .1 | |
| | must- | | | | reviewed and medication | | |
| | (i) Meet professional | standards of quality. | | | administration records for | | |
| | | is not met as evidenced | | | evidence of receiving | | |
| | by: Based on staff interv | riew, facility document | | | medications. | | |
| | review, and clinical re | ecord review, it was | | | | | |
| | | | 1 | | | | |

| CENTER | ENTERS FOR MEDICARE & MEDICAID SERVICES | | | | | (X3) DATE | SUBVEY |
|--------------------------|---|---|--------------------|-----|---|----------------------------------|--------------------|
| TATEMENT (| OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | \ \ \ -/ · · · | | CONSTRUCTION | | LETED |
| IND PLAN OF | CORRECTION | | A BUILDI | | - | | : |
| | | 495140 | B. WING | | | 12/ | 13/2023 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| BOSE UII | L HEALTH AND REHAB | | | 1 | 10 CHALMERS COURT | | |
| KOSE HIL | | | | В | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| (X4) ID PREFIX TAG | (FACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIOEFICIENCY) | iE ATE | COMPLETION DATE |
| F 658 | Continued From page determined the facility professional standard administration of med residents in the surverse, and #7. The findings include: 1. For Resident #11, administer the physical 10/27/2023. Review of the Octobe administration record following medications 10/27/2023 at 9:00 p. Hydrocortisone External of B. feet topically two (fungal rash) for 7 day - Keflex Oral Capsule (milligram); give 1 card day for cellulitis lowers. Lotrimin AF external of B. feet topically two (fungal rash) for 7 day - Tylenol Extra Streng 2 tablets by mouth two Review of the physical above orders. The mand failed to evidence why the medications notification to the physical professional professions of the physical professional | y staff failed to follow as of practice for the dications for three of 13 by sample, Residents #11, the facility staff failed to bian ordered medications on er 2023 MAR (medication of including | | 658 | DEFICIENCY) | be y. be nee nd P | |
| | practical nurse) #2 o LPN #2 was shown t | n 12/12/2023 at 2:25 p.m. he above MAR. When asked in 10/27/2023 indicate, LPN | | | | | |

| | C COD MEDICARE & | MEDICAID SERVICES | | | OMB N | O. 0938-0391 |
|--------------------------|--|---|--------------------|---|---|----------------------------|
| STATEMENT C | S FOR MEDICARE & DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | TIPLE CONSTRUCTION | | E SURVEY MPLETED |
| | | 495140 | B. WNG | | 12 | C 2/13/2023 |
| | ROVIDER OR SUPPLIER | 455140 | | STREET ADDRESS, CITY, STATE, ZIP CC 110 CHALMERS COURT BERRYVILLE, VA 22611 | DDE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | ARROSO PEREDENOED TO TH | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| F 658 | given. When asked if evening, LPN #2 state other two medication previous interim direct supposed to work on evening. A situation wand the DON had to she did the best she some of the residents her scheduled work of the sc | e medications were not she was working that ed she was working the carts on that evening. The ctor of nursing (DON) was the other two carts that with an employee came up deal with that. She stated could but never got down to s, as she was trying to get done. Inducted with ASM #2, the rsing, on 12/12/2023 at 3:58 at blanks on the MAR atted they weren't given. | F | The DON/designee value and the properties of the properties and the medication administrated for document medication not availated administered for not physician/NP and/or representative, daily and 5 x week for 60 DON will report the the audit to the QAP committee for recommendations. | audit ration tation of able or ification to resident x 14 days days. The results of | 1/16/2004 |

PRINTED: 01/02/2024 FORM APPROVED

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | 1 | - | - ALIGHBUOTION | (X3) DATE | SURVEY |
|--|---|---|-------------------|-----|--|-----------|----------------------------|
| TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | | CONSTRUCTION | COMPLETED | |
| MD PLAN OF | CORRECTION | IDEITH IO HISH HOMBER | A. BUILD | | | | ; |
| | | 495140 | B. WING | | | 12/1 | 13/2023 |
| NAME OF P | ROVIDER OR SUPPLIER | | -4 | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | | 0 CHALMERS COURT | | |
| ROSE HIL | L HEALTH AND REHAB | | | В | ERRYVILLE, VA 22611 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 658 | Review of the Octobe administration record following medications 10/27/2023 at 9:00 p.—Atorvastatin Calcium cholesterol - 40 mg; 0 bedtime for hyperlipic -Loratadine Oral Tablitime a day for allergie -Trazadone HCL Oral by mouth at bedtime -Buspirone HCL Oral by mouth two times a -Famotidine Oral tab mouth two times a day (gastroesophageal re-Furosemide Oral tab mouth two times a day for 10 central to the two times a day for 10 central to the two times a day for 10 central table to 10 central table | er 2023 MAR (medication) failed to evidence the swere administered on .m.: n Oral Tablet - high Give 1 tablet one es. I tablet - 50 mg; Give 1 tablet for depression. tablet 10 mg - Give 1 tablet by ay for GERD efflux disease). I tablet 40 mg; Give 1 tablet by ay for CHF (congestive heart tablet; Give 400 mg by mouth GERD. ER (extended release) Oral equivalents); give 1 tablet by ay for hypokalemia. I tablet 500 mg; Give 2 tablet by ay for hypokalemia. I tablet 500 mg; Give 2 tablet by ay for hypokalemia. I tablet 500 mg; Give 2 times a day for pain until tablet by give 1 tablet by ay for hypokalemia. I tablet 500 mg; Give 2 times a day for pain until tablet by give 1 tablet by ay for hypokalemia. | F | 658 | | | |

FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING _ C 12/13/2023 B. WING 495140 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 110 CHALMERS COURT **ROSE HILL HEALTH AND REHAB** BERRYVILLE, VA 22611 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 658 Continued From page 20 breath). -Sodium Bicarbonate Oral tablet 650 mg; give 1 tablet by mouth four times a day for GERD. -Sucralfate Oral tablet 1 GM (gram); Give 1 tablet four times a day for GERD. Review of the physician orders documented the above orders. The nurse's notes were reviewed and failed to evidence any documentation as to why the medications were not administered or notification to the physician that the medications were not given. An interview was conducted with LPN (licensed practical nurse) #2 on 12/12/2023 at 2:25 p.m. LPN #2 was shown the above MAR. When asked what do the blanks on 10/27/2023 indicate, LPN #2 stated it means the medications were not given. When asked if she was working that evening, LPN #2 stated she was working the other two medication carts on that evening. The previous interim director of nursing (DON) was supposed to work on the other two carts that evening. A situation with an employee came up and the DON had to deal with that. She stated she did the best she could but never got down to some of the residents, as she was trying to get her scheduled work done. An interview was conducted with ASM #2, the interim director of nursing, on 12/12/2023 at 3:58 p.m. When asked what blanks on the MAR indicated. ASM #2 stated they weren't given. ASM #1, the interim administrator, ASM #2, the

interim director of nursing, ASM #3, the regional clinical director and ASM #4 the interim assistant director of nursing, were made aware of the above findings on 12/12/2023 at 4:45 p.m.

PRINTED: 01/02/2024

FORM APPROVED OMB NO. 0938-0391

PRINTED: 01/02/2024

| CENTER | CENTERS FOR MEDICARE & MEDICAID SERVICES | | | | | | . 0938-0391 |
|--------------------------|--|---|--------------------|----------|---|-------------------|--------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MUL | TIPLE CO | DNSTRUCTION | (X3) DATE COMP | SURVEY LETED |
| | CORRECTION | IDENTIFICATION NUMBER: | A. BUILDI | NG | | | |
| | | | D 1441/0 | | | | 13/2023 |
| | | 495140 | B. WING | OTDI | EET ADDRESS, CITY, STATE, ZIP CODE | 121 | 13/2020 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | CHALMERS COURT | | 1 |
| ROSE HIL | L HEALTH AND REHAB | | | | RRYVILLE, VA 22611 | | 1 |
| KOOL IIII | | | | | PROVIDER'S PLAN OF CORRECTION | ON I | (X5) |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFI TAG | | (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP | DBE | COMPLETION DATE |
| F 658 | | | F | 658 | | | |
| | No further informatio | n was provided prior to exit. | | | | | |
| | 3. For Resident #7, t administer the physic 10/27/2023. | he facility staff failed to sian ordered medications on | | | 4 | | |
| | administration record following medication: 10/27/2023 at 9:00 p-Donepezil HCL Oral by mouth at bedtime -Melatonin Oral Table Give 1 tablet by mouth two times a dispersion or all Table give 1 tablet by mouth (myotonic muscular -Eliquis Oral Tablet 2 two times a day for A disease)Memantine HCL Oral by mouth two times a dispersion or all Tamouth two times a dispersion or all Tamouth two times a dispersion or all Tamouth two times and -Tramadol HCL Oral by mouth every 12 his -Gabapentin Oral Cacapsule by mouth the times dementia. | Tablet 10 mg; Give 2 tablets for dementia. et (used for sleep) 3 mg; th at bedtime for anemia. et 25 mg; give 1 tablet by ay for high blood pressure. et Delayed Release 125 mg; th two times a day for MMD dystrophy) 2.5 mg; give 1 tablet by mouth ASHD (arteriosclerotic heart al Tablet 10 mg; Give 1 tablet a day related to dementia. blet 2.5 mg; Give 1 tablet by ay related to anxiety. Tablet 50 mg; Give 1 tablet iours for pain. apsule 300 mg; Give 1 tablet ree times a day for chronic al Tablet 50 mg; Give 1 tablet s a day for anxiety and | | | | | |
| | above orders. The n | cian orders documented the urse's notes were reviewed ce any documentation as to | | | | | |

Facility ID: VA0210

| CENTERS | S FOR MEDICARE & | MEDICAID SERVICES | | | | | . 0938-0391 |
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| STATEMENT O | F DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | | | ONSTRUCTION | (X3) DATE : | SURVEY LETED |
| AND PLAN OF | CORRECTION | IDENTIFICATION NUMBER: | A. BUILDI | NG | | | |
| | | 495140 | B. WING | | | | 13/2023 |
| NAME OF PE | ROVIDER OR SUPPLIER | | | STR | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | | CHALMERS COURT | | |
| ROSE HILI | HEALTH AND REHAB | | | BE | RRYVILLE, VA 22611 | | |
| (X4) ID PREFIX TAG | /EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 658 | notification to the phy were not given. An interview was conpractical nurse) #2 or LPN #2 was shown the what do the blanks of #2 stated it means the given. When asked if evening, LPN #2 stated ther two medication previous interim direct supposed to work on evening. A situation wand the DON had to stated she did the best stated she did the | ducted with LPN (licensed in 12/12/2023 at 2:25 p.m. in above MAR. When asked in 10/27/2023 indicate, LPN in the was working that it ed she was working that earts on that evening. The cotor of nursing (DON) was the other two carts that with an employee came up deal with that. LPN #2 st she could but never got residents, as she was trying | F | 658 | | | |
| F 689 SS=D | An interview was cor interim director of nu p.m. When asked wh indicated, ASM #2 st ASM #1, the interim interim director of nu clinical director and A director of nursing, wabove findings on 12 No further information Free of Accident Haz CFR(s): 483.25(d) (1) §483.25(d) Accident: The facility must ens | aducted with ASM #2, the raing, on 12/12/2023 at 3:58 at blanks on the MAR ated they weren't given. administrator, ASM #2, the raing, ASM #3, the regional ASM #4 the interim assistant were made aware of the //12/2023 at 4:45 p.m. In was provided prior to exit. cards/Supervision/Devices (2) | F | 689 | Resident # 12 is cognitive intact with a BIMS of 15, physician order for LOA | | 1/16/2024 |

