PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

	OF OEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
•		407040	2 141110		С
		495249	B. WING		02/2 3/2 0 1 <u>8</u>
NAME OF PI	ROVIOER OR SUPPLIER	• •		TREET AOORESS, CITY, STATE, ZIP COOE	
FARMVILI	E REHABILITATION & H	IEALTH CARE CENTER LLC		575 SCOTT DRIVE ROUTE 5	
		<u> </u>	F	FARMVILLE, VA 23901	
(X4) IO		ATEMENT OF OEFICIENCIES	IO	PROVIDER'S PLAN OF CORREC	
PREFIX TAG		Y MUST BE PRECEOËO BY FULL SC IOENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCEO TO THE APPR	
				E006	
E 000	Initial Comments	•	E 000	2006	
		•		1. The administrator will u	pdate the
		ergency Preparedness		facility emergency prepare	
	survey was conducte				
	02/23/18. Correction	•		plan to include the facili	
	compliance with 42 C			assessment as it relates	ľ
F 000		g-Term Care Facilities.	F 000	strategies related to all	nazards
E 006		zards Risk Assessment	E 006	specific to the geograph	ic location
SS=C	CFR(s): 483.73(a)(1)	-(2)		of the facility 3-30-2018	
	(a) Emergency Plan	The [facility] must develop	1	0, 2	
		rgency preparedness plan	1	2 The administrator will w	ndata tha
		d, and updated at least		2. The administrator will u	'
	annually. The plan m	•		emergency preparedne	
			,	quarterly basis to ensur	e that
	(1) Be based on and	include a documented,		current strategies are a	ppropriate
	facility-based and cor		!	based upon the clinical	complexity
	assessment, utilizing	an all-hazards approach.*	:	of the resident populati	
		§483.73(a)(1):] (1) Be based		<u>.</u>	• .
		umented, facility-based and	,		
		k assessment, utilizing an	,	3. The facility staff develop	oment RN
	all-hazards approach	, including missing residents.		will provide in-service t	
	*(Eo. (CE/UDo of \$49)	2 475(a)(1):1 (1) Po based on		1	4,,,,,,,
		3.475(a)(1):] (1) Be based on ented, facility-based and		staff on the emergency	
		k assessment, utilizing an		preparedness plan by 3	-30-2018.
	•	, including missing clients.		· ·	
		,		4. The interdisciplinary qu	ality
	(2) Include strategies	s for addressing emergency		assurance team will rev	iew the
	events identified by the	ne risk assessment.		emergency prepared ne	ss plan on 🏖 🗷
		18.113(a)(2):] (2) Include		monthly basis for the n	ext timee
		sing emergency events		months and quarterly t	ess plan on AR 28 208
	_	assessment, including the		ensure continued comp	liance. 🖹 😕 🗸
		consequences of power			ess plan on MAR 2 8 2018 Marce.
		ters, and other emergencies	Ì		(C)
		hospice's ability to provide		5. Completion date: 3-30-	-
· / ·	care.			5. Completion date, 3-30-	
LABORATORY	OIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	₹E	TITLE	(X6) OATE
- 1		/		ADMINISTRATION	3-27-18

Any deliciency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other sateguards 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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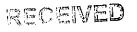
	F CORRECTION (X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CC		(X3) OATE SURVEY COMPLETEO
	495249	B. WING		C 02/23/2018
	PROVIDER OR SUPPLIER LE REHABILITATION & HEALTH CARE CENTER LLC	1575	EET AODRESS, CITY, STATE, ZIP COOE SCOTT DRIVE ROUTE 5 MVILLE, VA 23901	-
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOEO BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL(CROSS-REFERENCEO TO THE APPROP OEFICIENCY)	D BE COMPLÉTION
E 006	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.	E 006		
E 007 SS=C	No further information was provided prior to exit. 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	RECEIVI MAR 2 8 20 VDH/OL	118

FORM CMS-2567(02-99) Previous Versions Obsolete

Event IO: 62X711

Facility IO: VA0060

If continuation sheet Page 2 of 185



MAR 28 2018

VDHIOLC

	OF OEFICIENCIES F CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		E CONSTRUCTION	(X3) OATE SURVEY COMPLETEO	
		495249	B. WING		C 02/23/2018	
NAME OF P	ROVIOER OR SUPPLIER			STREET AOORESS, CITY, STATE, ZIP COOE	0 2/23/2 01 <u>8</u>	
EA ESMANTH I	I E DEMARKITATION & L	(Extru oxpe orbited to		575 SCOTT DRIVE ROUTE 5		
LWLINIAIP	LE KEMABILITATION & F	HEALTH CARE CENTER LLC	I	FARMVILLE, VA 23901		
(X4) IO PREFIX TAG	(EACH OFFICIENC	TATEMENT OF OEFICIENCIES BY MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI OEFICIENCY)	BE COMPLETION	
E 007	Continued From page	⇒ 2	E 007	E007		
	but not limited to, per services the [facility] an emergency; and concluding delegations plans.** *Note: ["Persons at rishospice, PACE, HHAFQHC, or ESRD facility in the service of the facility staff failed that the written emergency, how the facility]	is not met as evidenced iew and facility document ned the facility staff failed to ergency preparedness plan. If to evidence documentation gency plan included services able to provide during an facility plans to continue emergency, and delegations		 The administrator will update facility emergency prepared a plan to include services that the facility would be able to proving during an emergency, how the facility plans to continue operaduring an emergency and delegations of authority and succession plans by 3-30-2018 The administrator will review a update the emergency preparedness plan on a quarte basis when a change is noted in succession plans and plans of operation during an actual emergency. 	ess che ide e rations and	
	On 2/23/18 at approxi and interview of the fa preparedness plan wa (other staff member) a Review of the facility's plan failed to evidence written emergency pla facility would be able emergency, how the fo operations during an e	as conducted with OSM #8, director of maintenance. s emergency preparedness e documentation that the an included services the to provide during an facility plans to continue emergency, and delegations ession plans. OSM # 8		3. The facility staff development R will provide in-service education facility staff on the emergency preparedness plan by 3-30-2018	n to	

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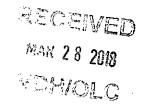
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		TRUCTION		TE SURVEY MPLETED
		495249	B. WNG				С
NAME OF D	DOVIDED OD CUDDUED	430243		·····	ADD-000 CIP/L CT-00-	0	2/23/201 <u>8 . </u>
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
FARMVILL	E REHABILITATION & F	EALTH CARE CENTER LLC			OTT DRIVE ROUTE 5		
-				ARMV	'ILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION OATE
E 013 SS=C	findings. No further information Development of EP F CFR(s): 483.73(b) (b) Policies and procedure policies and procedure plan set forth in paragand the communication this section. The policies and updates *Additional Requirem Facilities: *[For PACE at §460.8] procedures. The PAC develop and implement policies and procedure plan set forth in paragand the communication this section. The policies and procedure plan set forth in paragand the communication this section. The policies and procedure plan set forth in paragand the communication this section. The policies and procedure emergencies, including equipment, power, or emergencies; and nathreaten the health or staff, or the public. The	imately 1 p.m., ASM nember) # 1, the ide aware of the above in was provided prior to exit. Policies and Procedures edures. [Facilities] must ent emergency preparedness res, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must be did at least annually. ents for PACE and ESRD (4(b):] Policies and ESRD (4(b):] Policies and ESRD (5) Policies and emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must at of medical and nonmedical rig, but not limited to: Fire; water failure; care-related tural disasters likely to a safety of the participants, repolicies and procedures	E 013		The interdisciplinary qua assurance team will revie emergency prepared nesmonthly basis for the nexmonths and quarterly the ensure continued compli	ew the as plan on a axt three ereafter to lance.	
	mast ne reviewed gill	d updated at least annually.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 62X711

Facility ID: VA0080

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	ROVIDER OR SUPPLIER LE REHABILITATION & H	495249 EALTH CARE CENTER LLC	в. WNG s	STREET AODRESS, CITY, STATE, ZIP CODE 575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901	C 02 /23/20 1 <u>8</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES MUST BE PRECEOED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROPE DEFICIENCY)	BE COMPLETION
E 013	procedures. The dialy implement emergency procedures, based on forth in paragraph (a) assessment at paragrand the communication this section. The policity reviewed and updated emergencies include, equipment or power far emergencies, water sunatural disasters likely geographic area. This REQUIREMENT by: Based on staff interviewiew it was determine the disaster of the procedure of the procedure of the procedure of the procedure of the procedure.	at §494.62(b):] Policies and sis facility must develop and preparedness policies and the emergency plan set of this section, risk aph (a)(1) of this section, on plan at paragraph (c) of ies and procedures must be at least annually. These but are not limited to, fire,	E 013	 The facility Emergency Oper Plan policies and procedures updated by 3-30-2018 to ensith that they are relevant as it reto the community based risk assessment, communication while utilizing and all-hazard approach. All policies and procedures reto the facility Emergency Operations Plan will be revise and updated as appropriate 30-2018. 	s will be sure elates plan ls elated
	and community-based communication plan, trapproach. The findings include: On 2/23/18 at approximand interview of the fapreparedness plan was	ness policies and eloped based on the facilityrisk assessment and utilizing an all-hazards mately 11:45 a.m., a review cility's emergency s conducted with OSM		 Facility staff will receive add education on the facility Emotoperations Plan by the RN States Development Coordinator by 2018. The facility interdisciplinary team will review the update policies for the next three m 	ergency taff y 3-30- QA d
	Review of the facility's plan failed to evidence were developed based community-based risk communication plan, to			and quarterly thereafter to e continued compliance. 5. Completion date: 3-30-2018	

	F CORRECTION	IOENTIFICATION NUMBER:		PLE CONSTRU IG			E SURVEY PLETEO
		495249	B. WING				C .
NAME OF P	ROVIOER OR SUPPLIER	490249	B. WING _	STREET AO	ORESS, CITY, STATE, ZIP COOE	02	/23/201 <u>8</u>
FARMVILI	LE REHABILITATION & F	BEALTH CARE CENTER LLC	1575 SCOTT ORIVE ROUTE 5 FARMVILLE, VA 23901		T ORIVE ROUTE 5	· -	
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREFIX TAG		PROVIOER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCEO TO THE APPRO OEFICIENCY)	JLO BE	IX5I COMPLETION DATE
E 013	Continued From page have the documentat		ΕO	13			
E 020 SS=C	findings. No further information Policies for Evac. and CFR(s): 483.73(b)(3) [(b) Policies and procedure policies and procedure plan set forth in paragasessment at paragand the communication this section. The policies address the following Safe evacuation from consideration of care evacuees; staff respondentification of evacuerimary and alternate with external sources *[For RNHCs at §403 §416.54(b)(2):] Safe evacuation from includes the following	nember) # 1, the de aware of the above n was provided prior to exit. I Primary/Alt. Comm. edures. The [facilities] must nt emergency preparedness res, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of sies and procedures must be d at least annually. At a s and procedures must :] the [facility], which includes and treatment needs of nsibilities; transportation; ration location(s); and means of communication of assistance. .748(b)(3) and ASCs at the [RNHCI or ASC] which :	E 0	2.	The Administrator will a the Emergency Operation by 3-30-2018 to ensure contains a policy and property of a safe evacuation for a safe responsion transportation; identifice evacuation location(s), primary and alternate roommunication with expension of assistance. All policies and procedure a safe for a saf	ions Plan that it rocedure om the e care f the sibilities, cation of and means of cternal res Plan will ed as 18.	
	(i) Consideration of ca(ii) Staff responsibilities(iii) Transportation.(iv) Identification of ev(v) Primary and alternation	vacuation location(s).			facility Emergency Oper Plan by the RN Staff Development Coordinat 30-2018.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF OFFICIENCIES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

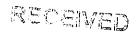
	OF OEFICIENCIES F CORRECTION	JX1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1	CONSTRUCTION	IX3) OATE COMP	SURVEY LETEO
		495249	B. WNG			23/2018
	PROVIOER OR SUPPLIER	HEALTH CARE CENTER LLC	15	REET AOORESS, CITY, STATE, ZIP COOE 75 SCOTT DRIVE ROUTE 5 ARMVILLE, VA 23901		
ĮX4) IO PREFIX TAG	JEACH OEFICIE	STATEMENT OF OEFICIENCIES NCY MUST BE PRECEOEO BY FULL R LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF COR IEACH CORRECTIVE ACTION CROSS-REFERENCEO TO THE A OEFICIENCY)	SHOULO BE	IX5 COMPLETION OATE
E 020	communication wit assistance. * [For CORFs at §4 Rehabilitation Ager §485.727(b)(1), an §494.62(b)(2):] Safe evacuation for Rehabilitation Ager Agencies as Provic Therapy and Speed Services; and ESR staff responsibilities. * [For RHCs/FQHC evacuation from the appropriate placem responsibilities and This REQUIREMED by: Based on staff intereview it was determined a complete erroredures for a sathat included care a evacuees, staff residentification of evaprimary and alternation with external source. The findings included on 2/23/18 at approand interview of the preparedness plan (other staff member 1988).	th external sources of 185.68(b)(1), Clinics, Incies, OPT/Speech at Id ESRD Facilities at 1 om the [CORF; Clinics, Incies, and Public Health Iders of Outpatient Physical Ich-Language Pathology ID Facilities], which includes Is, and needs of the patients. 1 s at §491.12(b)(1):] Safe Ider RHC/FQHC, which includes Ider extended Incidents Incident of exit signs; staff Inceds of the patients. 1 is not met as evidenced Incident and	E 020	 4. The facility interdist team will review the policies for the next months and quarte thereafter to ensure compliance. 5. Completion date: 3- 	e updated t three rly e continued	

FORM CMS-2567[02-99) Previous Versions Obsoleje

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Facility IO: VA0080

If ∞ntinualion sheet Page 7 of 185



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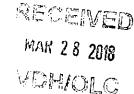
STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	B. WNG		C 0 2/2 3/ 2 018
NAME OF PROVIOER OR SUPPLIER FARMVILLE REHABILITATION & HEA	ALTH CARE CENTER LLC	l 1	STREET ADDRESS, CITY, STATE, ZIP COI 575 SCOTT ORIVE ROUTE 5 FARMVILLE, VA 23901	
PREFIX (EACH OFFICIENCY M	EMENT OF OEFICIENCIES AUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH OEFICIENCY	N SHOULO BE COMPLETION DATE
for a safe evacuation froincluded care and treatr staff responsibilities, trasof evacuation location(s alternate means of com sources of assistance. facility did not have it. On 2/23/18 at approxim (administrative staff me administrator was made findings. No further information vericles (Procedures for CFR(s): 483.73(b)(4) [(b) Policies and procedures plan set forth in paragral and the communication this section. The policies reviewed and updated a minimum, the policles and address the following:] (4) A means to shelter if and volunteers who rem (2),(3),(5),(6)] A means patients, staff, and voluteally (facility). *[For Inpatient Hospices and procedures.]	policies and procedures om the facility that ment needs of evacuees, insportation; Identification is), and primary and imunication with external OSM # 8 stated that the lately 1 p.m. ASM mber) # 1, the eaware of the above was provided prior to exit. Sheltening in Place dures. The [facilities] must emergency preparedness is, based on the emergency aph (a) of this section, plan at paragraph (c) of its and procedures must be at least annually. At a and procedures must in place for patients, staff, main in the [facility]. [(4) or	E 022	E022 1. The facility Emerg Operations Plan p procedures will be 3-30-2018 to ensure contains a policy a as to how the facilishelter in place for staff and voluntee	olicles and e updated by ire that it and procedure lity will safely r patients, rs who ity. The policy h the facility and Emergency ocedures ity cions Plan will pdated as 0-2018. ceive on on the Operations ff

