STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
	495249	A. BUILDING _____ B. WING _____	C 02/23/2018

NAME OF PROVIOER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZIP COOE
FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC	1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOEO BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETION OATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 02/21/18 through 02/23/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000	E006 1. The administrator will update the facility emergency preparedness plan to include the facility risk assessment as it relates to strategies related to all hazards specific to the geographic location of the facility 3-30-2018. 2. The administrator will update the emergency preparedness plan on a quarterly basis to ensure that current strategies are appropriate based upon the clinical complexity of the resident population. 3. The facility staff development RN will provide in-service training to all staff on the emergency preparedness plan by 3-30-2018. 4. The interdisciplinary quality assurance team will review the emergency prepared ness plan on a monthly basis for the next three months and quarterly thereafter to ensure continued compliance. 5. Completion date: 3-30-2018	
E 006 SS=C	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.	E 006		

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	ADMINISTRATOR	3-27-18

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 ere disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC	1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901

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E 006	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide documentation of the facility's risk assessments and associated strategies based on an all-hazards approach specific to the geographic location of the facility. The findings include: On 2/23/18 at approximately 11:45 a.m., a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) #8, director of maintenance. Review of the facility's emergency preparedness plan failed to evidence documentation of the facility's risk assessments and associated strategies based on an all-hazards approach specific to the geographic location of the facility. OSM #8 stated that the facility could not provide that information. On 2/23/18 at approximately 1 p.m., ASM (administrative staff member) # 1, the administrator was made aware of the above findings. No further information was provided prior to exit.	E 006		
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]	E 007		

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E 007	Continued From page 2 (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to evidence documentation that the written emergency plan included services the facility would be able to provide during an emergency, how the facility plans to continue operations during an emergency, and delegations of authority and succession plans. The findings include: On 2/23/18 at approximately 11:45 a.m., a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) #8, director of maintenance. Review of the facility's emergency preparedness plan failed to evidence documentation that the written emergency plan included services the facility would be able to provide during an emergency, how the facility plans to continue operations during an emergency, and delegations of authority and succession plans. OSM # 8 stated that the facility did not have this information.	E 007	**E007** 1. The administrator will update the facility emergency preparedness plan to include services that the facility would be able to provide during an emergency, how the facility plans to continue operations during an emergency and delegations of authority and succession plans by 3-30-2018. 2. The administrator will review and update the emergency preparedness plan on a quarterly basis when a change is noted in succession plans and plans of operation during an actual emergency. 3. The facility staff development RN will provide in-service education to facility staff on the emergency preparedness plan by 3-30-2018.	

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E 007	Continued From page 3 On 2/23/18 at approximately 1 p.m., ASM (administrative staff member) # 1, the administrator was made aware of the above findings. No further information was provided prior to exit.	E 007	4. The interdisciplinary quality assurance team will review the emergency prepared ness plan on a monthly basis for the next three months and quarterly thereafter to ensure continued compliance.	
E 013 SS=C	Development of EP Policies and Procedures CFR(s): 483.73(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually.	E 013	5. Completion date: 3-30-2018	

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E 013	Continued From page 4 *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to evidence that the Emergency Preparedness policies and procedures were developed based on the facility- and community-based risk assessment and communication plan, utilizing an all-hazards approach. The findings include: On 2/23/18 at approximately 11:45 a.m., a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) #8, director of maintenance. Review of the facility's emergency preparedness plan failed to evidence policies and procedures were developed based on the facility- and community-based risk assessment and communication plan, utilizing an all-hazards approach. OSM # 8 stated that the facility did not	E 013	**E013** 1. The facility Emergency Operations Plan policies and procedures will be updated by 3-30-2018 to ensure that they are relevant as it relates to the community based risk assessment, communication plan while utilizing and all-hazards approach. 2. All policies and procedures related to the facility Emergency Operations Plan will be reviewed and updated as appropriate by 3-30-2018. 3. Facility staff will receive additional education on the facility Emergency Operations Plan by the RN Staff Development Coordinator by 3-30-2018. 4. The facility interdisciplinary QA team will review the updated policies for the next three months and quarterly thereafter to ensure continued compliance. 5. Completion date: 3-30-2018	

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E 013	Continued From page 5 have the documentation. On 2/23/18 at approximately 1 p.m. ASM (administrative staff member) # 1, the administrator was made aware of the above findings. No further information was provided prior to exit.	E 013	020 1. The Administrator will update the Emergency Operations Plan by 3-30-2018 to ensure that it contains a policy and procedure for a safe evacuation from the facility that includes the care and treatment needs of the evacuees, staff responsibilities, transportation; identification of evacuation location(s), and primary and alternate means of communication with external sources of assistance. 2. All policies and procedures related to the facility Emergency Operations Plan will be reviewed and updated as appropriate by 3-30-2018. 3. Facility staff will receive additional education on the facility Emergency Operations Plan by the RN Staff Development Coordinator by 3-30-2018.	
E 020 SS=C	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.73(b)(3) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of	E 020		

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E 020	Continued From page 6 communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures for a safe evacuation from the facility that included care and treatment needs of evacuees, staff responsibilities, transportation; identification of evacuation location(s), and primary and alternate means of communication with external sources of assistance. The findings include: On 2/23/18 at approximately 11:45 a.m., a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) #8, director of maintenance. Review of the facility's emergency preparedness	E 020	4. The facility interdisciplinary QA team will review the updated policies for the next three months and quarterly thereafter to ensure continued compliance. 5. Completion date: 3-30-2018	

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E 020	Continued From page 7 plan failed to evidence policies and procedures for a safe evacuatlon from the facility that included care and treatment needs of evacuees, staff responsibilities, transportation; Identificatlon of evacuatlon location(s), and primary and alternate means of communication with external sources of assistance. OSM # 8 stated that the facility did not have it. On 2/23/18 at approximately 1 p.m. ASM (administrative staff member) # 1, the administrator was made aware of the above findings. No further information was provlded prlor to exit.	E 020		
E 022 SS=C	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4) [(b) Policies and procedures. The [facllltles] must develop and Implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of thls sectlon. The policies and procedures must be reviewed and updated at least annually. At a mlnlmum, the pollcles and procedures must address the followlng:] (4) A means to shelter in place for patients, staff, and volunteers who remain in the [facillty]. [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain In the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additlonal requirements for	E 022	**E022** 1. The facility Emergency Operations Plan policles and procedures will be updated by 3-30-2018 to ensure that it contains a policy and procedure as to how the facility will safely shelter in place for patients, staff and volunteers who remain in the facility. The policy will be aligned with the facility risk assessment and Emergency Operations Plan. 2. All policies and procedures related to the facility Emergency Operations Plan will be reviewed and updated as appropriate by 3-30-2018. 3. Facility staff will receive additional education on the facility Emergency Operations Plan by the RN Staff Development Coordinator by 3-30-2018.	

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E 022	Continued From page 8 hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures of how the facility will provide a means to shelter in place for patients, staff and volunteers who remain in the facility and how those policies and procedures are aligned with the facility's emergency plan and risk management. The findings include: On 2/23/18 at approximately 11:45 a.m., a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) #8, director of maintenance. Review of the facility's emergency preparedness plan failed to evidence policies and procedures for how the facility will provide a means to shelter in place for patients, staff and volunteers who remain in the facility and how those policies and procedures are aligned with the facility's emergency plan and risk management. OSM # 8 stated that the facility did not have it. On 2/23/18 at approximately 1 p.m. ASM (administrative staff member) # 1, the administrator was made aware of the above findings.	E 022	4. The facility interdisciplinary QA team will review the updated policies for the next three months and quarterly thereafter to ensure continued compliance. 5. Completion date: 3-30-2018	

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E 022	Continued From page 9 No further information was provided prior to exit.	E 022	023 . The facility Emergency Operations Plan policies and procedures will be updated by 3-30-2018 to ensure that there is a policy and procedure related to how the facility preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. . All policies and procedures related to the facility Emergency Operations Plan will be reviewed and updated as appropriate by 3-30-2018. . Facility staff will receive additional education on the facility Emergency Operations Plan by the RN Staff Development Coordinator by 3-30-2018. . The facility interdisciplinary QA team will review the updated policies for the next three months and quarterly thereafter to ensure continued compliance. . Completion date: 3-30-2018	
E 023 SS=C	Policies/Procedures for Medical Documentation CFR(s): 483.73(b)(5) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.	E 023		

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E 023	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures of how the facility preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. The findings include: On 2/23/18 at approximately 11:45 a.m., a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) #8, director of maintenance. Review of the facility's emergency preparedness plan failed to evidence policies and procedures of how the facility preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. OSM # 8 stated that the facility did not have it. On 2/23/18 at approximately 1 p.m., ASM (administrative staff member) # 1, the administrator was made aware of the above findings. No further information was provided prior to exit.	E 023	**E024** 1. The facility Emergency Operations Plan policies and procedures will be updated by 3-30-2018 to ensure that there is a policy that addresses how volunteers are utilized and the facility staffing strategy in the event of an emergency. 2. All policies and procedures related to the facility Emergency Operations Plan will be reviewed and updated as appropriate by 3-30-2018. 3. Facility staff will receive additional education on the facility Emergency Operations Plan by the RN Staff Development Coordinator by 3-30-2018. 4. The facility interdisciplinary QA team will review the updated policies for the next three months and quarterly thereafter to ensure continued compliance. 5. Completion date: 3-30-2018	
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency	E 024		

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E 024	Continued From page 11 plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures for the use of volunteers and other staffing strategies in the emergency plan. The findings include: On 2/23/18 at approximately 11:45 a.m., a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) #8, director of maintenance. Review of the facility's emergency preparedness plan failed to evidence policies and procedures for the use of volunteers and other staffing	E 024		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	A. BUILDING _____ B. WING _____	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC	1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901

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E 024	Continued From page 12 strategies in the emergency preparedness plan. OSM #8 stated that the facility did not have this information. On 2/23/18 at approximately 1 p.m., ASM (administrative staff member) # 1, the administrator was made aware of the above findings. No further information was provided prior to exit.	E 024	**E026** 1. The facility Emergency Operations Plan policies and procedures will be updated by 3-30-2018 to ensure that there is a policy that describes the facilities role in providing care and treatment at altered care sites under an 1135 waiver.	
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced	E 026	2. All policies and procedures related to the facility Emergency Operations Plan will be reviewed and updated as appropriate by 3-30-2018. 3. Facility staff will receive additional education on the facility Emergency Operations Plan by the RN Staff Development Coordinator by 3-30-2018. 4. The facility interdisciplinary QA team will review the updated policies for the next three months and quarterly thereafter to ensure continued compliance. 5. Completion date: 3-30-2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 026	Continued From page 13 by: Based on staff interview and facility document review it was determined the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures in the emergency plan that describe the facility's role in providing care and treatment at altered care sites under an 1135 waiver. The findings include: On 2/23/18 at approximately 11:45 a.m., a review and Interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) #8, director of maintenance. Review of the facility's emergency preparedness plan failed to evidence policies and procedures in the emergency plan that describe the facility's role in providing care and treatment at altered care sites under an 1135 waiver. OSM #8 stated that the facility did not have this information. On 2/23/18 at approximately 1 p.m., ASM (administrative staff member) # 1, the administrator was made aware of the above findings. No further information was provided prior to exit.	E 026	**E029** 1. The administrator will update the facility emergency preparedness plan to include the facility communication plan that contains how the facility coordinates patient care within the facility, across healthcare providers, and with state and local health departments by 3-30-2018. 2. The administrator will review and update as needed the emergency preparedness plan on a quarterly basis to ensure that the facility communication plan is appropriate and accurately reflects contact information of individual plan participants involved in the coordination of care.	
E 029 SS=C	Development of Communication Plan CFR(s): 483.73(c) (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced	E 029		

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 029	Continued From page 14 by: Based on staff interview and facility document review it was determined the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide a written emergency communication plan that contains how the facility coordinates patient care within the facility, across healthcare providers, and with state and local health departments. The findings include: On 2/23/18 at approximately 11:45 a.m., a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) #8, director of maintenance. Review of the facility's emergency preparedness plan failed to evidence a written emergency communication plan that contains how the facility coordinates patient care within the facility, across healthcare providers, and with state and local health departments. There was also no evidence that this plan was reviewed annually. OSM #8 stated that the facility did not have this information. On 2/23/18 at approximately 1 p.m., ASM (administrative staff member) # 1, the administrator was made aware of the above findings. No further information was provided prior to exit.	E 029	3. The facility staff development RN will provide in-service training to all staff on the emergency preparedness plan by 3-30-2018. 4. The interdisciplinary quality assurance team will review the emergency prepared ness plan on a monthly basis for the next three months and quarterly thereafter to ensure continued compliance. 5. Completion date: 3-30-2018	
E 030 SS=C	Names and Contact Information CFR(s): 483.73(c)(1) [(c) The [facility, except RNHCIs, hospices, transplant centers, and HHAs] must develop and	E 030		

STATEMENT OF DEFICIENCIES AND PLAN DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CDNSTRUCTION	(X3) DATE SURVEY CDMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CDDE
FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC	1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	[X5] COMPLETION DATE
E 030	Continued From page 15 maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the	E 030	**E030** 1. The administrator will update the facility communication plan to ensure that all the required facility contact information has been updated and is accurate by 3-30-2018. 2. The Administrator will update the contact information as needed on a quarterly basis to ensure that contact information is accurate reflected. 3. The facility staff development RN will provide in-service training to all staff on the emergency preparedness plan by 3-30-2018. 4. The interdisciplinary quality assurance team will review the emergency prepared ness plan on a monthly basis for the next three months and quarterly thereafter to ensure continued compliance. 5. Completion date: 3-30-2018	

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
	495249	A. BUILDING _____ B. WING _____	C 02/23/2018

NAME OF PROVIOER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZIP COOE
FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC	1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901

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E 030	Continued From page 16 following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to evidence a written emergency communication plan that included all the required facility contacts and evidence that this contact information was reviewed and updated at least annually. The findings include: On 2/23/18 at approximately 11:45 a.m., a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) #8, director of maintenance. Review of the facility's emergency preparedness plan failed to evidence a written emergency communication plan that included all the required facility contacts and evidence that this contact information was reviewed and updated at least	E 030		

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E 030	Continued From page 17 annually. OSM #8 stated that the facility did not have this Information. On 2/23/18 at approximately 1 p.m., ASM (administrative staff member) # 1, the administrator was made aware of the above findings. No further information was provided prior to exit.	E 030	**E032** 1. The facility administrator will ensure that the facility emergency communication plan includes primary and alternate means for communicating with facility staff, Federal, State, tribal and local emergency management agencies by 3-30-2018.	
E 032 SS=C	Primary/Alternate Means for Communication CFR(s): 483.73(c)(3) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide evidence of documentation that the communication plan Includes primary and alternate means for	E 032	2. The facility Administrator will review the alternate communication plan on a quarterly basis to ensure ongoing continued compliance. 3. The facility staff development RN will provide in-service training to all staff on the emergency preparedness plan by 3-30-2018. 4. The interdisciplinary quality assurance team will review the emergency prepared ness plan on a monthly basis for the next three months and quarterly thereafter to ensure continued compliance. 5. Completion date: 3-30-2018	

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E 032	Continued From page 18 communicating with facility staff, Federal, State, tribal, and local emergency management agencies by reviewing the communication plan. The findings include: On 2/23/18 at approximately 11:45 a.m., a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) #8, director of maintenance. Review of the facility's emergency preparedness plan failed to evidence documentation that the communication plan includes primary and alternate means for communicating with facility staff, Federal, State, tribal, and local emergency management agencies by reviewing the communication plan. OSM #8 stated that the facility did not have this information. On 2/23/18 at approximately 1 p.m., ASM (administrative staff member) # 1, the administrator was made aware of the above findings. No further information was provided prior to exit.	E 032		
E 033 SS=C	Methods for Sharing Information CFR(s): 483.73(c)(4)-(6) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to	E 033	**E033** 1. The facility Emergency Operations Plan policies and procedures will be updated by 3-30-2018 to ensure that the communication portion contains a method of sharing information and the medical documentation for patients under the facility's care, as necessary, with other health providers to maintain the continuity of care. 2. All policies and procedures related to the facility Emergency Operations Plan will be reviewed and updated as appropriate by 3-30-2018.	

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E 033	Continued From page 19 maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.22(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. Facility staff failed to provide evidence of documentation that the communication plan includes a method for sharing information and medical documentation for patients under the facility's care, as necessary, with other health	E 033	3. Facility staff will receive additional education on the facility Emergency Operations Plan by the RN Staff Development Coordinator by 3-30-2018. 4. The facility interdisciplinary QA team will review the updated policies for the next three months and quarterly thereafter to ensure continued compliance. 5. Completion date: 3-30-2018	

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E 033	Continued From page 20 providers to maintain the continuity of care by reviewing the communication plan and documentation that the facility has developed policies and procedures that address the means the facility will use to release patient information to include the general condition and location of patients by reviewing the communication plan. The findings include: On 2/23/18 at approximately 11:45 a.m., a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) #8, director of maintenance. Review of the facility's emergency preparedness plan failed to provide evidence of documentation that the communication plan includes a method for sharing information and medical documentation for patients under the facility's care, as necessary, with other health providers to maintain the continuity of care by reviewing the communication plan and documentation that the facility has developed policies and procedures that address the means the facility will use to release patient information to include the general condition and location of patients by reviewing the communication plan. OSM # 8 stated that the facility did not have it. On 2/23/18 at approximately 1 p.m., ASM (administrative staff member) # 1, the administrator was made aware of the above findings. No further information was provided prior to exit.	E 033		
E 034 SS=C	Information on Occupancy/Needs CFR(s): 483.73(c)(7)	E 034		

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E 034	Continued From page 21 [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113:] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide evidence of documentation that the communication plan includes a a means of providing information about the facility's needs, and its ability to provide assistance, to the authority having jurisdiction, the incident Command Center, or designee by reviewing the communication plan and documentation that the communication plan	E 034	**E034** 1. The facility Emergency Operations Plan policies and procedures will be updated by 3-30-2018 to ensure that the communication plan and policies and procedures, includes a means of providing information about the facility's needs, and its ability to provide assistance to the authority having jurisdiction, the incident command center, or designee by reviewing the communication plan and documentation that the communication plan includes a means of providing information about their occupancy. 2. All policies and procedures related to the facility Emergency Operations Plan will be reviewed and updated as appropriate by 3-30-2018.	

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E 034	Continued From page 22 includes a means of providing information about their occupancy. The findings include: On 2/23/18 at approximately 11:45 a.m., a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) # 8, director of maintenance. Review of the facility's emergency preparedness plan failed to provide evidence of documentation that the communication plan includes a means of providing information about the facility's needs, and its ability to provide assistance, to the authority having jurisdiction, the incident Command Center, or designee by reviewing the communication plan and documentation that the communication plan includes a means of providing information about their occupancy. OSM # 8 stated that the facility did not have it. On 2/23/18 at approximately 1 p.m., ASM (administrative staff member) # 1, the administrator was made aware of the above findings. No further information was provided prior to exit.	E 034	3. Facility staff will receive additional education on the facility Emergency Operations Plan by the RN Staff Development Coordinator by 3-30-2018. 4. The facility interdisciplinary QA team will review the updated policies for the next three months and quarterly thereafter to ensure continued compliance. 5. Completion date: 3-30-2018	
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:	E 035		

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E 035	Continued From page 23 (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide evidence of documentation that the communication plan includes a method for sharing information from the emergency plan, and that the facility has determined it is appropriate with residents or clients and their families or representatives by reviewing the plan. The findings include: On 2/23/18 at approximately 11:45 a.m., a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) # 8, director of maintenance. Review of the facility's emergency preparedness plan failed to provide evidence of documentation that the communication plan includes a method for sharing information from the emergency plan, and that the facility has determined it is appropriate with residents or clients and their families or representatives by reviewing the plan. OSM # 8 stated that the facility did not have it. On 2/23/18 at approximately 1 p.m., ASM (administrative staff member) # 1, the administrator was made aware of the above findings.	E 035	**E035** 1. The facility Emergency Operations Plan will be reviewed by 3-30-2018 to ensure that the communication plan includes information on the method of sharing information from the emergency plan, and that the facility has determined it is appropriate with residents or clients and their families by reviewing the plan. 2. All policies and procedures related to the facility Emergency Operations Plan will be reviewed and updated as appropriate by 3-30-2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	A. BUILDING _____ B. WING _____	C 02/23/2018

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E 035	Continued From page 24 No further information was provided prior to exit.	E 035		
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and	E 039	3. Facility staff will receive additional education on the facility Emergency Operations Plan by the RN Staff Development Coordinator by 3-30-2018. 4. The facility interdisciplinary QA team will review the updated policies for the next three months and quarterly thereafter to ensure continued compliance. 5. Completion date: 3-30-2018	

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E 039	Continued From page 25 maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide evidence of documentation of the facility's exercise analysis and response and how the facility updated its emergency program based on the exercise analysis. The findings include: On 2/23/18 at approximately 11:45 a.m., a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) # 8, director of	E 039	**E039** 1. The facility will conduct an emergency exercise by 3-30-2018 and update the facility emergency plan as indicated. 2. The facility will conduct one table top paper based emergency exercise by 4-6-2018. The facility emergency plan will be reviewed and updated as needed based upon the results of the exercise. 3. The facility staff development RN will provide in-service training to all staff on the emergency preparedness plan by 3-30-2018. 4. The interdisciplinary quality assurance team will review the emergency prepared ness plan on a monthly basis for the next three months and quarterly thereafter to ensure continued compliance. 5. Completion date: 4-6-2018.	

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
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E 039	Continued From page 26 maintenance. Review of the facility's emergency preparedness plan failed to provide evidence of documentation of the facility's exercise analysis and response and how the facility updated its emergency program based on the exercise analysis. OSM # 8 stated that the facility did not have it. On 2/23/18 at approximately 1 p.m., ASM (administrative staff member) # 1, the administrator was made aware of the above findings. No further information was provided prior to exit.	E 039		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid survey was conducted from 02/21/18 through 02/23/18. Two complaints were investigated during the survey. Corrections are required for compliance with the following 42 CFR Part 483 of the Federal Long Term Care requirements. The life safety code survey/report will follow. The census at this 120 certified bed facility was 112 at the time of the survey. The survey sample consisted of 25 current residents Resident #s (66, 64, 42, 73, 39, 271, 88, 56, 80, 9, 319, 49, 60, 83, 106, 51, 111, 104, 94, 25, 113, 46, 268, 50, 27) and five closed records, Residents #s (168, 120, 119, 118 and 421).	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident	F 580		

TATEMENT OF OEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
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F 580	Continued From page 27 representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, 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	F 580	Preparation and submission of this plan of correction by Farmville Rehabilitation and Health Care Center, LLC, does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under the state and federal laws. F580 1. Resident #66's order was updated on 3/7/18 to include notification to MD for blood sugar less than 60 and greater than 350. Medical Director was notified of elevations over 400 on 2/22/18 and no new orders were given. 2. The Director of Nursing and Assistant Director of Nursing conducted an audit on 2/23/18 to ensure any resident with physician orders related to blood sugars include parameters for physician notification within the text of the order and that physician notification is documented in the medical records as required.	