CENTERS FOR MEDICARE & MEDICAID SERVICES

| TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MIDENTIFICE GONG/NOOTHS (X3) MIDENTIFICE GONG | | COMPI | LETED | | | | |
|--|--|--|--------------------|-----|--|--------|----------------------------|
| | | 495140 | B. WING | | | 12/ | 13/2023 |
| | ROVIDER OR SUPPLIER | | | 11 | REET ADDRESS, CITY, STATE, ZIP CODE O CHALMERS COURT ERRYVILLE, VA 22611 | | |
| (X4) ID PREFIX TAG | (FACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 689 | as free of accident has §483.25(d)(2)Each resupervision and assist accidents. This REQUIREMENT by: Based on observation interview and facility determined the facility determined the facility physician order for suthe resident signs him one of 13 residents in Resident #12. The findings include: For Resident #12 (Resident #12 (Resident #12) (Resident #12) (Resident #13) (Resident #14) (Resident #15) (Resident #15) (Resident #16) (Resident #16) (Resident #17) (Resident #17) (Resident #18) (Resident | esident receives adequate stance devices to prevent is not met as evidenced on, resident interview, staff document review, it was y staff failed to implement a supervision of a resident when inself out of the building, for in the survey sample, 12), the physician orders the resident to be ses when he signs himself out of two occasions. | F | 689 | reviewed for LOA without 1 supervision. Resident #12 has been re—educated on the documentation process for his LOA. DON/designee reviewed current residents with LOA physician ordered have been reviewed with need of supervision noted, upon discovery, corrections were completed as applicable for changes in orders for LOA a indicated. | s s | |
| | assessment, a quarte assessment reference resident scored a 15 interview for mental seresident was not cog daily decisions. Resident was not cog daily decisions. Resident was not cog able to self-propel his can walk 150 feet. The shaving any behave coded as having had assessment. The physician order adocumented, "For page 150 feet." | MDS (minimum data set) erly assessment, with an erly assessment and erly ass | | | The Medical Director will educate nurse practitioners the proper procedure for writing physician orders for residents with LOA. | on | |

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | | . U930-U391 |
|--------------------------|---|---|-------------------|-----|---|----------------------|----------------------------|
| STATEMENT C | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1'' | | CONSTRUCTION | (X3) DATE : COMPI | |
| UMD I FVIA OL | 55.412011513 | | A. BOILD | | | (| ; |
| | | 495140 | B. WING | | | 12/ | 13/2023 |
| NAME OF PE | ROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| ROSE HIL | L HEALTH AND REHAB | | | ı | IO CHALMERS COURT ERRYVILLE, VA 22611 | 80 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | E ATE | (X5) COMPLETION DATE |
| F 689 | for October, Novembologs presented were ASM (administrative scould not locate the sThe October and Novembologumented R12's not an interview was con 12/12/2023 at 3:51 p. goes outside to the p stated he still goes outside with him, R12 if he still walked into a didn't because it was An interview was con interim director of nur p.m. The order above When asked what the stated, it means he stated, it means he sThe comprehensive and last revised on 1 part, "Focus: Resider to: history of falls, use by seizure disorder, rindependent ambulat documented in part, resident of the dange downtown alone and Resident #12 was ob wheelchair outside the side of the property lies." | for the resident sign-out logs er, and December. The only the October and November. staff member) #1 stated they ign out logs for December. rember logs only ame once for each month. ducted with Resident #12 on m. When asked if he still roperty line to smoke, R12 at with the other residents ked if a staff member goes a stated no. R12 was asked the town, R12 stated he too cold now. ducted with ASM #2, the resing, on 12/12/2023 at 3:58 as was reviewed with ASM #2. The order entails, ASM #2 should be monitored. care plan dated, 7/4/2023, 2/4/2023, documented in the startisk for falls, related the of medication, complicated required walked for inon." The "Interventions" 12/4/2023: Re-educate for signing out to go to | F | 689 | DON/ unit manager will aud residents with new LOA order and new admissions, to verify if any safety concerns to be addressed 5 x week for 30 days. The DON will report the results of the audits to the monthly QAPI committee for recommendations. | ers / e | 1/14/2024 |

PRINTED: 01/02/2024 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES

(X3) DATE SURVEY

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ` ' | | CONSTRUCTION | COMPLI | ETED |
|--------------------------|--|---|--------------------|-----|---|--------|----------------------------|
| | | | B. WING | | | 12/1 | 3/2023 |
| | ROVIDER OR SUPPLIER | 495140 | B. WING | ST | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| | L HEALTH AND REHAB | | | | CHALMERS COURT CRRYVILLE, VA 22611 | | |
| (X4) ID PREFIX TAG | (FACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 689 | nurse practitioner that 12/12/2023 at 11:07 wrote the order, ASM been falling a lot late parking lot. ASM #5 the expected person staff member? ASM responsible person. It another resident, AS that is responsible. An interview was continued in the resident of number. The order above When asked what the stated, it means he seems to responsible. | ducted with ASM #5, the at wrote the above order, on a.m. When asked why she are in the was asked who she felt was to go outside with him, a #5 stated he should have a When asked if it could be M #5 stated no, just a person aducted with ASM #2, the rsing, on 12/12/2023 at 3:58 are was reviewed with ASM #2. The order entails, ASM #2 | F | 689 | | | |
| F 755 SS=D | none was provided page 1. ASM #1, the interim interim director of nuclinical director and director of nursing, was above findings on 12. No further information Pharmacy Srvcs/Pro CFR(s): 483.45(a)(b) §483.45 Pharmacy Structures and biological them under an agree them. | administrator, ASM #2, the rsing, ASM #3, the regional ASM #4 the interim assistant were made aware of the 2/12/2023 at 4:45 p.m. In was obtained prior to exit. acedures/Pharmacist/Records (1)-(3) Services vide routine and emergency is to its residents, or obtain | F | 755 | Resident # 1 medication meloxicam was discontinu by physician on 11/27/23. Resident # 1 has a current physician order for Toprol and is administered as orde | XL | 1/16/2034 |