FORM CMS-2567(02-99) Previous Versions Obsolete

Event IO: 62X711

Facility IO: VA0080

If continuation sheet Pege is of 185



DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/09/2018 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		ATE SURVEY DMPLETED
NAME OF PI	ROVIDER OR SUPPLIER	495249	8. WNG	STREET ADDRESS, CITY, STATE, ZIP CODE		C 02/23/201 <u>8</u>
FARMVILL	E REHAB)L TATION & I	HEALTH CARE CENTER LLC		1575 SCOTT DRIVE ROUTE 5 FARMV[LLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION OATE
	The policies and proof following: (i) A means to she hospice employees with the REQUIREMENT by: Based on staff interview it was determined have a complete emetal that a complete emetal the facility staff failed procedures of how the means to shelter in provolunteers who remain those policies and protect facility's emergen management. The findings include: On 2/23/18 at approximation and interview of the facility's plan failed to evidence for how the facility will in place for patients, so remain in the facility approcedures are aligned emergency plan and instated that the facility of the facility of the facility approcedures are aligned emergency plan and instated that the facility of the facility of the facility of the facility approcedures are aligned emergency plan and instated that the facility of the facility approaches a stated that the facility of the faci	atient care facilities only. redures must address the ter in place for patients, who remain in the hospice. is not met as evidenced iew and facility document med the facility staff failed to regency preparedness plan. I to develop policies and re facility will provide a ace for patients, staff and n in the facility and how redures are aligned with recy plan and risk I mately 11:45 a.m., a review recility's emergency res conducted with OSM res, director of maintenance. Res emergency preparedness re policies and procedures reprovide a means to shelter retaff and volunteers who nd how those policies and d with the facility's risk management. OSM # 8 did not have it.	E 022		pdated ree ontinued	
	administrator was ma findings.	de aware of the above				

	OF OEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) OATE COMP	SURVEY LETEO
						(c
		495249	B. WING			02/	23/2018
NAME OF PI	ROVIOER OR SUPPLIER			ST	REET AOORESS, CITY, STATE, ZIP COD	E	
FARMVIII	E REHABILITATION &	HEALTH CARE CENTER LLC		15	75 SCOTT DRIVE ROUTE 5		
ANNIVICE	LE REMADILITATION &	HEALTH CARE CENTER EEC		FA	ARMVILLE, VA 23901		
(X4) IO		TATEMENT OF OEFICIENCIES	10		PROVIDER'S PLAN OF CO		[X5)
PREFIX TAG	•	CY MUST BE PRECEOED BY FULL LSC IOENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE OEFICIENCY)		COMPLETION OATE
		<u> </u>			023	•	
E 022	' `		E	022	. The facility Emergence	y Operations	-
		on was provided prior to exit.			Plan policies and prod	cedures will be	
E 023		for Medical Documentation	E	023	updated by 3-30-201		
SS=C	CFR(s): 483.73(b)(5	,			that there is a policy		
	(b) Policies and pro	cedures. The [facilities] must			related to how the fa		
		ent emergency preparedness			patient information,	* *	
	1 '	res, based on the emergency			confidentiality of pat	•	
		agraph (a) of this section, risk graph (a)(1) of this section,			information, and sec		
		ion plan at paragraph (c) of			·		
		icies and procedures must be		ĺ	maintains availability	or records.	
		ed at least annually. At a			_		
		es and procedures must		1	. All policies and proce		
	address the following	g:]			to the facility Emerge	ency	
	(E) A system of mod	ical documentation that			Operations Plan will	be reviewed	
	preserves patient inf	ical documentation that			and updated as appr	opriate by 3-	
		ient information, and secures			30-2018.		j l
		ability of records. [(5) or					·
		of medical documentation					
		nt information, protects			. Facility staff will rece	ive additional	
	, ,	ient information, and secures		l	•		
	and maintains availa	ability of records.		l	education on the fac	•	
	*iFor RNHCls at \$40	03.748(b):] Policies and			Operations Plan by the		
		stem of care documentation			Development Coordi	nator by 3-30-	
	that does the followi			1	2018.		
	(i) Preserves patient						
	1 • •	ntiality of patient information.			. The facility interdisci	plinary QA	
	records.	intains the availability of			team will review the	updated	
	1000lds.			1	policies for the next	three months	
	*[For OPOs at §486	.360(b):} Policies and			and quarterly therea		
	procedures. (2) A sy				continued compliant		
	ſ	preserves potential and actual			continued compilant		
		rotects confidentiality of					,
	1 '	donor information, and insthe availability of records.				20.2040	
	secures and maintai	me the availability of fecolus.			i. Completion date: 3-	30-2018	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING			1''	SURVEY PLETED
		495249	B. WING				C
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREE	ET ADDRESS, CITY, STATE, ZIP CODE	02/	/ 23/20 1 <u>8</u>
FARMVILI	LE REHABILITATION & F	HEALTH CARE CENTER LLC	1 1	1575 S	SCOTT DRIVE ROUTE 5		
-			f	ARM	IVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IOENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	IX5) COMPLETION DATE
E 023	Continued From page	e 10	E 023	E0:	24		
		is not met as evidenced		1.	The facility Emergency Operati	ons	
	by:	iew and facility document			Plan policies and procedures w	ill be	
		ned the facility staff failed to			updated by 3-30-2018 to ensur	e	
,		ergency preparedness plan.			that there is a policy that addre	sses	
	The facility stoff failes				how volunteers are utilized and	l the	
		I to develop policies and e facility preserves patient			facility staffing strategy in the	event	
		confidentiality of patient			of an emergency.		
	information, and secu						
	availability of records	•		2.	All policies and procedures rela	ted	
:	The findings include:				to the facility Emergency		
	-				Operations Plan will be reviewe		
	On 2/23/18 at approx and interview of the fa	imately 11:45 a.m., a review			and updated as appropriate by	3-	
		as conducted with OSM			30-2018.		
	(other staff member)	#8, director of maintenance.					
		s emergency preparedness		_			
		e policies and procedures of rves patient information,		3.	Facility staff will receive addition		
		y of patient information, and			education on the facility Emerg		:
		s availability of records.			Operations Plan by the RN Staf		
	OSM # 8 stated that t	he facility did not have it.	,		Development Coordinator by 3	-30-	
	On 2/23/18 at approx	imately 1 p.m., ASM			2018.		
	(administrative staff n	nember) # 1, the					
		de aware of the above		4.	The facility interdisciplinary QA		
	findings.				team will review the updated	e.b	
	No further information	was provided prior to exit.			policies for the next three mon		
E 024 SS=C	Policies/Procedures-V CFR(s): 483.73(b)(6)	olunteers and Staffing/	E 024		and quarterly thereafter to ens continued compliance.	ure	
	develop and impleme	edures. The [facilities] must nt emergency preparedness es, based on the emergency		5.	Completion date: 3-30-2018		· .

	OF OEFICIENCIES F CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING			SURVEY PLETED
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	ROVIDER OR SUPPLIER LE REHABIL(TATION &	HEALTH CARE CENTER LLC	STRE	EET ADORESS, CITY, STATE, ZIP COO 5 SCOTT DRIVE ROUTE 5 RMVILLE, VA 23901		/ 23 /201 <u>8</u>
(X4) IO PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDEO BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION OATE
E 0 2 4	Continued From page	ge 11	E 024			
	assessment at para and the communica this section. The po reviewed and updat	agraph (a) of this section, risk graph (a)(1) of this section, tion plan at paragraph (c) of icies and procedures must be ed at least annually. At a es and procedures must				·
	volunteers in an em- staffing strategies, in for integration of Sta	as noted above] The use of ergency or other emergency ncluding the process and role te and Federally designated onals to address surge needs y.				
	procedures. (6) The emergency and othe strategies to addres emergency. This REQUIREMEN by:	03.748(b):] Policies and use of volunteers in an or emergency staffing surge needs during an T is not met as evidenced view and facility document				
	review it was determ	ined the facility staff failed to ergency preparedness plan.				
	procedures for the u	d to develop policies and se of volunteers and other the emergency plan.				
	The findings include					
	and interview of the preparedness plan v (other staff member) Review of the facility plan failed to eviden	kimately 11:45 a.m., a review facility's emergency vas conducted with OSM #8, director of maintenance. 's emergency preparedness be policies and procedures eers and other staffing				

STATEMENT OF DEFICIENCIES (X1] PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED			
		•	f A. BOILDING_			ı	C
		495249	B. WING				23/ 20 18
NAME OF P	ROVIDER OR SUPPLIER		s	TREET AD	DRESS, CITY, STATE, ZIP CODE	-	
FARMVILI	LE REHABILITATION & H	EALTH CARE CENTER LLC	1		TT DRIVE ROUTE 5		
	[ARMVILI	LE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDEO BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		[X5] COMPLETION OATE
E 026 SS=C	strategies in the emer OSM #8 stated that the Information. On 2/23/18 at approx (administrative staff in administrator was malfindings. No further information Roles Under a Waive CFR(s): 483.73(b)(8) [(b) Policies and procedure plans and procedure policies and procedure plan set forth in paragrand the communication this section. The policies address the following: (8) [(6), (6)(C)(iv), (7), [facility] under a waive in accordance with seprovision of care and care site identified by officials. *[For RNHCIs at §403 procedures, (8) The rowaiver declared by the with section 1135 of A at an alternative care	gency preparedness plan. The facility did not have this simately 1 p.m., ASM Thember) # 1, the The de aware of the above was provided prior to exit. The provided prior	E 024	2. 3. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4.		will be ure scribes care e sites elated wed by 3-tional rgency aff 3-30-	
	management officials. This REQUIREMENT	is not met as evidenced		5. (Completion date: 3-30-2018		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER LE REHABILITATION & H	IEALTH CARE CENTER LLC	I 1	STREET ADDRESS, CITY, STATE, ZIP CODE 575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
E 029 SS=C	review it was determine have a complete eme. The facility staff failed procedures in the eme the facility's role in proat altered care sites upon The findings include: On 2/23/18 at approximand Interview of the facility's plan failed to evidence in the emergency plan role in providing care care sites under an 11 that the facility did not On 2/23/18 at approximate (administrative staff madministrative staff madministrative staff madministrator was madfindings. No further information Development of Commor CFR(s): 483.73(c) (c) The [facility] must demonstrate with Fedand must be reviewed annually.	iew and facility document need the facility staff failed to ergency preparedness plan. I to develop policies and ergency plan that describe oviding care and treatment ander an 1135 waiver. Imately 11:45 a.m., a review acility's emergency as conducted with OSM #8, director of maintenance. See energency preparedness to that describe the facility's and treatment at altered 135 waiver. OSM #8 stated to have this information. Imately 1 p.m., ASM member) # 1, the de aware of the above I was provided prior to exit. Imunication Plan develop and maintain an mess communication plan deral, State and local laws to and updated at least	E 029	E029 1. The administrator will update the facility emergency preparedness plan to include the facility communication plan that contain how the facility coordinates partically care within the facility, across healthcare providers, and with and local health departments be 30-2018. 2. The administrator will review and update as needed the emergents.	ains tient state by 3- nd ncy rly	
		is not met as evidenced		coordination of care.		

A95249 NAME OF PROVIOER OR SUPPLIER FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC (X4) IO SUMMARY STATEMENT OF DEFICIENCIES B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901 (X4) IO PROVIDER'S PLAN OF CORRECTION	STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
FARMIVILE REHABILITATION & HEALTH CARE CENTER LLC (XA)10 (XA)10 (XA)10 (CA)10 (CA			495249			C 02/23/20 18	
ECACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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: Con 2/23/18 at approximately 11:45 a.m., a review and interview of the facility semergency preparedness plan was conducted with OSM (other staff member) #8, director of maintenance. Review of 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 administrative was made aware of the above findings. No further information was provided prior to exit. E 030 Names and Contact Information E 039			HEALTH CARE CENTER LLC	1 1	575 SCOTT DRIVE ROUTE 5	02/23/20 10	
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: 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 of maintenance. Possible via the facility staff development RN will provide in-service training to all staff on the emergency preparedness plan by 3-30-2018. The facility staff development RN will provide in-service training to all staff on the emergency preparedness plan by 3-30-2018. The findings include: 4. The interdisciplinary quality assurance team will review the emergency preparedness plan by 3-30-2018. 5. Completion date: 3-30-2018 The facility staff development RN wi	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCEO TO THE APPRO	JLD BE COMPLETION	
E 030 Names and Contact Information E 030	E 029	by: Based on staff intender review it was determed have a complete emission of the facility staff failed emergency communities that and local health state and local health. The findings include: On 2/23/18 at approximation of the foreparedness plan we (other staff member). Review of the facility plan failed to evidence communication plan coordinates patient of healthcare providers, health departments. That this plan was revistated that the facility information. On 2/23/18 at approximation on 2/23/18 at approximation at approximation of the facility information.	view and facility document ined the facility staff failed to ergency preparedness plan. In the facility staff failed to ergency preparedness plan. In the facility are within the facility are within the facility, across and with state and local. There was also no evidence riewed annually. OSM #8 of did not have this.	E 029	will provide in-service train staff on the emergency preparedness plan by 3-30-4. The interdisciplinary quality assurance team will review emergency prepared ness pronthly basis for the next months and quarterly there ensure continued complian	ing to all -2018. y the plan on a three eafter to	
[(c) The [facility, except RNHCIs, hospices, transplant centers, and HHAs] must develop and	1	Names and Contact CFR(s): 483.73(c)(1) [(c) The [facility, exce	nformation ept RNHCIs, hospices,	E 030			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN DF CORRECTION IDENTIFICATION NUMBER:		4	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY CDMPLETED	
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		495249	B. WING			23/2018
NAME OF P	ROVIDER OR SUPPLIER		;	STREET ADDRESS, CITY, STATE, ZIP CDDE	024	20/2010
FARMVILI	E REHABILITATION & H	EALTH CARE CENTER LLC	Ι.	1575 SCOTT DRIVE ROUTE 5		
——				FARMVILLE, VA 23901		:
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E 030	State and local laws a		E 030	E030 1. The administrator will facility communication	•	· .
	plan must include all (1) Names and contar following: (i) Staff. (ii) Entitles providing s	of the following:] It information for the services under arrangement.		ensure that all the req contact information ha updated and is accurat 2018.	uired facility as been te by 3-30-	
	 (ii) Entitles providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For RNHCls at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: 			2. The Administrator will contact information as quarterly basis to ensu contact information is reflected.	needed on a re that	
	(iii) Next of kin, guard(iv) Other RNHCIs.(v) Volunteers.			3. The facility staff develo will provide in-service t staff on the emergency preparedness plan by 3	training to all	· · · · ·
	plan must include all to (1) Names and contact following: (i) Staff.	ct information for the services under arrangement.		4. The interdisciplinary que assurance team will revenue emergency prepared no monthly basis for the months and quarterly the ensure continued comp	view the ess plan on a ext three hereafter to	
	*[For Hospices at §41 communication plan in following: (1) Names and contact	nust include all of the		5. Completion date: 3-30-2	2018	