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F 580	Continued From page 28 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 a clinical record review, it was determined the facility staff failed to notify the physician of a change in condition for one of 30 residents in the survey sample, Resident #66. The facility staff failed to notify the physician when Resident #66's blood sugars were greater than 400 on four occasions in February 2018. The findings include: Resident #66 was admitted to the facility on 9/6/17, with a readmission on 12/30/17, with diagnoses that included but were not limited to diabetes, end stage kidney disease, congestive heart failure and dementia. Resident #66's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/3/18, coded Resident #66 as scoring a 10 out of a possible 15 on his BIMS (brief interview for mental status) indicating that Resident #66 is moderately impaired with decisions of daily living. A review of Resident #66's clinical record revealed, in part, the following physician order; "NovoLOG [1] (insulin) FlexPen (method of administration) Solution Pen-Injector 100 UNIT / ML (milliliters) Inject as per sliding scale: If 0-149 = 0 UNITS; 150 - 199 = 1 UNIT; 200- 249 = 2	F 580	The licensed nurses were re-educated on 2/26/18 by the Staff Development Coordinator related to Physician notification. 3. LPN's # 8 and #9 were re-educated by the Staff Development Coordinator on 2/23/18 regarding physician notification related to a change in condition and notifying physician on abnormal values concerning blood sugar readings. 4. The Assistant Director of Nursing and the Unit Manager will complete an audit weekly for 4 weeks and monthly for 2 months to ensure Physician notification with change in condition is obtained and documented as required in the medical record. The Staff Development Coordinator will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. Completion date: 3/30/18	

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F 580	Continued From page 29 UNITS; 250 - 299 = 3 UNITS; 300 - 349 = 4 UNITS; 350 - 400 = 5 UNITS, subcutaneously (beneath the skin) before meals and at bedtime related to TYPE 2 DIABETES MELLITUS WITH DIABETIC CHRONIC KIDNEY DISEASE." A review of Resident #66's February MAR (medication administration record) revealed, in part, the following entries; "NovoLOG FlexPen Solution Pen - Injector 100 UNIT / ML Inject as per sliding scale: If 0 -149 = 0 UNITS; 150 - 199 = 1 UNIT; 200-249 = 2 UNITS; 250 - 299 = 3 UNITS; 300 = 349 = 4 UNITS; 350 - 400 = 5 UNITS, subcutaneously before meals and at bedtime related to TYPE 2 DIABETES MELLITUS WITH DIABETIC CHRONIC KIDNEY DISEASE. " On the following dates and times, the blood sugars were documented as greater than 400 and a dose of NovoLOG was documented as given: - 1/8/18; 4:30 p.m. blood sugar = 466 10 units of insulin administered - 1/9/18; 11:30 a.m. blood sugar 411 5 units of insulin administered - 1/10/18; 4:30 p.m. blood sugar 436 5 units of insulin administered - 1/19/18; 4:30 p.m. blood sugar 491 5 units of insulin administered A review of Resident #66's progress notes did not reveal any documentation that the physician had been notified about the blood sugars being greater than 400 or evidence of an order received to treat a blood sugar of greater than 400. A review of Resident #66's comprehensive care plan dated 12/30/17 revealed, in part, the following documentation; "Focus: HX (history) of DM (diabetes mellitus) with refusal of care at	F 580		

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F 580	Continued From page 30	F 580		

times (refusing to have blood sugar checked) Date Initiated: 10/17/2017 Revision on: 2/21/2018. Interventions: INSULIN AS ORDERED, ACCU CHECKS AS ORDERED, NOTIFY MD (medical doctor) FOR ABNORMAL FINDINGS. MONITOR FOR SX (symptoms) of HYPO/HYPERGLYCEMIA, NOTIFY MD AS INDICATED Date Initiated 10/17/17. Revision on: 10/17/17."

On 2/23/18 at 7:59 a.m., an interview was conducted with LPN (licensed practical nurse) #9. LPN #9 was asked to describe what she would do if a resident's blood sugar was outside of the sliding scale parameter. LPN #9 stated, "If the blood sugar is within the parameters provided by the doctor then I would give the ordered insulin. If outside of the parameters, I would document that there was no ordered coverage for the recorded blood sugar and notify the doctor so that he would be aware and could give orders. If he gives orders for the insulin I would recheck the blood sugar 30 minutes following administration to make sure that the treatment provided was effective." LPN #9 was asked where she would document this information, LPN #9 stated, "In the progress notes."

On 2/23/18 at 8:52 a.m., a telephone interview was conducted with LPN #8. LPN #8 documented Resident #66's blood sugar and insulin treatment on 2/8/18, 2/10/18 and 2/19/18. LPN #8 was asked to describe the process followed for administering insulin on a sliding scale. LPN #8 stated that she would administer the insulin as ordered based on the accu check obtained. LPN #8 was asked what she did if the blood sugar was greater than the sliding scale provided, for example greater than 400 if the

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F 580	Continued From page 31 sliding scale only went to 400. LPN #8 stated that she would call the doctor and ask what he wanted her to do. When asked if she would get an additional order, LPN #8 stated, "Yes, I would write the order and include in my notes that I had talked with the doctor and what the new order was." LPN #8 was asked if she took care of Resident #66, LPN #8 stated that she did. LPN #8 was provided the dates and the accu check results in February that were greater than 400 and asked if she remembered contacting the doctor about the results. LPN #8 stated, "If I talked to the doctor I would have documented it. I do not remember that far back. So I can't say whether or not I called him." When asked where she would have documented her conversation with the doctor, LPN #8 stated, "In the progress notes." On 2/23/18 at 9:05 a.m., an interview was conducted with ASM (administrative staff member) #4, the medical doctor. ASM #4 was asked if a resident is on a sliding scale that addresses blood sugars up to 400 what should the nurses do if the blood sugar is greater than 400. ASM #4 stated, If the blood sugar is outside of the parameters then I expect the nursing staff to contact me and I would give a specific order to treat that incident." When asked if he was aware that Resident #66 had blood sugars recorded on his MAR on five occasions in February 2018 that were greater than 400, ASM #4 stated, "I was unaware that his blood sugars were that high. I should get called by the nursing staff so that I can address appropriately." On 2/23/18 at approximately 10:00 a.m., a meeting was conducted with ASM #1, the administrator, ASM #2, the director of nursing,	F 580		

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 580	Continued From page 32 and ASM #5, the administrator in training. ASM #1, ASM #2 and ASM #5 were made aware of the above concern at this time and a policy was requested to address physician notification. No further information was provided prior to the end of the survey process. [1] NovoLog is a rapid acting human insulin analog indicated to improve glycemic control in adults and children with diabetes mellitus. This information was obtained from the following website; https://dailymed.nlm.nih.gov/dailymed/druglnfo.cfm?setid=3a1e73a2-3009-40d0-876c-b4cb2be56fc5	F 580		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other	F 583		

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F 583	Continued From page 33 materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide full visual privacy and failed to ensure confidentiality of a medical record for one of 30 residents in a survey sample, Resident #25. a. The facility staff failed to provide full visual privacy to Resident #25 while administering medications via the resident's feeding tube (1). b. The facility staff failed to provide confidentiality of Resident #25's eMAR (electronic medication administration record). The eMAR was left open on top of the medication cart in the hall while LPN (licensed practical nurse) #2 administered medications to the resident in the bedroom. The findings include: a. Resident #25 was admitted to the facility on	F 583	F583 1. Resident #25's open and unattended eMAR was locked on the medication cart by LPN# 2 on 2/21/18. Resident #25 was assessed on 2/22/18 by the Unit Manager to ensure there were no dignity or privacy issues. LPN# 2 was re-educated by the Staffing Coordinator on 2/22/18 related to ensuring that eMARs are locked when left unattended to maintain confidentiality of resident information. LPN# 2 was also re-educated by the Staffing Coordinator on 2/22/18 related to providing privacy and dignity while delivering care/medication to a resident. 2. The Assistant Director of Nursing and the Unit Manager completed an audit on 2/26/18 to ensure confidentiality of the eMARs as required and visual inspection of residents to ensure there were no privacy or dignity issues while staff provided care.	

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F 583	Continued From page 34 12/6/07. Resident #25's diagnoses included but were not limited to seizures, diabetes and anxiety disorder. Resident #25's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 11/30/17, coded the resident's cognition as severely impaired. On 2/21/18 at approximately 4:38 p.m. observation of LPN (licensed practical nurse) #2, administering medications to Resident #25 via a feeding tube was conducted. Resident #25 was lying in bed (visible from the hall). LPN #2 lifted Resident #25's shirt, exposing the resident's abdomen, and administered water and medications through the resident's feeding tube. The resident's roommate was in the room. Staff members and another resident were in the hall (visible from the room). LPN #2 did not pull the privacy curtain or shut the door. On 2/21/18 at 4:52 p.m., an interview was conducted with LPN #2. LPN #2 was asked what should be done in regards to providing visual privacy when providing tube-feeding care to a resident. LPN #2 stated the privacy curtain should be pulled and normally he pulls the curtain but this surveyor was present. On 2/22/18 at approximately 8:00 a.m., an interview was conducted with LPN #1. LPN #1 was asked about the facility process for ensuring privacy during tube feeding medication administration and care. LPN #1 stated she would either pull the privacy curtain or close the door. LPN #1 stated a nurse might have to do both, depending on the setup of the room, so the resident is provided privacy from the roommate.	F 583	3. LPN# 2 was re-educated by the Staffing Coordinator on 2/22/18 related to ensuring that eMARs are locked when left unattended to maintain confidentiality of resident information. LPN# 2 was also re-educated by the Staffing Coordinator on 2/22/18 related to providing privacy and dignity while delivering care/medication to a resident. The licensed nursing staff were re-educated on 2/26/18 by the Staff Development Coordinator related to ensuring eMARs are locked when unattended as well as ensuring privacy and dignity are maintained while delivering care to residents as required.	

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	495249	A. BUILDING _____ B. WING _____	C 02/23/2018

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F 583	Continued From page 35 On 2/22/18 at 10:55 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. On 2/22/18 at 2:28 p.m., ASM #1 and ASM #2 stated the facility did not have a policy regarding privacy and dignity. No further information was presented prior to exit. (1) "A PEG (percutaneous endoscopic gastrostomy) feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach." This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000900.htm b. On 2/21/18 at 4:38 p.m. observation of LPN #2 preparing and administering medications to Resident #25 was conducted. LPN #2 prepared the medications at the medication cart in the hall across from the resident's room. LPN #2 then left the medication cart with the eMAR open to the resident's confidential information while administering the medications to the resident in the bedroom. Two staff members and a resident were observed in the hall approximately three feet from the medication cart. On 2/21/18 at 4:52 p.m., an interview was conducted with LPN #2. LPN #2 was asked what should be done with the resident's medication administration record before leaving the medication cart. LPN #2 stated, "Locked." When asked if he should leave the computer screen	F 583	4. The Assistant Director of Nursing and the Unit Manager will complete an audit weekly for 4 weeks and monthly for 2 months to ensure confidentiality of eMARS and privacy and dignity are provided to residents while staff are delivering care as required. The Staff Development Coordinator will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. Completion date: 3/30/18	

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F 583	Continued From page 36 with no resident information showing, LPN #2 stated, "Yes." On 2/22/18 at approximately 8:00 a.m., an interview was conducted with LPN #1. LPN #1 was asked what should be done when a nurse leaves a medication cart. LPN #1 stated nurses should lock the computer screen so no information is visible. On 2/22/18 at 10:55 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. The facility policy titled, "HIPAA (Health Insurance Portability and Accountability Act) Security Rules Policy and Procedures Summary" documented, "PURPOSE: The Company is committed to implementing a policy to protect the confidentiality, integrity and availability of protected health information (PHI) that the Company and its covered affiliates create, access, transmit, and receive..." No further information was presented prior to exit.	F 583		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to	F 584	**F584** 1. Resident #64's room will be repaired and cables removed by 3-30-2018. 2. Resident #42 room will be repaired, cables removed and medicine cabinet will be replaced by 3-30-2018.	

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F 584	Continued From page 37 use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, it was determined the facility staff failed to maintain a clean and comfortable homelike environment for four of 30 residents in the survey sample; Residents #64, #42, #104 and #113.	F 584	3. Resident #104's room will be repaired, cables removed and medicine cabinet will be replaced by 3-30-2018. 4. Resident #113's wheelchair was replaced on 2-23-2018. 5. The Administrator and Maintenance director will complete an audit of all resident rooms by 3-30-2018 to identify additional rooms and wheelchairs needing repairs and maintenance. 6. During the daily VIP rounds auditors will identify new maintenance issues. A maintenance repair request will be logged into the electronic work order system for further follow-up. 7. The interdisciplinary quality assurance team will review the work order log monthly for the next three months and quarterly thereafter to ensure continued compliance. 8. Completion date: 3-30-2018.	

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F 584	Continued From page 38 1. The facility staff failed to maintain Resident #64's room in a clean, comfortable, homelike manner. Approximately 6 to 8 feet of television cable was observed hanging from the ceiling and multiple items in need of repair. 2. The facility staff failed to maintain Resident #42's room in a clean, comfortable, homelike manner. Long cables were observed hanging from the ceiling, down the wall, and the medication cabinet (used to store toiletries) was rusty. 3. The facility staff failed to maintain Resident #104's room in a clean, comfortable, homelike manner. A hole in the wall next to the bathroom door, long cables hanging down from the ceiling, medication cabinet (used to store toiletries) was rusty, broken co-base modeling and chair rail were observed. 4. The facility staff failed to maintain Resident # 113's wheelchair armrests free from torn areas, exposing foam that was unable to be sanitized. The findings include: 1. For Resident #64, the facility staff failed to maintain the resident's room in a clean, comfortable, homelike manner. Resident #64 was admitted to the facility on 3/22/16 with the diagnoses of but not limited to high blood pressure, end stage renal disease, diabetes, and psychosis. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 12/20/17. The resident was coded as being	F 584		

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F 584	Continued From page 39 cognitively intact in ability to make daily life decisions. Resident #64 was coded as requiring limited to extensive assistance for activities of daily living and was independent for eating. Observations made of Resident #64's room revealed the following: television cabling approximately 6 to 8 feet was observed hanging from the ceiling, and dangling down the wall, next to her bed. She did not have a television connected. An area of the wall had a discolored painted area, where something had once been affixed to the wall and was removed, and was not repainted to match the rest of the room. The discolored area was also noted to be dirty. A piece of co-base molding approximately 4x4 inches square was missing from the wall. The paper towel dispenser was rusty. On 2/22/18 at 1:00 p.m., in an interview with Resident #64, she stated the dangling cables bothers her. On 2/22/18 at 1:37 p.m., in an interview with CNA #4 (Certified Nursing Assistant) she stated that if a room has maintenance care issues, she notifies the charge nurse who then notifies maintenance. On 2/22/18 at 1:39 p.m., in an interview with LPN #6 (Licensed Practical Nurse), she stated that she fills out a maintenance repair form and gives it to maintenance. LPN #6 stated if the issue is still present a few days later, she would follow up with maintenance to be sure they got the repair slip. On 2/22/18 at 2:12 p.m., a tour was conducted with OSM #8 (Other Staff Member, the Maintenance Director). He was shown the	F 584		

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F 584	Continued From page 40 resident's room and the concerns documented above. On 2/22/18 at 2:46 p.m., OSM #8 provided a list of items that facility had identified as concerns to work on. Resident #64's room was checked off as having had "refresh" work completed. He identified the "refresh" work as not specific tasks for all rooms, but a variety of tasks individualized to the need of the room. However, some of the identified items were not recently developed concerns and was not repaired during a room refresh. On 2/22/18 at 5:16 p.m., at the end of day meeting, the Administrator (ASM #1 - Administrative Staff Member) and Director of Nursing (ASM #2) were made aware of the findings. A facility policy on the provision of maintenance needs / maintaining a clean comfortable homelike environment was requested via a written list of needed documents. This list was provided to the facility at the end of the end of day meeting on 2/22/18. On 2/23/18 at 08:00 a.m., the written list of needed documents was returned by the facility, and next to the request for this policy, was documented that there was no policy for this. No further information was provided by the end of the survey. 2. The facility staff failed to maintain Resident #42's room in a clean, comfortable, homelike manner. Resident #42 was admitted to the facility on 9/9/10 and readmitted on 12/7/17 with the	F 584		

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F 584	Continued From page 41 diagnoses of but not limited to oral cancer, gastrostomy tube, convulsions, high blood pressure, hypothyroidism, and peripheral vascular disease. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 12/14/17. The resident was coded as cognitively intact in ability to make daily life decisions. Resident #42 was coded as requiring total care for eating via tube feeding administration, and was coded as otherwise independent for activities of daily living. Observations made of Resident #42's room revealed the following: long cables hanging from the ceiling, down the wall, to the resident's TV on his table. The medication cabinet (used to store toiletries) was rusty. On 2/22/18 at 1:37 p.m., in an interview with CNA #4 (Certified Nursing Assistant) she stated that if a room has maintenance care issues, she notifies the charge nurse who then notifies maintenance. On 2/22/18 at 1:39 p.m., in an interview with LPN #6 (Licensed Practical Nurse), she stated that she fills out a maintenance repair form and gives it to maintenance. LPN #6 stated if the issue is still present a few days later, she would follow up with maintenance to be sure they got the repair slip. On 2/22/18 at 2:12 p.m., a tour was conducted with OSM #8 (Other Staff Member, the Maintenance Director). He was shown the resident's room and concerns. On 2/22/18 at 5:16 PM, at the end of day meeting, the Administrator (ASM #1 - Administrative Staff Member) and Director of	F 584		

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F 584	Continued From page 42 Nursing (ASM #2) were made aware of the findings. No further information was provided by the end of the survey. 3. The facility staff failed to maintain Resident #104's room in a clean, comfortable, homelike manner. Resident #104 was admitted to the facility on 4/6/17 and readmitted on 1/24/18 with the diagnoses of but not limited to metabolic encephalopathy, chronic kidney disease, pressure ulcer, high blood pressure, neurogenic bladder, dysphagia, hypothyroidism, diabetes, heart disease, and anxiety disorder. The most recent MDS (Minimum Data Set) coded the resident as being cognitively intact in ability to make daily life decisions. Resident #104 was coded as requiring extensive assistance for all areas of activities of daily living. Observations made of Resident #104's room revealed the following: A hole in the wall next to the bathroom door. The hole was the appropriate size, shape, and location, of the doorknob of the door to the room, being opened all the way and pushed into the wall. Long cables hanging down from the ceiling, draped on the support of a wall shelf that contained the resident's personal items. The medication cabinet (used to store toiletries) was rusty. A buildup of dark green-black substance around the pump of the hand soap dispenser. A piece of co-base molding approximately 4x4 inches was peeled from the wall near the corner of the closet and sink area. A piece of the wooden chair rail that runs behind	F 584		

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F 584	Continued From page 43 the bed was broken and separated from the part attached to the wall. On 2/22/18 at 1:37 p.m., in an interview with CNA #4 (Certified Nursing Assistant) she stated that if a room has maintenance care issues, she notifies the charge nurse who then notifies maintenance. On 2/22/18 at 1:39 p.m., in an interview with LPN #6 (Licensed Practical Nurse), she stated that she fills out a maintenance repair form and gives it to maintenance. LPN #6 stated if the issue is still present a few days later, she would follow up with maintenance to be sure they got the repair slip. On 2/22/18 at 2:12 p.m., a tour was conducted with OSM #8 (Other Staff Member, the Maintenance Director). He was shown the resident's room and concerns. On 2/22/18 at 5:16 p.m., at the end of day meeting, the Administrator (ASM #1 - Administrative Staff Member) and Director of Nursing (ASM #2) were made aware of the findings. No further information was provided by the end of the survey. 4. The facility staff failed to maintain Resident # 113's wheelchair armrests free from torn areas, exposing foam that was unable to be sanitized. Resident # 113 was admitted to the facility on 10/10/14 with a readmission of 10/30/17 with diagnoses that included but were not limited to subarachnoid hemorrhage (1), hypertension (2), heart failure (3) dysphagia (4), and type II diabetes mellitus (5).	F 584		

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F 584	Continued From page 44 Resident # 113's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 01/31/18 coded Resident # 113 as being moderately impaired of cognition for making daily decisions. Resident # 113 was coded as requiring limited to extensive assistance of one staff member for activities of daily living. On 02/21/18 at approximately 10:17 a.m., observation of Resident # 113's wheelchair revealed the right and left armrests were cracked, torn and there was exposed foam. Resident # 113 stated she would like to have them replaced because she is unable able to press down on them because the cracks pinch her arms. On 02/21/18 at approximately 5:00 p.m., on 02/22/18 at approximately 8:30 a.m., and on 02/22/18 at approximately 2:15 p.m., observations of Resident #113's wheelchair revealed the right and left armrests were cracked, torn and there was exposed foam. On 02/22/18 at approximately 3:15 p.m., an interview was conducted with LPN (licensed practical nurse) # 4. When asked about the process for identifying and maintaining a resident's equipment in good repair and the staff responsible for this, LPN # 4 stated, "Daily spot checks are done by staff and needed repairs are reported to maintenance." LPN # 4 was then asked to accompany this surveyor to Resident # 113's room. Upon observing Resident # 113's wheelchair, LPN #4 verbally agreed the right and left armrests were cracked, torn and exposing foam. LPN #4 stated, "They should have been replaced." When asked if the arm rests could be	F 584		

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F 584	Continued From page 45 properly cleaned LPN # stated, "No because the debris could be in the open areas and could not be properly cleaned." On 02/22/18 at 5:00 p.m. ASM (administrative staff member) # 1, the administrator, ASM # 2, the director of nursing, and ASM # 5, administrator in training, were made aware of the above concerns. No further information was provided prior to exit. References: 1. Bleeding in the area between the brain and the thin tissues that cover the brain. This area is called the subarachnoid space. This information was obtained from the website: https://medlineplus.gov/ency/article/000701.htm. 2. High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. 3. A condition in which the heart is no longer able to pump oxygen-rich blood to the rest of the body efficiently. This causes symptoms to occur throughout the body. This information was obtained from the website: https://medlineplus.gov/ency/article/000158.htm. 4. A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html. 5. A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website:	F 584		

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F 584	Continued From page 46 https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.	F 584		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident	F 622		

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	495249	A. BUILDING _____ B. WING _____	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC	1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 47 exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident.	F 622	F622 1. Residents # 25, #49, #60, #80, #106, #111, # 113 and # 319 were transferred to the emergency room by order of the physician for emergency treatment and returned to the facility. 2. All residents transferred to the hospital prior to 2/23/18 have the ability to be affected by deficient practice. Audit shows these transfers were affected. Education initiated. 3. Medical Director, Licensed Nurses and Administrative Nurses will be re-educated by 3/14/18 the Staff Development Coordinator related to ensuring written physician documentation of necessity of emergency transfer is provided in the medical record as required	

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F 622	Continued From page 63 physician to explain why the transfers were necessary. On 2/22/18 at 10:45 a.m., an interview was conducted with ASM (administrative staff member) #4 (Resident #25's physician). ASM #4 was asked to describe his role when a resident is transferred to the hospital. ASM #4 stated the nursing staff calls him before a resident is transferred to the hospital. ASM #4 was asked if he documents a note explaining why the transfer is necessary. ASM #4 stated he usually does not and he expects the nurses to document they talked to him about patient going to the hospital. On 2/22/18 at 10:55 a.m., ASM #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. On 2/22/18 at 1:58 p.m., ASM #2 stated the facility did not have a current policy regarding the physician's responsibilities for transfers. No further information was presented prior to exit.	F 622	4. The Assistant Director of Nursing and the Unit Manager will audit emergency transfers weekly for 4 weeks and monthly for 2 months to ensure written physician necessity of emergency transfer as required. The Staff Development Coordinator will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. Completion date: 3/30/18	
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or	F 623		

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F 623	Continued From page 64 discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email),	F 623	**F623** 1. Residents #113, #106, #319, #49, #80, #60, #111 and #125 were transferred to the emergency room by order of the physician for emergency treatment and returned to the facility. 2. All residents transferred to the hospital prior to 2/23/18 have the ability to be affected by deficient practice. Audit shows these transfers were affected. Education initiated. 3. Licensed Nurses and Administrative Nurses will be educated by the Staff Development Coordinator related to ensuring written notification to resident's representative of transfers.	