PRINTED: 01/02/2024 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING _ 12/13/2023 B. WNG 495140 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 110 CHALMERS COURT ROSE HILL HEALTH AND REHAB BERRYVILLE, VA 22611 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 755 Continued From page 26 personnel to administer drugs if State law permits, but only under the general supervision of DON/designee reviewed a licensed nurse. current residents who reside in §483.45(a) Procedures. A facility must provide the facility, that have the pharmaceutical services (including procedures potential to be affected. No that assure the accurate acquiring, receiving, other residents were identified. 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-Licensed nursing staff will be re – educated on obtaining §483.45(b)(1) Provides consultation on all medications from pharmacy aspects of the provision of pharmacy services in and reviewing back up the facility. pharmacy e-box in facility. In §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in addition, licensed nursing staff sufficient detail to enable an accurate will be instructed on physician reconciliation; and notification and documentation §483.45(b)(3) Determines that drug records are in for further recommendation order and that an account of all controlled drugs indicated, by DON/Designee. is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced

Resident #1.

The findings include:

bv:

Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide pharmacy services for one of 13 residents in the survey sample,

For Resident #1, the facility staff failed to ensure two medications were available for administration, Meloxicam (used for pain) and Toprol XL (used

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

| | | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MUL | IPLE | CONSTRUCTION | (X3) DATE S | |
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| | OF DEFICIENCIES CORRECTION | IDENTIFICATION NUMBER: | \ ' ' | | <u></u> | COMPL | ETED |
| | | | | | | _ c | SAVES IN PACE |
| | | 495140 | B. WING | | | 12/1 | 3/2023 |
| | ROVIDER OR SUPPLIER | | | 11 | TREET ADDRESS, CITY, STATE, ZIP CODE O CHALMERS COURT ERRYVILLE, VA 22611 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | E ATE | (X5) COMPLETION DATE |
| F 755 | mg (milligrams); give a day for pain. The November 2023 administration record order. On the followindose, a "7" was docu other/see nurse note: 11/2/2023 11/3/2023 11/6/2023 11/6/2023 The nurse's note for part, "Awaiting pharm box." The nurse's note for part, "Reordered - ph The nurse's note date: "This nurse outreach request a RF (refill) obut the pharmacy state Meloxicam cannot be Metoprolol on 11/22. doctor) book for revied The nurse's note for nurse's note for nurse's note for this request, "pharmacy with delivered." The nurse's note date in part, "pharmacy with delivered." The nurse's note date in part, "pharmacy with delivered." | dated, 8/22/2023, (Meloxicam) Oral tablet 15 1 tablet by mouth one time MAR (medication) documented the above ag dates at the 9:00 a.m. mented, a "7" indicated, 11/2/2023, documented in arracy delivery, not in back up 11/3/2023, documented in arracy notified." ed, 11/4/2023, documented, ed (name of pharmacy) to an Meloxicam and Metoprolol tes they are unable to do so. a RF until 11/16 and Placed in MD (medical aw." 11/6/2023, there was no missed dose. ed, 11/7/2023, documented as notified of not being ed, 11/8/2023, documented as notified several times - no | F | 755 | DON /unit manager will review new physician order 24-hour report, and MAR/TAR's, 5x week for 3 days. The DON will report monthly to the QAPI committee the results of the physician and mar/tar audits for further recommendations | 0 | 1/16/2024 |

PRINTED: 01/02/2024 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING _ 12/13/2023 B. WING 495140 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 110 CHALMERS COURT **ROSE HILL HEALTH AND REHAB** BERRYVILLE, VA 22611 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 755 Continued From page 28 F 755 The physician order dated, 11/15/2023, documented in part, "Mobic Oral Tablet 15 mg; Give 1 tablet by mouth one time a day for back pain." The November MAR documented the above order. on 11/16/2023 and 11/17/2023 for the 9:00 a.m. dose, a "7" was documented. The nurse's note dated, 11/16/2023, documented in part, "Not available at this time." The nurse's note dated, 11/17/2023, documented in part, "Medication on order from Pharmacy." The physician order dated, 4/19/2023, documented, "Toprol XL Oral Tablet Extended Release 24 hour 50 mg (Metoprolol Succinate); Give 1 tablet by mouth one time a day for HTN (high blood pressure)." The November MAR documented the above order. On 11/2/2023, 11/14/2023, 11/16/2023, and 11/17/2023, there was documented a "7" for the 9:00 a.m. doses of Toprol XL. The nurse's notes dated, 11/2/2023, documented in part, "Awaiting pharmacy delivery, not available in back up box."

The nurse's note dated, 11/14/2023, documented in part, "Medication on order from Pharmacy." The nurse's note dated, 11/16/2023, documented

The nurse's note dated, 11/17/2023, documented in part, "Medication on order from Pharmacy."

The list of the contents of the backup pharmacy box failed to evidence the two medications.