ANO PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) OATE SURVEY COMPLETEO	
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NAME OF P	ROVIOER OR SUPPLIER			STREET AOORESS, CITY, STATE, ZIP COOE	02/23/2018
FARMVILI	LE REHABILITATION &	HEALTH CARE CENTER LLC	ı	1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901	
(X4) IO PREFIX TAG	(EACH OEFICIENC	IATEMENT OF OEFICIENCIES BY MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCEO TO THE AP OEFICIENCY)	HOULO BE COMPLETION
€ 030	following: (i) Hospice employed (ii) Entities providing (iii) Patients' physicia (iv) Other hospices. *[For OPOs at §486. plan must include all (1) Names and conta following: (i) Staff. (ii) Entities providing (iii) Volunteers. (iv) Other OPOs. (v) Transplant and do Donation Service Are This REQUIREMEN' by: Based on staff interv review it was determinave a complete eme The facility staff failed emergency community the required facility of this contact informatic	es. services under arrangement. ins. 360(c):] The communication of the following: ct information for the services under arrangement. onor hospitals in the OPO's ea (DSA). T is not met as evidenced riew and facility document ned the facility staff failed to ergency preparedness plan. If to evidence a written cation plan that included all ontacts and evidence that on was reviewed and	E 030		
	updated at least annuated. The findings include:				
	and interview of the f preparedness plan w (other staff member) Review of the facility' plan failed to evidence communication plant facility contacts and e	imately 11:45 a.m., a review acility's emergency as conducted with OSM #8, director of maintenance. s emergency preparedness a written emergency that included all the required evidence that this contact ewed and updated at least			

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	ROVIOER OR SUPPLIER LE REHABILITATION &	HEALTH CARE CENTER LLC	, 1 F	02/23/2016		
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	annually. OSM #8 s have this Information On 2/23/18 at approx (administrative staff administrative staff administrator was m findings. No further information Primary/Alternate Me CFR(s): 483.73(c)(3) [(c) The [facility] must emergency prepared that complies with Fe and must be reviewed annually.] The commall of the following: (3) Primary and alter communicating with (i) [Facility] staff. (ii) Federal, State, the emergency manager *[For ICF/IIDs at §48 alternate means for CICF/IID's staff, Feder local emergency manager with the staff of the staff interview it was determined a complete emember of the facility staff faile.	tated that the facility did not it. Idmately 1 p.m., ASM member) # 1, the ade aware of the above in was provided prior to exit. The early are and in the early and maintain an increase communication plan and and updated at least nunleation plan must include in the following: Ideal, regional, and local ment agencies. 3.475(c):] (3) Primary and communicating with the early State, tribal, regional, and	E 032	The facility administrator will ensure that the facility emerge communication plan includes primary and alternate means communicating with facility sederal, State, tribal and local emergency management age.	for taff, all notes t RN g to all D18. ne an on a ree fter to	
		alternate means for		5. Completion date: 3-30-2018		

	F CORRECTION (X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIOER OR SUPPLIER LE REHABILITATION & HEALTH CARE CENTER LLC	s 1	STREET AODRESS, CITY, STATE, ZIP COOE 575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901	02/23/201 <u>8</u>
(X4) IO 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 SHOULO B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
	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. 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 032	E033 1. The facility Emergency Operat Plan policies and procedures vupdated by 3-30-2018 to ensuthat the communication portion contains a method of sharing information and the contain	vill be re on ider r, ated
			00 2020.	

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) OATE SURVEY COMPLETEO	
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	ROVIOER OR SUPPLIER	& HEALTH CARE CENTER LLC	1 1	575 S	FAOORESS, CITY, STATE, ZIP COOE COTT DRIVE ROUTE 5 VILLE, VA 23901		. •	
(X4) IO PREFIX TAG	(EACH OEFICI	Y STATEMENT OF OEFICIENCIES ENCY MUST BE PRECEOEO BY FULL OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG		PROVIOER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCEO TO THE APPRI OEFICIENCY)	JLO BE	(X5) COMPLETION OATE	
E 033	release patient inf CFR 164.510(b)(1) required for HHAs under §485.68(c), §491.12(c).] (6) [(4) or (5)]A meabout the general patients under the under 45 CFR 164 *[For RNHCls at § sharing information patients under the with care provider care, based on the made by the patier representative. *[For RHCs/FQHC of providing information and local facility's care as periodition and local facility's care as periodition and local facility's care as periodition and local facility is care as perio	e event of an evacuation, to ormation as permitted under 45 (ii). [This provision is not under §484.22(c), CORFs and RHCs/FQHCs under eans of providing information condition and location of [facility's] care as permitted 4.510(b)(4). 6403.748(c):] (4) A method for and care documentation for RNHCl's care, as necessary, is to maintain the continuity of ewritten election statement and or his or her legal Cs at §491.12(c):] (4) A means that on about the general atton of patients under the ermitted under 45 CFR ENT is not met as evidenced therefore and facility document remined that the facility staff complete emergency in.	E 033		Facility staff will receive ad education on the facility Er Operations Plan by the RN Development Coordinator 2018. The facility interdisciplinary team will review the updat policies for the next three rand quarterly thereafter to continued compliance. Completion date: 3-30-2018	mergency Staff by 3-30- y QA ed months ensure		
	includes a method medical documen	d for sharing information and tation for patients under the necessary, with other health						

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	The state of the s			STREET ADDRESS, CITY, STATE, ZIP COL	Æ		
FARMVILI	LE REHABILITATION & HEA	LTH CARE CENTER LLC		1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901	•		
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E 033	Continued From page 2)	E 03:	3			
	providers to maintain the reviewing the communic documentation that the	ation plan and					
	policies and procedures	that address the means ease patient information					
	patients by reviewing the						
;	The findings include:						
	and interview of the facilipreparedness plan was						
	(other staff member) #8, Review of the facility's e	director of maintenance. mergency preparedness dence of documentation					
	that the communication for sharing information a	olan includes a method nd medical					
	documentation for patier care, as necessary, with maintain the continuity of	other health providers to					
	communication plan and facility has developed pot that address the means		;				
	release patient informati	on to include the general patients by reviewing the					
	On 2/23/18 at approxima (administrative staff men administrator was made findings.	nber) # 1, the					
E 034 SS=C	No further information w Information on Occupan CFR(s): 483.73(c)(7)		E 034	•			

PRINTED: 03/09/2018 FORM APPROVED. OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER LE REHABILITATION &	HEALTH CARE CENTER LLC] 15	TREET ADDRESS, CITY, STATE, ZIP CODE 575 SCOTT DRIVE ROUTE 5 ARMVILLE, VA 23901	V 2.	20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	JX5) COMPLETION DATE	
E 034	[(c) The [facility] must emergency prepared that complies with F and must be reviewed annually.] The commall of the following: (7) [(5) or (6)] A mean about the [facility's] of ability to provide assonaving jurisdiction, the Center, or designeed. *[For ASCs at 416.5] providing information its ability to provide a having jurisdiction, the Center, or designeed. *[For Inpatient Hosping of providing information in patient occupancy, provide assistance, the inpatient occupancy, provide assistance, the includes as a means of the facility staff failed documentation that the includes a a means of the facility staff failed documentation that the includes a a means of the facility staff failed documentation that the includes a a means of the facility staff failed documentation that the includes a a means of the facility staff failed and the facility staff failed documentation that the includes a a means of the facility staff failed and the facility staff failed documentation that the includes a a means of the facility staff failed and the facility	ast develop and maintain an dness communication plan ederal, State and local laws ed and updated at least nunication plan must include ans of providing information occupancy, needs, and its sistance, to the authority ne Incident Command (c): (7) A means of a about the ASC's needs, and assistance, to the authority ne Incident Command	E 034	1. The facility Emergency Operations Plan policies and procedured updated by 3-30-2018 to that the communication proposed and procedures, in means of providing information about the facility's needs, ability to provide assistant authority having jurisdictifunction incident command center designee by reviewing the communication plan and documentation that the communication plan inclumeans of providing information plan inclumeans of providing infor	res will be ensure plan and ncludes a nation and its ce to the on, the des a nation s related viewed		
	assistance, to the au incident Command C reviewing the common	thority having jurisdiction, the center, or designee by					

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Eveni ID: 62X711

Facility ID: VA0080

If conlinuation sheet Page 22 of 185



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	l	(X2) MULTIPLE CONSTRUCTION A. BUILDING		lx	(X3) DATE SURVEY COMPLETED	
	ROVIDER OR SUPPLIER	495249			ADDRESS, CITY, STATE, ZIP CODE		C 02/23 /	201 8
FARMVILL	E REHABILITATION & I	HEALTH CARE CENTER LLC	l		ILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) OMPLETION DATE
E 034	includes a means of their occupancy. The findings include: On 2/23/18 at approxand interview of the f preparedness plan w (other staff member) maintenance. Review preparedness plan fadocumentation that the includes a means of the facility's needs, a assistance, to the aurincident Command Coreviewing the communication that the includes a means of their occupancy. OS did not have it. On 2/23/18 at approxand (administrative staff in administrative staff in administrator was material from the communication that it includes a means of their occupancy. OS did not have it. On 2/23/18 at approxand (administrative staff in administrator was material formation). No further information LTC and ICF/IID Share CFR(s): 483.73(c)(8)	cimately 11:45 a.m., a review acility's emergency as conducted with OSM # 8, director of w of the facility's emergency iled to provide evidence of the communication plan providing information about and its ability to provide ethority having jurisdiction, the enter, or designee by enication plan and the communication plan providing information about M # 8 stated that the facility imately 1 p.m., ASM the aware of the above the was provided prior to exit. Fing Plan with Patients and ICF/IID] must develop regency preparedness	E 034	 4. 5. 	Facility staff will receive education on the facility Operations Plan by the Development Coordinat 2018. The facility interdisciplinate will review the uppolicies for the next thrand quarterly thereafte continued compliance. Completion date: 3-30-	y Emerger RN Staff tor by 3-3 mary QA adated ree month	ncy 80- ns	
	State and local laws	that complies with Federal, and must be reviewed and ually.] The communication of the following:						- =

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION (X		(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILOĪNG			(X3) OATE SURVEY COMPLETEO	
		495249	B. WING			02/2040	
	SUMMARY:	HEALTH CARE CENTER LLC STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL	1 F	STREET AOORESS, CITY, STATE, ZIP COOE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901 PROVIDER'S PLAN OF CORRECTION	DN	23/201 <u>8</u>	
TAG	•	R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF OEFICIENCY)	PRIATE	COMPLETION OATE	
E 035	emergency plan, the is appropriate, with families or represent This REQUIREMENT by: Based on staff interview it was determined a complete emergency plan determined it is appulated and their families and their families and their families and their families and interview of the preparedness plan of the emergency plan determined it is appulated. The findings included On 2/23/18 at appropriate and interview of the preparedness plan of the emergency plan documentation that includes a method of the emergency plan determined it is appulated and their families and	aring information from the at the facility has determined residents [or clients] and their statives. IT is not met as evidenced review and facility document nined the facility staff failed to nergency preparedness plan. The document of the communication plan for sharing information from and that the facility has repriate with residents or nilles or representatives by The communication plan facility's emergency was conducted with OSM of the facility's emergency failed to provide evidence of the communication plan for sharing information from and that the facility has repriate with residents or sharing information from and that the facility has repriate with residents or nilles or representatives by OSM # 8 stated that the it.	E 035	 The facility Emergency Opera Plan will be reviewed by 3-30 to ensure that the communicipal includes information or method of sharing information the emergency plan, and the facility has determined it is appropriate with residents of clients and their families by reviewing the plan. All policies and procedures to the facility Emergency Operations Plan will be reviewed and updated as appropriate 30-2018. 	eation the on from t the		

STATEMENT OF OEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETEO		
		495249	B. WING		C	
NAME OF D	RÖVIDER OR SUPPLIER	400240			02/23/201 <u>8</u>	
INNINE OF F	NOVIDEN OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
FARMVILL	LE REHABILITATION & F	EALTH CARE CENTER LLC		1575 SCOTT DRIVE ROUTE 5		
				FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLET	
E 035	Continued From page	e 24	E 035			
	, -	n was provided prior to exit.			امر منظله الد	
E 039	EP Testing Requirem		E 039	3. Facility staff will receive	additional	
SS=C	l · · · · · · · · · · · · · · · · ·		2 000	education on the facility		
00 0				Operations Plan by the R	N Staff	
	(2) Testing. The [facili	ity, except for LTC facilities,		Development Coordinate	or by 3-30-	
		nust conduct exercises to		1		
		lan at least annually. The		2018.		
		IHCIs and OPOs] must do				
	all of the following:			4. The facility interdisciplin		
			-	team will review the upo	lated	
		. §483.73(d):] (2) Testing.		policies for the next three	e months	
		conduct exercises to test		and quarterly thereafter		
		it least annually, including ills using the emergency		continued compliance.		
		facility must do all of the		Continued compliance:		
	following:]	radiity made at an or the				
	,					
	(i) Participate in a full-	-scale exercise that is		5. Completion date: 3-30-2	2018	
		when a community-based		·		
	exercise is not access	sible, an individual,				
		facility] experiences an				
		-made emergency that				
		the emergency plan, the				
	[facility] is exempt from					
	•	ndividual, facility-based				
	the actual event.	1 year following the onset of				
		onal exercise that may			•	
	include, but is not limi					
	**	cale exercise that is				
		ndividual, facility-based.				
İ	•	cise that includes a group				
		cilitator, using a narrated,				
	clinically-relevant eme	ergency scenario, and a set		1		
		s, directed messages, or				
		esigned to challenge an				İ
	emergency plan.					
	(iii) Analyze the [facilit	ty's] response to and				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		STRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF P	ROVIDER OR SUPPLIER	495249	B. WING	STREET	r Address, city, state, zip code		C 23/2 01 <u>8</u>
FARMVILL	E REHABILITATION & H	EALTH CARE CENTER LLC			COTT DRIVE ROUTE 5 VILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	IX5) COMPLETION OATE
E 039	exercises, and emerge [facility's] emergency *[For RNHCIs at §403 §486.360] (d)(2) Testi must conduct exercise plan. The [RNHCI and following: (i) Conduct a paper-kleast annually. A table discussion led by a facilinically relevant emergency plan. (ii) Analyze the [RNH to and maintain documergency plan. (iii) Analyze the [RNH to and maintain documexercises, and emerge [RNHCI's and OPO's] needed. This REQUIREMENT by: Based on staff intervireview it was determinated a complete emergency program to analysis. The findings include:	ency events, and revise the plan, as needed. 3.748 and OPOs at ng. The [RNHCl and OPO] es to test the emergency d OPO] must do the passed, tabletop exercise at etop exercise is a group cilitator, using a narrated, ergency scenario, and a set is, directed messages, or esigned to challenge an CI's and OPO's] response mentation of all tabletop ency events, and revise the emergency plan, as is not met as evidenced few and facility document need the facility staff failed to rgency preparedness plan. to provide evidence of facility's exercise analysis withe facility updated its passed on the exercise	E 03	2. 3.	The facility will conduct an emergency exercise by 3-30-2 and update the facility emerg plan as indicated. The facility will conduct one to top paper based emergency exercise by 4-6-2018. The facility emergency plan will be review and updated as needed based the results of the exercise. The facility staff development will provide in-service training staff on the emergency preparedness plan by 3-30-20. The interdisciplinary quality assurance team will review the emergency prepared ness plan monthly basis for the next thromonths and quarterly thereaftensure continued compliance.	ency able lity ved upon RN to all	
	and interview of the fa	as conducted with OSM		5.	Completion date: 4-6-2018.		