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F 623	Continued From page 65 and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of	F 623	4. The Assistant Director of Nursing and the Unit Manager will audit emergency transfers weekly for 4 weeks and monthly for 2 months to ensure written notification of transfer to residents representative are completed as required. The Staff Development Coordinator will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. Completion date: 3/30/18	

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F 623	Continued From page 66 the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined the facility staff failed to provide the required written notifications at the time of a facility initiated transfer for eight of 30 residents in the survey sample, Residents # 49, 80, 60, 111, 113, 25, 106, 3 t9. 1. The facility staff failed to provide the required written notifications to the responsible party (RP) and the ombudsman when Resident #49 was transferred to the hospital on 12/14/17. 2. The facility staff failed to provide a written notification to Resident #80's RP (responsible party) when he was transferred to the hospital on 8/7/17, 12/17/17 and 1/2/18. 3. The facility staff failed to provide a written notification to Resident #60's RP (responsible party) when she was transferred to the hospital on 2/8/ t8. 4. The facility staff failed to provide written documentation evidencing Resident # 111's RP (responsible party) was notified in writing when Resident #111 was transferred to the hospital on 12/02/17. 5. The facility staff failed to provide written documentation evidencing Resident # 113's RP (responsible party), was notified in writing when Resident #113 was transferred to the hospital on	F 623		

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F 623	Continued From page 67 10/27/17. 6a. Resident #25 was transferred to the hospital on 12/12/17. The facility staff failed to provide written notification of the facility initiated transfer to the ombudsman and resident representative. 6b. Resident #25 was transferred to the hospital on 1/22/18. The facility staff failed to provide written notification of the facility initiated transfer to the resident representative. 7. Resident #106 was transferred to the hospital on 1/30/18 and 2/8/18. The facility staff failed to provide written notification of the facility initiated transfer to the resident or resident representative. 8. Resident #319 was transferred to the hospital on 1/22/18 and 2/1/18. The facility staff failed to provide written notification of the facility initiated transfer to the resident or resident representative. The findings include: 1. Resident # 49 was admitted to the facility on 4/29/17 with diagnoses that included but were not limited to syncope (passing out) and collapse, hypothyroidism, schizophrenia, dementia with lewy bodies, and COPD (chronic obstructive pulmonary disease). Resident #49's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 12/19/17. Resident #49 was coded as being moderately impaired in cognitive function scoring 10 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #49's nursing notes revealed Resident #49 was sent out to the hospital on	F 623		

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F 623	Continued From page 68 12/14/17 at 11:12 a.m. The following note was documented. "At approximately 1035 (10:35 a.m.), resident was observed leaning against the wall in the hallway, pallor noted to skin tone with cyanotic [1] oral muscosa (sic). Resident's legs began to give out and she was lowered to the floor by two nurses. Jerking motions noted lasting approximately 10 seconds and resident unable to follow verbal commands. Bowel incontinence noted as well. Resident assisted to bed, 02 (oxygen) applied via nasal cannula. 911 called and MD (medical doctor) contacted. Sa02 registered (oxygen saturation) at 96 % (percent). respirations 20/min (minute). BP (blood pressure) 72/50 mm/Hg (millimeters of mercury), in left arm, pulse 60 bpm (beats per minute) and weak. Accucheck (blood sugar monitoring device) obtained - 137 mg/dL (milligram/deciliter). RP (responsible party) notified of resident's condition. Report called to (Name of ER [emergency room] nurse)..." Further review of the clinical record revealed that Resident #49 returned to the facility on 12/14/17 at 5:50 p.m. with a diagnosis of a syncope episode. Further review of Resident #49's clinical record failed to evidence that the RP (responsible party) was notified in writing of the reason for Resident #49's transfer to the hospital, and that the ombudsman received a copy of this written notification. On 2/21/18 at 3:49 p.m., an interview was conducted with OSM (other staff member) #1, the social worker, regarding her role when a resident is transferred to the hospital. OSM #1 stated the nurses notify the family verbally, she does not	F 623		

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F 623	Continued From page 69 provide written notification to the family or resident explaining why the resident was transferred to the hospital. When asked if she notifies the ombudsman of a facility-initiated transfer to the hospital, OSM #1 stated she would notify the ombudsman every month of residents who were discharged from the facility. OSM #1 stated she does not provide written notification to the ombudsman for every facility- initiated transfer to the hospital. On 2/22/18 at 11:41 a.m., an interview was conducted with LPN (licensed practical nurse) #3, regarding her role when a resident is transferred out to the hospital. LPN #3 stated the process is to first assess the resident to determine the need for hospital transfer. LPN #3 stated that she would call the medical doctor to get the order for transfer, fill out the required paperwork for transfer, call the emergency squad and notify the family or responsible party. LPN #3 stated she does not provide written notification to the resident or responsible party regarding a facility initiated transfer. LPN #3 stated she will tell the resident and/or RP (responsible party) verbally. When asked if she notifies the ombudsman of a facility-initiated transfer to the hospital, LPN #3 stated she does not contact the ombudsman. On 2/22/18 at 12:33 p.m., an interview was conducted with ASM (administrative staff member) #1, the administrator. ASM #1 stated that they have never provided written notification of the reason for a hospital transfer to the RP and ombudsman. ASM #1 stated, "We were never told that." On 2/22/18 at 3:28 p.m., an interview was conducted with OSM (other staff member) #2, the	F 623		

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F 623	Continued From page 70 admissions director. When asked about her role, when a resident is transferred to the hospital that is initiated by the facility, OSM #2 stated, "Nothing." On 2/22/18 at 5:01 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the ADON (Assistant Director of Nursing) were made aware of the above concerns. The facility policy titled, "Transfer Form" and facility policy titled, "Discharge of Resident" did not address the above concerns. [1] Cyanotic- bluish color to the mucous membranes resulting from inadequate oxygenation of the blood or circulation. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/books/NBK367/ 2. The facility staff failed to provide a written notification to Resident #80's RP (responsible party) when he was transferred to the hospital on 8/7/17, 12/17/17 and 1/2/18. Resident #80 was admitted to the facility on 4/17/15 with a readmission date on 1/5/18 with diagnoses that include but not limited to high blood pressure, difficulty speaking following a stroke, depression, difficulty swallowing and cognitive communication deficit. Resident #80's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/3/18, coded Resident #80 as scoring a six out of a possible 15 on the BIMS (brief interview for mental status),	F 623		

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F 623	Continued From page 71 indicating that Resident #80 is severely cognitively impaired with decisions of daily living. A review of Resident #80's clinical record revealed, in part, that Resident #80 was transferred by the facility to an acute care hospital on 8/7/17, 12/17/17 and 1/2/18. Further review of Resident #80's clinical record did not reveal any evidence that the RP (responsible party) had been sent a written notification regarding the transfers that occurred on the above referenced dates. On 2/21/18 at 3:48 p.m., an interview was conducted with OSM (other staff member) #1, the director of social services. OSM #1 was asked to describe her role when a resident was transferred out of the facility to an acute care setting. OSM #1 stated that she did not have any responsibility; it was up to the nursing staff to notify the RP. When asked if she was responsible for doing any written notifications to the RP, OSM #1 stated that she was not. On 2/21/18 at 4:28 p.m., an interview was conducted with OSM #2, the admissions director. OSM #2 was asked to describe her responsibility for notifications, for facility- initiated transfers of residents to an acute care hospital. OSM #2 stated that she did not have any responsibility in regards to notifications. An end of day meeting was conducted on 2/21/18 at 5:01 p.m. With ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #5, the administrator in training. ASM #1, ASM #2 and ASM #5 were made aware of the above concerns. A policy was	F 623		

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F 623	Continued From page 72 requested at this time for facility-initiated transfers. On 2/22/18 at 11:41 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked if she was responsible for providing a written notification to the resident's RP (responsible party) if a resident was transferred out of the facility to an acute care hospital. LPN #3 stated, "Not from me, I don't send a written notification, I just call to notify the RP of the transfer." No further information was provided prior to the end of the survey process. 3. The facility staff failed to provide a written notification to Resident #60's RP (responsible party) when she was transferred to the hospital on 2/8/18. Resident #60 was admitted to the facility on 7/7/16 with a readmission on 2/14/18 with diagnoses that included, but not limited to, psychosis, Parkinson's disease, high blood pressure and glaucoma (a degenerative disease effecting eyesight). Resident #60's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/23/17, coded Resident #60 as being unable to answer the questions on the BIMS (brief interview for mental status). The staff assessment coded Resident #60 as being severely impaired to make daily decisions. A review of Resident #60's clinical record	F 623		

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F 623	Continued From page 73 revealed, in part, that she had been transferred to an acute care hospital on 2/8/18. Further review of Resident #60's clinical record did not reveal any evidence that the RP (responsible party) had been sent a written notification regarding the transfers that occurred on the above referenced date. On 2/21/18 at 3:48 p.m., an interview was conducted with OSM (other staff member) #1, the director of social services. OSM #1 was asked to describe her role when a resident was transferred out of the facility to an acute care setting. OSM #1 stated that she did not have any responsibility; it was up to the nursing staff to notify the RP. When asked if she was responsible for doing any written notifications to the RP, OSM #1 stated that she was not. On 2/21/18 at 4:28 p.m., an interview was conducted with OSM #2, the admissions director. OSM #2 was asked to describe her responsibility for notifications, for facility- initiated transfers of residents to an acute care hospital. OSM #2 stated that she did not have any responsibility in regards to notifications. An end of day meeting was conducted on 2/21/18 at 5:01 p.m. With ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #5, the administrator in training. ASM #1, ASM #2 and ASM #5 were made aware of the above concerns. A policy was requested at this time for facility-initiated transfers. On 2/22/18 at 11:41 a.m., an interview was conducted with LPN (licensed practical nurse) #3.	F 623		

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
	495249	A. BUILOING _____ B. WING _____	C 02/23/2018

NAME OF PROVIOER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZIP COOE
FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC	1575 SCOTT ORIVE ROUTE 5 FARMVILLE, VA 23901

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F 623	Continued From page 74 LPN #3 was asked if she was responsible for providing a written notification to the resident's RP (responsible party) if a resident was transferred out of the facility to an acute care hospital. LPN #3 stated, "Not from me, I don't send a written notification, I just call to notify the RP of the transfer." No further information was provided prior to the end of the survey process. 4. The facility staff failed to provide written documentation evidencing Resident # 111's RP (responsible party) was notified in writing when Resident #111 was transferred to the hospital on 12/02/17. Resident # 111 was admitted to the facility on 12/02/10 with a readmission of 12/13/17 with diagnoses that included but were not limited to epilepsy (1), schizoaffective disorder (2), aphasia (3) gastroesophageal reflux disease (4), and tracheostomy (5). Resident # 111's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 01/29/18 coded Resident # 111 as being moderately impaired of cognition for making daily decisions. Resident # 111 was coded as requiring extensive assistance of one staff member for activities of daily living. The facilities "Progress Notes," dated 12/02/17 for Resident # 111 documented, "09:21 (9:21 a.m.) At 6 a.m. (6:00 a.m.) resident in bed with eye closed. Aroused easily. At 7 am (7:00 a.m.) resident in bed eyes closed. Unable to arouse resident. Sent resident to ER (emergency room)	F 623		

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F 623	Continued From page 75 per MD (medical doctor) order. Continue to monitor." Review of the clinical record for Resident # 111 failed to evidence written notification to Resident # 111's family or RP (responsible party) of the facility initiated transfer to the hospital on 12/02/2017. On 02/21/18 at approximately 3:49 p.m., an interview was conducted with OSM (other staff member) # 1, director of social service regarding written notification- facility to the family or RP of a facility initiated transfer. OSM # 1 stated, "When a resident goes out to the hospital, nurses notify loved one that resident is going out to the hospital. There is no written notification given to the family or RP." On 02/22/18 at 5:00 p.m. ASM (administrative staff member) # 1, the administrator, ASM # 2, the director of nursing, and ASM # 5, administrator in training, were made aware of the above concerns. No further information was provided prior to exit. References: 1. A brain disorder that causes people to have recurring seizures. The seizures happen when clusters of nerve cells, or neurons, in the brain send out the wrong signals. People may have strange sensations and emotions or behave strangely. They may have violent muscle spasms or lose consciousness. This information was obtained from the website: https://medlineplus.gov/epilepsy.html. 2. A mental condition that causes both a loss of	F 623		

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F 623	Continued From page 76 contact with reality [psychosis] and mood problems [depression or mania]. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/000930.htm. 3. A disorder caused by damage to the parts of the brain that control language. It can make it hard for you to read, write, and say what you mean to say. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/aphasia.html. 4. Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. 5. A surgical procedure to create an opening through the neck into the trachea (windpipe). A tube is most often placed through this opening to provide an airway and to remove secretions from the lungs. This information was obtained from the website: https://medlineplus.gov/ency/article/002955.htm. 5. The facility staff failed to provide written documentation evidencing Resident # 113's RP (responsible party), was notified in writing when Resident #113 was transferred to the hospital on 10/27/17. Resident # 113 was admitted to the facility on 10/10/14 with a readmission of 10/30/17 with diagnoses that included but were not limited to subarachnoid hemorrhage (1), hypertension (2), heart failure (3) dysphagia (4), and type II	F 623		

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F 623	Continued From page 77 diabetes mellitus (5). Resident # 113's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 01/31/18 coded Resident # 113 as being moderately impaired of cognition for making daily decisions. Resident # 113 was coded as requiring limited to extensive assistance of one staff member for activities of daily living. The facility's "Progress Notes" dated 10/27/17 for Resident # 113 documented, "11:04 a.m. Restorative aide returned resident to unit. Observed resident and noted right sided face drooping and slurred speech. Contacted ER (emergency room) and EMS (emergency medical services). Resident sent to ER for evaluation. MD (medical doctor) and RP (responsible party) notified." Review of the clinical record for Resident # 113 failed to evidence written notification to Resident # 113's family or RP (responsible party) of the facility initiated transfer to the hospital on 10/27/2017. On 02/21/18 at approximately 3:49 p.m., an interview was conducted with OSM (other staff member) # 1, director of social service regarding written notification- facility to the family or RP of a facility initiated transfer. OSM # 1 stated, "When a resident goes out to the hospital, nurses notify loved one that resident is going out to the hospital. There is no written notification given to the family or RP." On 02/22/18 at 5:00 p.m. ASM (administrative staff member) # 1, the administrator, ASM # 2,	F 623		

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F 623	Continued From page 78 the director of nursing, and ASM # 5, administrator in training, were made aware of the above concerns. No further information was provided prior to exit. References: 1. Bleeding in the area between the brain and the thin tissues that cover the brain. This area is called the subarachnoid space. This information was obtained from the website: https://medlineplus.gov/ency/article/000701.htm. 2. High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. 3. A condition in which the heart is no longer able to pump oxygen-rich blood to the rest of the body efficiently. This causes symptoms to occur throughout the body. This information was obtained from the website: https://medlineplus.gov/ency/article/000158.htm. 4. A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html. 5. A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. 6a. Resident #25 was transferred to the hospital on 12/12/17. The facility staff failed to provide written notification of the facility initiated transfer to the ombudsman and resident representative.	F 623		

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F 623	Continued From page 79 Resident #25 was admitted to the facility on 12/6/07. Resident #25's diagnoses included but were not limited to seizures, diabetes and anxiety disorder. Resident #25's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 11/30/17, coded the resident's cognition as severely impaired. Review of Resident #25's clinical record revealed the resident was transferred to the hospital on 12/12/17 for a fall with a laceration on the forehead. Further review of Resident #25's clinical record failed to reveal written notification was provided to the ombudsman or resident representative. On 2/21/18 at 3:50 p.m. an interview was conducted with OSM (other staff member) #1 (the social services director). OSM #1 was asked about the facility process for providing written notification to the ombudsman, resident and resident representative when a resident is transferred to the hospital. OSM #1 stated a resident might go to the hospital anytime day or night. OSM #1 stated the nurses notify the resident's loved one that the resident is going to the hospital. When asked if written notification is provided to the resident's representative, OSM #1 stated, "No. Not for hospital visits." In regards to written notification to the ombudsman, OSM #1 stated she sends a list to the ombudsman that documents any resident that leaves the building each month. OSM #1 was asked to provide these lists. On 2/22/18 at approximately 8:00 a.m., an interview was conducted with LPN (licensed	F 623		

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F 623	Continued From page 80 practical nurse) #1. LPN #1 was asked about the facility process for providing written notification to the ombudsman, resident and resident representative when a resident is transferred to the hospital. LPN #1 confirmed nurses do not provide written notification to the ombudsman, resident or resident representative. Review of the lists provided from the social services director to the ombudsman failed to reveal the ombudsman was notified when Resident #25 was transferred to the hospital on 12/12/17. The lists documented a handwritten note that documented, "Discharges @ requested. If resident does not stay overnight/Admitted then they will not appear on the report for discharged." On 2/22/18 at 8:55 a.m. another interview was conducted with OSM #1, regarding ombudsman notification of residents transferred to the hospital. OSM #1 stated she goes into the computer system and reviews the residents "discharged" from the facility. OSM #1 stated she sends the list of those residents who are "discharged" from the facility to the ombudsman. OSM #1 confirmed that if a resident is sent to the hospital and returns without being discharged from the computer system then his/her name is not on the list that is sent to the ombudsman. OSM #1 confirmed written notification regarding Resident #25's transfer to the hospital on 12/12/17 was not provided to the ombudsman because the resident was not discharged from the computer system. On 2/22/18 at 10:55 a.m., ASM #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.	F 623		

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F 623	Continued From page 81 On 2/22/18 at 1:58 p.m., ASM #2 stated the facility did not have a policy regarding ombudsman and resident representative notification. No further information was presented prior to exit. 6b. Resident #25 was transferred to the hospital on 1/22/18. The facility staff failed to provide written notification of the facility initiated transfer to the resident representative. Review of Resident #25's clinical record revealed the resident was transferred to the hospital on 1/22/18 for a non-responsive episode. Further review of Resident #25's clinical record failed to reveal the resident representative was provided written notification of the transfer. On 2/21/18 at 3:50 p.m. an interview was conducted with OSM (other staff member) #1 (the social services director). OSM #1 was asked about the facility process for providing written notification to the resident representative when a resident is transferred to the hospital. OSM #1 stated a resident might go to the hospital anytime day or night. OSM #1 stated the nurses notify the resident's loved one that the resident is going to the hospital. When asked if written notification is provided to the resident's representative, OSM #1 stated, "No. Not for hospital visits." On 2/22/18 at approximately 8:00 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked about the facility process for providing written notification to the resident representative when a resident is transferred to the hospital. LPN #1 confirmed	F 623		

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F 623	Continued From page 82 nurses do not provide written notification to the resident representative. On 2/22/18 at 10:55 a.m., ASM #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. On 2/22/18 at 1:58 p.m., ASM #2 stated the facility did not have a policy regarding resident representative notification. No further information was presented prior to exit. 7. Resident #106 was transferred to the hospital on 1/30/18 and 2/8/18. The facility staff failed to provide written notification of the facility initiated transfer to the resident or resident representative. Resident #106 was admitted to the facility on 10/3/17. Resident #106's diagnoses included but were not limited to heart failure, chronic kidney disease and diabetes. Resident #106's most recent MDS (minimum data set), a five day Medicare assessment with an ARD (assessment reference date) of 2/2/18, coded the resident as cognitively intact. Review of Resident #106's clinical record revealed the resident was transferred to the hospital on 1/30/18 for abdominal pain and returned to the facility on 2/1/18. Further review of Resident #106's clinical record revealed the resident was transferred to the hospital on 2/8/18 for low blood sugar and returned to the facility on 2/9/18. The clinical record failed to reveal the resident or resident representative was provided written notification of the transfers.	F 623		

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F 623	Continued From page 83 On 2/21/18 at 3:50 p.m. an interview was conducted with OSM (other staff member) #1 (the social services director). OSM #1 was asked about the facility process for providing written notification to the resident representative when a resident is transferred to the hospital. OSM #1 stated a resident might go to the hospital anytime day or night. OSM #1 stated the nurses notify the resident's loved one that the resident is going to the hospital. When asked if written notification is provided to the resident's representative, OSM #1 stated, "No. Not for hospital visits." On 2/22/18 at approximately 8:00 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked about the facility process for providing written notification to the resident or the resident representative when a resident is transferred to the hospital. LPN #1 confirmed nurses do not provide written notification to the resident or the resident representative. On 2/22/18 at 10:55 a.m., ASM #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. On 2/22/18 at 1:58 p.m., ASM #2 stated the facility did not have a policy regarding resident representative notification. No further information was presented prior to exit. 8. Resident #319 was transferred to the hospital on 1/22/18 and 2/1/18. The facility staff failed to provide written notification of the facility initiated transfer to the resident or resident representative.	F 623		

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F 623	Continued From page 84 Resident #319 was admitted to the facility on 12/12/17. Resident #319 was also discharged from the facility on 2/1/18 and readmitted on 2/8/18. Resident #319's diagnoses included but were not limited to seizures, high blood pressure and pancreatic insufficiency. Resident #319's most recent MDS (minimum data set), a five day Medicare assessment with an ARD (assessment reference date) of 2/1/18, coded the resident as cognitively intact. Review of Resident #319's clinical record revealed the resident was transferred to the hospital on 1/22/18 for behaviors and diarrhea and returned to the facility on 1/26/18. Further review of the clinical record revealed Resident #319 was transferred to the hospital on 2/1/18 for a fall with lethargy/ laceration on his head and returned to the facility on 2/8/18. The clinical record failed to reveal the resident or resident representative was provided written notification of the transfers. On 2/21/18 at 3:50 p.m. an interview was conducted with OSM (other staff member) #1 (the social services director). OSM #1 was asked about the facility process for providing written notification to the resident representative when a resident is transferred to the hospital. OSM #1 stated a resident might go to the hospital anytime day or night. OSM #1 stated the nurses notify the resident's loved one that the resident is going to the hospital. When asked if written notification is provided to the resident's representative, OSM #1 stated, "No. Not for hospital visits." On 2/22/18 at approximately 8:00 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked about the	F 623		

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F 623	Continued From page 85 facility process for providing written notification to the resident or the resident representative when a resident is transferred to the hospital. LPN #1 confirmed nurses do not provide written notification to the resident or the resident representative. On 2/22/18 at 10:55 a.m., ASM #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. On 2/22/18 at 1:58 p.m., ASM #2 stated the facility did not have a policy regarding resident representative notification. No further information was presented prior to exit.	F 623	**F625** 1. Resident #80 has had no discharges since the annual survey. To educate his family a copy of the bed-hold agreement along with a cover letter will be sent to the RR by 3-30-2018. 2. Resident #60 no longer resides in the facility.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1)	F 625	3. Resident #113 has had no discharges since the annual survey. To educate her family a copy of the bed-hold agreement along with a cover letter will be sent to the RR by 3-30-2018. 4. A copy of the facility bed-hold policy and agreement will be sent to all RR along with a cover letter to educate them on the bed-hold process by 3-30-2018. Residents will be educated on the bed-hold policy during the resident council meeting held in March.	