An interview was conducted with LPN (licensed

in part, "On order from Pharmacy."

CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT C AND PLAN OF | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED C |
|----------------------------|--|--|-----------------------------|--|------------------------------|
| | | 495140 | B. WING | | 12/13/2023 |
| | ROVIDER OR SUPPLIER L HEALTH AND REHAB | | | STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611 | |
| (X4) ID PREFIX TAG | (FACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICENCY) | D BE COMPLETION |
| F 755 | When asked the step medication is not ava of administration, LP the bottom of the car there, where extra m there, the nurse show not there the nurse see if it's been sent a can't administer the notify the doctor and responsible party. LF the steps they have they have the steps they have the have they have the have the have they have they have they have they have they have the have they have they have they have the have | n 12/12/2023 at 2:25 p.m. is a nurse takes when a silable at the scheduled time N #2 stated you first look in to see if the medication is edication is stored. If not all go to the backup box. If hould call the pharmacy to and the status of it. If you still medication, the nurse should the resident and/or PN #2 was asked where all aken are documented, LPN gress notes. rovider Pharmacy imented in part, "4. The grees to perform the tical services, including but listing the nursing care | F 75 | | |
| F 760 SS=D | interim director of nu- clinical director and a director of nursing, v above findings on 12 No further information Residents are Free | administrator, ASM #2, the rsing, ASM #3, the regional ASM #4 the interim assistant were made aware of the 2/12/2023 at 4:45 p.m. In was obtained prior to exit. of Significant Med Errors | F 76 | Resident # 7 is currently receiving Lantus as ordere the physician. Resident # 1 has a new physician order Trulicity effective 1 /4/24 non-dialysis day. | 10 for |

| OCNITED | C FOR MEDICARE & | MEDICAID SERVICES | | | | | 0938-0391 |
|---|---|--|---------------------|-----|--|------------------------------|----------------------------|
| CENTERS FOR MEDICARE & ME STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X' | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | LIER/CLIA (X2) MULT | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED C | |
| | | 495140 | B. WNG | | | 1 | 3/2023 |
| | ROVIDER OR SUPPLIER L HEALTH AND REHAB | | | 11 | REET ADDRESS, CITY, STATE, ZIP CODE O CHALMERS COURT ERRYVILLE, VA 22611 | | |
| (X4) ID PREFIX TAG | (FACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | 3E | (X5) COMPLETION DATE |
| F 760 | Continued From page 30 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, it was determined the facility staff failed to ensure two of 13 residents were free of significant medication errors, Residents #7 and Resident #10. The findings include: 1. For Resident #7, the facility staff failed to administer Lantus Insulin on 10/27/2023 and the resident's blood sugar was elevated the next | | | 760 | DON/designee reviewed current residents identified with medication errors, and h been reviewed with medical director and nursing administration to address with pharmacy as indicated upon discovery. | | |
| | assessment, a quarter assessment reference resident scored a five interview for mental aresident was severel decisions. In Section resident was coded a for seven days of the The physician order documented, "Lantual 100 UNIT/ML (millilit subcutaneously two The October 2023 Madministration record order. The place for p.m. was blank on the | dated, 8/17/2023, s Subcutaneous Solution (1) ers); Inject 34 units times a day for diabetes." IAR (medication d) documented the above the 10/27/2023 dose at 9:00 | | | Licensed nursing staff have been re educated by DON/designee on obtaining medications and documentation of physician notification of medication availability or not given for further recommendations. | | |

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

| STATEMENT C | F DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | , , | | CONSTRUCTION | (X3) DATE S | SURVEY LETED |
|-------------|--|--|--------------------|---------|---|----------------|----------------------------|
| AND PLAN OF | CORRECTION | IDENTIFICATION NUMBER: | A, BUILDI | NG_ | | | ; |
| | | 495140 | B. WNG | | | 12/1 | 3/2023 |
| | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | 11 B | TREET ADDRESS, CITY, STATE, ZIP CODE 10 CHALMERS COURT ERRYVILLE, VA 22611 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERICED TO THE APPROPR DEFICIENCY) | 3E | (X5) COMPLETION DATE |
| F 760 | from 110 to 299. The comprehensive of documented in part, for hyper/hypoglycem of DM (diabetes mell The "Interventions" of "Administer medication affect." An interview was corpractical nurse) #2 or interview was conducted nurse) #2, v. Resident #7 resided stated the interim din work the floor that ever up with one of the ento give all of the schestated she tried to give that night, but she was too. An interview was cornurse) #1, on 12/12/2 asked what blanks of stated, it wasn't give the facility policy, M. General Guidelines, Medications are admaccordance with man good nursing princip persons legally authorized the administ immediately following immediately following the part of the part of the part of the properson of the administ immediately following the part of the par | care plan dated, 7/3/2023, "Focus: Resident is at risk nic episodes due to diagnosis itus). Insulin dependent." ocumented in part, ons per order observing Inducted with LPN (licensed In 12/12/2023 at 2:25 p.m. An octed with LPN (licensed In 10/27/2023. She ector of nursing was going to rening, but something came inployees and she didn't get eduled medications. LPN #2 we some of the medications as busy with her assignment Inducted with RN (registered 2023 at 3:19 p.m. When In the MAR indicated, RN #1 In. Indication Administration - documented in part, "Policy: Ininistered as prescribed in Infurfacturers' specifications, Iles and practices and only by | F | 760 | The DON will review the 24-hour reports for documentation of medication not available, pharmacy needs to include physician notification, the dawill be reported to the month QAPI committee with medication error trends and educational needs of staff to addressed, and or further recommendations. | on ta ly | i jii jasi4 |