	OF OEFICIENCIES F CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILOING		(X3) OATE SURVEY COMPLETEO	
A95249 NAME OF PROVIOER OR SUPPLIER FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC			I 1	STREET AOORESS, CITY, STATE, ZIP CODE 575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		C /23/201 <u>8</u>
(X4) IO PREFIX TAG	(EACH OEFICIE)	STATEMENT OF OEFICIENCIES NCY MUST BE PRECEOEO BY FULL R LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO B CROSS-REFERENCEO TO THE APPROPRIA DEFICIENCY)	E ATE	(X5) COMPLETION DATE
E 039	preparedness plan documentation of the and response and hemergency program analysis. OSM # 8 have it. On 2/23/18 at approximation (administrative staff administrator was mindings.	ew of the facility's emergency failed to provide evidence of the facility's exercise analysis how the facility updated its in based on the exercise stated that the facility did not eximately 1 p.m., ASM member) # 1, the hade aware of the above	E 039			
	conducted from 02/2 complaints were inv Corrections are required following 42 CFR Patern Care requirem survey/report will fol. The census at this 1 112 at the time of the consisted of 25 curre 64, 42, 73, 39, 271, 106, 51, 111, 104, 94 and five closed reco 119, 118 and 421).	20 certified bed facility was e survey. The survey sample ent residents Resident #s (66, 88, 56, 80, 9, 319, 49, 60, 83, 4, 25, 113, 46, 268, 50, 27) rds, Residents #s (168, 120,				
SS=D	CFR(s): 483.10(g)(1 §483.10(g)(14) Notif (i) A facility must impropriate the consult with the resident		F 580			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
	OF OEFICIENCIES F CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
		495249	B. WING		C 0 2/23/2 018
	SUMMARY	& HEALTH CARE CENTER LLC STATEMENT OF OEFICIENCIES	l 1	TREET AOORESS, CITY, STATE, ZIP COOE 575 SCOTT DRIVE ROUTE 5 ARMVILLE, VA 23901 PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG		NCY MUST BE PRECEOED BY FULL DR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS REFERENCED TO THE APPROI DEFICIENCY)	O BE COMPLETION
F 580	results in injury and physician intervent (B) A significant chemental, or psychost deterioration in heast status in either lifeclinical complicatio (C) A need to alter a need to disconting treatment due to accommence a new (D) A decision to the resident from the fast (B) A decision to the resident from the fast (B) (C) (1) (ii) (ii) (iii) (iii) (iii) (iii) (iii) (iiii) (iii) (iii) (iiii) (iiii) (iiii) (iiiii) (iiiii) (iiiiii) (iiiiii) (iiiiiii) (iiiiiiii	when there is- rolving the resident which d has the potential for requiring ion; ange in the resident's physical, ocial status (that is, a alth, mental, or psychosocial threatening conditions or ns); treatment significantly (that is, ue an existing form of dverse consequences, or to form of treatment); or ansfer or discharge the acility as specified in otification under paragraph (g) on, the facility must ensure that ation specified in §483.15(c)(2) ovided upon request to the st also promptly notify the sident representative, if any, om or roommate assignment 3.10(e)(6); or ident rights under Federal or tions as specified in paragraph on. st record and periodically is (mailing and email) and	F 580	Preparation and submission of to for correction by Farmville Rehabilitation and Health Care LLC, does not constitute an adm or agreement by the provider of truth of the facts alleged or the correctness of the conclusions son the statement of deficiencies plan of correction is prepared as submitted solely pursuant to the requirements under the state as federal laws. F580 1. Resident #66's order was up on 3/7/18 to include notifice MD for blood sugar less that greater than 350. Medical Edwas notified of elevations on 2/22/18 and no new ord were given. 2. The Director of Nursing and Assistant Director of Nursing conducted an audit on 2/23 ensure any resident with phorders related to blood sugainclude parameters for phynotification within the text order and that physician	Center, hission If the et forth s. The hid e hid odated ation to his 60 and birector ver 400 ers If the By 18 to hysician ars sician

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that is a composite distinct part (as defined in

§483.5) must disclose in its admission agreement

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Facility ID: VAuuso

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notification is documented in the

medical records as required.

'ATEMENT OF OFFICIENCIES

(X1) PROVIOER/SUPPLIER/CLIA

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(X3) OATE SURVEY

O PLAN OF	- CORRECTION IDENTIFICATION NUMBER;	A. BUILOING _		COMPLETED
			·	С
	495249	B. WING		02/23/2018
AME OF P	ROVIOER OR SUPPLIER	\$	FREET AOORESS, CITY, STATE, ZIP COOE	
ARMVILL	LE REHABILITATION & HEALTH CARE CENTER LLC	1	575 SCOTT DRIVE ROUTE 5	
		F.	ARMVILLE, VA 23901	
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDED 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 DEFICIENCY)	(X5) COMPLETION DATE
.			The licensed nurses were re-	
F 580	Continued From page 28	F 580	educated on 2/26/18 by the Staff	
	its physical configuration, including the various		Development Coordinator related	
	locations that comprise the composite distinct part, and must specify the policies that apply to		to Physician notification.	
	room changes between its different locations			1
	under §483.15(c)(9).		3. LPN's # 8 and #9 were re-educate	ea
	This REQUIREMENT is not met as evidenced		by the Staff Development	
	by:		Coordinator on 2/23/18 regarding	- 1
	Based on staff interview, facility document review and a clinical record review, it was determined	1	physician notification related to	
	the facility staff failed to notify the physician of a		change in condition and notifying	g
	change in condition for one of 30 residents in the		physician on abnormal values	
	survey sample, Resident #66.		concerning blood sugar readings	·
	The facility staff failed to notify the physician		4. The Assistant Director of Nursing	3
	when Resident #66's blood sugars were greater	ļ	and the Unit Manager will comp	lete
	than 400 on four occasions in February 2018.		an audit weekly for 4 weeks and	
			monthly for 2 months to ensure	
	The findings include:		Physician notification with chang	e
	Resident #66 was admitted to the facility on		in condition is obtained and	
	9/6/17, with a readmission on 12/30/17, with		documented as required in the	
	diagnoses that included but were not limited to		medical record. The Staff	
	diabetes, end stage kidney disease, congestive		Development Coordinator will	
	heart failure and dementia.		submit a report to the Quality	
	Resident #66's most recent MDS (minimum data	`	Assurance Committee monthly fo	ur 2
	set), a quarterly assessment with an ARD		months. The Director of Nursing V	11 5 11 5
	(assessment reference date) of 1/3/18, coded		be responsible for monitoring and	VIII
	Resident #66 as scoring a 10 out of a possible 15 on his BIMS (brief interview for mental status)		follow up.	⁷
	indicating that Resident #66 is moderately		I show up.	
	impaired with decisions of daily living.		Completion date: 3/30/18	
	A review of Resident #66's clinical record			
	revealed, in part, the following physician order;			
	"NovoLOG [1] (insulin) FlexPen (method of			ĺ
	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			1
	1 - 0 0MH3, 100 - 188 - 1 0MH, 200-248 - 2	1	Î.	1

(X2) MULTIPLE CONSTRUCTION

ATEMENT OF OEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) OATE SURVEY COMPLETEO		
		495249	8. WNG			C /23/2018
NAME OF PROVIDER OR SUPPLIER FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC			1575	EET AOORESS, CITY, STATE, ZIP COO 5 SCOTT DRIVE ROUTE 5 RMVILLE, VA 23901		
(X4) IO PREFIX TAG	(EACH OEFIC	Y STATEMENT OF OEFICIENCIES IENCY MUST BE PRECEOEO BY FULL OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCEO TO THE OEFICIENCY)	I SHOULO BE	1X5 COMPLETION OATE
F 580	UNITS; 250 - 299 UNITS; 350 - 400 (beneath the skin related to TYPE 2 DIABETIC CHRO A review of Resid (medication admin part, the following Solution Pen - Injuper sliding scale: = 1 UNIT; 200-24 UNITS; 300 = 349 UNITS, subcutant bedtime related to MELLITUS WITH DISEASE. " On the blood sugars than 400 and a documented as g - 1/8/18; 4:30 p.m insulin administer - 1/9/18; 11:30 a.r insulin administer	= 3 UNITS; 300 - 349 = 4 = 5 UNITS, subcutaneously) before meals and at bedtime c DIABETES MELLITUS WITH NIC KIDNEY DISEASE." ent #66's February MAR histration record) revealed, in entries; "NovoLOG FlexPen ector 100 UNIT / ML Inject as If 0 -149 = 0 UNITS; 150 - 199 9 = 2 UNITS; 250 - 299 = 3 9 = 4 UNITS; 350 - 400 = 5 eously before meals and at 0 TYPE 2 DIABETES DIABETIC CHRONIC KIDNEY the following dates and times, were documented as greater ose of NovoLOG was iven: blood sugar = 466 10 units of ed m. blood sugar 411 5 units of	F 580			
	insulin administer	n. blood sugar 491 5 units of ed				
	reveal any documbeen notified abour greater than 400 to treat a blood sun A review of Residulan dated 12/30/following docume	ent #66's progress notes did not pentation that the physician had but the blood sugars being per evidence of an order received agar of greater than 400. ent #66's comprehensive care 17 revealed, in part, the ntation; "Focus: HX (history) of litus) with refusal of care at				

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SCIALCIA	O I ON MEDICARE O	X MEDICAID SERVICES	,		UNID IV	<u>U. 0930-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING			E SURVEY MPLETED
		495249	8. WING		0:	C 2/23/2018
NAME OF PI	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		-
			. 1575	SCOTT DRIVE ROUTE 5		
*ARMVILL	.e rehab(Litation &	HEALTH CARE CENTER LLC		MVILLE, VA 23901		·
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IOENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION OATE
F 580	Date Initiated: 10/17 2/21/2018. Interver ORDERED, ACCU NOTIFY MD (medic FINDINGS. MONIT HYPO/HYPERGLYC INDICATED Date In 10/17/17." On 2/23/18 at 7:59 a conducted with LPN LPN #9 was asked a if a resident's blood sliding scale parame blood sugar is within the doctor then I wo outside of the param there was no ordere blood sugar and not be aware and could orders for the insulin sugar 30 minutes fo make sure that the effective." LPN #9 document this inform progress notes." On 2/23/18 at 8:52 a was conducted with documented Reside insulin treatment on LPN #8 was asked	ave blood sugar checked) 7/2017 Revision on: ritions: INSULIN AS CHECKS AS ORDERED, ral doctor) FOR ABNORMAL TOR FOR SX (symptoms) of CEMIA, NOTIFY MD AS ritiated 10/17/17. Revision on: a.m., an interview was I (licensed practical nurse) #9, to describe what she would do sugar was outside of the eter. LPN #9 stated, "If the in the parameters provided by huld give the ordered insulin. If meters, I would document that ed coverage for the recorded tify the doctor so that he would I give orders. If he gives in I would recheck the blood following administration to treatment provided was was asked where she would mation, LPN #9 stated, "In the a.m., a telephone interview	F 580			
		ed that she would administer ed 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

ATEMENT OF OEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA ID PLAN OF CORRECTION IOENTIFICATION NUMBER:		1	IPLE CONSTRUCTION	1, ,	(X3) OATE SURVEY COMPLETEO	
		495249	B, WING_			С
JAME OF PROVIOER OR SUPPLIER FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC			STREET AOORESS, CITY, STATE, ZIP COOE 1575 SCOTT ORIVE ROUTE 5 FARMVILLE, VA 23901	02	/23/201 <u>8</u>	
(X4) IO PREFIX TAG	(EACH OEFICIENC	TATEMENT OF OEFICIENCIES BY MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCEO TO THE AF OEFICIENCY)	HOULO BE	(X5) COMPLETION DATE
F 580	she would call the do her to do. When ask additional order, LPN write the order and in talked with the docto was." LPN #8 was a Resident #66, LPN # #8 was provided the results in February thand asked if she rem doctor about the rest talked to the doctor I do not remember that whether or not I called she would have doct with the doctor, LPN notes." On 2/23/18 at 9:05 a conducted with ASM member) #4, the memasked if a resident is addresses blood sugthen urses do if the the 400. ASM #4 stated of the parameters that to contact me and I was treat that incident." In that Resident #66 has his MAR on five occasional get called by address appropriated. On 2/23/18 at approximate of the 2/23/18 a	nt to 400. LPN #8 stated that octor and ask what he wanted and if she would get an if #8 stated, "Yes, I would include in my notes that I had read what the new order sked if she took care of if 8 stated that she did. LPN dates and the accu check nat were greater than 400 hembered contacting the fulls. LPN #8 stated, "If I would have documented it. I would have documented it. I would have documented it. I would have documented it. I would have documented it. I would have documented it. I would have documented where the stated, "In the progress in the pr	F5	580		
;		ted with ASM #1, the #2, the director of nursing,				

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ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
			С
	495249	B. WING	0 2/23/20 1 <u>8</u>
IAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	

