STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495187	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsville Health & Rehab Center	222 Fulcher Street Hillsville, VA 24343

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 42353 Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to ensure residents receive treatment and care in accordance with the comprehensive person-centered care plan and medical provider orders for 2 of 18 sampled residents (Resident #157 and #11). The findings included: 1. For Resident #157, the facility staff failed to administer Paxlovid, an antiviral medication used to treat COVID-19, according to the medical provider orders on 8/09/22. This was a closed record review. Resident #157's diagnosis list indicated diagnoses, which included, but not limited to Pneumonia, Chronic Obstructive Pulmonary Disease, Gastrointestinal Hemorrhage, and Diverticulitis. The minimum data set (MDS) with an assessment reference date (ARD) of 8/01/22 assigned the resident a brief interview for mental status (BIMS) summary score of 8 out of 15 indicating the resident was moderately cognitively impaired. Resident #157's clinical record revealed the resident tested positive for COVID-19 on 8/08/22. Resident #157 was seen by the nurse practitioner (NP) on 8/08/22, the progress note read in part .Resident seen today on rounds as [he/she] has tested positive for COVID-19 virus this morning .Continues to have dry cough .To be started on COVID treatment with antivirals .Start Paxlovid 1 dose p.o. [by mouth] twice daily for 5 days . According to Resident #157's August 2022 Medication Administration Record (MAR), the first dose of Paxlovid was administered on 8/09/22 at 10:00 AM and no additional doses were documented as being administered on 8/09/22. The second 8/09/22 dose was scheduled to be given at 2:00 PM and the nurse documented a code of 19 indicating Other/See Nurse Notes instead of signing for administration. Surveyor was unable to locate a corresponding nursing note explaining why the Paxlovid was not administered at that time or rescheduled for a later time on the same day. Resident #157 received the second administration of Paxlovid the following day, 8/10/22 at 10:00 AM. On 8/10/22, the medication administration times were changed to 10:00 AM and 10:00 PM. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/02/24 at 4:13 PM, surveyor spoke with the Director of Nursing (DON) regarding the omission of the second dose of Paxlovid on 8/09/22. DON stated it appeared the second dose was initially scheduled to close to the 10:00 AM dose. Surveyor requested to speak with the nurse present on 8/09/22, however, they were no longer employed by the facility. Resident #157's comprehensive person-centered care plan included a focus area stating in part [Resident #157] has a respiratory infection r/t [related to] COVID-19 . with an intervention to Give medications as ordered. On 7/03/24 at 11:09 AM, the survey team met with the Administrator, DON, and Regional Director of Clinical Services and discussed the concern of Resident #157 only receiving one dose of Paxlovid on 8/10/22. No further information regarding this concern was presented to the survey team prior to the exit conference on 7/03/24. 49622 2. For Resident #11, the facility staff failed to follow the provider orders for no straws to promote the resident's swallowing safety to reduce the risk of aspiration. Resident #11's diagnosis list indicated diagnoses, which included, but not limited to Alzheimer's Disease with late onset, Dysphagia-oropharyngeal phase, Moderate protein-calorie malnutrition, and Abnormal weight loss. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 06/27/24 assigned the resident a brief interview for mental status (BIMS) summary score of 5 out of 15 for cognitive abilities, indicating the resident was severely cognitively impaired. On 07/02/24 at 12:02 PM, surveyor observed Resident #11's room and observed a Styrofoam cup of ice water on resident's nightstand by the bed. Resident's name was written on the cup and a date of, 7/2/24 was written on the cup. The cup had a white plastic lid with a straw inserted into the cup. A review of Resident #11's provider orders included an active diet order with a start date of 03/07/24, that read in part, .No straws . Further review of the clinical record revealed an Observation Detail List Report dated 06/28/24, that read in part, .Medical Nutritional Therapy Observation .Adaptive feeding devices .Yes .no straws .Nutrition Goal .to tolerate diet consistency with no preventable s/s (signs and/or symptoms) aspiration through next review . Nutrition Interventions .no straws d/t (due to) dysphagia .Nutritional Monitoring meal/fluid intake, s/s aspiration . A review of the current care plan with a Last Reviewed/Revised date of, 06/28/2024, read in part, .Monitor for s/s of aspiration .provide diet per order . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/02/24 at 12:32 PM, surveyor interviewed registered nurse #1 (RN#1) and informed her that a straw was observed in Resident #11's bedside water cup. RN#1 stated she would take care of it. On 07/02/24 at 1:50 PM, surveyor observed the straw had been removed from Resident #11's cup on the nightstand in his room. Surveyor requested and received Resident #11's tray tickets for breakfast, lunch, and dinner for 07/02/24. All three tray tickets read in part, .no straws . On 07/02/24 at 4:50 PM, surveyor interviewed Other Staff #9 (OS#9) and she provided surveyor with a Diet Order Communication slip dated 3/7/24, that read in part, .NO Straws per SLP (speech-language pathologist) . Surveyor requested and received, a Speech Therapy Treatment Encounter Note dated 3/7/24, that read in part, .SLP targeted swallowing safety to reduce risk of aspiration. SLP trialed thin liquids. Pt (patient) with immediate cough noted following trials of thin liquids with straw. Pt. with functional swallow given cupside sips. Diet upgrade to thin liquids with no straws . This concern was reviewed with the Administrator, Director of Nursing, and the Regional Director of Clinical Services at the end of day meeting on 07/02/24 at 4:29 PM and again at the pre-exit meeting on 07/03/24 at 11:10 AM. Surveyor requested and received a facility policy titled, Physician/Provider Orders that read in part, .The Charge Nurse shall .review all physician/provider orders . No further information regarding this concern was presented to the survey team prior to the exit conference on 07/03/24.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 42353 Based on resident interview, staff interview, and clinical record review, the facility staff failed to provide respiratory care consistent with the comprehensive person-centered care plan and the medical provider orders for 1 of 14 sampled residents (Resident #46). The findings included: For Resident #46, the facility staff failed to administer supplemental oxygen as ordered by the provider. Resident #46's diagnosis list indicated diagnoses, which included, but not limited to Chronic Obstructive Pulmonary Disease, Hypertensive Heart Disease with Heart Failure, Multiple Sclerosis, Acute and Chronic Respiratory Failure, and Congestive Heart Failure. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 6/16/24 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. Resident #46's current comprehensive person-centered care plan included a focus area stating the resident was at risk for altered cardiac and respiratory status due to diagnoses including Chronic Obstructive Pulmonary Disease and Congestive Heart Failure with an intervention for oxygen as ordered. On 7/01/24 at 3:03 PM and 7/02/24 at 8:18 AM, surveyor observed Resident #46 in bed receiving oxygen via nasal cannula at the delivery rate of 3 liters per minute (l/m) per the oxygen concentrator setting. Resident #46's current provider orders included an order dated 3/28/24 to administer oxygen via nasal cannula continuously at 2 l/m. The resident's July 2024 Medication Administration Record (MAR) indicated the resident was receiving oxygen at 2 l/m. On 7/02/24 at 1:41 PM, surveyor observed Resident #46 sitting up in a wheelchair without the use of oxygen. When questioned, the resident stated they only use oxygen when needed. Surveyor asked the resident if they ever adjust the oxygen setting on the concentrator, the resident stated no and added they could not stand up. Surveyor spoke with the resident's nurse, licensed practical nurse (LPN) #1, who verified the resident's order was for oxygen at 2 l/m. On 7/02/24 at 4:30 PM, the survey team met with the Administrator, Director of Nursing, and Regional Director of Clinical Services and discussed the concern of Resident #46 receiving oxygen at the rate of 3 l/m instead of the ordered rate of 2 l/m. No further information regarding this concern was presented to the survey team prior to the exit conference on 7/03/24.