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

| AEDICAID SERVICES | | | OMB NO. 0938-0391 |
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| | (X2) MULT | TIPLE CONSTRUCTION | (X3) DATE SURVEY |
| IDENTIFICATION NUMBER: | | | COMPLETED |
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| 495140 | B. WING_ | | 12/13/2023 |
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| TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | THE PROPERTY OF ACTION | ION SHOULD BE COMPLETION DATE |
| as off-duty without first ration of any medications." Itaff member) #1, the interim the interim director of regional clinical director and sistant director of nursing, the above findings on the interimental status and provided prior to exit, the facility failed to rection on 10/16/2023. DS (minimum data set) resion assessment, with an example and and a set) resion assessment, with an example and and a set of 10/11/2023, the rest of | F | 760 | |
| | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495140 TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 32 c off-duty without first ration of any medications." taff member) #1, the interim regional clinical director and regio | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495140 B. WING TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) 32 c off-duty without first tration of any medications." taff member) #1, the interimed, the interimed director of regional clinical director and sistant director of nursing, the above findings on m. was provided prior to exit, treat diabetes. This med from the following to wide from the following to wide from the following to section on 10/16/2023. DS (minimum data set) to section on 10/16/2023. | MEDICAID SERVICES (X1) PROVIDER/SUPPLE/ECLIA IDENTIFICATION NUMBER: 495140 B. WING STREET ADDRESS, CITY, STATE, ZIP C 110 CHALMERS COURT BERRYVILLE, VA 22611 TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) TAG TAG FROSS-REFERENCED TO T DEFICIENCE 32 off-duty without first ration of any medications." taff member) #1, the interim director of regional clinical director and sistant director of nursing, he above findings on m. was provided prior to exit, reat diabetes. This need from the following v/druginfo/meds/a600027.h the facility failed to section on 10/16/2023. DS (minimum data set) sion assessment, with an old atte of 10/11/2023, the secring a 14 out of 15 on ew for mental status) score, is not cognitively impaired ions. In Section N - lent was coded as receiving even days of the look back ated, 10/5/2023, / Subcutaneous Solution G/0.5ML (milligrams per; inject 0.5 ml me a day every Mon |

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PRINTED: 01/02/2024 FORM APPROVED OMB NO. 0938-0391

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | _ | | (X3) DATE | SI IDVEV |
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| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | COMPI | |
| , and i Lak Of | 23.0120.000 | | A. BUILD | •0 | | (| |
| | | 495140 | B. WNG | | | 12/ | 13/2023 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | ı | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| ROSE HIL | L HEALTH AND REHAB | | | I " | ERRYVILLE, VA 22611 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | E ATE | (X5) COMPLETION DATE |
| | Continued From page The October MAR do On 10/16/2023 a "5" of the administration indicated, LOA (leave Review of the nurse's documentation of the not given, nor docume and/or nurse practition wasn't given. The resident had a ph 10/5/2023, document dialysis Mon, Wed, First Comprehensive of documented in part, "placing resident at rise episodes. Resident is treatment." The "Interpart, "Diabetic medical physician." An interview was con 12/12/2023 at 3:19 p. medication is not give to dialysis, and it's a visteps should the nurse would see what the migiven later but mostly their orders. It could resident got back from weekly medication. Fithat order, she would and scheduled it arous schedule, but the nurse would see what the nurse would and scheduled it arous schedule, but the nurse would and scheduled it arous schedule, but the nurse would see what the nurse would and scheduled it arous schedule, but the nurse would see what the nurse would and schedule it arous schedule, but the nurse would see would and schedule it arous schedule, but the nurse would see what the nurse would and schedule it arous schedule, but the nurse would schedule it arous schedule, but the nurse would see what the nurse would and schedule it arous schedule, but the nurse would see what the nurse would and schedule it arous schedule, but the nurse would see what the nurse would see what the nurse would and schedule it arous schedule, but the nurse would see what the nurse woul | e 33 cumented the above order. was documented in the box of the Trulicity. A "5" of absence). note failed to evidence reason the medications was entation of the physician ner being notified that is nysician order dated, ed in part, "Resident has ri, pick up is 9:15 a.m." eare plan dated, 10/6/2023, Focus: I am a diabetic k for hypo/hyperglycemia receiving insulin and diet as ventions" documented in ations as ordered by | - | 760 | | N L | |

Facility ID: VA0210

| DEPARTMENT OF HEALTH AN | | | | | OMB NO. 0938-0391 |
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| CENTERS FOR MEDICARE & | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULT | TPLE C | ONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| TATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION | IDENTIFICATION NUMBER: | 1 | | | |
| | 495140 | B. WING_ | | | C 12/13/2023 |
| NAME OF PROVIDER OR SUPPLIER | | | STR | EET ADDRESS, CITY, STATE, ZIP CODE | |
| | | | | CHALMERS COURT | |
| ROSE HILL HEALTH AND REHAB | | | BEI | RRYVILLE, VA 22611 | 445 |
| (FACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | BE COMPLETION |
| F 760 Continued From page ASM (administrative administrator, ASM # nursing, ASM #3, the ASM #4 the interim a were made aware of 12/12/2023 at 4:45 p No further information (2) Dulaglutide inject exercise program to adults and children 1 type 2 diabetes (concorted the amount of information was obtain website: https://medlineplus.gtml. F 842 SS=D CFR(s): 483.20(f)(5) Reside (i) A facility may not resident-identifiable (ii) The facility may resident-identifiable accordance with a congress not to use or except to the extent to do so. §483.70(i) Medical metals and are sident and are sident accordance with a congressional standary stand | staff member) #1, the interim 2, the interim director of regional clinical director and ssistant director of nursing, the above findings on .m. In was provided prior to exit. It ion is used with a diet and control blood sugar levels in 0 years of age or older with dition in which the body does ally and therefore cannot if sugar in the blood). This ined from the following ov/druginfo/meds/a614047.h dentifiable Information 483.70(i)(1)-(5) Int-identifiable information that is to the public. Blease information that is to an agent only in ontract under which the agent disclose the information the facility itself is permitted | | 842 | Resident # 3 has documentation in the medic record for 9-11-23 by the podiatrist. Resident # 3 wa identified on 11/11 with COVID and was on isolatic and would not have been visited by podiatrist. The m identified as author of the nursing note written on 11/1/23 is no longer employ | on urse |