'ARMVILLE REHABILITATION & HEALTH CARE CENTER LLC

1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901

		ARMVILLE, 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 CATE
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.	F 580		
F 583 SS=D	[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.cf m?setid=3a1e73a2-3009-40d0-876c-b4cb2be56f c5 Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii)	F 583		
	§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			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
		495249	B. WING	·	C 02 /23 /2 01 8
NAME OF PROVIDER OR SUPPLIER FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC		157	REET ADDRESS, CITY, STATE, ZIP CODE 75 SCOTT DRIVE ROUTE 5 RMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL ' OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SECROSS-REFERENCED TO THE APDEFICIENCY)	HOULD BE COMPLETION
F 583	including those d than a postal sen §483.10(h)(3) Th and confidential p (i) The resident h of personal and r provided at §483 federal or state la (ii) The facility monotonic of the State to examine a result administrative relaw. This REQUIREM by: Based on observing document review was determined provide full visual confidentiality of residents in a sure a. The facility staprivacy to Residents	ed to the facility for the resident, elivered through a means other vice. e resident has a right to secure personal and medical records. as the right to refuse the release medical records except as (70(i)(2) or other applicable	F 583	1. Resident #25's open as unattended eMAR was the medication cart by 2/21/18. Resident #25 on 2/22/18 by the Unit ensure there were no privacy issues. LPN# 2 was re-educate Staffing Coordinator or related to ensuring the locked when left unatt maintain confidentialit information. LPN# 2 we educated by the 5taffing Coordinator on 2/22/1 providing privacy and delivering care/medicaresident.	s locked on 2/LPN# 2 on was assessed to Manager to dignity or ed by the n 2/22/18 at eMARs are sended to ty of resident as also rengers. 8 related to dignity while
	of Resident #25' administration re on top of the me (licensed practic medications to the findings inclined to the finding			 The Assistant Director and the Unit Manager an audit on 2/26/18 to confidentiality of the e required and visual ins residents to ensure the privacy or dignity issue provided care. 	completed ensure MARs as spection of ere were no
	La Resident #25	was admitted to the facility on	1		

STATEMENT OF OFFICIENCIES

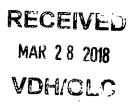
(X1) PROVIOER/SUPPLIER/CLIA

PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

(X3) OATE SURVEY

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	ROVIOER OR SUPPLIER LE REHABIL)TAT)ON & HEALTH CARE CENTER LLC	s I	TREET AOORESS, CITY, STATE, ZIP COOE 575 SCOTT DRIVE ROUTE 5 ARMV)LLE, VA 23901	02/23/201 <u>8</u>
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOEO BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP OEFICIENCY)	DULO BE COMPLETION
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 (minmum 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 Staffing Coordinator on 2/related to ensuring that ell locked when left unattend maintain confidentiality of information. LPN# 2 was a educated by the Staffing Coordinator on 2/22/18 reproviding privacy and dignical delivering care/medication resident. The licensed nursing staff we educated on 2/26/18 by the Development Coordinator in to ensuring eMARs are lock unattended as well as ensuring ensuring care to resident.	MARs are led to f resident lso re- lated to itv while to a vere re- e Staff related ed when ring ntained
ORM CMS-256	67(02-99) Previous Versions Obsolete Event IO:	:62X711 Fa	acilily IO: VA0080 If	continuation sheet Page 35 of 18

(X2) MULTIPLE CONSTRUCTION



PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
495249			B. WING		C - 02/23/2018	
NAME OF PROVIDER OR SUPPLIER FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 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/0 00900.htm		F 583	F 583 4. The Assistant Director of and the Unit Manager was an audit weekly for 4 weekly for 4 weekly for 2 months to confidentiality of eMARS privacy and dignity are presidents while staff are care as required. The Standard Submit a report to the CASSURANCE Committee manner of the responsible for monifollow up. Completion date: 3/30/18		
	preparing and admin Resident #25 was co the medications at th across from the resident was confident administering the medication. Two swere observed in the from the medication. On 2/21/18 at 4:52 p conducted with LPN should be done with administration record medication cart. LPI	dications to the resident in taff members and a resident hall approximately three feet cart. .m., an interview was #2. LPN #2 was asked what the resident's medication				

	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495249	B. WING		C	
_	ROVIDER OR SUPPLIER LE REHABILITATION &	HEALTH CARE CENTER LLC	s 1	TREET ADDRESS, CITY, STATE, ZIP CODE 575 SCOTT DRIVE ROUTE 5 ARMVILLE, VA 23901	0 2/23/20 1 <u>8</u> DDE	
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F 583	stated, "Yes." On 2/22/18 at approximaterview was conditive was asked what she leaves a medication should lock the common information is visible. On 2/22/18 at 10:55 staff member) #1 (till (the director of nursiabove findings. The facility policy till Portability and According and Proceduration a	eximately 8:00 a.m., an acted with LPN #1. LPN #1 build be done when a nurse a cart. LPN #1 stated nurses aputer screen so no e. is a.m., ASM (administrative and administrator) and ASM #2 ing) were made aware of the suntability Act) Security Rules are Summary" documented, company is committed to cy to protect the grity and availability of ormation (PHI) that the overed affiliates create,	F 583			
F 584 SS=E	Safe/Clean/Comfor CFR(s): 483.10(i) (1 §483.10(i) Safe En The resident has a comfortable and he but not limited to resupports for daily li The facility must pr §483.10(i)(1) A saf	vironment. right to a safe, clean, melike environment, including ceiving treatment and ving safely.	F 584	 Resident #64's room repaired and cables repaired and cables repaired and cables repaired and cables removed and cables removed and cables removed and cables. 	removed by 3- rill be repaired, medicine	

(X1) PROVIDER/SUPPLIER/CLIA

IOENTIFICATION NUMBER:

STATEMENT OF OFFICIENCIES

ANO PLAN OF CORRECTION

PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

(X3) OATE SURVEY

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		495249	B. WNG _			02/2	2 3/2 018
	ROVIOER OR SUPPLIER	HEALTH CARE CENTER LLC		1575	EET AOORESS, CITY, STATE, ZIP COOE 5 SCOTT DRIVE ROUTE 5 RMVILLE, VA 23901		•
(X4) ID PREFIX TAG	(EACH OEFICIENC	TATEMENT OF OEFICIENCIES BY MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	t	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCEO TO THE APPR DEFICIENCY)	JLO BE	(X5) COMPLETION DATE
F 584	possible. (i) This includes ensureceive care and semphysical layout of the independence and di) The facility shall extra protection of the or theft. §483.10(i)(2) Housels services necessary trand comfortable interested in good condition; §483.10(i)(3) Clean bing good condition; §483.10(i)(4) Private resident room, as spreading the services in all areas; §483.10(i)(6) Comform levels. Facilities initial	aring that the resident can vices safely and that the extent exception of the control of the con	F 5		 Resident #104's room will repaired, cables removed medicine cabinet will be reby 3-30-2018. Resident #113's wheelcha replaced on 2-23-2018. The Administrator and Maintenance director will an audit of all resident room 30-2018 to identify addition rooms and wheelchairs ne repairs and maintenance. During the daily VIP round will identify new maintenaissues. A maintenance reparequest will be logged into electronic work order systefurther follow-up. 	and eplaced ir was complete oms by 3- onal eding s auditors ince air the	
	§483.10(i)(7) For the sound levels. This REQUIREMEN by: Based on observation interview, and clinical determined the facilic clean and comfortable four of 30 residents.	e maintenance of comfortable T is not met as evidenced on, resident interview, staff al record review, it was ty staff failed to maintain a the homelike environment for in the survey sample;			 The interdisciplinary qualit assurance team will review work order log monthly for three months and quarterl thereafter to ensure contincompliance. Completion date: 3-30-201 	y the r the next y nued	
	Residents #64, #42,	#104 and #113.	1	,	,		

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	OF OEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	rovider or supplier Le rehabilitation & F	HEALTH CARE CENTER LLC	l 18	TREET ADDRESS, CITY, STATE, ZIP CODE 575 SCOTT DRIVE ROUTE 5 ARMV LLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROPR DEFICIENCY)	BE .	tX5) COMPLETION OATE
F 584	#64's room in a clean manner. Approximate cable was observed in multiple items in need 2. The facility staff fa #42's room in a clean manner. Long cables from the ceiling, down medication cabinet (urusty. 3. The facility staff fa #104's room in a clean manner. A hole in the door, long cables har medication cabinet (urusty, broken co-base were observed. 4. The facility staff fa 113's wheelchair arm exposing foam that where the findings include: 1. For Resident #64, maintain the resident comfortable, homelik Resident #64 was ad 3/22/16 with the diag high blood pressure, diabetes, and psychological points with the diag high blood pressure, diabetes, and psychological points with the diag high blood pressure, diabetes, and psychological processure, diabetes, and psychological processure.	ailed to maintain Resident a, comfortable, homelike ely 6 to 8 feet of television manging from the ceiling and d of repair. ailed to maintain Resident a, comfortable, homelike were observed hanging an the wall, and the used to store toiletries) was ailed to maintain Resident an, comfortable, homelike wall next to the bathroom aging down from the ceiling, used to store toiletries) was a modeling and chair rail ailed to maintain Resident # arests free from torn areas, aras unable to be sanitized. A the facility staff failed to a room in a clean, a manner. Imitted to the facility on moses of but not limited to end stage renal disease, asis. The most recent MDS was a quarterly assessment	F 584			
		ment Reference Date) of ent was coded as being				

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF OFFICIENCIES

FORM CMS-2567(02-99) Previous Versions Obsolete

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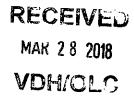
(X3) DATE SURVEY

NO PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILOING _		COMPLETED
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	ROVIDER OR SUPPLIER LE REHABILITATION & H	495249 EALTH CARE CENTER LLC	1	TREET AODRESS, CITY, STATE, ZIP CODE 575 SCOTT DRIVE ROUTE 5 ARMVILLE, VA 23901	0 2/2 3/ 2 01 <u>8</u>
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F 584	decisions. Resident # limited to extensive as daily living and was in Observations made or revealed the following approximately 6 to 8 from the ceiling, and to her bed. She did not connected. An area or painted area, where saffixed to the wall and repainted to match the discolored area was a piece of co-base mole inches square was manaper towel dispense. On 2/22/18 at 1:00 p. Resident #64, she state bothers her. On 2/22/18 at 1:37 p. #4 (Certified Nursing a room has maintenathe charge nurse who on 2/22/18 at 1:39 p. #6 (Licensed Practices she fills out a mainter it to maintenance. Lestill present a few day with maintenance to I slip.	polity to make daily life #64 was coded as requiring resistance for activities of redependent for eating. If Resident #64's room resistance to realing reet was observed hanging reading down the wall, next resident wall had a discolored remething had once been rest of the room. The realiso noted to be dirty. A reading approximately 4x4 reading approximately 4x4 reading approximately 4x4 reading approximately approximated the dangling cables m., in an interview with read the dangling cables m., in an interview with CNA reading approximately approximately reading ap	F 584		
	with OSM #8 (Other	m., a tour was conducted Staff Member, the r). He was shown the			

Event ID: 62X711

Facility IO: VA0080

(X2) MULTIPLE CONSTRUCTION



If continuation sheet Page 40 of 185

(X1) PROVIDER/SUPPLIER/CLIA

TATEMENT OF DEFICIENCIES

PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

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		495249	B. WING _			02/	23/2018
IAME OF PI	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
ARMVILL	E REHABILITATION & HE	ALTH CARE CENTER LLC	ļ		SCOTT DRIVE ROUTE 5		
_ 				FARN	MVILLE, VA 23901		
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F 584	Continued From page		F	584			
	resident's room and th above.	e concerns documented					
	of items that facility ha work on. Resident #64 as having had "refresh identified the "refresh" for all rooms, but a var to the need of the room identified items were n	n., OSM #8 provided a list didentified as concerns to the room was checked off work completed. He work as not specific tasks liety of tasks individualized here. However, some of the pot recently developed repaired during a room					
	Nursing (ASM #2) wer findings. A facility poli maintenance needs / r comfortable homelike requested via a writter. This list was provided the end of day meeting 08:00 a.m., the written was returned by the face.	ator (ASM #1 - ember) and Director of e made aware of the cy on the provision of naintaining a clean environment was a list of needed documents, to the facility at the end of g on 2/22/18. On 2/23/18 at list of needed documents					
		was provided by the end of					
		led to maintain Resident comfortable, homelike					
	Resident #42 was adr 9/9/10 and readmitted	nitted to the facility on on 12/7/17 with the					

TATEMENT OF OFFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

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(X3) OATE SURVEY

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	495249	B. WING		02/23/20 18
NAME OF P	ROVIOER OR SUPPLIER	STRE	ET AOORESS, CITY, STATE, ZIP COOE	
FARMVILL	LE REHABILITATION & HEALTH CARE CENTER LLC	1575	SCOTT ORIVE ROUTE 5	
		FARI	MVILLE, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULO CROSS-REFERENCEO TO THE APPROPI OEFICIENCY)	BE COMPLETION
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 12/114/17. 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	F 584		
	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			

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

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(X3) DATE SURVEY

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			ı	1575	SCOTT DRIVE ROUTE 5		
FARMVILI	LE REHABILITATION & H	EALTH CARE CENTER LLC		FAR	MVILLE, VA 23901		
361:15	OUMMADY OT	ATEMENT OF DEFICIENCIES	ir.		PROVIDER'S PLAN OF CORRECTION		(VE)
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F 584	Continued From page	÷ 42	F	584			
		re made aware of the					
,	No further information the survey.	n was provided by the end of					
	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 diagnoses of but not encephalopathy, chropressure ulcer, high bladder, dysphagia, hheart disease, and ar recent MDS (Minimus resident as being cogmake daily life decision	d on 1/24/18 with the limited to metabolic pric kidney disease, plood pressure, neurogenic hypothyroidism, diabetes, exiety disorder. The most im Data Set) coded the gritively intact in ability to ons. Resident #104 was ktensive assistance for all					
	revealed the following the bathroom door. To size, shape, and local door to the room, being pushed into the wall. It is from the ceiling, drap shelf that contained to the medication cabing was rusty. A buildup substance around the dispenser. A piece of approximately 4x4 in wall near the corner of the state of the proximately and the state of the proximately and the state of the proximately and the state of the proximately and the state of the proximately and the state of the proximately and the state of the proximately and the state of the proximately and the state of the proximately and the proxima	of Resident #104's room g: A hole in the wall next to the hole was the appropriate ation, of the doorknob of the ng opened all the way and Long cables hanging down led on the support of a wall he resident's personal items. The term of the hand soap of dark green-black led pump of the hand soap of co-base molding ches was peeled from the of the closet and sink area. The chair rail that runs behind					