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
	495249	A. BUILOING _____ B. WING _____	C 02/23/2018

NAME OF PROVIOER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZIP COOE
FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC	1575 SCOTT ORIVE ROUTE 5 FARMVILLE, VA 23901

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F 625	Continued From page 86 of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide a bed hold notice at the time of a facility initiated transfer for three of 30 residents in the survey sample, Resident #s 80, 60 and 113. 1. The facility staff failed to provide evidence that Resident #80 and or his RP (responsible party) were provided written notification of the bed hold policy, and offered a bed hold when he was transferred to the hospital on 8/7/17, 12/17/17 and 1/2/18. 2. The facility staff failed to provide evidence that Resident #6 and or her RP (responsible party) were provided written notification of the bed hold policy, and offered a bed hold when she was transferred to the hospital on 2/8/18. 3. The facility staff failed to provide Resident # 113 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 10/27/17. The findings include:	F 625	5. During resident council on 3-27-2018 the Administrator has been asked to present information on the facility bed-hold policy and process. 6. The admissions director will be responsible for contacting residents or RR when a discharge occurs to offer a bed-hold. A copy of the declination or acceptance of the bed-hold will be placed in their social service file. 7. The interdisciplinary QA team will perform a random audit on a monthly basis for the next three months and quarterly thereafter to ensure continued compliance. 8. Completion date: 3-30-2018	

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F 625	Continued From page 87 1. The facility staff failed to provide evidence that Resident #80 and or his RP (responsible party) were provided written notification of the bed hold policy, and offered a bed hold when he was transferred to the hospital on 8/7/17, 12/17/17 and 1/2/18. Resident #80 was admitted to the facility on 4/17/15 with a readmission date on 1/5/18 with diagnoses that include but not limited to high blood pressure, difficulty speaking following a stroke, depression, difficulty swallowing and cognitive communication deficit. Resident #80's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/3/18, coded Resident #80 as scoring a six out of a possible 15 on the BIMS (brief interview for mental status), indicating that Resident #80 is severely cognitively impaired with decisions of daily living. A review of Resident #80's clinical record revealed, in part, that Resident #80 was transferred by the facility to an acute care hospital on 8/7/17, 12/17/17 and 1/2/18. Further review of Resident #80's clinical record did not reveal any evidence that Resident #80 or his RP was offered a bed hold at the time of the above referenced transfers to the hospital. An end of day meeting was conducted on 2/21/18 at 5:01 p.m. With ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #5, the administrator in training. ASM #1, ASM #2 and ASM #5 were made aware of the above concerns. A policy was requested at this time for facility-initiated transfer	F 625		

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F 625	Continued From page 88 and bed holds. On 2/22/18 at 4:28 p.m., an interview was conducted with OSM (other staff member) #2, the admissions director. OSM #2 was asked about the process followed for providing bed hold information to the residents and family members at the time of a facility-initiated transfer to an acute care hospital. OSM #2 stated, "The day after the transfer, I contact the RP and ask how the resident is doing and then ask at that point about a bed hold. If they want one or not. I explain the process, how it works and the costs associated with it." When asked where the conversation is documented OSM #2 stated, "I do not have documentation privileges in (name of the electronic medical record program) so I have nowhere to document. If the resident RP does want to do, a bed hold then the family comes in and signs a form and I keep that in a folder in the admissions office. The bed hold conversation is actually started by nursing at the time of the transfer; they should document that at that time." OSM #2 was asked to provide evidence that a bed hold was offered to Resident #80 on 8/7/17, 12/17/17 and 1/2/18. No further information was provided prior to the end of the survey process. 2. The facility staff failed to provide evidence that Resident #6 and or her RP (responsible party) were provided written notification of the bed hold policy, and offered a bed hold when she was transferred to the hospital on 2/8/18. Resident #60 was admitted to the facility on 7/7/16 with a readmission on 2/14/18 with	F 625		

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F 625	Continued From page 89 diagnoses that included, but not limited to, psychosis, Parkinson's disease, high blood pressure and glaucoma (a degenerative disease effecting eyesight). Resident #60's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/23/17, coded Resident #60 as being unable to answer the questions on the BIMS (brief interview for mental status). The staff assessment coded Resident #60 as being severely impaired to make daily decisions. A review of Resident #60's clinical record revealed, in part, that she had been transferred to an acute care hospital on 2/8/18. Further review of Resident #60's clinical record did not reveal any evidence that Resident #60 or her RP were offered a bed hold at the time of the above referenced transfer to the hospital. An end of day meeting was conducted on 2/21/18 at 5:01 p.m. With ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #5, the administrator in training. ASM #1, ASM #2 and ASM #5 were made aware of the above concerns. A policy was requested at this time for facility-initiated transfer and bed holds. On 2/22/18 at 4:28 p.m., an interview was conducted with OSM (other staff member) #2, the admissions director. OSM #2 was asked about the process followed for providing bed hold information to the residents and family members at the time of a facility-initiated transfer to an acute care hospital. OSM #2 stated, "The day	F 625		

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F 625	Continued From page 90	F 625		

after the transfer, I contact the RP and ask how the resident is doing and then ask at that point about a bed hold. If they want one or not. I explain the process, how it works and the costs associated with it." When asked where the conversation is documented OSM #2 stated, "I do not have documentation privileges in (name of the electronic medical record program) so I have nowhere to document. If the resident RP does want to do, a bed hold then the family comes in and signs a form and I keep that in a folder in the admissions office. The bed hold conversation is actually started by nursing at the time of the transfer; they should document that at that time." OSM #2 was asked to provide evidence that a bed hold was offered to Resident #60 on 2/8/18.

No further information was provided prior to the end of the survey process.

3. The facility staff failed to provide Resident # 113 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 10/27/17.

Resident # 113 was admitted to the facility on 10/10/14 with a readmission of 10/30/17 with diagnoses that included but were not limited to subarachnoid hemorrhage (1), hypertension (2), heart failure (3) dysphagia (4), and type II diabetes mellitus (5).

Resident # 113's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 01/31/18 coded Resident # 113 as being moderately impaired of cognition for making daily decisions. Resident # 113 was coded as requiring limited to extensive assistance of one staff member for

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F 625	Continued From page 91 activities of daily living. The facility's "Progress Notes" dated 10/27/17 for Resident # 113 documented, "11:04 a.m. Restorative aide returned resident to unit. Observed resident and noted right sided face drooping and slurred speech. Contacted ER (emergency room) and EMS (emergency medical services). Resident sent to ER for evaluation. MD (medical doctor) and RP (responsible party) notified." A review of the clinical record failed to reveal any evidence that the resident and/or responsible party was provided with a copy of the "Bed Hold" policy within 24 hours of transfer to the hospital. On 02/22/18 at 3:30 p.m., in an interview with OSM (other staff member) #2, the admissions director. When asked to describe her role in regarding resident transfers discharges OSM # 2 stated, "If the resident is transferred I contact the family or RP (responsible party) and give an update. I explain the process if they choose to hold the bed and explain the costs. If the resident is discharged, nursing should document and initiate contact the family or RP regarding the bed hold." When asked about documenting her contact with the Family or RP regarding the bed hold OSM # 2 stated, "I don't document it anywhere. I don't have access rights to PCC (Point Click Care - the electronic health record system for resident's records)." On 02/23/18 at 9:50 a.m., in an interview with OSM (other staff member) #2, the admissions director. When asked if a bed hold was offered to Resident # 113's family or RP for her facility-initiated transfer to the emergency room	F 625		

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F 625	Continued From page 92 on 10/27/17, OSM # 2 stated, "The bed hold was offered but the family refused due to finances." When asked for documentation to support the offer of the bed hold, OSM # 2 stated she did not have any and further stated, "Because I don't have any documentation I can't say the bed hold was offered." On 02/22/18 at 5:00 p.m. ASM (administrative staff member) # 1, the administrator, ASM # 2, the director of nursing, and ASM # 5, administrator in training were made aware of the above concerns. No further information was provided prior to exit. References: 1. Bleeding in the area between the brain and the thin tissues that cover the brain. This area is called the subarachnoid space. This information was obtained from the website: https://medlineplus.gov/ency/article/000701.htm. 2. High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. 3. A condition in which the heart is no longer able to pump oxygen-rich blood to the rest of the body efficiently. This causes symptoms to occur throughout the body. This information was obtained from the website: https://medlineplus.gov/ency/article/000158.htm. 4. A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.	F 625		

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F 625	Continued From page 93 5. A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to complete an accurate assessment for one of 30 residents in the survey sample, Resident #94. The facility staff failed to capture Resident #94's urinary catheter on a significant change MDS (minimum data set) assessment with an ARD (assessment reference date) of 1/24/18. The findings include: Resident #94 was admitted to the facility on 1/02/09 and readmitted on 7/2/17 with diagnoses that included but were not limited to manic depression, Schizophrenia, and Benign prostatic hyperplasia (enlarged prostate). Resident #94's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 1/24/18. Resident #94 was coded as being moderately impaired in the ability to make daily decisions scoring 08 out of 15 on the BIMS	F 641		

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F 641	Continued From page 94 (Brief Interview for Mental Status) exam. Resident #49 was coded as requiring extensive assistance from one staff member with bed mobility, transfers, toileting, personal hygiene; total dependence on staff with bathing, and independent with meals. Resident #49 was coded in section O "(Special Treatments, Procedures, and Programs)" as receiving Hospice Care. On 2/21/18 through 2/23/18, several observations were made of Resident #49. Resident #49 was observed with a catheter bag hanging from the bed, below the level of the bladder, draining clear to yellow urine. Review of Resident #94's clinical record revealed the following active order dated 11/29/17: "Suprapubic catheter [1] 24 fr (french) 10 cc (cubic centimeter) bulb. Change prn (as needed) or as ordered by physician for occlusive BPH." Review of Resident #94's significant change MDS with an ARD of 1/24/18 documented the following in Section H (Bladder and Bowel): "H0100. Appliances. Check all that apply. A. Indwelling catheter (including suprapubic catheter and nephrostomy tube) B. External Catheter C. Ostomy (including urostomy, ileostomy, and colostomy) D. Intermittent catheterization. Z. None of the above." An "X" was coded under response "none of the above" indicating that Resident #49 did not have a catheter in place. Further review of Section H (Bladder and Bowel) documented the following under section H0300.	F 641	F641 1. Resident #94's Minimum Data Set (MDS) was modified on 3/12/18 to include coding for urinary catheter. 2. The MDS Director will complete an audit of the current MDS assessments by 3/14/18 to validate accuracy of coding related to urinary catheters. 3. The MDS Director and Coordinator will be re-educated by the Corporate Clinical Reimbursement Specialist regarding accuracy of assessments by 3/14/18. 4. The MDS Director will audit 5 MDS assessments on each unit weekly for 4 weeks and monthly for 2 months to ensure MDS assessments continue to be completed accurately as required. The MDS Director will submit a report to the Quality Assurance Committee monthly for 3 months. Completion date: 3/30/18	

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F 641	Continued From page 95 (Urinary Incontinence): "Urinary incontinence-Select the one category that best describes the resident. 0. Always continent 1. Occasionally incontinent 2. Frequently incontinent 3. Always incontinent 9. Not rated, resident had a catheter (indwelling, condom) urinary ostomy, or no urine output for the entire 7 days." A "9" was coded indicating that the resident either had a catheter in place, ostomy, or had no urine output for the entire 7 days. Review of Resident #49's clinical record revealed that at no point was his catheter removed during the look back period. On 2/22/18 at 8:33 a.m., an interview was conducted with RN (registered nurse) #2, the MDS coordinator. RN #2 stated the MDS nurse who filled out Section H of Resident #94's MDS was out sick and was not doing well. When asked about the process for filling out section H of the MDS, RN #2 stated she would check the resident's ADL record, incontinence information, and interview staff and/or the resident on the resident's urinary needs prior to filling out the MDS assessment. When asked if Resident #94 had an indwelling catheter, RN #2 stated that he did. RN #2 stated, "He has had one for some time and it wasn't removed." RN #2 stated his 1/24/18 MDS was coded incorrectly in section H0100. When asked what was used as a point of reference when completing the MDS assessment, RN #2 stated the MDS staff use the RAI (Resident Assessment Instrument) manual when completing the MDS.	F 641		

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F 641	Continued From page 96 On 2/22/18 at 5:01 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the ADON (Assistant Director of Nursing) were made aware of the above concerns. The RAI (Resident Assessment Instrument) 3.0 Manual documents the following for Section H: The intent of the items in this section is to gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns. Each resident who is incontinent or at risk of developing incontinence should be identified, assessed, and provided with individualized treatment (medications, non-medicinal treatments and/or devices) and services to achieve or maintain as normal elimination function as possible. Steps for Assessment Examine the resident to note the presence of any urinary or bowel appliances. Review the medical record, including bladder and bowel records, for documentation of current or past use of urinary or bowel appliances. Coding Instructions Check next to each appliance that was used at any time in the past 7 days. Select none of the above if none of the appliances A-D were used in the past 7 days. ·H0100A, indwelling catheter (including suprapubic catheter and nephrostomy tube) ·H0100B, external catheter ·H0100C, ostomy (including urostomy, ileostomy,	F 641		

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F 641	Continued From page 97 and colostomy) ·H0100D, intermittent catheterization ·H0100Z, none of the above Coding Tips and Special Populations ·Suprapubic catheters and nephrostomy tubes should be coded as an indwelling catheter (H0100A) only and not as an ostomy (H0100C). [1] A suprapubic catheter (tube) drains urine from your bladder. It is inserted into your bladder through a small hole in your belly. You may need a catheter because you have urinary incontinence (leakage), urinary retention (not being able to urinate), surgery that made a catheter necessary, or another health problem. This information was obtained from The National Institutes of Health. https://wwwqa.nlm.nih.gov/medlineplus/275/ency/patientinstructions/000145.htm.	F 641	**F655** 1. Resident #268's respiratory status was assessed on 2/22/18 by the Assistant Director of Nursing with no distress noted. Resident #268 oxygen flow rate was adjusted to 4 liters per minute by the Unit Manager on 2/22/18. Resident #268 care plan was updated to include oxygen on 2/23/18.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders.	F 655	Resident #268's physician was notified on 2/22/18 by the Unit Manager of the oxygen not being administered at the ordered setting. No new orders noted. 2. The Assistant Director of Nursing and the Unit Manager completed on 2/22/18 an audit of current residents on oxygen to ensure oxygen setting were on correct settings as required. Unit Manager and Assistant Director of nursing reviewed all current residents' care plan for oxygen on 2/23/18.	

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	495249	A. BUILDING _____ B. WING _____	C 02/23/2018

NAME OF PROVIOER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZIP COOE
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F 655	Continued From page 98 (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, it was determined the facility staff failed to implement a baseline care plan for one of 30 residents in the survey sample, Residents #268. The facility staff failed to implement Resident # 268's baseline care plan for oxygen. The findings include:	F 655	F655 3. Charge Nurse was re-educated by the Staff Development Coordinator on 2/23/18 related to ensuring oxygen is administered as ordered and care planned. The Licensed Nurses will be re-educated by the Staff Development Coordinator by 3/14/18 related to ensuring oxygen orders are followed according to plan of care. 4. The Assistant Director of Nursing and the Unit Manager will complete an audit of 5 current residents on each unit weekly for 4 weeks and monthly for 2 months to ensure oxygen is administered as ordered and care planned. The Staff Development Coordinator will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for the monitoring and follow up. Completion date: 3/30/18	

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F 655	Continued From page 99 Resident # 268 was admitted to the facility on 01/26/18 with a readmission on 02/14/18 with diagnoses that included but were not limited to: kidney failure, hypertension (2), dementia (3), multiple myeloma relapse (4) gastroesophageal reflux disease (5) and renal failure (6). Resident # 268's MDS (minimum data set) assessment was not due at the time for the survey. Review of the facility's "Readmission Evaluation dated 02/15/18 for Resident # 268 revealed he was orientated to person, place time and situation. Resident # 268 was documented as being independent with ADLs (activities of daily living). An observation conducted on 02/21/18 at 1:55 p.m., revealed Resident # 268 was in his room sitting in his wheelchair. Resident #268 was observed receiving oxygen by nasal cannula (plastic tube placed in the nostrils to deliver oxygen) connected to an oxygen concentrator. Observation of the flow meter on the oxygen concentrator revealed the oxygen flow rate was set between four and a half liters and five liters per minute. An observation conducted on 02/21/18 at 2:48 p.m. revealed Resident # 268 was in his room sitting in his wheelchair, and was receiving oxygen by nasal cannula. Observation of the flow meter on the oxygen concentrator revealed the oxygen flow rate was set between four and a half liters and five liters per minute. An observation conducted on 02/22/18 at 7:50 a.m. revealed Resident # 268 was in his room sitting in his wheelchair and was receiving oxygen	F 655		

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F 655	Continued From page 100 by nasal cannula. Observation of the flow meter on the oxygen concentrator revealed the oxygen flow rate was set between four and a half liters and five liters per minute. The physician's order dated Feb (February) 2018 for Resident # 268 documented, "Oxygen at 4lpm (four liters per minute) via (by) nasal cannula at all times every shift for SOB (short of breath). Order Date: 02/15/2018. Start Date: 02/15/2018." The eMAR (electronic medication administration record) dated February 2018 documented, "Oxygen at 4lpm (four liters per minute) via (by) nasal cannula at all times every shift for SOB (short of breath). Order Date: 02/15/2018." Further review of the eMAR revealed Resident # 268 received oxygen at four liters per minute on 02/21/18 on the day, evening and night shift and on 02/22/18 on the day shift. The comprehensive care plan for Resident # 268 was not due at the time of survey. Review of Resident # 268's baseline care plan dated 2/14/18, documented, "Oxygen: 4L N.C. 2/15 (four liters per minute by nasal cannula. 02/15/18)." On 02/23/18 at 8:25 a.m., an interview was conducted with ASM (administrative staff member) # 3, assistant director of nursing. When asked to describe the purpose of the care plan, ASM # 3 stated, "It guides the care and treatment for resident." After being informed of the observations of Resident # 268's oxygen flow rate and reviewing the baseline care plan for Resident # 268, ASM # 3 was asked if the care plan was being implemented. ASM # 3 stated, "No."	F 655		

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F 655	Continued From page 101 On 02/23/18 at 9:30 a.m., an interview was conducted with ASM (administrative staff member) # 2, the director of nursing. When asked to describe the purpose of the care plan, ASM # 2 stated, "To have a written document of care for the resident." After being informed of the observations of Resident # 268's oxygen flow rate and reviewing the baseline care plan for Resident # 268, ASM # 2 was asked if the care plan was being implemented. ASM # 2 stated, "No." On 02/22/18 at 5:00 p.m., ASM (administrative staff member) # 1, the administrator, ASM # 2, the director of nursing, and ASM # 5, administrator in training were made aware of the above concerns. No further information was provided prior to exit. References: (1) If you have asthma, your doctor may prescribe a nebulizer as treatment or breathing therapy. The device delivers the same types of medication as metered-dose inhalers (MDIs), which are the familiar pocket-sized inhalers. Nebulizers may be easier to use than MDIs, especially for children who aren't old enough to properly use inhalers, or adults with severe asthma. A nebulizer turns liquid medicine into a mist to help treat your asthma. They come in electric or battery-run versions. They come in both a portable size you can carry with you and a larger size that's meant to sit on a table and plug into a wall. Both are made up of a base that holds an air compressor, a small container for liquid medicine, and a tube that connects the air compressor to the medicine container. Above the medicine container is a mouthpiece or mask you use to inhale the mist. This information was obtained from the website:	F 655		

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F 655	Continued From page 102 https: https://www.healthline.com/health/asthma-nebulizer-machine. (2) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (3) A group of symptoms caused by disorders that affect the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/dementia.html. (4) A cancer that begins in plasma cells, a type of white blood cell. These cells are part of your immune system, which helps protect the body from germs and other harmful substances. In time, myeloma cells collect in the bone marrow and in the solid parts of bones. This information was obtained from the website: https://medlineplus.gov/multiplemyeloma.html.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 656	Continued From page 103 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, it was determined the facility staff failed to develop and implement a comprehensive care plan for three of 30 residents in the survey sample, Residents #15, #80 and #104. 1. The facility staff failed to implement the pain care plan for Resident # 51.	F 656	Past noncompliance: no plan of correction required.	

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F 656	Continued From page 104 2. The facility staff failed to develop a comprehensive care plan that addressed Resident #80's diabetes and treatment with insulin. 3. The facility staff failed to implement Resident #104's comprehensive care plan for the administration of oxygen as ordered. The findings include: 1. The facility staff failed to implement the pain care plan for Resident # 51. Resident # 51 was admitted to the facility on 04/10/2017with diagnoses that included but were not limited to kidney failure, diabetes mellitus without complication (1), hypertension (2), and anxiety (3). Resident # 51's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/21/17, coded Resident # 51 as scoring a 99 indicating Resident # 51 was unable to complete the brief interview for mental status (BIMS). Resident # 51 was coded as being moderately impaired of cognition on the "Staff Assessment for Mental Status." Resident # 51 was coded as requiring total assistance of one staff member for activities of daily living. The POS (Physician's Order Sheet) for Resident # 51 dated "Feb (February), 2018 documented, "Acetaminophen Suppository (4) - 650 MG (milligrams) Insert 1 (one) suppository rectally	F 656		

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F 656	Continued From page 105 every 8 (eight) hours for pain NTE (not to exceed) 4 (four) grams in 24 hours. Order Date: 10/19/2017. Start Date: 10/19/2017." The eMAR (electronic medication administration record) dated December, 2017 documented, "Acetaminophen Suppository - 650 MG. Insert 1 suppository rectally every 8 hours for pain NTE 4 grams in 24 hours. Order Date: 10/19/2017." Further review of the eMAR failed to evidence the administration of Acetaminophen Suppository - 650 MG on 12/03/17 at 6:00 a.m., 12/04/17 at 6:00 a.m., 12/08/17 at 10:00 p.m., 12/09/17 at 6:00 a.m., 12/10/17 at 6:00 a.m.; 21/21/17 at 6:00 a.m., and 12/31/17 at 6:00 a.m. Review of the facility's "Progress Notes" dated 12/01/17 through 12/31/17 for Resident # 51 failed to evidence documentation of the missing administration of Acetaminophen Suppository - 650 MG on 12/03/17 at 6:00 a.m., 12/04/17 at 6:00 a.m., 12/08/17 at 10:00 p.m., 12/09/17 at 6:00 a.m., 12/10/17 at 6:00 a.m.; 21/21/17 at 6:00 a.m., and 12/31/17 at 6:00 a.m. The comprehensive care plan for Resident # 51 with a revision date of 02/21/2018 documented, "Focus: Alteration in comfort R/T (related to) disease process. Date initiated: 04/11/2017." Under "Interventions" it documented, "Administer medications as ordered. Observe for tolerance and effectiveness. Observe for possible adverse side effects. Notify MD (medical doctor) if indicated. Date initiated: 04/11/2017." On 02/23/18 at 8:25 a.m., an interview was conducted with ASM (administrative staff member) # 3, the assistant director of nursing. When asked to describe the purpose of the care	F 656		

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F 656	Continued From page 106	F 656		

plan, ASM # 3 stated, "It guides the care and treatment for resident." After reviewing the eMAR, progress notes and care plan for Resident # 51, ASM # 3 stated, "The care plans was not being followed."

On 02/23/18 at 9:30 a.m., an interview was conducted with ASM (administrative staff member) # 2, the director of nursing. When asked to describe the purpose of the comprehensive care plan, ASM # 2 stated, "To have a written document of care for the resident." After reviewing the eMAR, progress notes and care plan for Resident # 51, ASM # 2 stated, "The care plans was not being followed."