that are-(i) Complete; PRINTED: 01/02/2024 FORM APPROVED

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

| STATEMENT (| OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED C | |
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| | | 495140 | B, WING | | REET ADDRESS, CITY, STATE, ZIP CODE | 1 12/ | 13/2023 |
| | ROVIDER OR SUPPLIER | | | 11 | 0 CHALMERS COURT ERRYVILLE, VA 22611 | | |
| (X4) ID PREFIX TAG | (FACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 842 | (ii) Accurately docum (iii) Readily accessib (iv) Systematically or §483.70(i)(2) The fact all information contains regardless of the formation contains regardless of the formation contains regardless of the formation of the individual, representative where (ii) Required by Law (iii) For treatment, particularly poperations, as perming with 45 CFR 164.50(iv) For public health neglect, or domestic activities, judicial and law enforcement purpurposes, research medical examiners, a serious threat to he by and in compliance §483.70(i)(3) The farecord information a unauthorized use. §483.70(i)(4) Medication formation in the period of time (ii) Five years from the period of time (iii) For a minor, 3 yellegal age under Statistical Systems (iii) For a minor, 3 yellegal age under Statistical Systems (iii) Sufficient information in Sufficient in Sufficient information in Sufficient in Suffic | sented; le; and ganized stility must keep confidential ned in the resident's records, mor storage method of the nor release isport their resident expermitted by applicable law; sayment, or health care tted by and in compliance 3; activities, reporting of abuse, violence, health oversight diadministrative proceedings, poses, organ donation purposes, or to coroners, funeral directors, and to avert ealth or safety as permitted exwith 45 CFR 164.512. In the safeguard medical gainst loss, destruction, or all records must be retained the required by State law; or he date of discharge when the eart in State law; or hears after a resident reaches | F | 842 | DON/designee reviewed current residents who are scheduled to be seen by the podiatrist have the potential be affected. Review of the residents seen by podiatrist were reviewed for proper documentation. No other residents were identified. The licensed nurse will be educated by the DON / designee on ensuring proper documentation per podiatricists will be transcribed or in the appropriate medical records. | re er y n the | |

| CENTERS FOR MEDICARE & ME |) PROVIDER/SUPPLIER/CLIA | AVON MALIET | | | | |
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| JIMILINILITY OF BLITTON | IDENTIFICATION NUMBER: | 1 ' ' | | CONSTRUCTION | COMPL | SURVEY .ETED |
| AND PLAN OF CORRECTION | IDENTIFICATION NOWIBER. | A, BUILDII | NG _ | | 0 | ; |
| | 495140 | B. WING_ | | | | 3/2023 |
| NAME OF PROVIDER OR SUPPLIER | | | ST | FREET ADDRESS, CITY, STATE, ZIP CODE | | |
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| ROSE HILL HEALTH AND REHAB | | | В | ERRYVILLE, VA 22611 | | OVE) |
| (FACH DEFICIENCY MU | MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | E ATE | (X5) COMPLETION DATE |
| provided; (iv) The results of any prand resident review eval determinations conducted (v) Physician's, nurse's, professional's progress of (vi) Laboratory, radiology services reports as requited This REQUIREMENT is by: Based on resident intercolinical record review, it facility staff failed to mai accurate clinical record of the survey sample, Resident survey sample, Resident accuracy of a The findings include: For Resident #3, the fact document accuracy of a The nurse's note dated documented, "Resident care on 10/31/23." A request was made for note dated, 10/31/2023 a.m. An interview was condumember) #1 on 12/12/20 #1 informed this writer the seen by the podiatrist or resident was scheduled but due to COVID-19, the | plan of care and services readmission screening luations and ded by the State; and other licensed notes; and y and other diagnostic ired under §483.50. In not met as evidenced view, staff interview and was determined the ntain a complete and for one of 13 residents in dent #3. Itility staff failed to podiatrist visit. 11/1/2023 at 4:53 p.m. received routine podiatry on 12/12/2023 at 11:14 Interest with OSM (other staff 10:23 at 12:32 p.m. OSM hat Resident #3 was not in 10/31/2023. The to be seen on 11/15/2023 the resident was not seen. Itember of 2023. When | F | 842 | Social services/ Unit Managers/medical record star will review for appropriate documentation in the residen medical record after schedule podiatry visit. Any discrepancies will be reported by DON to the monthly QAI committee for further recommendations. | t's ed | 1/14/2024 |