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		E SURVEY PLETED
	ROVIDER OR SUPPLIER LE REHABILITATION 8	495249 HEALTH CARE CENTER LLC	B. WING _	157	REET ADDRESS, CITY, STATE, ZIP CODE 75 SCOTT DRIVE ROUTE 5 RMVILLE, VA 23901	02	C 2/23/201 <u>8</u>
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IOENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	tX5) COMPLETION DATE
F 584	attached to the wal On 2/22/18 at 1:37 #4 (Certified Nursin a room has mainten the charge nurse worder of the charge nurse worder of the charge nurse worder of the charge nurse worder of the charge nurse worder of the charge nurse worder of the charge nurse worder of the charge nurse worder of the charge nurse worder of the charge of th	p.m., in an interview with CNA ag Assistant) she stated that if nance care issues, she notifies ho then notifies maintenance. p.m., in an interview with LPN ical Nurse), she stated that tenance repair form and gives LPN #6 stated if the issue is lays later, she would follow up to be sure they got the repair p.m., a tour was conducted or Staff Member, the tor). He was shown the disconcerns. p.m., at the end of day histrator (ASM #1 - if Member) and Director of were made aware of the ion was provided by the end of a failed to maintain Resident #1 rmrests free from torn areas, it was unable to be sanitized. Is admitted to the facility on admission of 10/30/17 with uded but were not limited to orrhage (1), hypertension (2), sphagia (4), and type II	F	584			

PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

	OF OEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) OATE COMF	SURVEY PLETEO
	ROVIOER OR SUPPLIER LE REHABILITATION 8	495249 3 HEALTH CARE CENTER LLC	I 157	REET AOORESS, CITY, STATE, ZIP COO S SCOTT DRIVE ROUTE 5 RMVILLE, VA 23901	02	C / 23/2 01 <u>8</u>
(X4) 10 PREFIX TAG	(EACH OEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEOEO BY FULL OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCEO TO THI OEFICIENCY)	N SHOULO BE E APPROPRIATE	(X5) COMPLETION DATE
F 584	data set), a significan ARD (assessme coded Resident # impaired of cognitive Resident # 113 was extensive assistant activities of daily like. On 02/21/18 at appropriate of the right at the compact of the responsible for this checks are done by reported to mainter asked to accompant 13's room. Upon wheelchair, LPN # left armrests were foam. LPN #4 sta	nost recent MDS (minimum ant change assessment with ent reference date) of 01/31/18 113 as being moderately on for making daily decisions is coded as requiring limited to ce of one staff member for ving. Droximately 10:17 a.m., ident # 113's wheelchair and left armrests were cracked, exposed foam. Resident # uld like to have them replaced able able to press down on cracks pinch her arms. Droximately 5:00 p.m., on cimately 8:30 a.m., and on timately 2:15 p.m., esident #113's wheelchair and left armrests were cracked,	F 584			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event IO: 62X711

Facility IO: VA0080

If continuation sheet Page 45 of 185



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	OF OEFICIENCIES F CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION		E SURVEY IPLETEO
		495249	B. WING		O.	C 2/23/2018
	PROVIOER OR SUPPLIER	HEALTH CARE CENTER LLC	157	EET AOORESS, CITY, STATE, ZIP C 5 SCOTT DRIVE ROUTE 5 RMVILLE, VA 23901		3237231 <u>0</u>
(X4) IO PREFIX TAG	(EACH OEFICIE	STATEMENT OF OEFICIENCIES NCY MUST BE PRECEOEO BY FULL R LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCEO TO T DEFICIENC	TON SHOULO BE THE APPROPRIATE	IX5) COMPLETION DATE
F 584	properly cleaned Lidebris could be in the properly cleaned On 02/22/18 at 5:0 staff member) # 1, the director of nurs administrator in tra above concerns. No further informat References: 1. Bleeding in the athin tissues that concalled the subaract was obtained from https://medlineplus. 2. High blood presobtained from the whitps://www.nlm.nilessure.html. 3. A condition in whit to pump oxygen-rice efficiently. This cast throughout the boot obtained from the whitps://medlineplus. 4. A swallowing disobtained from the whitps://www.nlm.nilesorders.html. 5. A chronic disease	PN # stated, "No because the he open areas and could not d." O p.m. ASM (administrative the administrator, ASM # 2, ing, and ASM # 5, ining, were made aware of the ion was provided prior to exit. Area between the brain and the ver the brain. This area is moid space. This information the website: agov/ency/article/000701.htm. Assure. This information was website: agov/medlineplus/highbloodpr Thich the heart is no longer able ch blood to the rest of the body uses symptoms to occur by. This information was website: agov/ency/article/000158.htm. Border. This information was	F 584			

	OF DEFICIENCIES			(X2) MULTIPLE CONSTRUCTION		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILOING	 	COMPLETED	
					С	
		495249	B. WNG		02/23/2018	
NAME OF P	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
FARM\/III	E REHABILITATION	& HEALTH CARE CENTER LLC	l ¹⁵⁷⁵	SCOTT DRIVE ROUTE 5		
CARMINIC	LE RENABILITATION	& REALTH CARE CENTER LLC	FARI	MVILLE, VA 23901		
(X4) IO		Y STATEMENT OF DEFICIENCIES	10	PROVIDER'S PLAN OF COR		
PREFIX TAG		ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		
F 584	Continued From page 46		F 584			
,	https://www.nlm.r	nih.gov/medlineplus/ency/article/				
F 622	Transfer and Disc	charge Requirements	F 622			
SS=E	CFR(s): 483.15(c					
	§483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to					
				•		
		lity, and not transfer or				
		ident from the facility unless-				
		or discharge is necessary for the				
		and the resident's needs				
'	cannot be met in	- ·				
		or discharge is appropriate				
		lent's health has improved				
		resident no longer needs the				
	services provided	•				
		individuals in the facility is				
		to the clinical or behavioral				
	status of the resid					
	1	individuals in the facility would				
	otherwise be end	•				
	1 ' '	has failed, after reasonable and e, to pay for (or to have paid				
		e, to pay lot (of to have paid or Medicaid) a stay at the facility.				
		lies if the resident does not				
	, , ,	sary paperwork for third party				
		the third party, including				
		icaid, denies the claim and the				
		to pay for his or her stay. For a	1			
		omes eligible for Medicaid after				
		cility, the facility may charge a				
		wable charges under Medicaid;				
	or					
	(F) The facility ce	eases to operate.				
		ay not transfer or discharge the				
		e appeal is pending, pursuant to				
	•	chapter, when a resident				

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495249	B. WING _				23/2018
	ROVIDER OR SUPPLIER	HEALTH CARE CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901				23/23 10
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION OATE
F 622	discharge notice fro 431.220(a)(3) of thi discharge or transfe or safety of the resi facility. The facility that failure to transf §483.15(c)(2) Docu When the facility tra resident under any in paragraphs (c)(1 section, the facility or discharge is doc medical record and communicated to tr institution or provid (i) Documentation i must include: (A) The basis for th (i) of this section. (B) In the case of p section, the specific be met, facility atte needs, and the ser facility to meet the (ii) The documenta (2)(i) of this section (A) The resident's p discharge is neces (A) or (B) of this se (B) A physician wh necessary under p this section. (iii) Information pro must include a min (A) Contact informa	right to appeal a transfer or on the facility pursuant to § schapter, unless the failure to be would endanger the health dent or other individuals in the must document the danger er or discharge would pose. mentation. Insfers or discharges a softhe circumstances specified of the circumstance information is the receiving health care er. In the resident's medical record of the resident need(s) that cannot mpts to meet the resident vice available at the receiving need(s). It is to meet the resident of the receiving need(s). It is to meet the resident of the receiving need(s). It is to meet the receiving need(s). It is to meet the resident of the receiving need(s). It is to meet the receiving need(s). It is to meet the receiving need(s).	F	522	 Residents # 25, #49, #66 #111, # 113 and # 319 w transferred to the emer by order of the physicial emergency treatment at to the facility. All residents transferred hospital prior to 2/23/18 ability to be affected by practice. Audit shows the transfers were affected. initiated. Medical Director, License and Administrative Nurse re-educated by 3/14/18 to be ensuring written physidocumentation of necess emergency transfer is prothe medical record as required. 	to the 3 have the deficient ese Education ed Nurses es will be the Staff or related ician sity of ovided in	

PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''		CONSTRUCTION		(X3) DATE COMP	SURVEY
		40.57.40		-			. (c
		495249	B, WING _				02/	2 3/ 2 01 <u>8</u>
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
FARMVILL	E REHABILITATION &	HEALTH CARE CENTER LLC	1		75 SCOTT DRIVE ROUTE 5			
				FA	RMVILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF COR (EACH CDRRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD B		JX5) COMPLETION DATE
	necessary. On 2/22/18 at 10:45 conducted with ASM member) #4 (Reside was asked to descritransferred to the honursing staff calls hitransferred to the hone documents a not is necessary. ASM and he expects the talked to him about On 2/22/18 at 10:55 administrator) and Anursing) were made On 2/22/18 at 1:58 facility did not have physician's responsi	why the transfers were is a.m., an interview was if (administrative staff ent #25's physician). ASM #4 ibe his role when a resident is respital. ASM #4 stated the im before a resident is respital. ASM #4 was asked if the explaining why the transfer if explaining why the transfer if a stated he usually does not nurses to document they patient going to the hospital. is a.m., ASM #1 (the a.SM #2 (the director of a ware of the above findings. i.p.m., ASM #2 stated the a current policy regarding the a current policy regarding the ibilities for transfers. on was presented prior to exit. ts Before Transfer/Discharge is a.M. (6)(8)	F6		4. The Assistant Director and the Unit Manager emergency transfers weeks and monthly for ensure written physicia of emergency transfer at The Staff Development will submit a report to the Assurance Committee of months. The Director of the responsible for monit follow up. Completion dis 3/30/18	will aud eekly for 2 month necessity coordinate the Quality Nursing toring a	it or 4 chs to esity red. eator ity for 3	
	resident, the facility (i) Notify the resider representative(s) of the reasons for the language and manr facility must send a	nsfers or discharges a						

Long-Term Care Ombudsman.

(ii) Record the reasons for the transfer or

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

PRINTED: 03/09/2018

				FORM APPROVED
CENTER	S FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	405040	D MAINO		С
	495249	B. WING		02/23/2018
NAME OF PI	ROVIDER OR SUPPLIER		FREET ADDRESS, CITY, STATE, ZIP CODE	
FARMVILL	LE REHABILITATION & HEALTH CARE CENTER LLC	l 15	75 SCOTT DRIVE ROUTE 5	
		F#	ARMVILLE, 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 APPROPRIA OEFICIENCY)	
F 623	Continued From page 64	F 623	F623	
. 020		. F.023	· 525	
į	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.		1. Da 11	
			1. Residents #113, #10 6 , #319,	#49,
	§483.15(c)(4) Timing of the notice.		#80, #60, #111 and #125 we	re
	(i) Except as specified in paragraphs (c)(4)(ii) and		transferred to the emergenc	y room
	(c)(8) of this section, the notice of transfer or		by order of the physician for	y 100Ht
	discharge required under this section must be		emergency treatment	
	made by the facility at least 30 days before the		emergency treatment and re	turned
	resident is transferred or discharged.		to the facility.	
	(ii) Notice must be made as soon as practicable			
	before transfer or discharge when- (A) The safety of individuals in the facility would		All residents transferred to the	ne .
	be endangered under paragraph (c)(1)(i)(C) of		hospital prior to 2/23/18 have	
	this section;	•	ability to be account of 100 have	e the
	(B) The health of individuals in the facility would		ability to be affected by defic	ient
	be endangered, under paragraph (c)(1)(i)(D) of		practice. Audit shows these	÷
	this section;		transfers were affected. Educ	cation
	(C) The resident's health improves sufficiently to		initiated.	1
	allow a more immediate transfer or discharge,			1
l	under paragraph (c)(1)(i)(B) of this section;		3. Licensed Nurses and Administra	
	(D) An immediate transfer or discharge is			rative
	required by the resident's urgent medical needs,		Nurses will be educated by the	e Staff
	under paragraph (c)(1)(i)(A) of this section; or		Development Coordinator rela	ated
	(E) A resident has not resided in the facility for 30		to ensuring written notificatio	n to
	days.		resident's representative of	" (0
			transfers.	
	§483.15(c)(5) Contents of the notice. The written		uansiers.	
	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),

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF OFFICIENCIES

PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

(X3) OATE SURVEY

AND PLAN O	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
					C
		495249	B. WING		0 2/2 3/ 2 01 <u>8</u>
	ROVIDER OR SUPPLIER LE REHABILITATION & H	EALTH CARE CENTER LLC	Ι,	STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901	
(X4) ID PREFIX TAG	(EACH OEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
· F 623	to obtain an appeal for completing the form a hearing request; (v) The name, address telephone number of Long-Term Care Ombour (vi) For nursing facility and developmental didisabilities, the mailing telephone number of the protection and addevelopmental disabilities of the Developmental disability of the Developmental disability of the Developmental disability of the Developmental disability of the Developmental disability of the Developmental disability of the Developmental disability of the Developmental disability of the Developmental disability of the Developmental disability of the Information in the for Mentally III Individual established under the for Mentally III Individual \$483.15(c)(6) Change of the information in the effecting the transfer must update the recipal as practicable once the becomes available. §483.15(c)(8) Notice of the Information of the Case of facility the administrator of the Written notification prito the State Survey A	er of the entity which tis; and information on how arm and assistance in and submitting the appeal s (mailing and email) and the Office of the State audsman; a residents with intellectual sabilities or related g and email address and the agency responsible for avocacy of individuals with lities established under Part tal Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and by residents with a mental sabilities, the mailing and the protection and als with a mental disorder are Protection and Advocacy usuals Act.	F 623	4. The Assistant Director and the Unit Manager emergency transfers w weeks and monthly for ensure written notifica transfer to residents re are completed as requi The Staff Development will submit a report to the Assurance Committee in months. The Director of the responsible for monifollow up. Completion date: 3/3	will audit reekly for 4 2 months to tion of presentative red. Coordinator the Quality nonthly for 3 F Nursing will toring and

(X1) PROVIOER/SUPPLIER/CLIA

STATEMENT OF OFFICIENCIES

	OF OEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	7 7	E CONSTRUCTION		E SURVEY PLETEO
		495249	B. WING			C 2/23/2018
	ROVIOER OR SUPPLIER LE REHABILITATION	& HEALTH CARE CENTER LLC	1.	STREET AOORESS, CITY, STATE, ZIP CO 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		123120 10
(X4) ID PREFIX TAG	(EACH OEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDEO BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIOER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCEO TO THE DEFICIENCY	ON SHOULO BE HE APPROPRIATE	(X5) COMPLETION DATE
F 623	well as the plan for relocation of the relocation of the relocation of the relocation of the relocation of the relocation of the relocation of the relocation of the relocation of the relocation and facility documents transfer for survey sample, Research of the relocation of the survey sample, Research of the relocation of the survey sample, Research of the relocation of the survey sample, Research of the relocation of the survey sample, Research of the relocation of the survey sample, Research of the relocation of the survey of the relocation of	e resident representatives, as or the transfer and adequate esidents, as required at § ENT is not met as evidenced terview, clinical record review, nent review, it was determined fled to provide the required as at the time of a facility or eight of 30 residents in the esidents # 49, 80, 60, 111, 113, ff failed to provide the required as to the responsible party (RP) man when Resident #49 was hospital on 12/14/17. Iff failed to provide a written sident #80's RP (responsible as transferred to the hospital on	F 623			