On 02/22/18 at 5:00 p.m. ASM (administrative staff member) # 1, the administrator, ASM # 2, the director of nursing, and ASM # 5, administrator in training were made aware of the above concerns.

No further information was provided prior to exit.

References:

(1) A chronic disease in which the body cannot regulate the amount of sugar in the blood. The goal of treatment at first is to lower your high blood glucose level. Long-term goals are to prevent complications. The most important way to treat and manage type 2 diabetes is by being active and eating healthy foods. This information was obtained from the website: https://medlineplus.gov/ency/article/000313.htm.

(2) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpr

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F 656	Continued From page 107 essure.html. (3) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary. (4) Used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body. This information was obtained from the website: https: https://medlineplus.gov/druginfo/meds/a681004.html. (5) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. (6) The rapid (less than 2 days) loss of your kidneys' ability to remove waste and help balance fluids and electrolytes in your body. This information was obtained from the website: https://medlineplus.gov/ency/article/000501.htm. 2. The facility staff failed to develop a comprehensive care plan that addressed Resident #80's diabetes and treatment with insulin.	F 656		

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F 656	Continued From page 108 Resident #80 was admitted to the facility on 4/17/15 with a readmission date on 1/5/18 with diagnoses that include but not limited to high blood pressure, difficulty speaking following a stroke, depression, difficulty swallowing and cognitive communication deficit. Resident #80's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/3/18, coded Resident #80 as scoring a six out of a possible 15 on the BIMS (brief interview for mental status), indicating that Resident #80 is severely cognitively impaired with decisions of daily living. A review of Resident #80's physician orders reveal, in part, the following order: "Insulin Lispro [1] (insulin to treat high blood sugar) Prot (protamine) & (and) Lispro Suspension (75-25) 100 UNIT/ML (milliliters) Inject 12 unit subcutaneously (under the skin) in the evening for DM (diabetes mellitus). Insulin Lispro Prot & Lispro Suspension (75-25) 100 UNIT/ML Inject 12 unit subcutaneously in the morning for DM." A review of Resident #80's comprehensive care plan dated 1/5/18 did not have any documentation regarding treatment with insulin for diabetes. On 2/22/18 at 2:44 p.m. an interview was conducted with RN (registered nurse) #2, the MDS coordinator. RN #2 was asked to describe the purpose of the care plans. RN #2 stated, "To try to foresee any problems that may occur and put interventions into place. Once something happens we try to prevent it happening again." When asked who was responsible for developing a care plan, RN #2 stated it was MDS's	F 656		

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F 656	Continued From page 109 responsibility to develop the comprehensive care plans. Once developed the IDT (interdisciplinary team) reviewed and revised the care plans as needed. When asked if a care plan had been completed for Resident #80's insulin treatments and diabetes, RN #2 was unable to locate a care plan and stated she would get back with this writer. On 2/23/18 at approximately 10:00 a.m. a meeting was conducted with ASM #1, the administrator, ASM #2, the director of nursing, and ASM #5, the administrator in training. ASM #1, ASM #2 and ASM #5 were made aware of the above concern at this time and a policy was requested for the development of a comprehensive care plan. No further information was provided prior to the end of the survey process. [1] Insulin Lispro: Insulin lispro is a short-acting, man-made version of human insulin. Insulin lispro works by replacing the insulin that is normally produced by the body and by helping move sugar from the blood into other body tissues where it is used for energy. It also stops the liver from producing more sugar. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697021.html 3. The facility staff failed to implement Resident #104's comprehensive care plan for the	F 656		

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F 656	Continued From page 110 administration of oxygen as ordered. Resident #104 was admitted to the facility on 4/6/17 and readmitted on 1/24/18 with the diagnoses of but not limited to metabolic encephalopathy, chronic kidney disease, pressure ulcer, high blood pressure, neurogenic bladder, dysphagia, hypothyroidism, diabetes, heart disease, and anxiety disorder. The most recent MDS (Minimum Data Set) coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring extensive assistance for all areas of activities of daily living. A review of the physician's orders revealed one dated 1/24/18 for "Oxygen at 2 liters via nasal cannula..." A review of the resident's care plan revealed one for "I have altered respiratory status/difficulty breathing r/t (related to) my disease process and I require the use of oxygen." This care plan was dated 1/3/18. The interventions included, "Administer my O2 (oxygen) as ordered." This intervention was dated 1/3/18. On 2/21/18 at 9:30 a.m., 2/21/18 at 2:32 p.m., and 2/22/18 at 3:04 p.m., Resident #104's oxygen was observed set at 3.5 liters per minute. On 2/22/18 at 3:04 p.m., LPN #6 (Licensed Practical Nurse) stated the resident's oxygen should be set at 2 liters. LPN #6 checked Resident #104's oxygen concentrator unit and stated that it was at 3.5 liters and this was the incorrect setting. On 2/23/18 at 8:16 a.m., an interview was conducted with LPN #10 regarding	F 656		

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F 656	Continued From page 111 implementation of the care plan. LPN #10 stated if it was on the care plan to administer as ordered, and it was not being administered as ordered, then the care plan was not being followed. A review of the facility policy, "Care Plan" documented, "Each resident will have an individualized Care Plan that is developed by the interdisciplinary team with input from the resident and family. All nursing personnel will refer to the Care Plan when providing care..." On 2/22/18 at 5:16 p.m., at the end of day meeting, the Administrator (ASM #1 - Administrative Staff Member) and Director of Nursing (ASM #2) were made aware of the findings. No further information was provided by the end of the survey.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 657		

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F 657	Continued From page 112 the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, it was determined the facility staff failed to review and revise the comprehensive care plan for one of 30 residents in the survey sample, Resident #319. The facility staff failed to review and revise Resident #319's comprehensive care plan for the discontinuation of a chair pad alarm. The finding include: Resident #319 was admitted to the facility on 12/12/17 and readmitted on 1/26/18. Resident #319 was also discharged from the facility on 2/1/18 and readmitted on 2/8/18. Resident #319's diagnoses included but were not limited to seizures, high blood pressure and pancreatic insufficiency. Resident #319's most recent MDS (minimum data set), a five day Medicare assessment with an ARD (assessment reference date) of 2/1/18, coded the resident as cognitively intact.	F 657	**F657** 1. Resident #319's orders were updated to include a Chair alarm on 3/10/18. 2. The Assistant Director of Nursing and the Unit Manager completed an audit on 2/26/18 to ensure all alarms had physician's order and were reflected correctly on the care plan as required. 3. The Licensed Nurses will be re-educated on the review and revising of care plans as required by 3/14/18.	

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F 657	Continued From page 113 Resident #319's comprehensive care plan revised on 1/22/18 documented, "I AM AT RISK FOR FALL RELATED INJURIES...PROVIDE ME WITH A CHAIR PAD ALARM..." On 2/21/18 at 12:35 p.m., an employee was observed propelling Resident #319 in a wheelchair in the hall. A chair pad alarm was observed in the resident's wheelchair with the end of the cord dangling. The end of the cord was not attached to a box to make the alarm function. On 2/21/18 at 1:40 p.m., Resident #319 was observed in a wheelchair in an alcove near the nurses' station. The chair pad alarm was observed in the wheelchair with the end of the cord dangling and was not attached to a box to make the alarm function. On 2/22/18 at 1:45 p.m. ASM (administrative staff member) #3 (the assistant director of nursing) provided Resident #319's nurse aide's information sheet, per this surveyor's request. A chair pad alarm was not documented as being required for the resident. ASM #3 stated the chair pad alarm was not ordered by the physician when the resident was readmitted from the hospital. On 2/22/18 at 1:58 p.m., ASM #2 (the director of nursing) stated Resident #319 had no current physician's order for a chair pad alarm and the alarm should have been resolved from the care plan. On 2/22/18 at 2:28 p.m. ASM #1 (the administrator) and ASM #2 were made aware of the above findings. The facility policy titled, "Care Plans"	F 657	4. The Assistant Director of Nursing and the Unit Manager will complete an audit of 5 current residents on each unit to ensure care plans are reviewed and revised for alarms weekly for 4 weeks and monthly for 2 months. The Staff Development Coordinator will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. Completion date: 3/30/18	

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F 657	Continued From page 114 documented, "5. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change..." No further information was presented prior to exit.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to follow professional standards of practice for two of 30 residents in the survey sample, Residents #27 and 66. 1. The facility staff failed to clarify an order to contact the Hospice physician prior to the administration of Ativan [1] 0.5 mg (milligrams) to Resident #27. 2. The facility staff administered insulin to Resident #66 on five occasions when his blood sugar was greater than 400 without a physician order. The findings include: 1. Resident #27 was admitted to the facility on 9/1/17 with diagnoses that include but were not limited to Alzheimer's disease, high blood	F 658		

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F 658	Continued From page 115 pressure, colon cancer, and atherosclerotic heart disease. Resident #27's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 12/9/17. Resident #27 was coded as being severely impaired in cognitive function scoring a 06 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #27 was coded as being independent and requiring supervision only with bed mobility, transfers, meals and ambulation; and extensive assistance from one staff member with dressing, bathing, personal hygiene and toileting. Resident #27 was coded in section O "(Special Treatments, Procedures, and Programs)" as receiving Hospice Care. Review of Resident #27's physician order sheets dated and signed by the physician on 9/2017 through 12/2017 documented the following order: "Lorazepam (Ativan) Tablet 0.5 mg (milligrams) Give 1 tablet as every 4 hours as needed for Anxiety...Call HOSPICE MD (medical doctor) BEFORE USE!" This order was discontinued on 1/4/18. Review of Resident #27's September 2017 MAR (medication administration record) revealed that Resident #27 received Ativan 0.5 mg on 9/3/17 at 3:17 a.m., and 11:44 p.m., and 9/13/17 at 5:14 p.m. Review of Resident #27's November 2017 MAR revealed that Resident #27 received Ativan 0.5 mg at 11/9/17 at 9:59 p.m., and 11/17/17 at 5:49 p.m. The following note was documented on 9/3/17 at 3:17 a.m.: "Lorazepam Tablet 0.5 mg every 4	F 658	F658 1. On 2/19/18, a physician's order was obtained to discontinue Ativan for resident # 27. 2. The Medical Director was notified 2/23/18 that resident #66 was receiving insulin without a physician's order. 3. LPN's # 8 was re-educated by the Staff Development Coordinator on 2/23/18 related to following physician orders and obtaining physician orders for a change in condition of a resident. The Licensed Nurses will be re-educated by Staff Development Coordinator regarding physician notification and obtaining orders from a physician by 3/14/18.	

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F 658	Continued From page 116 hours as needed for Anxiety...call Hospice MD before use! Ativan 0.5 mg (milligrams) given by mouth as ordered for increased anxiety." The next note dated 9/3/17 at 4:04 a.m. documented the following: "(Name of Hospice) notified made aware of Ativan 0.5 mg 1 tablet by mouth administered as ordered for anxiety." Further review of Resident #27's nursing notes dated September 2017 through November 2017 failed to evidence that hospice was notified PRIOR to the administration of Ativan. A hospice note dated 9/3/17 documented the following at 9:36 a.m.: "Phone call from: (Name of facility nurse), calling stating patient anxious. (Name of nurse) administered Lorazepam 0.5 mg at 0300 (3:00 a.m.). (Name of nurse) unaware to call Hospice before giving initial dose of Lorazepam. (Name of nurse) stated patient sleeping now. Notified (Name of Hospice) MD (medical doctor) patient received Lorazepam for anxiety. No visit needed at this time." No further hospice notes regarding Lorazepam administration could be found in the clinical record. On 2/22/18 at 9:33 a.m., an interview was conducted with RN (registered nurse) #5, the hospice nurse. RN #5 was asked about the process followed prior to nursing staff administering prn Ativan for Resident #27. RN #5 stated that nursing staff should first be assessing the need for Ativan, checking vital signs, and trying other methods such as toileting the resident prior to administering Ativan. RN #5 stated that for every hospice patient, nursing staff must	F 658	4. The Assistant Director of Nursing and the Unit Manager will audit 5 medical records weekly for 4 weeks and monthly for 2 months to ensure physician notification and physician orders are in place as required. The Staff Development Coordinator will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. Completion date: 3/30/18	

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F 658	Continued From page 117 contact hospice prior to administering the first initial dose of Ativan. RN #5 stated that it is ok for nursing staff to administer other doses of Ativan without notifying hospice after the first initial dose. When asked the rationale for nursing staff to notify hospice prior to administering the first initial dose of Ativan, RN #5 stated the hospice staff, and the hospice physician, need to be aware of the behaviors that warrant the need for Ativan. RN #5 stated hospice needs to be aware that nursing staff are administering Ativan as well. RN #5 confirmed the nurse working on 9/3/17 administered Ativan to Resident #27 before she notified hospice. RN #5 stated hospice was made aware after administration. RN #5 stated the order was not followed that morning. RN #5 stated she had no documentation in her hospice notes of nursing staff notifying them (hospice), prior to the administration of Ativan on 9/3/17 at 11:44 p.m., 9/13/17 at 5:14 p.m., 11/9/17 at 9:59 p.m. and 11/17/17 at 5:49 p.m., but that nursing staff did not have to notify them. RN #5 stated the Ativan order should have been clarified. RN #5 stated again the nursing does not have to notify hospice after the first initial dose has been given. On 2/22/18 at: 12:43 p.m., an interview was conducted with LPN (licensed practical nurse) #5. When asked if she could interpret the above Ativan order, LPN #5 stated she would call hospice prior to giving Ativan. When asked if she would call hospice every time Ativan was needed or just for the first initial dose, LPN #5 stated. "Every time I would call before use. That is what the order says." On 2/23/18 at 8:53 a.m., an interview was conducted with LPN (licensed practical nurse) #8,	F 658		

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F 658	Continued From page 118 the nurse who administered Ativan on 11/9/17. LPN #8 stated she was not sure if she was supposed to notify hospice prior to administering Ativan to Resident #27. LPN #8 could not remember if she had notified hospice prior to administering Ativan on 11/9/17. On 2/22/18 at 5:01 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the ADON (Assistant Director of Nursing) were made aware of the above concerns. [1] Ativan is used to treat symptoms of anxiety. Ativan is a benzodiazepine that depresses the central nervous system. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010988/?report=details. 2. The facility staff administered insulin to Resident #66 on five occasions when his blood sugar was greater than 400 without a physician order. Resident #66 was admitted to the facility on 9/6/17 with a readmission on 12/30/17 with diagnoses that included but were not limited to diabetes, end stage kidney disease, congestive heart failure and dementia. Resident #66's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/3/18, coded Resident #66 as scoring a 10 out of a possible 15 on his BIMS (brief interview for mental status) indicating that Resident #66 is moderately impaired with decisions of daily living.	F 658		

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F 658	Continued From page 119 A review of Resident #66's clinical record revealed, in part, the following physician order; "NovoLOG [1] (insulin) FlexPen (method of administration) Solution Pen-Injector 100 UNIT / ML (milliliters) Inject as per sliding scale: If 0-149 = 0 UNITS; 150 - 199 = 1 UNIT; 200- 249 = 2 UNITS; 250 - 299 = 3 UNITS; 300 - 349 = 4 UNITS; 350 - 400 = 5 UNITS, subcutaneously (beneath the skin) before meals and at bedtime related to TYPE 2 DIABETES MELLITUS WITH DIABETIC CHRONIC KIDNEY DISEASE." A review of Resident #66's February MAR (medication administration record) revealed, in part, the following entries; "NovoLOG FlexPen Solution Pen - Injector 100 UNIT / ML Inject as per sliding scale: If 0 -149 = 0 UNITS; 150 - 199 = 1 UNIT; 200-249 = 2 UNITS; 250 - 299 = 3 UNITS; 300 = 349 = 4 UNITS; 350 - 400 = 5 UNITS, subcutaneously before meals and at bedtime related to TYPE 2 DIABETES MELLITUS WITH DIABETIC CHRONIC KIDNEY DISEASE. " On the following dates and times, the blood sugars were documented as greater than 400 and a dose of NovoLOG documented as given: - 1/8/18; 4:30 p.m. blood sugar = 466 10 units of insulin administered - 1/9/18; 11:30 a.m. blood sugar 411 5 units of insulin administered - 1/10/18; 4:30 p.m. blood sugar 436 5 units of insulin administered - 1/19/18; 4:30 p.m. blood sugar 491 5 units of insulin administered A review of Resident #66's progress notes did not reveal any documentation that the physician had been notified about the blood sugars being greater than 400 or evidence of an order received	F 658		

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F 658	Continued From page 120 to treat a blood sugar of greater than 400. A review of Resident #66's comprehensive care plan dated 12/30/17 revealed, in part, the following documentation; "Focus: HX (history) of DM (diabetes mellitus) with refusal of care at times (refusing to have blood sugar checked) Date Initiated: 10/17/2017 Revision on: 2/21/2018. Interventions: INSULIN AS ORDERED, ACCU CHECKS AS ORDERED, NOTIFY MD (medical doctor) FOR ABNORMAL FINDINGS. MONITOR FOR SX (symptoms) of HYPO/HYPERGLYCEMIA, NOTIFY MD AS INDICATED Date Initiated 10/17/17. Revision on: 10/17/17." On 2/23/18 at 7:59 a.m., an interview was conducted with LPN (licensed practical nurse) #9. LPN #9 was asked to describe what she would do if a resident's blood sugar was outside of the sliding scale parameter. LPN #9 stated, "If the blood sugar is within the parameters provided by the doctor then I would give the ordered insulin. If outside of the parameters, I would document that there was no ordered coverage for the recorded blood sugar and notify the doctor so that he would be aware and could give orders. If he gives orders for the insulin I would recheck the blood sugar 30 minutes following administration to make sure that the treatment provided was effective." LPN #9 was asked where she would document this information, LPN #9 stated, "In the progress notes." On 2/23/18 at 8:52 a.m., a telephone interview was conducted with LPN #8. LPN #8 documented Resident #66's blood sugar and insulin treatment on 2/8/18, 2/10/18 and 2/19/18. LPN #8 was asked to describe the process	F 658		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOED BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	ID PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCED TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 121 followed for administering insulin on a sliding scale. LPN #8 stated that she would administer the insulin as ordered based on the accu check obtained. LPN #8 was asked what she did if the blood sugar was greater than the sliding scale provided, for example greater than 400 if the sliding scale only went to 400. LPN #8 stated that she would call the doctor and ask what he wanted her to do. When asked if she would get an additional order, LPN #8 stated, "Yes, I would write the order and include in my notes that I had talked with the doctor and what the new order was." LPN #8 was asked if she took care of Resident #66, LPN #8 stated that she did. LPN #8 was provided the dates and the accu check results in February that were greater than 400 and asked if she remembered contacting the doctor about the results. LPN #8 stated, "If I talked to the doctor I would have documented it. I do not remember that far back. So I can't say whether or not I called him." When asked where she would have documented her conversation with the doctor, LPN #8 stated, "In the progress notes." On 2/23/18 at 9:05 a.m., an interview was conducted with ASM (administrative staff member) #4, the medical doctor. ASM #4 was asked if a resident is on a sliding scale that addresses blood sugars up to 400 what should the nurses do if the blood sugar is greater than 400. ASM #4 stated, If the blood sugar is outside of the parameters then I expect the nursing staff to contact me and I would give a specific order to treat that incident." When asked if he was aware that Resident #66 had blood sugars recorded on his MAR on five occasions in February 2018 that were greater than 400, ASM #4 stated, "I was unaware that his blood sugars were that high. I	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	A. BUILDING _____ B. WING _____	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC	1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901

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F 658	Continued From page 122 should get called by the nursing staff so that I can address appropriately." On 2/23/18 at approximately 10:00 a.m., a meeting was conducted with ASM #1, the administrator, ASM #2, the director of nursing, and ASM #5, the administrator in training. ASM #1, ASM #2 and ASM #5 were made aware of the above concern at this time. ASM #2 was asked which standard of practice the facility nursing staff followed. ASM #2 stated that they followed the standards of practice set forth by the Virginia Board of Nursing. No further information was provided prior to the end of the survey process. [1] NovoLog is a rapid acting human insulin analog indicated to improve glycemic control in adults and children with diabetes mellitus. This information was obtained from the following website; https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=3a1e73a2-3009-40d0-876c-b4cb2be56fc5 In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419 "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 684	Continued From page 123 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. 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 residents received treatment and care in accordance with professional standards of practice and the comprehensive person centered care plan for two of 29 residents in the survey sample, Resident #s 66 and 27. 1. The facility staff administered insulin to Resident #66 on five occasions when his blood sugar was greater than 400 without a physician order. 2. The facility staff failed to notify hospice prior to administering as needed, Ativan [1] 0.5 mg (milligrams) to Resident #27 per the physician's order. The findings include: 1. The facility staff administered insulin to Resident #66 on five occasions when his blood sugar was greater than 400 without a physician order. Resident #66 was admitted to the facility on 9/6/17 with a readmission on 12/30/17 with	F 684	F684 1. On 2/19/18, a physician's order was obtained to discontinue Ativan for resident #27. The Medical Director was notified 2/23/18 that resident #66 was receiving insulin without a physician's order. 2. Unit Manager and Assistant Director of Nursing completed an audit of all current residents to ensure no insulin was given without a physician order. 3. LPN's # 8 was re-educated by the Staff Development Coordinator on 2/23/18 related to following physician orders and obtaining physician orders for a change in condition of a resident. The Licensed Nurses will be re-educated physician notification and obtaining orders from a physician by 3/14/18.	

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
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F 684	Continued From page 124 diagnoses that included but were not limited to diabetes, end stage kidney disease, congestive heart failure and dementia. Resident #66's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/3/18, coded Resident #66 as scoring a 10 out of a possible 15 on his BIMS (brief interview for mental status) indicating that Resident #66 is moderately impaired with decisions of daily living. A review of Resident #66's clinical record revealed, in part, the following physician order; "NovoLOG [1] (insulin) FlexPen (method of administration) Solution Pen-Injector 100 UNIT / ML (milliliters) Inject as per sliding scale: If 0-149 = 0 UNITS; 150 - 199 = 1 UNIT; 200- 249 = 2 UNITS; 250 - 299 = 3 UNITS; 300 - 349 = 4 UNITS; 350 - 400 = 5 UNITS, subcutaneously (beneath the skin) before meals and at bedtime related to TYPE 2 DIABETES MELLITUS WITH DIABETIC CHRONIC KIDNEY DISEASE." A review of Resident #66's February MAR (medication administration record) revealed, in part, the following entries; "NovoLOG FlexPen Solution Pen - Injector 100 UNIT / ML Inject as per sliding scale: If 0 -149 = 0 UNITS; 150 - 199 = 1 UNIT; 200-249 = 2 UNITS; 250 - 299 = 3 UNITS; 300 = 349 = 4 UNITS; 350 - 400 = 5 UNITS, subcutaneously before meals and at bedtime related to TYPE 2 DIABETES MELLITUS WITH DIABETIC CHRONIC KIDNEY DISEASE. " On the following dates and times, the blood sugars were documented as greater than 400 and a dose of NovoLOG documented as given: - 1/8/18; 4:30 p.m. blood sugar = 466 10 units of	F 684	4. The Assistant Director of Nursing and the Unit Manager will audit 5 medical records weekly for 4 weeks and monthly for 2 months to ensure physician notification and physician orders are in place as required. The Staff Development Coordinator will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. Completion date: 3/30/18	

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
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F 684	Continued From page 125 insulin administered - 1/9/18; 11:30 a.m. blood sugar 411 5 units of insulin administered - 1/10/18; 4:30 p.m. blood sugar 436 5 units of insulin administered - 1/19/18; 4:30 p.m. blood sugar 491 5 units of insulin administered A review of Resident #66's progress notes did not reveal any documentation that the physician had been notified about the blood sugars being greater than 400 or evidence of an order received to treat a blood sugar of greater than 400. A review of Resident #66's comprehensive care plan dated 12/30/17 revealed, in part, the following documentation; "Focus: HX (history) of DM (diabetes mellitus) with refusal of care at times (refusing to have blood sugar checked) Date Initiated: 10/17/2017 Revision on: 2/21/2018. Interventions: INSULIN AS ORDERED, ACCU CHECKS AS ORDERED, NOTIFY MD (medical doctor) FOR ABNORMAL FINDINGS. MONITOR FOR SX (symptoms) of HYPO/HYPERGLYCEMIA, NOTIFY MD AS INDICATED Date Initiated 10/17/17. Revision on: 10/17/17." On 2/23/18 at 7:59 a.m., an interview was conducted with LPN (licensed practical nurse) #9. LPN #9 was asked to describe what she would do if a resident's blood sugar was outside of the sliding scale parameter. LPN #9 stated, "If the blood sugar is within the parameters provided by the doctor then I would give the ordered insulin. If outside of the parameters, I would document that there was no ordered coverage for the recorded blood sugar and notify the doctor so that he would be aware and could give orders. If he gives	F 684		

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F 684	Continued From page 126	F 684		

orders for the insulin I would recheck the blood sugar 30 minutes following administration to make sure that the treatment provided was effective." LPN #9 was asked where she would document this information, LPN #9 stated, "In the progress notes."