CENTERS FOR MEDICARE & MEDICAID SERVICES

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED C |
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| | | 495140 | B. WING | | 12/13/2023 |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 110 CHALMERS COURT BERRYVILLE, VA 22611 | |
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| F 842 | doesn't know why the (Resident #3)'s medic (Resident #3)'s medic ASM #1, the interim a interim director of nursing, wabove findings on 12. No further information Infection Prevention & CFR(s): 483.80(a)(1) §483.80 Infection Conthe facility must estainfection prevention a designed to provide a | cord, OSM #1 stated she documentation is in cal record. administrator, ASM #2, the sing, ASM #3, the regional SM #4 the interim assistant ere made aware of the /12/2023 at 4:45 p.m. In was provided prior to exit. A Control ((2)(4)(e)(f) Introl blish and maintain an and control program | F 842 | | |
| | development and traidiseases and infection §483.80(a) Infection program. The facility must esta and control program a minimum, the follow §483.80(a)(1) A system reporting, investigating and communicable distaff, volunteers, visit providing services unarrangement based used to conducted according accepted national states. | nsmission of communicable ns. orevention and control blish an infection prevention (IPCP) that must include, at ving elements: em for preventing, identifying, ng, and controlling infections iseases for all residents, ors, and other individuals der a contractual upon the facility assessment to §483.70(e) and following | | current residents in the facilia who are receiving antibiotics or new orders for antibiotic therapy have the potential to affected. No concerns were noted. The Reginal Clinical Direct will educate DON on compliance of maintaining accuracy of infection contilogs. | be ctor |

CENTERS FOR MEDICARE & MEDICAID SERVICES

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | CONSTRUCTION | (X3) DATE S | SURVEY |
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| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | COMPL | |
| AND PLAN OF | CORRECTION | ISENTING WISH | A. BUILD | | | | ; |
| | | 495140 | B. WING | | | 12/1 | 3/2023 |
| | ROVIDER OR SUPPLIER | | | 11 | REET ADDRESS, CITY, STATE, ZIP CODE O CHALMERS COURT ERRYVILLE, VA 22611 | | |
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| F 880 | but are not limited to: (i) A system of survei possible communicati infections before they persons in the facility (ii) When and to who communicable diseas reported; (iii) Standard and trart to be followed to prev (iv) When and how is cresident; including but (A) The type and durate depending upon the involved, and (B) A requirement that least restrictive possicircumstances. (v) The circumstance must prohibit employ disease or infected so contact will transmit to (vi) The hand hygiene by staff involved in disease of the following staff | Illance designed to identify ble diseases or a can spread to other can spread to other can possible incidents of se or infections should be a can spread of infections; blation should be used for a set to the isolation, infectious agent or organism at the isolation should be the ble for the resident under the cases with a communicable kin lesions from direct so or their food, if direct the disease; and a procedures to be followed irect resident contact. The process of the isolation incidents accility's IPCP and the ten by the facility. The process, and is to prevent the spread of incidents as to prevent the spread of incidents as to prevent the spread of incidents as to prevent the spread of | F | 880 | The administrator will review the infection control logs for completion monthly for reeducation or further recommendations. | | 1/16/2024 |

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

| | | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | | | (X3) DATE SURVEY COMPLETED | | |
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| | CORRECTION | IDENTIFICATION NUMBER: | A. BUILDI | NG | | | С | | |
| | | 495140 | B. WING | | | | 12/13/2023 | | |
| | ROVIDER OR SUPPLIER | | | 110 C | ET ADDRESS, CITY, STATE, ZIP CODE HALMERS COURT RYVILLE, VA 22611 | • | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | × | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP | IOULD BE | (X5) COMPLETION DATE | | |
| F 880 | Continued From pag IPCP and update the This REQUIREMEN' by: Based on staff interveview, it was determinated infection conthe three months reducted by: The findings include: Upon entrance on 12 request was made for tracking logs for Octobecember 2023. On 12/11/2023 at ap (administrative staff nursing, provided a confection control logs a list from the pharmantibiotics were presided and infection of a could not find the Normantibiotics were presided and the Normantibiotics were presided and the Normantibiotics were presided to the Normantibiotics were presided and maintation of a formantibiotic were presided and maintation of the facility policy, "I documented in part, Committee (ICC) dirprogram and maintation of the scope of surveil Establishing baseling. Review of microbresident infections to infection is nosocomfor disease control) | e 39 sir program, as necessary. T is not met as evidenced view and facility document nined the facility staff failed to ntrol tracking logs for two of quested. 2/11/2023 at 9:15 a.m. a or the infection control ober, November, and approximately 11:00 a.m. ASM member) #2, the director of copy of the October 2023 a. She also provided a copy of facy that documented what scribed, but not the full tracking log. She stated she ovember logs and the e not been started. Infection Control Surveillance" "1. The Infection Control ects the infection control inis minutes of all activities. | | 880 | DEFICIENCY) | | | | |

| | S SOO MEDICADE S | MEDICAID SERVICES | | | | OMB NO. | 0938-0391 |
|--------------------------|--|---|--|--|---|-------------------------------|----------------------------|
| STATEMENT C | S FOR MEDICARE & OF DEFICIENCIES CORRECTION | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
| | | 495140 | B. WING | | | 12/1 | 3/2023 |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, C 110 CHALMERS CO BERRYVILLE, VA | | | |
| (X4) ID PREFIX TAG | SUMMARY ST | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | PRO\ X (EACH C | VIDER'S PLAN OF CORRECTIC CORRECTIVE ACTION SHOULD EFERENCED TO THE APPROP DEFICIENCY) | DBE | (X5) COMPLETION DATE |
| F 880 | which are: a. high ris problem prone. 2. So or the environment for done unless approve accordance with approf surveillance data sonset. B. Body site. Appropriate culture in surveillance workshed determine trends." ASM (administrative administrator, ASM # nursing, ASM # 3, the ASM # 4 the interim a were made aware of 12/12/2023 at 4:45 p. | ions, procedure or policies k. b. high volume. c. urveillance sampling of staff or infective agents is not ed by the ICC an in licable regulations. Analysis should include: A. Date of C. Geographic location. D. information. 3. The eet will be used as a tool to staff member) #1, the interim et regional clinical director and essistant director of nursing, if the above findings on | F | 880 | | | |