STATEMENT OF OFFICIENCIES

PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

	OF OEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CO		1, ,	SURVEY PLETED	
		495249	B. WING			С	
	ROVIOER OR SUPPLIER	& HEALTH CARE CENTER LLC	STREET ADORESS, CITY, STATE, ZIP COOE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901			02/23/201 <u>8</u>	
(X4) IO PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULO BE IE APPROPRIATE	(X5) COMPLETION OATE	
F 623	on 12/12/17. The written notification to the ombudsman 6b. Resident #25 on 1/22/18. The fawritten notification to the resident rep. 7. Resident #106 on 1/30/18 and 2/8 provide written not transfer to the resident repident repident with the resident repident repid	was transferred to the hospital facility staff failed to provide of the facility initiated transfer and resident representative. was transferred to the hospital acility staff failed to provide of the facility initiated transfer resentative. was transferred to the hospital /18. The facility staff failed to ification of the facility initiated dent or resident representative. was transferred to the hospital /18. The facility staff failed to ification of the facility initiated dent or resident representative. was transferred to the hospital /18. The facility staff failed to ification of the facility initiated dent or resident representative. e: as admitted to the facility on oses that included but were not (passing out) and collapse, hizophrenia, dementia with copp (chronic obstructive e). Resident #49's most recent ta set) assessment was a ent with an ARD (assessment 12/19/17. Resident #49 was oderately impaired in cognitive of out of 15 on the BIMS (Brief	F 623				

FORM CMS-2567(02-99) Previous Versions Obsolele

EvenI ID: 62X711

Facility IO: VA0060

If continuation sheet Page 68 of 185



	OF OEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1''	IPLE CONSTRUCTION	_	(X3) OATE S COMPL C	ETEO
		495249	B. WING _			02/2	3/2018
	ROVIOER OR SUPPLIER LE REHABİLİTATİON (HEALTH CARE CENTER LLC		STREET AOORESS, CITY, S 1575 SCOTT DRIVE ROU' FARMVILLE, VA 23901	TE 5		
(X4) IO PREFIX TAG	(EACH OEFICIE	STATEMENT OF OEFICIENCIES NCY MUST BE PRECEOEO BY FULL PR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULO BE ENCEO TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION OATE
F 623	12/14/17 at 11:12 a documented. "At a a.m.), resident was wall in the hallway, cyanotic [1] oral mubegan to give out a floor by two nurses lasting approximate unable to follow ve incontinence noted bed, 02 (oxygen) a called and MD (me registered (oxygen respirations 20/min pressure) 72/50 min left arm, pulse 6 weak. Accucheck device) obtained - RP (responsible pacondition. Report of [emergency room] Further review of the Resident #49 return at 5:50 p.m. with a episode. Further review of Refailed to evidence the was notified in writi #49's transfer to the ombudsman receivence in the first social worker, regains transferred to the social worker, regains transferred to the social worker, regains transferred to the social worker, regains transferred to the social worker, regains transferred to the social worker, regains transferred to the social worker, regains transferred to the social worker, regains transferred to the social worker, regains transferred to the social worker, regains transferred to the social worker, regains transferred to the social worker, regains transferred to the social worker, regains transferred to the social worker, regains transferred to the social worker, regains transferred to the social worker, regains transferred to the social worker, regains transferred to the social worker, regains transferred to the social worker.	a.m. The following note was opproximately 1035 (10:35 observed leaning against the pallor noted to skin tone with uscosa (sic). Resident's legs and she was lowered to the . Jerking motions noted ely 10 seconds and resident robal commands. Bowel as well. Resident assisted to as well. Resident assisted to as well. Resident assisted to pplied via nasal cannula. 911 dical doctor) contacted. Sa02 saturation) at 96 % (percent). (minute). BP (blood m/Hg (millimeters of mercury), object to be at sper minute) and (blood sugar monitoring 137 mg/dL (milligram/deciliter). rty) notified of resident's alled to (Name of ER	F	523			

	F CORRECTION (X1)	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		STRUCTION			E SURVEY PLETED	
·		495249	B. WNG					C <i>i</i> 23/2018	
	ROVIDER OR SUPPLIER LE REHABILITATION & HEAL	TH CARE CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901				123120 18	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFI TAG	I	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED DEFICI	ACTION SHOULD TO THE APPROPR	BE	IX5) COMPLETION OATE	
F 623	Continued From page 69 provide written notification resident explaining why the transferred to the hospital notifies the ombudsman of transfer to the hospital, Onotify the ombudsman every who were discharged from stated she does not provide the ombudsman for every transfer to the hospital. On 2/22/18 at 11:41 a.m., conducted with LPN (licentegarding her role when a count to the hospital. LPN # to first assess the resident for hospital transfer. LPN would call the medical dotransfer, fill out the require transfer, call the emergen family or responsible particulated transfer. LPN #3 resident and/or RP (responsible particulated transfer to stated she does not containstated she does not containstated she does not containstated she does not containstated transfer to stated she does not containstant.	the resident was When asked if she of a facility-initiated SM #1 stated she would bery month of residents on the facility. OSM #1 de written notification to facility- initiated an interview was used practical nurse) #3, resident is transferred dis stated the process is to determine the need dis stated that she ctor to get the order for ed paperwork for cy squad and notify the function to the rty regarding a facility stated she will tell the nsible party) verbally. The transferred stated the mill tell the sible party) verbally. The transferred stated she will tell the sible party) verbally. The transferred stated she onbudsman of a the hospital, LPN #3	F	623					
	On 2/22/18 at 12:33 p.m., conducted with ASM (adm member) #1, the administ that they have never prov of the reason for a hospita pmbudsman. ASM #1 statold that."	inistrative staff rator. ASM #1 stated ded written notification il transfer to the RP and			. In the same of t	·			
	On 2/22/18 at 3:28 p.m., a								

	OF OEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION .	(X3) OATE COMF	SURVEY PLETEO
	ROVIOER OR SUPPLIER LE REHABILITATION	495249 & HEALTH CARE CENTER LLC	l 1575	EET AOORESS, CITY, STATE, ZIP CO S SCOTT DRIVE ROUTE 5 RMVILLE, VA 23901	· 0 2 /	C 23/201 <u>8</u>
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F 623	when a resident is is initiated by the is initiated by the is involving." On 2/22/18 at 5:00 staff member) #1, DON (Director of I ADON (Assistant aware of the above the above the facility policy facility policy titled not address the above the information was of the information was of the information was of the information was of the information was of the information was of the information was of the information was of the information was of the information was of the information to Resident #80 was 4/17/17 at the interior was 4/17/15 with a real was 4/17/17 was 4/17/17 was 4/17/17 was 4/17/17 with a real was 4/17/17 was	or. When asked about her role, a transferred to the hospital that facility, OSM #2 stated, If p.m., ASM (administrative the administrator, ASM #2, the Nursing) and ASM #3, the Director of Nursing) were made e concerns. Ititled, "Transfer Form" and , "Discharge of Resident" did bove concerns. In color to the mucous ing from inadequate e blood or circulation. This botained from The National and the color to the mucous in the color to the mucous in the color of the color of t	F 623			
	blood pressure, di	fficulty speaking following a n, difficulty swallowing and			· .	i.
	set), a quarterly as (assessment refer Resident #80 as s	ost recent MDS (minimum data seessment with an ARD ence date) of 2/3/18, coded coring a six out of a possible 15 interview for mental status),		In France Manage Age age age .		,

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
<u>-</u> .	ROVIDER OR SUPPLIER LE REHABILITATION &	495249 HEALTH CARE CENTER LLC	, 157	REET ADDRESS, CITY, STATE, ZIP CO 5 SCOTT DRIVE ROUTE 5 RMVILLE, VA 23901	C 02/23/201 <u>8</u> DE
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE COMPLETION DATE
F 623	A review of Resider revealed, in part, the transferred by the factor on 8/7/17, 12/17/17 Further review of Redid not reveal any expensible party) notification regarding on the above refered on 2/21/18 at 3:48 conducted with OSI director of social sed describe her role whout of the facility to #1 stated that she continued it was up to the number of the written notifications that she was not. On 2/21/18 at 4:28 conducted with OSI OSM #2 was asked for notifications, for residents to an acustated that she did regards to notification. An end of day mee at 5:01 p.m. With A member) #1, the acd director of nursing, training. ASM #1, A	dent #80 is severely with decisions of daily living. It #80's clinical record at Resident #80 was acility to an acute care hospital and 1/2/18. Resident #80's clinical record vidence that the RP had been sent a written g the transfers that occurred nced dates. In man interview was with (other staff member) #1, the rvices. OSM #1 was asked to hen a resident was transferred an acute care setting. OSM lid not have any responsibility; sing staff to notify the RP was responsible for doing any to the RP, OSM #1 stated In man interview was with #2, the admissions director. It describe her responsibility facility- initiated transfers of the care hospital. OSM #2 not have any responsibility in	F 623		

(X1) PROVIOER/SUPPLIER/CLIA

STATEMENT OF OFFICIENCIES

PRINTED: 03/09/2018 FORM APPROVED OMB_NO. 0938-0391

(X3) OATE SURVEY

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		495249	B. WNG		02/2 3/ 2 01 <u>8</u>
	ROVIOER OR SUPPLIER LE REHABILITATION & H	EALTH CARE CENTER LLC	1575	EET AOORESS, CITY, STATE, ZIP COOE S SCOTT ORIVE ROUTE 5 MVILLE, VA 23901	
(X4) IO PREFIX TAG	(EACH OEFICIENC)	TEMENT OF OEFICIENCIES 'MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIA OEFICIENCY)	
F 623	LPN #3 was asked if a providing a written no RP (responsible party transferred out of the hospital. LPN #3 stat send a written notificat RP of the transfer." No further information end of the survey provided in the survey provid	for facility-initiated .m., an interview was icensed practical nurse) #3. she was responsible for iffication to the resident's if a resident was facility to an acute care ed, "Not from me, I don't tion, I just call to notify the was provided prior to the exes. Iled to provide a written at #60's RP (responsible transferred to the hospital mitted to the facility on sion on 2/14/18 with ed, but not limited to, is disease, high blood in (a degenerative disease ecent MDS (minimum data is sment with an ARD e date) of 12/23/17, coded gunable to answer the S (brief interview for mental essment coded Resident impaired to make daily	F 623		

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

COMPLETED

	105010	B MAINO		С
	495249	B. WING		02/23/2 01 <u>8</u>
	ROVIDER OR SUPPLIER LE REHABILITATION & HEALTH CARE CENTER LLC	l 1	STREET ADDRESS, CITY, STATE, ZIP CODE 575 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 CF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION OATE
F 623	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 put 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	F 623		
	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.			

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

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	OF OEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETEO
	ROVIOER OR SUPPLIER LE REHABILITATION	495249 & HEALTH CARE CENTER LLC	I 157	REET AOORESS, CITY, STATE, ZIP COO 5 SCOTT ORIVE ROUTE 5 RMVILLE, VA 23901		C 2/23/201 <u>8</u>
(X4) IO PREFIX TAG	(EACH OEFIC	Y STATEMENT OF OEFICIENCIES IENCY MUST BE PRECEOEO BY FULL OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE OEFICIENCY)	I SHOULD BE	JX5J COMPLETION OATE
F 623	providing a writte RP (responsible particles) transferred out of hospital. LPN #3 send a written no RP of the transfer	and if she was responsible for an notification to the resident's party) if a resident was the facility to an acute care stated, "Not from me, I don't tification, I just call to notify the r."	F 623			
	documentation ev (responsible party Resident #111 wa 12/02/17. Resident # 111 w 12/02/10 with a re diagnoses that in epilepsy (1), schi	off failed to provide written videncing Resident # 111's RP v) was notified in writing when as transferred to the hospital on as admitted to the facility on eadmission of 12/13/17 with cluded but were not limited to zoaffective disorder (2), aphasia geal reflux disease (4), and				
	Resident # 111's data set), a quart (assessment refe Resident # 111 a: cognition for mak 111 was coded a: of one staff mem The facilities "Pro for Resident # 11 a.m.) At 6 a.m. (6 eye closed. Arou resident in bed e	most recent MDS (minimum erly assessment with an ARD rence date) of 01/29/18 coded is being moderately impaired of ing daily decisions. Resident # is requiring extensive assistance ber for activities of daily living. Ogress Notes," dated 12/02/17 1 documented, "09:21 (9:21 in its extensive) documented in its extensive assistance ber for activities of daily living.				



If continuation sheet Page 75 of 185

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	COMPLETED		
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	495249	8. WING	······································	02/2	23/ 2 01 8
NAME OF P	ROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
FARMVILI	E REHABILITATION & HEALTH CARE CENTER LLC	l 1575	SCOTT DRIVE ROUTE 5		
		FARI	MVILLE, VA 23901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST 8E PRECEDED 8Y FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D 8E	(X5) COMPLETION OATE
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	F 623			
	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				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			1, ,	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIOER OR SUPPLIER FARMVILLE REHABILITATION & HEA	•	s 1	TREET ADDRESS, CITY, STATE, ZIP COOE 575 SCOTT DRIVE ROUTE 5 ARMVILLE, VA 23901		2/23/201 <u>8</u>
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was obtained from the whttps://www.nlm.nih.gov 000930.htm. 3. A disorder caused by the brain that control lar hard for you to read, wrimean to say. This inform the website: https://www.nlm.nih.gov 1. 4. Stomach contents to the esophagus and irrita was obtained from the whttps://www.nlm.nih.gov 5. A surgical procedure through the neck into the tube is most often place provide an airway and the lungs. This informathe website: https://medlineplus.gov/ 5. The facility staff failed documentation evidence (responsible party), was Resident #113 was tran 10/27/17. Resident # 113 was addingnoses that included	chosis] and mood r mania]. This information website: //medlineplus/ency/article/ // damage to the parts of nguage. It can make it ite, and say what you mation was obtained from //medlineplus/aphasia.htm // leak back, or reflux, into ate it. This information website: //medlineplus/gerd.html. to create an opening re trachea (windpipe). A red through this opening to o remove secretions from tion was obtained from //ency/article/002955.htm. red to provide written ing Resident # 113's RP is notified in writing when isferred to the hospital on mitted to the facility on sision of 10/30/17 with if but were not limited to age (1), hypertension (2),	F 623			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495249 NAME OF PROVIDER OR SUPPLIER FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		l 157	REET ADDRESS, CITY, STATE, ZIP CODE 75 SCOTT DRIVE ROUTE 5 RMVILLE, VA 23901	C 0 2/23/2 01 <u>8</u>	
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F 623	data set), a significan ARD (assessme coded Resident # 1 impaired of cognitic Resident # 113 was extensive assistant activities of daily liv The facility's "Program Resident # 113 door Restorative aide re Observed resident drooping and slurre (emergency room) services). Resident MD (medical doctor notified." Review of the clinic failed to evidence where the composition of the clinic facility initiated transplantation of the composition of the clinic facility initiated transplantation of the composition of the composition of the composition of the clinic facility initiated transplantation of the composition of the composition of the clinic facility initiated transplantation of the composition of the compos	ost recent MDS (minimum ant change assessment with nt reference date) of 01/31/18 13 as being moderately on for making daily decisions. It coded as requiring limited to be of one staff member for	F 623		

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ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901	0 2/2 3/201 <u>8</u>
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F 623	the director of nursi administrator in trai above concerns. No further informati References: 1. Bleeding in the a thin tissues that coucalled the subarach was obtained from	ong, and ASM # 5, ning, were made aware of the on was provided prior to exit. rea between the brain and the rer the brain. This area is noid space. This information he website:	F 62	3	
	2. High blood pression the white the street obtained from the white street obtained from the white street obtained from the work obtained from the white obtained from the work of the work of the w	gov/medlineplus/highbloodpr ich the heart is no longer able h blood to the rest of the body ses symptoms to occur // This information was			
	obtained from the v https://www.nlm.nif sorders.html. 5. A chronic diseas regulate the amour information was ob https://www.nlm.nif 001214.htm. 6a. Resident #25 w on 12/12/17. The f	order. This information was vebsite: gov/medlineplus/swallowingdi e in which the body cannot tof sugar in the blood. This tained from the website: gov/medlineplus/ency/article/ as transferred to the hospital acility staff failed to provide of the facility initiated transfer			

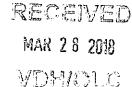
FORM CMS-2567(02-99) Previous Versions Obsolete

to the ombudsman and resident representative.