On 2/23/18 at 8:52 a.m., a telephone interview was conducted with LPN #8. LPN #8 documented Resident #66's blood sugar and insulin treatment on 2/8/18, 2/10/18 and 2/19/18. LPN #8 was asked to describe the process followed for administering insulin on a sliding scale. LPN #8 stated that she would administer the insulin as ordered based on the accu check obtained. LPN #8 was asked what she did if the blood sugar was greater than the sliding scale provided, for example greater than 400 if the sliding scale only went to 400. LPN #8 stated that she would call the doctor and ask what he wanted her to do. When asked if she would get an additional order, LPN #8 stated, "Yes, I would write the order and include in my notes that I had talked with the doctor and what the new order was." LPN #8 was asked if she took care of Resident #66, LPN #8 stated that she did. LPN #8 was provided the dates and the accu check results in February that were greater than 400 and asked if she remembered contacting the doctor about the results. LPN #8 stated, "If I talked to the doctor I would have documented it. I do not remember that far back. So I can't say whether or not I called him." When asked where she would have documented her conversation with the doctor, LPN #8 stated, "In the progress notes."

On 2/23/18 at 9:05 a.m., an interview was conducted with ASM (administrative staff

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F 684	Continued From page 127 member) #4, the medical doctor. ASM #4 was asked if a resident is on a sliding scale that addresses blood sugars up to 400 what should the nurses do if the blood sugar is greater than 400. ASM #4 stated, If the blood sugar is outside of the parameters then I expect the nursing staff to contact me and I would give a specific order to treat that incident." When asked if he was aware that Resident #66 had blood sugars recorded on his MAR on five occasions in February 2018 that were greater than 400, ASM #4 stated, "I was unaware that his blood sugars were that high. I should get called by the nursing staff so that I can address appropriately." On 2/23/18 at approximately 10:00 a.m., a meeting was conducted with ASM #1, the administrator, ASM #2, the director of nursing, and ASM #5, the administrator in training. ASM #1, ASM #2 and ASM #5 were made aware of the above concern at this time. ASM #2 was asked which standard of practice the facility nursing staff followed. ASM #2 stated that they followed the standards of practice set forth by the Virginia Board of Nursing. No further information was provided prior to the end of the survey process. [1] NovoLog is a rapid acting human insulin analog indicated to improve glycemic control in adults and children with diabetes mellitus. This information was obtained from the following website; https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=3a1e73a2-3009-40d0-876c-b4cb2be56fc5	F 684		

TATEMENT OF OEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
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F 684	Continued From page 128 2. The facility staff failed to notify hospice prior to administering as needed, Ativan [1] 0.5 mg (milligrams) to Resident #27 per the physician's order. Resident #27 was admitted to the facility on 9/1/17 with diagnoses that include but were not limited to Alzheimer's disease, high blood pressure, colon cancer, and atherosclerotic heart disease. Resident #27's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 12/9/17. Resident #27 was coded as being severely impaired in cognitive function scoring a 06 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #27 was coded as being independent and requiring supervision only with bed mobility, transfers, meals and ambulation; and extensive assistance from one staff member with dressing, bathing, personal hygiene and toileting. Resident #27 was coded in section O "(Special Treatments, Procedures, and Programs)" as receiving Hospice Care. Review of Resident #27's physician order sheets dated and signed by the physician on 9/2017 through 12/2017 documented the following order: "Lorazepam (Ativan) Tablet 0.5 mg (milligrams) Give 1 tablet as every 4 hours as needed for Anxiety...Call HOSPICE MD BEFORE USE!" This order was discontinued on 1/4/18. Review of Resident #27's September 2017 MAR (medication administration record) revealed that Resident #27 received Ativan 0.5 mg on 9/3/17 at 3:17 a.m., and 11:44 p.m., and 9/13/17 at 5:14 p.m.	F 684		

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F 684	Continued From page 129 Review of Resident #27's November 2017 MAR revealed that Resident #27 received Ativan 0.5 mg at 11/9/17 at 9:59 p.m., and 11/17/17 at 5:49 p.m. The following note was documented on 9/3/17 at 3:17 a.m.: "Lorazepam Tablet 0.5 mg every 4 hours as needed for Anxiety...call Hospice MD before use! Ativan 0.5 mg (milligrams) given by mouth as ordered for increased anxiety." The next note dated 9/3/17 at 4:04 a.m. documented the following: "(Name of Hospice) notified made aware of Ativan 0.5 mg 1 tablet by mouth administered as ordered for anxiety." Further review of Resident #27's nursing notes dated September 2017 through November 2017 failed to evidence that hospice was notified PRIOR to the administration of Ativan. A hospice note dated 9/3/17 documented the following at 9:36 a.m.: "Phone call from: (Name of facility nurse), calling stating patient anxious. (Name of nurse) administered Lorazepam 0.5 mg at 0300. (Name of nurse) unaware to call Hospice before giving initial dose of Lorazepam. (Name of nurse) stated patient sleeping now. Notified (Name of Hospice) MD (medical doctor) patient received Lorazepam for anxiety. No visit needed at this time." No further hospice notes regarding Lorazepam administration could be found in the clinical record. Review of Resident #27's psychotropic care plan dated 9/13/17 documented the following	F 684		

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F 684	Continued From page 130 intervention: "Administer PSYCHOTROPIC medications as ordered by the physician." On 2/22/18 at 9:33 a.m., an interview was conducted with RN (registered nurse) #5, the hospice nurse. When asked the process; what should be done prior to nursing staff administering prn Ativan for Resident #27, RN #5 stated that nursing staff should first be assessing the need for Ativan, checking vital signs, and trying other methods such as toileting the resident prior to administering Ativan. RN #5 stated that for every hospice patient, nursing staff must contact hospice prior to administering the first initial dose of Ativan. RN #5 stated that it is ok for nursing staff to administer other doses of Ativan without notifying hospice after the first initial dose. When asked the rationale for nursing staff to notify hospice, prior to administering the first initial dose of Ativan, RN #5 stated the hospice staff, and the hospice physician, need to be aware of the behaviors that warrant the need for Ativan. RN #5 stated the hospice staff needs to be aware that nursing staff are administering Ativan as well. RN #5 confirmed that the nurse working on 9/3/17 administered Ativan to Resident #27 before she notified hospice. RN #5 stated hospice was made aware after administration. RN #5 stated the order was not followed that morning. RN #5 stated that she had no documentation in her hospice notes of nursing staff notifying them prior to the administration of Ativan on 9/3/17 at 11:44 p.m., 9/13/17 at 5:14 p.m., 11/9/17 at 9:59 p.m. and 11/17/17 at 5:49 p.m., but that nursing staff did not have to notify them. RN #5 stated that the Ativan order should have also been clarified. RN #5 stated again that nursing does not have to notify hospice after the first initial dose has been given.	F 684		

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F 684	Continued From page 131 On 2/22/18 at 9:47 a.m., 10:30 a.m., and 12:35 p.m. attempts were made to reach the nurse who administered the first initial dose of Ativan on 9/3/17. This nurse could not be reached for an interview. On 2/22/18 at 5:01 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the ADON (Assistant Director of Nursing) were made aware of the above concerns. ASM #2 stated that the facility used The Virginia Board of Nursing professional standards as a professional standard to guide nursing care. In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients. Therefore all orders must be assessed if one is found to be erroneous or harmful further clarification from the physician is necessary" [1] Ativan is used to treat symptoms of anxiety. Ativan is a benzodiazepine that depresses the central nervous system. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010988/?report=details.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on	F 690		

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F 690	Continued From page 132 admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, facility document review, and clinical record review, it was determined the facility staff failed to provide one of 29 residents in the survey sample, (Resident #94), treatment and services for care of a catheter.	F 690	**F690** 1. Resident #94's Subra Pubic catheter was changed 2/8/18 by Hospice Nurse. Resident #94's skin was assessed for rash on 2/22/18 by the Assistant Director of Nursing and no rash was noted. 2. The Assistant Director of Nursing and the Unit Manager completed an audit on 2/26/18 of current residents with a catheter to ensure care and treatment were in place as required. 3. The Licensed Nurses will be re-educated by 3/14/18 related to the care and treatment of catheters as required.	

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
	495249	A. BUILOING _____ B. WING _____	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET AODRESS, CITY, STATE, ZIP COOE
FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC	1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEO TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 133 Resident #94 was documented as having a leaking catheter on 1/29/18 at 10:26 p.m. Hospice did not come in to change his catheter until 2/7/18 (10 days later). The findings include: Resident #94 was admitted to the facility on 1/02/09 and readmitted on 7/2/17 with diagnoses that included but were not limited to manic depression, Schizophrenia, and Benign prostatic hyperplasia (enlarged prostate). Resident #94's most recent MDS (minimum data set) assessment, was a significant change assessment with an ARD (assessment reference date) of 1/24/18. Resident #94 was coded as being moderately impaired in the ability to make daily decisions scoring 08 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #94 was coded as requiring extensive assistance from one staff member with bed mobility, transfers, toileting, personal hygiene; total dependence on staff with bathing, and independent with meals. Resident #49 was coded in section O "(Special Treatments, Procedures, and Programs)" as receiving Hospice Care. Review of Resident #94's clinical record revealed the following active order dated 11/29/17: "Suprapubic catheter 24 fr (french) 10 cc bulb. Change prn (as needed) or as ordered by physician for occlusive BPH." Review of the nursing notes revealed the following note dated 1/29/18, that documented the following: "Res, (Resident) Supra-pubic Catheter[1] leaking (Name of Hospice) RN (registered nurse) from (Name of Hospice group)	F 690	4. The Assistant Director of Nursing and Unit Manager will audit 5 residents on each unit weekly for 4 weeks and monthly for 2 months to ensure the treatment and care of catheters are carried out as required. The Staff Development Coordinator will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for the monitoring and follow up. Completion date: 3/30/18	

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F 690	Continued From page 134 made aware and stated someone from (Name of Hospice group) will come in and change it." The next note dated 2/8/17 documented the following: "Hospice RN in to change suprapubic catheter. Rash noted to waist due to leakage. Referred to MD (medical doctor)." Review of Resident #94's physician orders revealed the following order dated 2/9/18, "Hydrocortisone cream 1 % (percent): Apply to rash to abdomen topically every shift for 7 days." This rash was documented as "Resolved" on 2/16/18. Review of the January and February 2018 hospice notes revealed that hospice changed Resident #94's suprapubic catheter on 2/7/18. (10 days after leak was identified). Further review of the hospice notes revealed the following note dated 2/8/18: "Was integumentary assessed? Yes. Indicate integumentary assessment findings: (Mark all that apply) Rash. Indicate location of rash: On both sides." Resident #94's care plan dated 7/7/17 and revised 8/14/17 documented the following: "I have alteration in elimination indwelling foley catheter R/T (related to) BPH...please change indwelling foley (suprapubic), as ordered." On 2/22/18 at 8:49 a.m., an interview was conducted with LPN (licensed practical nurse) #7, and the nurse who documented that Resident #94's catheter was leaking on 1/29/18. When asked about the process staff follows if a resident's indwelling catheter is leaking, LPN #7 stated she would check to see where the leakage	F 690		

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F 690	Continued From page 135	F 690		

was coming from and determine if she would need to change the catheter. LPN #7 stated she would have to check the order to change the catheter before changing the catheter. LPN #7 stated some residents have to be sent out to urology for a catheter change especially those with a Suprapubic catheter. When asked if it was ever ok to wait ten days to change a leaking catheter, LPN #7 stated, "No that is not ok. That should be done earlier." When asked the complications of waiting to change a leaking catheter, LPN #7 stated the resident could develop skin issues, like skin breakdown. When asked if she could recall when Resident #94's catheter was leaking on 1/29/18, LPN #7 stated that she did. LPN #7 stated that only Hospice was allowed to change Resident #94's catheter. LPN #7 stated she could not recall when Hospice came in to change the catheter. LPN #7 could not recall where the catheter was leaking, and how big the leak was. LPN #7 stated she did not regularly work with Resident #94. When asked what nursing should do if a resident's catheter had been leaking for some time and hospice had not been in to change it, LPN #7 stated that she would call the physician to get an order to either change the catheter or send the resident out for a catheter change. When asked if Resident #94 had a rash when she noticed the catheter was leaking on 1/29/18, LPN #7 stated that she did not notice any skin issues.

On 2/22/18 at 9:52 a.m., an interview was conducted with RN (registered nurse) #4, the hospice nurse. When asked who was allowed to change Resident #94's suprapubic catheter, RN #4 stated, "Hospice only. The facility's policy is that they cannot do suprapubic." RN #4 stated she recalled Resident #94's catheter leaking

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F 690	Continued From page 136	F 690		

towards the end of January. RN #4 stated she changed the catheter but could not recall when. RN #4 wasn't sure if she had documented the date. RN #4 stated every visit from hospice should be documented. RN #4 was asked when a leaking catheter should be changed. RN #4 stated, "Right away. As soon as possible." RN #4 stated she is usually at the facility 5 days a week. RN #4 stated that Resident #94's catheter leaks a lot because he has a tendency to pull on it. When asked if she could recall a rash to Resident #94's abdomen after the catheter change on 2/7/18, RN #4 stated she did recall a slight rash on his sides from him scratching or itching. RN #4 stated that she does not recall the rash being caused by the catheter leaking. When asked about the consequence of waiting ten days to change a leaking catheter, RN #4 stated the resident could develop skin breakdown or an infection.

On 2/22/18 at 1:17 p.m., an interview was conducted with LPN (licensed practical nurse) #1, the unit manager and the nurse who wrote the note on 2/8/18. When asked what nursing should do if they notice an indwelling catheter is leaking, LPN #1 stated that first nursing should try to reposition the resident to see if positioning is the cause of the leak. LPN #1 stated if the catheter continues to leak, then the physician should be notified for further instructions. When asked who is responsible for changing Resident #94's catheter, LPN #1 stated that hospice is responsible. When asked if ten days was a long period to wait for changing a leaking catheter, LPN #1 stated it was a long period but that she didn't think the leak was consistent. LPN #1 stated she did not recall any further information. LPN #1 stated the resident should be sent out or

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F 690	Continued From page 137 sent to urology if the catheter continued to leak and there was no follow up from Hospice. LPN #1 stated she could recall that Resident #94 had a rash on his abdomen on 2/8/18. LPN #1 could not recall specifically it was related to his catheter leaking. When LPN #1 was shown her note written on 2/8/18, LPN #1 stated, "My thinking is that he was leaking from the stoma site." LPN #1 stated the leak had to have been from the stoma for the rash to appear on the sides of his abdomen. On 2/22/18 at 5:01 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the ADON (Assistant Director of Nursing) were made aware of the above concerns. The facility policy titled, "Suprapubic Catheter Care" did not address the above concerns. No further information was presented prior to exit. [1] A suprapubic catheter (tube) drains urine from your bladder. It is inserted into your bladder through a small hole in your belly. You may need a catheter because you have urinary incontinence (leakage), urinary retention (not being able to urinate), surgery that made a catheter necessary, or another health problem. This information was obtained from The National Institutes of Health. https://wwwqa.nlm.nih.gov/medlineplus/275/ency/patientinstructions/000145.htm.	F 690		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who	F 695		

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F 695	Continued From page 138 needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, it was determined that the facility staff failed to administer oxygen at the physician ordered rate for two of 30 residents in the survey sample; Residents #104 and #268. 1. The facility staff failed to administer Resident #104's oxygen in accordance with the physician ordered rate. During multiple observations Resident #104's oxygen flow rate was observed set at 3.5 liters per minute. The physician's orders documented the oxygen flow rate should be at 2 liters. 2a. The facility staff failed to keep Resident # 268's nebulizer mask (1) covered when not in use. 2b. The facility staff failed to administer Resident # 268's oxygen according to the physician's orders. The findings include: 1. The facility staff failed to administer Resident #104's oxygen in accordance with the physician ordered rate. During multiple observations Resident #104's oxygen flow rate was observed set at 3.5 liters per minute. The physician's orders documented the oxygen flow rate should	F 695	**F695** 1. Resident #104's respiratory status was assessed on 2/22/18 by the Assistant Director of Nursing with no distress noted. Resident #104 oxygen flow rate was adjusted to 4 liters per minute by the Unit Manager on 2/22/18. Resident #104's Physician was notified on 2/22/18 by the Unit Manager of the oxygen not being administered at the ordered setting. Resident #268's nebulizer mask was covered on 2/22/18 by the Charge Nurse. Resident #268's oxygen rate was adjusted to the physician ordered rate on 2-22-2018. Residents respiratory status was assessed on 2-22-2018 by ADON no issues were noted. Physician was notified on 2-22-2018 by the unit manager that oxygen had not been administered at the ordered setting. LPN #6 and LPN #4 were re-educated by the Staff Development Coordinator on 2/26/18 related to oxygen orders are followed as required and nebulizer equipment is stored when not in use.	

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F 695	Continued From page 139 be at 2 liters. Resident #104 was admitted to the facility on 4/6/17 and readmitted on 1/24/18 with the diagnoses of but not limited to metabolic encephalopathy, chronic kidney disease, pressure ulcer, high blood pressure, neurogenic bladder, dysphagia, hypothyroidism, diabetes, heart disease, and anxiety disorder. The most recent MDS (Minimum Data Set) coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring extensive assistance for all areas of activities of daily living. A review of the physician's orders revealed one dated 1/24/18 for "Oxygen at 2 liters via nasal cannula..." A review of the resident's care plan revealed one for "I have altered respiratory status/difficulty breathing r/t (related to) my disease process and I require the use of oxygen." This care plan was dated 1/3/18. The interventions included, "Administer my O2 (oxygen) as ordered." This intervention was dated 1/3/18. On 2/21/18 at 9:30 a.m., 2/21/18 at 2:32 p.m., and 2/22/18 at 3:04 p.m., Resident #104's oxygen was observed set at 3.5 liters per minute. On 2/22/18 at 3:04 p.m., LPN #6 (Licensed Practical Nurse) stated the resident's oxygen should be set at 2 liters. LPN #6 checked Resident #104's oxygen concentrator unit and stated that it was at 3.5 liters and this was the incorrect setting. On 2/22/18 at 5:16 p.m., at the end of day meeting, the Administrator (ASM #1 -	F 695	2. The Assistant Director of Nursing and the Unit Manager completed on 2/22/18 an audit of all residents on oxygen orders to ensure oxygen setting were on correct settings as required as required. The Assistant Director of Nursing and Unit Manger completed an audit on 2/22/18 of current residents with nebulizer treatments to ensure equipment was stored appropriately while not in use. 3. Charge Nurse was re-educated by the Staff Development Coordinator on 2/23/18 related to ensuring oxygen is administered as ordered. The Licensed Nurses will be re-educated by the Staff Development Coordinator by 3/14/18 related to ensuring oxygen orders are followed as required and storing nebulizer equipment appropriately when not in use. LPN #6 and LPN #4 were re-educated by the Staff Development Coordinator on 2/26/18 related to oxygen orders are followed as required and nebulizer equipment is stored when not in use.	

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F 695	Continued From page 140 Administrative Staff Member) and Director of Nursing (ASM #2) were made aware of the findings. A facility policy on the provision of oxygen therapy/services was requested via a written list of needed documents. This list was provided to the facility at the end of the end of day meeting on 2/22/18. On 2/23/18 at 08:00 a.m., the written list of needed documents was returned by the facility, and next to the request for policy for oxygen services, was documented that there was no policy for this. No further information was provided by the end of the survey. 2a. The facility staff failed to keep Resident # 268's nebulizer mask (1) covered when not in use. Resident # 268 was admitted to the facility on 01/26/18 with a readmission on 02/14/18 with diagnoses that included but were not limited to: kidney failure, hypertension (2), dementia (3), multiple myeloma relapse (4) gastroesophageal reflux disease (5) and renal failure (6). Resident # 268's MDS (minimum data set), was not due at the time for the survey. Review of the facility's "Readmission Evaluation dated 02/15/18 for Resident # 268 revealed he was orientated to person, place time and situation. Resident # 268 was documented as being independent with ADLs (activities of daily living). Observations conducted on 02/21/18 at 1:55 p.m., 02/21/18 at 2:48 p.m. and 02/22/18 at 7:50 a.m., revealed Resident # 268 was in his room, sitting in his wheelchair. Further observation of the resident's room revealed the nebulizer mask	F 695	4 .The Assistant Director of Nursing and the Unit Manager will complete an audit of 5 current residents on each unit weekly for 4 weeks and monthly for 2 months to ensure oxygen is administered as ordered and nebulizer equipment is stored appropriately when not in use. The Staff Development Coordinator will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for the monitoring and follow up. Completion date: 3/30/18	

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F 695	Continued From page 141 lying on top of small dresser uncovered. The physician's order dated Feb (February) 2018 for Resident # 268 documented, "DuoNeb Solution 0.5-2.5 MG (Ipratropium-Albuterol [7]) 1 (one) inhalation orally every 4 (four) hours as needed for SOB (short of breath). Order Date: 02/21/18. Start Date: 02/21/18." On 02/22/18, an interview was conducted at 11:15 a.m. with LPN (licensed practical nurse) # 4. When asked about the procedure for storing a resident's nebulizer mask when not in use LPN # 4 stated it should be covered. LPN # 4 did not have a response when informed of the above observations of Resident # 268's nebulizer mask not being stored in a bag. On 02/23/18, an interview was conducted at 9:30 a.m. with ASM (administrative staff member) # 2, director of nursing. When asked about the procedure for storing a resident's nebular mask when not in use ASM # 2 stated, "It should be placed in a bag when not in use." When informed of the observations of Resident # 268's nebular mask not covered, ASM # 2 stated she was not aware of it. On 02/22/18 at 5:00 p.m. ASM (administrative staff member) # 1, the administrator, ASM # 2, the director of nursing, and ASM # 5, administrator in training were made aware of the above concerns. No further information was provided prior to exit. References: (1) If you have asthma, your doctor may prescribe	F 695		

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F 695	Continued From page 142	F 695		

a nebulizer as treatment or breathing therapy. The device delivers the same types of medication as metered-dose inhalers (MDIs), which are the familiar pocket-sized inhalers. Nebulizers may be easier to use than MDIs, especially for children who aren't old enough to properly use inhalers, or adults with severe asthma. A nebulizer turns liquid medicine into a mist to help treat your asthma. They come in electric or battery-run versions. They come in both a portable size you can carry with you and a larger size that's meant to sit on a table and plug into a wall. Both are made up of a base that holds an air compressor, a small container for liquid medicine, and a tube that connects the air compressor to the medicine container. Above the medicine container is a mouthpiece or mask you use to inhale the mist. This information was obtained from the website: https: https://www.healthline.com/health/asthma-nebulizer-machine.

(2) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(3) A group of symptoms caused by disorders that affect the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/dementia.html.

(4) A cancer that begins in plasma cells, a type of white blood cell. These cells are part of your immune system, which helps protect the body from germs and other harmful substances. In time, myeloma cells collect in the bone marrow and in the solid parts of bones. This information

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F 695	Continued From page 143 was obtained from the website: https://medlineplus.gov/multiplemyeloma.html. (5) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. (6) The rapid (less than 2 days) loss of your kidneys' ability to remove waste and help balance fluids and electrolytes in your body. This information was obtained from the website: https://medlineplus.gov/ency/article/000501.htm. (7) The combination of albuterol and ipratropium is used to prevent wheezing, difficulty breathing, chest tightness, and coughing in people with chronic obstructive pulmonary disease (COPD; a group of diseases that affect the lungs and airways) such as chronic bronchitis (swelling of the air passages that lead to the lungs) and emphysema (damage to the air sacs in the lungs). Albuterol and ipratropium combination is used by people whose symptoms have not been controlled by a single inhaled medication. Albuterol and ipratropium are in a class of medications called bronchodilators. Albuterol and ipratropium combination works by relaxing and opening the air passages to the lungs to make breathing easier. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601063.html. 2b. The facility staff failed to administer Resident # 268's oxygen according to the physician's orders. An observation conducted on 02/21/18 at 1:55	F 695		

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
	495249	A. BUILOING _____ B. WING _____	C 02/23/2018

NAME OF PROVIOER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZIP COOE
FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC	1575 SCOTT ORIVE ROUTE 5 FARMVILLE, VA 23901

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F 695	Continued From page 144 p.m., revealed Resident # 268 was sitting up in his wheelchair in his room receiving oxygen by nasal cannula (plastic tube placed in the nostrils to deliver oxygen). Observation of the flow meter on the oxygen concentrator revealed the oxygen flow rate was set between four and a half liters and five liters per minute. An observation conducted on 02/21/18 at 1:55 p.m., revealed Resident # 268 was in his room sitting in his wheelchair. Resident #268 was observed receiving oxygen by nasal cannula (plastic tube placed in the nostrils to deliver oxygen) connected to an oxygen concentrator. Observation of the flow meter on the oxygen concentrator revealed the oxygen flow rate was set between four and a half liters and five liters per minute. An observation conducted on 02/21/18 at 2:48 p.m. revealed Resident # 268 was in his room sitting in his wheelchair, and was receiving oxygen by nasal cannula. Observation of the flow meter on the oxygen concentrator revealed the oxygen flow rate was set between four and a half liters and five liters per minute. An observation conducted on 02/22/18 at 7:50 a.m. revealed Resident # 268 was in his room sitting in his wheelchair and was receiving oxygen by nasal cannula. Observation of the flow meter on the oxygen concentrator revealed the oxygen flow rate was set between four and a half liters and five liters per minute. The physician's order dated Feb (February) 2018 for Resident # 268 documented, "Oxygen at 4lpm (four liters per minute) via (by) nasal cannula at all times every shift for SOB (short of breath).	F 695		

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F 695	Continued From page 145 Order Date: 02/15/2018. Start Date: 02/15/2018." The eMAR (electronic medication administration record) dated February 2018 documented, "Oxygen at 4lpm (four liters per minute) via (by) nasal cannula at all times every shift for SOB (short of breath). Order Date: 02/15/2018." Further review of the eMAR revealed Resident # 268 received oxygen at four liters per minute on 02/21/18 on the day, evening and night shift and on 02/22/18 on the day shift. The comprehensive care plan for Resident # 268 was not due at the time of survey. Review of Resident # 268's baseline care plan dated 2/14/18 revealed, "Oxygen: 4L N.C. 2/15 (four liters per minute by nasal cannula. 02/15/18)." On 02/22/18, an interview was conducted at 11:15 a.m. with LPN (licensed practical nurse) # 4. When asked about the oxygen flow rate for Resident # 268, LPN # 4 stated, "Four liters per minute." When asked how often the flow rate of Resident # 268's oxygen is checked, LPN # 4 stated, "Q (every) shift." When asked if it was check at the beginning of his shift, LPN # 4 stated, "Early this morning I check his O2 (oxygen) SATS (saturation) and gave him a breathing treatment." LPN # 4 was asked to accompany this surveyor to Resident # 268's room. Upon entering the room, LPN # 4 was asked to read the oxygen flow rate on the oxygen concentrator. LPN # 4 stated, "It's set between four and a half and five liters." LPN # 4 further stated it was set incorrectly and proceeded to readjust the oxygen flow rate. When asked how the flow rate is read, LPN # 4 stated, "The liter mark should pass through the center of the ball."	F 695		

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F 695	Continued From page 146 On 02/23/18, an interview was conducted at 9:30 a.m. with ASM (administrative staff member) # 2, director of nursing. When asked how the flow rate for oxygen is read, ASM # 2 stated, "The liter mark should pass through the center of the bubble or ball." When informed of the observations of Resident # 268's incorrect oxygen flow rate, ASM # 2 stated she was not aware of it. On 02/22/18 at 5:00 p.m. ASM (administrative staff member) # 1, the administrator, ASM # 2, the director of nursing, and ASM # 5, administrator in training were made aware of the above concerns. No further information was provided prior to exit.	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, it was determined that the facility staff failed to ensure the resident received treatment and care in accordance with professional standards of practice and the comprehensive person centered care plan for one of 30 residents in the survey sample, Resident # 51. The facility staff failed to administer scheduled pain medication according to the physician's orders for Resident # 51.	F 697		

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F 697	Continued From page 147 The findings include: Resident # 51 was admitted to the facility on 04/10/2017 with diagnoses that included but were not limited to kidney failure, diabetes mellitus without complication (1), hypertension (2), and anxiety (3). Resident # 51's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/21/17, coded Resident # 51 as scoring a 99 indicating Resident # 51 was unable to complete the brief interview for mental status (BIMS). Resident # 51 was coded as being moderately impaired of cognition on the "Staff Assessment for Mental Status." Resident # 51 was coded as requiring total assistance of one staff member for activities of daily living. The POS (Physician's Order Sheet) for Resident # 51 dated "Feb (February), 2018 documented, "Acetaminophen Suppository (4) - 650 MG (milligrams) Insert 1 (one) suppository rectally every 8 (eight) hours for pain NTE (not to exceed) 4 (four) grams in 24 hours. Order Date: 10/19/2017. Start Date: 10/19/2017." The eMAR (electronic medication administration record) dated December, 2017 documented "Acetaminophen Suppository - 650 MG. Insert 1 suppository rectally every 8 hours for pain NTE 4 grams in 24 hours. Order Date: 10/19/2017." Further review of the eMAR failed to evidence the administration of Acetaminophen Suppository - 650 MG on 12/03/17 at 6:00 a.m., 12/04/17 at 6:00 a.m., 12/08/17 at 10:00 p.m., 12/09/17 at 6:00 a.m., 12/10/17 at 6:00 a.m.; 21/21/17 at 6:00	F 697	F697 1. Resident #51 was reassessed for pain by the Assistant Director of Nursing on 2/23/18. Resident #51's physician was notified by the Director of Nursing 2/23/18 regarding omissions related to Tylenol suppository in December 2017. 2. The Assistant Director of Nursing and the Unit Manager will audit the current residents medication administration records by 3/14/18 to ensure medications have been documented as required. 3. The Licensed Nurses will be re-educated by the Staff Development Coordinator by 3/14/18 related to ensuring medication administration is documented as required.	

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F 697	Continued From page 148 a.m., and 12/31/17 at 6:00 a.m. Review of the facility's "Progress Notes" dated 12/0/17 through 12/31/17 for Resident # 51 failed to evidence documentation of the missing administration of Acetaminophen Suppository - 650 MG on 12/03/17 at 6:00 a.m., 12/04/17 at 6:00 a.m., 12/08/17 at 10:00 p.m., 12/09/17 at 6:00 a.m., 12/10/17 at 6:00 a.m.; 21/21/17 at 6:00 a.m., and 12/31/17 at 6:00 a.m. The care plan for Resident # 51 with a revision date of 02/21/2018 documented, "Focus: Alteration in comfort R/T (related to) disease process. Date initiated: 04/11/2017." Under "Interventions" it documented, "Administer medications as ordered. Observe for tolerance and effectiveness. Observe for possible adverse side effects. Notify MD (medical doctor) if indicated. Date initiated: 04/11/2017." On 02/23/18 at 8:25 a.m., an interview was conducted with ASM (administrative staff member) # 3, the assistant director of nursing. When asked to describe the process for documenting on the eMAR when a medication is administered ASM # 3 stated, "After administering the medication a check mark appears in the box for the date the medication was given. If for some reason the medication was not given a numeric (number) code appears in the box." When asked about the box on the eMAR being blank ASM # 3 stated, "If it is not documented it wasn't given. Documentation should be in the nurse's notes." After reviewing the eMAR and the progress notes dated 12/01/17 through 12/31/17 ASM # 3 stated, "Unable to say that the medication was given on those dates without documentation."	F 697	4. The Assistant Director of Nursing and the Unit Manager will audit 5 resident's medical records on each unit weekly for 4 weeks and monthly for 2 months to ensure medication administration continue to be documented as required. The Staff Development Coordinator will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. Completion date: 3/30/18	

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F 697	Continued From page 149 On 02/23/18 at 9:30 a.m. an interview was conducted with ASM (administrative staff member) # 2, the director of nursing regarding the administration of the Acetaminophen Suppository - 650 MG on 12/03/17 at 6:00 a.m., 12/04/17 at 6:00 a.m., 12/08/17 at 10:00 p.m., 12/09/17 at 6:00 a.m., 12/10/17 at 6:00 a.m.; 21/21/17 at 6:00 a.m., and 12/31/17 at 6:00 a.m. for Resident # 51. After reviewing the eMAR and the progress notes dated 12/01/17 through 12/31/17 ASM # 3 stated, "I can't say the medication was given." On 02/22/18 at 5:00 p.m. ASM (administrative staff member) # 1, the administrator, ASM # 2, the director of nursing, and ASM # 5, administrator in training, were made aware of the above concerns. No further information was provided prior to exit. References: (1) A chronic disease in which the body cannot regulate the amount of sugar in the blood. The goal of treatment at first is to lower your high blood glucose level. Long-term goals are to prevent complications. The most important way to treat and manage type 2 diabetes is by being active and eating healthy foods. This information was obtained from the website: https://medlineplus.gov/ency/article/000313.htm. (2) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.	F 697		

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F 697	Continued From page 150 (3) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary. (4) Used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body. This information was obtained from the website: https: https://medlineplus.gov/druginfo/meds/a681004.html.	F 697		
F 742 SS=D	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on resident observation, staff interview, facility document review and clinical record	F 742	**F742** 1. Resident #73 no longer resides at the facility. 2. An audit of all residents with a DX of Schizoaffective, Schizophrenia, Bipolar Disorder, and Intellectual Disabilities will be conducted by 3-30-2018 by the Social Service Director to identify additional residents requiring psychiatric services based upon mood or behavior issues, follow-up services will be scheduled as needed. 3. The Social Services Director along with the clinical team will be educated on regulation (CFR(s) 483.40(b)(1) by 3-30-2018 by the Administrator. Any future follow up psych evaluations recommended by the physician will be referred to a licensed mental health professional as clinically indicated.	

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F 742	Continued From page 151 review, it was determined the facility staff failed to ensure appropriate treatment and services were provided to address mental/psychosocial concerns for one of 30 residents in the survey sample, Resident #73. The facility staff failed to assess Resident #73's need for continued psychiatric / psychotherapy services following her last visit in March 2017; and failed to obtain a psychiatric consult to address Resident #73's increased behaviors as ordered by the physician on 2/9/2018. The findings include: Resident #73 was admitted to the facility on 1/3/17 with diagnoses that include but not limited to major depressive disorder, schizophrenia, intellectual disabilities, schizoaffective disorder and bipolar. Resident #73's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 1/11/18 coded Resident #73 as scoring a 14 out of a possible 15 on the BIMS (brief interview for mental status) indicating that Resident #73 is cognitively intact with daily decisions. Resident #73 was observed at the time of entry into the facility on 2/21/18 at approximately 7:00 a.m. walking up and down the hallways yelling at the staff, stating her tooth was hurting. Resident #73 was loud and disruptive going in and out of her room and walking up and down the hallway. On 2/21/18 at approximately 8:00 a.m., Resident #73 was observed in the dining room, yelling out loud, moaning, and then eating breakfast.	F 742	4. The Social Services Director or their designee will randomly audit residents with DX of Schizoaffective, Schizophrenia, Bipolar Disorder, and Intellectual Disabilities weekly for the next 4 weeks then monthly thereafter; for any disruptive/mood/behavior changes that may need a psych evaluation and/or medication management. 5. Completion date: 3-30-2018	

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F 742	Continued From page 152 Resident #73 was observed talking to herself, constantly getting up and pacing around the dining room despite the efforts of the staff to keep her calm. Resident #73 was observed on 2/22/18 walking up and down the hallways throughout the day, talking to herself. A review of the physician orders since admission revealed, in part, the following orders: -"Psych (psychiatric) consult for increased behavior, paranoia, agitation, pacing, stealing one time only for 1 Day. Order Status: Completed. Completed. Revision Date 2/9/2018. Last Order Date 2/9/18." -"Geodon [1] (an antipsychotic medication) 40 MG (milligrams) Give 1 capsule by mouth two times a day related to SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE, MAJOR DEPRESSIVE DISORDER, OTHER SCHIZOPHRENIA. Active. Revision Date 2/9/18. Last Order Date 2/9/18" Further review of Resident #73's clinical record did not reveal that a psychiatric consult appointment had been made as ordered. Further review of Resident #73's clinical record did reveal documentation related to two psychiatric consults that occurred on January 23, 2017 and March 15, 2017. There was no further documentation regarding the plan to continue the consultations either on the consultation notes or in the clinical record. A review of Resident #73's comprehensive care plan dated 1/3/17 revealed, in part, the following documentation: "Focus: I have an alteration in	F 742		

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F 742	Continued From page 153	F 742		

my behavior Crying out loud, cussing, talking to herself, the walls and an imaginary friend. Interventions: Administer my medications as ordered. Focus: Potential for adverse side effects r/t (related to) use of psychotropic medications. Interventions: Psych (psychiatric) eval (evaluation) and follow up prn (as needed.)"

A review of Resident #73's physician note with a date of service of 1/5/18 revealed, in part, the following documentation: "Social History: She (Resident #73) was followed by (name of behavioral health center) up until her admission here (at the facility.) Assessment: She (Resident #73) still continues to have some auditory and visual hallucinations and she does have outbursts and sometimes gets aggressive towards other people and relatives."

Further review of Resident #73's physician notes failed to reveal any documentation regarding the need for continued psychiatric services.

A review of Resident #73's social services notes did not reveal any documentation regarding continuing psychiatric / psychotherapy treatments.

On 2/22/18 at 3:43 p.m., an interview was conducted with OSM (other staff member) #1, the director of social services. OSM #1 was asked what she could tell this writer about Resident #73's ongoing psychiatric treatment. OSM #1 stated, "I would have to say that I meet with her each quarter and there was no recommendation for her to be followed up by psych (psychiatry)." OSM #1 was provided the two psychiatry consult visit notes from January 2017 and March 2017. OSM #1 was asked if there was any

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F 742	Continued From page 154 documentation to evidence that Resident #73 should not continue seeing psychiatry. OSM #1 stated there was not. OSM #1 was asked if there was a conversation with the doctor about Resident #73's continued need for behavioral health services. OSM #1 stated that there was not. OSM #1 was asked if she could look into the behavioral services made available for Resident #73 and was asked to provide this writer evidence that Resident #73's behavioral health needs were met. On 2/23/18 at 9:45 a.m., OSM #1 returned to this writer. OSM #1 was asked to describe her role in the facility. OSM #1 stated that her role was to facilitate meetings between families, to arrange care plan meetings, to make sure the needs of the residents were being met in regards to their rights, psychosocial needs, discharge planning and MDS. OSM #1 was asked if she was responsible for arranging medical appointments outside of the facility. OSM #1 stated, "I have vision, dental and psychiatry when we have referrals to psychiatry. We did have a licensed psychiatric nurse practitioner but she left." When asked what the facility did to ensure the continuance of psychiatric services for residents, in particular Resident #73. OSM #1 stated, "When she (the psychiatric nurse practitioner) left she made sure that they were on the medications they needed to be on and the pharmacist continued his monitoring and the staff did behavior monitoring." When asked if there was any clarification as to the continued need for psychiatric services for Resident #73, OSM #1 stated that there was nothing in the clinical record about continuing psychiatric services. OSM #1 further stated, "She (Resident #73) is complex, she has always had the walking / talking to	F 742		

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
	495249	A. BUILOING _____ B. WING _____	C 02/23/2018

NAME OF PROVIOER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZIP COOE
FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC	1575 SCOTT ORIVE ROUTE 5 FARMVILLE, VA 23901

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F 742	Continued From page 155	F 742		

herself, but hasn't really had the outbursts as we have seen lately." OSM #1 was asked if anyone had talked to the doctor about continuing the psychiatric services after the psychiatric nurse practitioner left. OSM #1 stated, "Not that I am aware of." OSM #1 was unaware about the order dated 2/9/18 for a psychiatric consult.

On 2/23/18 at 9:05 a.m., an interview was conducted with ASM (administrative staff member) #4, the medical doctor. ASM #4 was asked when a resident would be referred to psychiatric / psychotherapy care. ASM #4 stated, "Access and availability is an issue. However, any behaviors, non-controllable behaviors, failure to thrive, psychiatric illness without improvement or complications with the medications that I prescribe, would all be reasons. We used to have a psychiatric nurse practitioner but she left and we don't have anything in the facility at this time." ASM #4 was asked if he was familiar with Resident #73, ASM #4 stated that he was and had recently started her on some new medication, Geodon, because of her increased behaviors. ASM #4 was asked what his intention was in regards to psychiatric services for Resident #73. ASM #4 stated, "I would like to have the services continued. She needs them." When asked if he had been involved in any discussions about Resident #73 having continued psychiatric services after the psychiatric nurse practitioner left the facility. ASM #4 stated that he had not. ASM #4 further stated, "I interact with the resident on a regular basis, I try to cover the psychiatric piece because I have been told it is not available, but I cannot be effective.

On 2/23/18 at 10:30 a.m., an interview was conducted with ASM #1, the administrator, and

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F 742	Continued From page 156 ASM #2, the director of nursing. When asked who was responsible for ensuring that psychiatric services are made available to those residents needing the service, ASM #1 stated that social services are responsible, if the psychiatric services are available to us. When asked what was done for Resident #73 when her psychiatric services stopped and were no longer available. ASM #1 stated, "I don't know." A policy was requested regarding the use of antipsychotics and behavioral health services at this time. No further information was provided prior to the end of the survey process.	F 742	**F745** 1. Resident # 73 no longer resides at the facility. 2. The Social Service Director will complete an audit by 3-30-2018 to identify other residents with psychiatric diagnosis that require psychiatric follow-up. 3. On admission the social services director will review admission documentation and schedule psychiatric follow-up services as needed. 4. The interdisciplinary quality assurance team will monitor for continued compliance monthly for the next three months and quarterly thereafter. 5. Completion date 3-30-2018	
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide medically related social services for one of 30 residents in the survey sample, Resident #73. The facility staff failed to assess Resident #73's need for continued psychiatric / psychotherapy services after the psychiatric nurse practitioner discontinued services with the facility and failed to obtain a psychiatric consult as ordered by the physician on 2/9/18. The findings include:	F 745		

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F 745	Continued From page 157 Resident #73 was admitted to the facility on 1/3/17 with diagnoses that include but not limited to major depressive disorder, schizophrenia, intellectual disabilities, schizoaffective disorder and bipolar. Resident #73's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 1/11/18 coded Resident #73 as scoring a 14 out of a possible 15 on the BIMS (brief interview for mental status) indicating that Resident #73 is cognitively intact with daily decisions. Resident #73 was observed at the time of entry into the facility on 2/21/18 at approximately 7:00 a.m. walking up and down the hallways yelling at the staff, stating her tooth was hurting. Resident #73 was loud and disruptive going in and out of her room and walking up and down the hallway. On 2/21/18 at approximately 8:00 a.m., Resident #73 was observed in the dining room, yelling out loud, moaning, and then eating breakfast. Resident #73 was observed talking to herself, constantly getting up and pacing around the dining room despite the efforts of the staff to keep her calm. Resident #73 was observed on 2/22/18 walking up and down the hallways throughout the day, talking to herself. A review of the physician orders since admission revealed, in part, the following orders: -"Psych (psychiatric) consult for increased behavior, paranoia, agitation, pacing, stealing one time only for 1 Day. Order Status: Completed. Completed. Revision Date 2/9/2018. Last Order	F 745		

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F 745	Continued From page 158 Date 2/9/18." -"Geodon [1] (an antipsychotic medication) 40 MG (milligrams) Give 1 capsule by mouth two times a day related to SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE, MAJOR DEPRESSIVE DISORDER, OTHER SCHIZOPHRENIA. Active. Revision Date 2/9/18. Last Order Date 2/9/18" Further review of Resident #73's clinical record did not reveal that a psychiatric consult appointment had been made as ordered. Further review of Resident #73's clinical record did reveal documentation related to two psychiatric consults that occurred on January 23, 2017 and March 15, 2017. There was no further documentation regarding the plan to continue the consultations either on the consultation notes or in the clinical record. A review of Resident #73's comprehensive care plan dated 1/3/17 revealed, in part, the following documentation: "Focus: I have an alteration in my behavior Crying out loud, cussing, talking to herself, the walls and an imaginary friend. Interventions: Administer my medications as ordered. Focus: Potential for adverse side effects r/t (related to) use of psychotropic medications. Interventions: Psych (psychiatric) eval (evaluation) and follow up prn (as needed.)" A review of Resident #73's physician note with a date of service of 1/5/18 revealed, in part, the following documentation: "Social History: She (Resident #73) was followed by (name of behavioral health center) up until her admission here (at the facility.) Assessment: She (Resident #73) still continues to have some auditory and	F 745		

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F 745	Continued From page 159 visual hallucinations and she does have outbursts and sometimes gets aggressive towards other people and relatives." Further review of Resident #73's physician notes did not reveal any documentation regarding the need for continued psychiatric services. A review of Resident #73's social services notes did not reveal any documentation regarding continuing psychiatric / psychotherapy treatments. On 2/22/18 at 3:43 p.m., an interview was conducted with OSM (other staff member) #1, the director of social services. OSM #1 was asked what she could tell this writer about Resident #73's ongoing psychiatric treatment. OSM #1 stated, "I would have to say that I meet with her each quarter and there was no recommendation for her to be followed up by psych (psychiatry)." OSM #1 was provided the two psychiatry consult visit notes from January 2017 and March 2017. OSM #1 was asked if there was any documentation to evidence that Resident #73 should not continue seeing psychiatry. OSM #1 stated there was not. OSM #1 was asked if there was a conversation with the doctor about Resident #73's continued need for behavioral health services. OSM #1 stated that there was not. OSM #1 was asked if she could look into the behavioral services made available for Resident #73 and was asked to provide this writer evidence that Resident #73's behavioral health needs were met. On 2/23/18 at 9:45 a.m., OSM #1 returned to this writer. OSM #1 was asked to describe her role in the facility. OSM #1 stated that her role was to	F 745		

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F 745	Continued From page 160	F 745		

facilitate meetings between families, to arrange care plan meetings, to make sure the needs of the residents were being met in regards to their rights, psychosocial needs, discharge planning and MDS. OSM #1 was asked if she was responsible for arranging medical appointments outside of the facility. OSM #1 stated, "I have vision, dental and psychiatry when we have referrals to psychiatry. We did have a licensed psychiatric nurse practitioner but she left." When asked what the facility did to ensure the continuance of psychiatric services for residents, in particular Resident #73. OSM #1 stated, "When she (the psychiatric nurse practitioner) left she made sure that they were on the medications they needed to be on and the pharmacist continued his monitoring and the staff did behavior monitoring." When asked if there was any clarification as to the continued need for psychiatric services for Resident #73, OSM #1 stated that there was nothing in the clinical record about continuing psychiatric services. OSM #1 further stated, "She (Resident #73) is complex, she has always had the walking / talking to herself, but hasn't really had the outbursts as we have seen lately." OSM #1 was asked if anyone had talked to the doctor about continuing the psychiatric services after the psychiatric nurse practitioner left. OSM #1 stated, "Not that I am aware of." OSM #1 was unaware about the order dated 2/9/18 for a psychiatric consult.

On 2/23/18 at 9:05 a.m., an interview was conducted with ASM (administrative staff member) #4, the medical doctor. ASM #4 was asked when a resident would be referred to psychiatric / psychotherapy care. ASM #4 stated, "Access and availability is an issue. However, any behaviors, non-controllable behaviors, failure

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F 745	Continued From page 161 to thrive, psychiatric illness without improvement or complications with the medications that I prescribe, would all be reasons. We used to have a psychiatric nurse practitioner but she left and we don't have anything in the facility at this time." ASM #4 was asked if he was familiar with Resident #73, ASM #4 stated that he was and had recently started her on some new medication, Geodon, because of her increased behaviors. ASM #4 was asked what his intention was in regards to psychiatric services for Resident #73. ASM #4 stated, "I would like to have the services continued. She needs them." When asked if he had been involved in any discussions about Resident #73 having continued psychiatric services after the psychiatric nurse practitioner left the facility. ASM #4 stated that he had not. ASM #4 further stated, "I interact with the resident on a regular basis, I try to cover the psychiatric piece because I have been told it is not available, but I cannot be effective. On 2/23/18 at 10:30 a.m., an interview was conducted with ASM #1, the administrator, and ASM #2, the director of nursing. When asked who was responsible for ensuring that psychiatric services are made available to those residents needing the service, ASM #1 stated that social services are responsible, if the psychiatric services are available to us. When asked what was done for Resident #73 when her psychiatric services stopped and were no longer available. ASM #1 stated, "I don't know." A policy was requested regarding the use of antipsychotics and behavioral health services at this time. A review of the social services job description revealed, in part, the following documentation: "Gives assistance or help in locating and	F 745		

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F 745	Continued From page 162 arranging for services of other professionals or agencies as needed." No further information was provided prior to the end of the survey process.	F 745		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented	F 758		

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F 758	Continued From page 163 in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure residents were free from unnecessary medications for two of 30 residents in the survey sample, Resident #27 and #66. 1. The facility staff failed to attempt non-pharmacological interventions prior to the administration of prn (as needed) Ativan [1] on 9/3/17, 9/13/17, 11/9/17 and 11/17/17. 2. The facility staff failed to provide a clinical indication for the administration of Seroquel [1] (an antipsychotic medication) to Resident #66. The findings include: 1. Resident #27 was admitted to the facility on 9/1/17 with diagnoses that include but were not limited to Alzheimer's disease, high blood	F 758	Past noncompliance: no plan of correction required.	

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F 758	Continued From page 164 pressure, colon cancer, and atherosclerotic heart disease. Resident #27's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 12/9/17. Resident #27 was coded as being severely impaired in cognitive function scoring a 06 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #27 was coded as being independent and requiring supervision only with bed mobility, transfers, meals and ambulation; and extensive assistance from one staff member with dressing, bathing, personal hygiene and toileting. Resident #27 was coded in section O "(Special Treatments, Procedures, and Programs)" as receiving Hospice Care. Review of Resident #27's physician order sheets dated and signed by the physician on 9/2017 through 12/2017 documented the following order: "Lorazepam (Ativan) Tablet 0.5 mg (milligrams) Give 1 tablet as every 4 hours as needed for Anxiety...Call HOSPICE MD BEFORE USE!" This order was discontinued on 1/4/18. Review of Resident #27's September 2017 MAR (medication administration record) revealed Resident #27 received Ativan 0.5 mg on 9/3/17 at 3:17 a.m., and 11:44 p.m., and 9/13/17 at 5:14 p.m. Review of Resident #27's November 2017 MAR revealed Resident #27 received Ativan 0.5 mg at 11/9/17 at 9:59 p.m., and 11/17/17 at 5:49 p.m. Further review of Resident #27's nursing notes dated September 2017 through November 2017 and MARS failed to evidence that non-pharmacological interventions were offered	F 758		

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F 758	Continued From page 165 or attempted prior to the administration of Ativan. Review of Resident #27's psychotropic care plan dated 9/13/17 did not document an intervention to attempt non-pharmacological intervention prior to the administration of prn Ativan. On 2/22/18 at 9:33 a.m., an interview was conducted with RN (registered nurse) #5, the hospice nurse. When asked about the process followed prior to nursing staff administering prn Ativan for Resident #27, RN #5 stated the nursing staff should first be assessing the need for Ativan, checking vital signs, and trying other methods such as toileting the resident prior to administering Ativan. On 2/22/18 at 11:41 a.m., an interview was conducted with LPN (licensed practical nurse) #3. When asked the about process followed prior to administering prn anti-anxiety medication, LPN #3 stated she would attempt non-pharmacological interventions such as providing a quiet environment to the resident before administering medication. LPN #3 stated interventions attempted should be documented on the MAR (medication administration record) or in a nursing note. On 2/23/18 at 8:53 a.m., an interview was conducted with LPN (licensed practical nurse) #8, the nurse who administered Ativan on one of the occasions. When asked about the process followed prior to administering prn (as needed) Ativan, LPN #8 stated she would try another alternative first such as a non-pharmacological intervention. When asked of non-pharmacological interventions attempted or offered are documented in the clinical record,	F 758		

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F 758	Continued From page 166 LPN #8 stated they should be. When asked if she attempted non-pharmacological interventions prior to administering prn Ativan to Resident #27 back in November of 2017, LPN #8 stated that she could not remember. On 2/22/18 at 5:01 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the ADON (Assistant Director of Nursing) were made aware of the above concerns. The facility policy titled, "Psychopharmacological Medication Use" did not address the above concerns. No further information was presented prior to exit. [1] Ativan is used to treat symptoms of anxiety. Ativan is a benzodiazepine that depresses the central nervous system. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010988/?report=details. 2. The facility staff failed to provide a clinical indication for the administration of seroquel [1] (an antipsychotic medication) to Resident #66. Resident #66 was admitted to the facility on 9/6/17 with a readmission on 12/30/17 with diagnoses that included but were not limited to diabetes, end stage kidney disease, congestive heart failure and dementia. Resident #66's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/3/18, coded Resident #66 as scoring a 10 out of a possible 15 on his BIMS (brief interview for mental status) indicating that Resident #66 is moderately	F 758		

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
	495249	A. BUILOING _____ B. WING _____	C 02/23/2018

NAME OF PROVIOER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZIP COOE
FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC	1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901

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F 758	Continued From page 167 impaired with decisions of daily living. A review of Resident #66's physician orders revealed, in part, the following order: "QUEtiapine Fumarate (seroquel) [1] (an antipsychotic medication) 100 MG (milligrams) Give 1 tablet by mouth at bedtime related to DEMENTIA WITH LEWY BODIES. Active. Order Date 12/30/2017. Start Date 12/30/2017." A Review of Resident #66's physician note dated 1/3/18 did not reveal any documentation as to why Quetiapine Fumarate was started on 12/30/17. A review of Resident #66's clinical record did not reveal any documented behaviors demonstrated by Resident #66. A review of Resident #66's comprehensive care plan dated 12/30/17 did not reveal any documentation regarding behaviors. On 2/23/18 at 9:05 a.m., an interview was conducted with ASM (administrative staff member) #4, the medical doctor. ASM #4 was asked why he normally prescribed Seroquel. ASM #4 stated, "I treat schizophrenia/ psychosis / bipolar disorder or dementia with psychosis. Sometimes I may treat anxiety that has been proven to be resistant to other types of treatment." ASM #4 was asked if he treated dementia with Lewy Bodies with Quetiapine Fumarate. ASM #4 stated, "Sometimes. If the resident is having extrapyramidal symptoms [2] (dystonic movements) I would consider using it (Seroquel)." ASM #4 was asked where he had documented the clinical indication for the use of Seroquel in Resident #66's situation. ASM #4	F 758		

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F 758	Continued From page 168 stated, "He was on the drug when he came in and I chose to keep it in place to be consistent with treating his Parkinson's type movements. I didn't clearly document why I wanted to keep him on Seroquel." A meeting was held with ASM #1, the administrator, ASM #2, the director of nursing and ASM #5, the administrator in training on 2/23/18 at 10:30 a.m. ASM #1, ASM #2 and ASM #5 were made aware of the above findings, the use of Seroquel without a documented clinical indication. A policy was requested that addressed the use of antipsychotic medications at this time. No further information was provided prior to the end of the survey process. [1] Seroquel is a medication used to treat schizophrenia and bipolar disorder. This information was obtained from the following website: https://www.fda.gov/downloads/Drugs/DrugSafety/ucm089126.pdf [2] Extrapyramidal symptoms - this information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmed/1359485	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		

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F 761	Continued From page 169 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined the facility staff failed to secure medication for two of 4 medication carts on the 100 and 200 hall. 1. The facility staff failed to lock the medication cart on the 200 hall while the cart was not in use. Three residents and on staff nurse, were observed walking by the medication cart while it was unlocked. 2. LPN (Licensed Practical Nurse) #2 failed to ensure a medication cart in the 100 hall was fully locked while in a resident's room administering medications. Other staff and a resident were observed approximately three feet from the medication cart. The findings include:	F 761	**F761** 1. Medication carts on 100 and 200 were noted locked and secure on 2/23/18. 2. An observational audit was conducted on 2/23/18 by Director of nursing to validate that all medication carts were locked. No negative findings were noted. 3. Licensed Nurses were re-educated by the Staff Development Coordinator on 2/23/18 related to locking of medication storage carts. 4. The Assistant Director of Nursing and the Unit Manager will audit medications carts weekly for 4 weeks and monthly for 2 months to ensure medication carts are locked when not in use or out of Nurses sight.	

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F 761	Continued From page 170 1. On 2/22/18 at 12:51 p.m., observation of the 200 hall was conducted. The medication cart parked near room 212, was observed unlocked. On 2/22/18 at 12:52 p.m., LPN (licensed practical nurse) #5 was observed walking by the medication cart and entering into room 212. On 2/22/18 at 12:53 p.m., a resident was observed propelling himself in his wheelchair past the medication cart. The medication cart was still unlocked at this time. On 2/22/18 at 12:55 p.m., another resident was observed propelling himself in his wheelchair past the medication cart. On 2/22/18 at 12:56 p.m., a third resident was observed ambulating in the hallway passing the medication cart. On 2/22/18 at 12:56 p.m., the nurse was observed walking out of room 212 and back to the nurses' station. On 2/22/18 at 12:58 p.m., an interview was conducted with LPN #5. When asked how the medication cart should be kept when not in use, LPN #5 stated the cart should be locked with no medications lying on top of the cart. When asked if the medication cart on the 200 hall was locked, LPN #5 stated it was not locked and that the cart was not her medication cart. LPN #5 stated, "I don't know why she left it unlocked." LPN #5 stated the other nurse was assigned to that particular medication cart and it must have been unlocked for about twenty minutes. LPN #5 stated the nurse had been on her break for at least 20 minutes. When asked why it is important for medication carts to be kept locked when not in use, LPN #5 stated that any resident could open the cart if not locked and eat medications or injure themselves on needles that were kept in the top drawer.	F 761	The Staff Development Coordinator will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. Completion date: 3/30/18	

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F 761	Continued From page 171 On 2/22/18 at 5:01 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the ADON (Assistant Director of Nursing) were made aware of the above concerns. The facility policy titled, "Security of Medication Cart" documented, "4. Medication carts must be securely locked at all times when out of the nurse's view..." 2. LPN (Licensed Practical Nurse) #2 failed to ensure a medication cart in the 100 hall was fully locked while in a resident's room administering medications. Other staff and a resident was observed approximately three feet from the unlocked medication cart. On 2/21/18 at 4:38 p.m. observation of LPN #2 preparing and administering medications to a resident was conducted. LPN #2 prepared the medications at the medication cart in the hall across from the resident's room then pushed the lock button on the cart and entered the resident's room. The lock button was not fully pushed in. This surveyor was able to pull the lock button out and open the drawers to access medications. LPN #2's back was turned from the medication cart while administering medications to the resident in the room. Two staff members and a resident were observed in the hall approximately three feet from the unlocked medication cart. On 2/21/18 at 4:52 p.m., LPN #2 and this surveyor returned to the medication cart. LPN #2 was shown the lock button on the medication cart that was not fully pushed in. LPN #2 was asked what should be done before leaving the medication cart. LPN #2 stated he thought he locked the medication cart.	F 761		

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F 761	Continued From page 172 On 2/22/18 at approximately 8:00 a.m., an interview was conducted with LPN #1. LPN #1 was asked what should be done when a nurse leaves a medication cart. LPN #1 stated nurses should lock the computer screen so no information is visible and secure the medications. When asked how the nurse should secure medications, LPN #1 stated the nurse should make sure medications are not left on top of the cart and lock the cart. LPN #1 stated she turns the cart to where it is visible to her when she goes in the room. When asked if she still locks the cart, LPN #1 stated, "Yes." On 2/22/18 at 10:55 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. The facility policy titled, "Security of Medication Cart" documented, "4. Medication carts must be securely locked at all times when out of the nurse's view..." No further information was presented prior to exit.	F 761		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812		

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F 812	Continued From page 173 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to serve food in a sanitary manner. The facility staff failed to wear gloves while preparing toast and bread for three residents in the dining room during breakfast. The findings include: On 02/21/18 at approximately 7:30 a.m. the following observations of the dining room were conducted during the breakfast meal: On 02/21/18 at approximately 8:01 a.m. a staff member was observed holding the resident's bread in their bare hands while spreading jelly on it, folding the bread, handing it to the resident and assisting the resident in holding the bread in resident's hand with hand over hand assistance. On 02/21/18 at approximately 8:05 a.m. a staff member was observed holding the resident's bread in their bare hands while spreading jelly on it and folding it and handing it to the resident. On 02/21/18 at approximately 8:12 a.m. a staff	F 812	F812 1. No specific resident identifiers were noted within the plan of correction 2. An observational audit was conducted on 2/22/18 by Director of Nursing to validate residents are being served food in a sanitary manner by the nursing staff. 3. The Staff Development Coordinator will re-educate nursing staff by 3/14/18 on the proper handling of food. CNA's #5 and #6 were re-educated by the Staff Development Coordinator on 2/21/18 related to proper food handling.	

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F 812	Continued From page 174 member was observed holding the resident's toast in their bare hands while buttering it and then handing to the resident. On 02/21/18 at approximately 8:21 a.m. an interview with CNA (certified nursing assistant) # 5. When asked if she held a piece of bread for a resident with her bare hands while spreading jelly on it, folded it and provided hand over hand assistance to help the resident hold onto the bread, CNA # 5 stated, "Yes." When asked if her hands were bare when she handed the bread to the resident, CNA # 5, "Yes. I should have had gloves on when I was handling the food." On 02/21/18 at approximately 8:24 a.m. an interview with CNA # 6. When asked if she held a resident's piece of bread with her bare hands while spreading jelly on it and then folded it for the resident, CNA # 6 stated, "Yes." When asked if she held a piece of toast with her bare hands for a resident while spreading butter on it, CNA # 6 stated, "Yes." On 02/21/18 at approximately 8:28 a.m. an interview was conducted with OSM # 9, dietary manager. When asked about staff handling the resident's food, OSM # 9 stated, "When handling food directly staff should have gloves on, no bare hand contact with food." On 02/22/18 at 5:00 p.m. ASM (administrative staff member) # 1, the administrator, ASM # 2, the director of nursing, and ASM # 5, administrator in training, were made aware of the above concerns. According to the Federal Food Code: "(B) Except when washing fruits and vegetables as specified	F 812	4. The Assistant Director of Nursing and the Unit Manager will conduct weekly audits of dining services weekly for 4 weeks and monthly for 2 months to ensure proper handling of food by staff. The Staff Development Coordinator will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. The Staff Development Coordinator will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. Completion date: 3/30/18	

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F 812	Continued From page 175 under §3-302.15 or as specified in (D) and (E) of this section, FOOD EMPLOYEES may not contact exposed, READY-TO-EAT FOOD with their bare hands and shall use suitable UTENSILS such as deli tissue, spatulas, tongs, single-use gloves, or dispensing EQUIPMENT." No further information was provided prior to exit.	F 812		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law;	F 842		

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F 842	Continued From page 176 (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical document	F 842	**F842** 1. Resident #50's representative and physician were notified on 2/22/18 of falls without injury that occurred on 6/12/17, 9/4/17 and 1/5/18 by the Unit Manager. 2. An audit was performed on 2/22/18 by the Unit Manager and Assistant Director of Nursing of all current resident's falls within the last 30 days to validate resident representative and physician were notified. Any identified issues were corrected. 3. Licensed staff will be re-educated by the Staff Development Coordinator by 3/14/18 on notification of resident representative and physician after a fall.	

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F 842	Continued From page 177 review, it was determined the facility staff failed to maintain a complete and accurate clinical record for one of 30 residents in the survey sample, Resident #50. The facility staff failed to document Resident #50's physician was notified the resident sustained falls on 6/12/17 and 9/4/17, and failed to document the resident's representative was notified the resident sustained falls on 9/4/17 and 1/5/18. The findings include: Resident #50 was admitted to the facility on 7/1/14. Resident #50's diagnoses included but were not limited to traumatic brain injury, anxiety disorder and depression. Resident #50's quarterly MDS (minimum data set) with an ARD (assessment reference date) of 12/21/17, coded the resident's cognition as severely impaired. Review of Resident #50's clinical record and fall investigations revealed the resident sustained falls on 6/12/17, 9/4/17 and 1/5/18. Further review of the resident's clinical record (including nurse's notes) failed to reveal the resident's physician was notified regarding the falls on 6/12/17 and 9/4/17. The clinical record also failed to reveal Resident #50's representative was notified regarding the falls on 9/4/17 and 1/5/18. On 2/22/18 at approximately 8:00 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated nurses notify the physician and resident representatives regarding falls. When asked where the notification is documented, LPN #1 stated the notification is documented on incident reports	F 842	4. The Assistant Director of Nursing and the Unit Manager will conduct audits involving a fall to ensure notification to the resident's representative and physician weekly for 4 weeks and monthly for 2 months. The Staff Development Coordinator will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. Completion date: 3/30/18	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC	1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 178 (confirmed as a form that is not part of the clinical record) and sometimes documented in nurses' notes. When asked if the notification should be documented in the clinical record, LPN #1 asked if she could get back to this surveyor with an answer. On 2/22/18 at 12:54 p.m. LPN #1 presented facility internal forms that were not part of the clinical record (including 24-hour reports and physician communication forms). The forms revealed the physician was notified regarding the falls on 6/12/17 and 9/4/17, and Resident #50's representative was notified regarding the falls on 9/4/17 and 1/5/18. LPN #1 stated physician and resident representative notification of falls should be documented in the resident's chart. On 2/22/18 at 1:58 p.m. ASM (administrative staff member) #2 (the director of nursing) stated the facility did not have a requested policy regarding documentation. On 2/22/18 at 2:28 p.m. ASM #1 (the administrator) and ASM #2 were made aware of the above findings. No further information was presented prior to exit.	F 842		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	[X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[X2) MULTIPLE CONSTRUCTION	[X3) OATE SURVEY COMPLETED
	495249	A. BUILDING _____ B. WING _____	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZIP COOE
FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC	1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901

[X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES [EACH DEFICIENCY MUST BE PRECEOED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION [EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OEFICIENCY)	[X5) COMPLETION OATE
F 880	Continued From page 181 1. On 2/22/18 at 2:37 PM, a linen cart was noted to be dirty, with tacky residue from old tape on the posts, the residue was blackened with dirt, and in contact with linens, the linen cart cover was noted to be worn, and had a dried whitish substance that had dripped down the side of it. At this time, all facility linen carts were inspected, with OSM #7 (Other Staff Member), the laundry department account manager. The inspection revealed eleven linen carts, seven of which needed cleaning or repair and were unsanitary. Observation of the seven identified carts revealed the carts were dirty, with tacky residue from old tape on the posts, the residue was blackened with dirt, and in contact with linens, the linen cart covers were noted to be worn, and one cover had a tear of approximately 6 inches in the top of it. OSM #7 stated that these carts were not in a sanitary condition. A review of the facility policy, "Laundry In-service; Care of Equipment" documented, "Laundry carts must be sanitized daily...Clean Linen carts must be free of trash and lint and sanitized daily." On 2/22/18 at 5:16 PM, at the end of day meeting, the Administrator (ASM #1 - Administrative Staff Member) and Director of Nursing (ASM #2) were made aware of the findings. No further information was provided by the end of the survey. 2. The facility staff failed to maintain Resident # 113's wheelchair armrests free from torn areas, exposing foam that was unable to be sanitized.	F 880		

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
	495249	A. BUILOING _____ B. WING _____	C 02/23/2018

NAME OF PROVIOER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZIP COOE
FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC	1575 SCOTT ORIVE ROUTE 5 FARMVILLE, VA 23901

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOEO BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 183 checks are done by staff and needed repairs are reported to maintenance." LPN # 4 was then asked to accompany this surveyor to Resident # 113's room. Upon observing Resident # 113's wheelchair, LPN #4 verbally agreed the right and left armrests were cracked, torn and exposing foam. LPN #4 stated, "They should have been replaced." When asked if the arm rests could be properly cleaned LPN # stated, "No because the debris could be in the open areas and could not be properly cleaned." On 02/22/18 at 5:00 p.m. ASM (administrative staff member) # 1, the administrator, ASM # 2, the director of nursing, and ASM # 5, administrator in training, were made aware of the above concerns. No further information was provided prior to exit. References: 1. Bleeding in the area between the brain and the thin tissues that cover the brain. This area is called the subarachnoid space. This information was obtained from the website: https://medlineplus.gov/ency/article/000701.htm. 2. High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. 3. A condition in which the heart is no longer able to pump oxygen-rich blood to the rest of the body efficiently. This causes symptoms to occur throughout the body. This information was obtained from the website: https://medlineplus.gov/ency/article/000158.htm.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	A. BUILOING _____ B. WING _____	C 02/23/2018

NAME OF PROVIOER OR SUPPLIER	STREET AODRESS, CITY, STATE, ZIP CODE
FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC	1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901

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F 880	Continued From page 184 4. A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html. 5. A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.	F 880		