Event ID: 62X711

Facility ID: VA0090

If continuation sheet Page 79 of 185



(X1) PROVIOER/SUPPLIER/CLIA

STATEMENT OF OFFICIENCIES

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(X3) OATE SURVEY

NO PLAN OF	CORRECTION IOENTIFICATION NUMBER:	A. BUILOING		COMPLETEO
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	495249	B. WING		02/23/2018
NAME OF PI	ROVIOER OR SUPPLIER	STRE	ET AOORESS, CITY, STATE, ZIP COOE	
FARM\/III	LE REHABILITATION & HEALTH CARE CENTER LLC	1 1575	SCOTT DRIVE ROUTE 5	
		FARI	MVILLE, VA 23901	
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F 623	Continued From page 79	F 623		
	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 and 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			

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STATEMENT OF OEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) OATE SURVEY COMPLETEO	
NAME OF PROVIOER OR SUPPLIER			REET AOORESS, CITY, STATE, ZIP COOE	C 02/23/201 <u>8</u>	
FARMVILLE REHABILITATION & H	EALTH CARE CENTER LLC	ì	75 SCOTT DRIVE ROUTE 5 RMV LLE, VA 23901		
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facility process for prothe ombudsman, residerepresentative when a the hospital. LPN #1 provide written notificatesident or resident resident or resident resident or resident resident and reveal the ombudsman Resident #25 was tran 12/12/17. The lists do note that documented if resident does not stately will not appear or conducted with OSM in notification of resident hospital. OSM #1 state computer system and "discharged" from the sends the list of those "discharged" from the OSM #1 confirmed the hospital and returns we from the computer system and rot on the list that is so OSM #1 confirmed wr Resident #25's transfer 12/12/17 was not provide the computer system. On 2/22/18 at 10:55 a administrator) and AS	PN #1 was asked about the oviding written notification to dent and resident a resident is transferred to confirmed nurses do not ation to the ombudsman, expresentative. In was notified when a nesterned to the hospital on ocumented a handwritten and overnight/Admitted then and the report for discharged." In another Interview was #1, regarding ombudsman at transferred to the reviews the residents facility. OSM #1 stated she are residents who are facility to the ombudsman, at if a resident is sent to the without being discharged atem then his/her name is sent to the ombudsman. The ordification regarding for the hospital on wided to the ombudsman was not discharged from a.m., ASM #1 (the	F 623			

TATEMENT OF OEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER: 495249 NAME OF PROVIDER OR SUPPLIER FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC			(X2) MULTIPLE CO A. BUILOING		(X3) OATE SURVEY COMPLETEO	
		l ¹⁵⁷⁵	ET AOORESS, CITY, STATE, ZIP COO SCOTT DRIVE ROUTE 5 MVILLE, VA 23901	C 02/23/201 <u>8</u> DE		
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F 623	On 2/22/18 at 1:5 facility did not have ombudsman and notification.	page 81 8 p.m., ASM #2 stated the re a policy regarding resident representative retrieve atton was presented prior to exit.	F 623			
	on 1/22/18. The to written notification to the resident representation Review of Resident was to the resid	was transferred to the hospital facility staff failed to provide of the facility initiated transfer presentative. Int #25's clinical record revealed ransferred to the hospital on presponsive episode. Further				
	review of Resider	at #25's clinical record failed to at representative was provided				
	conducted with O social services di about the facility notification to the resident is transfe stated a resident day or night. OSI resident's loved of the hospital. Whe provided to the resident to the resid	O p.m. an interview was SM (other staff member) #1 (the rector). OSM #1 was asked process for providing written resident representative when a serred to the hospital. OSM #1 might go to the hospital anytime M #1 stated the nurses notify the ne that the resident is going to en asked if written notification is sident's representative, OSM #1 for hospital visits."				
	interview was cor practical nurse) # facility process fo the resident repre	proximately 8:00 a.m., an aducted with LPN (licensed 1. LPN #1 was asked about the reproviding written notification to esentative when a resident is the provided of the second to be sentative.				

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STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			(X3) OATE SURVEY COMPLETEO			
		495249	B. WING			C 23/20 18
	ROVIOER OR SUPPLIER LE REHABILITATION &	HEALTH CARE CENTER LLC		STREET AOORESS, CITY, STATE, ZIP COOE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		
(X4) IO PREFIX TAG	(EACH OEFICIEN	STATEMENT OF OEFICIENCIES CY MUST BE PRECEOEO BY FULL R LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCEO TO THE APPRO OEFICIENCY)	LO BE	(X5) COMPLETION OATE
F 623	nurses do not provice resident representa On 2/22/18 at 10:55 administrator) and Anursing) were made on 2/22/18 at 1:58 facility did not have representative notification. No further information on 1/30/18 and 2/8/provide written notification of transfer to the resident #106 was 10/3/17. Resident were not limited to I disease and diabeter recent MDS (minim Medicare assessmere ference date) of 2 cognitively intact. Review of Resident revealed the reside hospital on 1/30/18 returned to the facil of Resident #106's resident was transfer low blood sugar 2/9/18. The clinical	de written notification to the tive. a.m., ASM #1 (the ASM #2 (the director of aware of the above findings. b.m., ASM #2 stated the apolicy regarding resident cation. but was presented prior to exit. was transferred to the hospital 18. The facility staff failed to ication of the facility initiated ent or resident representative. admitted to the facility on #106's diagnoses included but heart failure, chronic kidney es. Resident #106's most but data set), a five day ent with an ARD (assessment 1/2/18, coded the resident as #106's clinical record the for abdominal pain and ity on 2/1/18. Further review clinical record revealed the erred to the hospital on 2/8/18 and returned to the facility on record failed to reveal the representative was provided	F 62	3		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
NAME OF P	ROVIDER OR SUPPLIER	495249	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE		C 23/201 8
FARMVIL	E REHABILITATION & H	IEALTH CARE CENTER LLC		1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 623	social services directs about the facility processident is transferred stated a resident might day or night. OSM #*resident's loved one to the hospital. When a provided to the residestated, "No. Not for home of the hospital of the residestated, "No. Not for home of the resident or the resident or the resident or the resident is transferred confirmed nurses do notification to the resident is transferred confirmed nurses do notification to the resident representative. On 2/22/18 at 10:55 and administrator) and AS nursing) were made as on 2/22/18 at 1:58 p. facility did not have a representative notification to the resident is transferred and as nursing) were made as on 1/22/18 at 1:58 p. facility did not have a representative notification to the resident with the resident at 1:58 p. facility did not have a representative notification to the resident with the resident at 1:58 p. facility did not have a representative notification to the resident with the resident at 1:58 p. facility did not have a representative notification with the resident at 1:58 p. facility did not have a representative notification with the resident at 1:58 p. facility did not have a representative notification with the resident at 1:58 p. facility did not have a representative notification with the resident at 1:58 p. facility did not have a representative notification with the resident at 1:58 p. facility did not have a representative notification with the resident at 1:58 p. facility did not have a representative notification with the resident at 1:58 p. facility did not have a representative notification with the resident at 1:58 p. facility did not have a representative notification at 1:58 p. facility did not have a representative notification at 1:58 p. facility did not have a representative notification at 1:58 p. facility did not have a representative notification at 1:58 p. facility did not have a representative notification at 1:58 p. facility did not have a facility did not have a representative notification at 1:58 p. facility	m. an interview was (other staff member) #1 (the or). OSM #1 was asked ess for providing written dent representative when a d to the hospital. OSM #1 hit go to the hospital anytime 1 stated the nurses notify the hat the resident is going to sked if written notification is ent's representative, OSM #1 hospital visits." imately 8:00 a.m., an otted with LPN (licensed LPN #1 was asked about the oviding written notification to esident representative when a d to the hospital. LPN #1 not provide written ident or the resident a.m., ASM #1 (the SM #2 (the director of aware of the above findings. m., ASM #2 stated the policy regarding resident	F 623	3		

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

no Plan of Correction IDENTIFICATION NUMBER:		A. BUILOING		COMPLETED		
				(
	495249	B. WNG		02/	23/201 <u>8</u>	
NAME OF PI	ROVIDER OR SUPPLIER		ET AOORESS, CITY, STATE, ZIP CODE			
FARMVILL	E REHABILITATION & HEALTH CARE CENTER LLC	1	SCOTT DRIVE ROUTE 5			
		FAR	MVILLE, VA 23901			
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCEO TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION OATE	
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."	F 623				
	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					

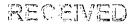
(X2) MULTIPLE CONSTRUCTION

FORM CMS-2567(02-99) Previous Versions Obsole(e

Event ID:62X711

Facility IO: VA0080

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STATEMENT OF OEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ANO PLAN OF CORRECTION IOENTIFICATION NUMBER: A. BUILDING			(X3) OATE SURVEY COMPLETEO		
		495249	B. WING		C 02/23/20 18
	ROVIOER OR SUPPLIER LE REHABILITATION & F	HEALTH CARE CENTER LLC	I 18	TREET AOORESS, CITY, STATE, ZIP COOE 575 SCOTT ORIVE ROUTE 5 ARMV[LLE, VA 23901	<u>-</u>
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEDEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR OEFICIENCY)	BE COMPLETION
F 625 SS=D	facility process for prothe resident or the resident is transferred confirmed nurses do notification to the resirepresentative. On 2/22/18 at 10:55 a administrator) and AS nursing) were made at On 2/22/18 at 1:58 p. facility did not have a representative notification. No further information. Notice of Bed Hold Poce (CFR(s): 483.15(d)(1) (S483.15(d)(1)) (S483.15(d	by iding written notification to sident representative when a d to the hospital. LPN #1 not provide written ident or the resident ident or the resident ident or the director of aware of the above findings. m., ASM #1 (the SM #2 (the director of aware of the above findings. m., ASM #2 stated the policy regarding resident action. In was presented prior to exit. policy Before/Upon Trnsfr (2) bed-hold policy and returnation to a hospital or therapeutic leave, the provide written information to ant representative that the state bed-hold policy, if a resident is permitted to sidence in the nursing the state of this chapter, if any; y's policies regarding ich must be consistent with his section, permitting a	F 623	 Resident #80 has had no disc since the annual survey. To end his family a copy of the bedagreement along with a cover will be sent to the RR by 3-30. Resident #60 no longer resident the facility. Resident #113 has had no discharges since the annual story bed-hold agreement along we cover letter will be sent to the by 3-30-2018. A copy of the facility bed-hold policy and agreement will be to all RR along with a cover letter them on the bed-hold process by 3-30-2018. Resident will be educated on the bed-hold policy during the resident counterting held in March. 	educate hold er letter D-2018. es in survey. of the ith a e RR

FORM CMS-2567(02-99) Previous Versions Obsolete

EvenI ID:62X711

Facility IO: VA0080

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STATEMENT OF OEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA ANO PLAN OF CORRECTION (IOENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILOING	CONSTRUCTION	(X3) OATE SURVEY COMPLETEO	
		495249	B, WING		C
NAME OF B	ROVIOER OR SUPPLIER	400240			02/23/2018
		HEALTH CARE CENTER LLC	l 1	FTREET AOORESS, CITY, STATE, 2 575 SCOTT ORIVE ROUTE 5 FARMVILLE, VA 23901	ZIP COOE
(X4) IO PREFIX TAG	(EACH OEFICIENC	TATEMENT OF OEFICIENCIES BY MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCEO	
F 625	the time of transfer of hospitalization or the facility must provide resident representation specifies the duration described in paragra. This REQUIREMENT by: Based on staff intervand clinical record refacility staff failed to put the time of a facility in 30 residents in the sum 80, 60 and 113. 1. The facility staff failed to put the time of a facility staff failed to put the time of a facility in 30 residents in the sum 80, 60 and 113. 1. The facility staff failed to put the time of a facility staff failed to put the time of a facility staff failed to the hospital staff failed to the	pold notice upon transfer. At fa resident for rapeutic leave, a nursing to the resident and the ve written notice which in of the bed-hold policy ph (d)(1) of this section. If is not met as evidenced riew, facility document review view, it was determined the provide a bed hold notice at initiated transfer for three of purvey sample, Resident #s willed to provide evidence that his RP (responsible party) in notification of the bed hold bed hold when he was spital on 8/7/17, 12/17/17	F 625	2018 the Admini asked to present facility bed-hold 6. The admissions or responsible for cor RR when a disoffer a bed-hold declination or ac bed-hold will be social service file 7. The interdiscipling perform a randomonthly basis for the present the social service for the social service file the service file the social service file the service file the social service file the service file the service file the service file the service file the service file the service file the service file the service file the service file the service file the service file the service file the service file the servi	strator has been information on the policy and process. director will be ontacting residents charge occurs to A copy of the ceptance of the placed in their mary QA team will m audit on a or the next three rterly thereafter to d compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495249 NAME OF PROVIDER OR SUPPLIER FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC			(X2) MULTIPLE C	•	(X3) DATE SURVEY COMPLETED
		495249	B. WING		C
			STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		02/23/201 <u>8</u>
(X4) IO PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETIO
F 625	Resident #80 and were provided wripolicy, and offered transferred to the and 1/2/18. Resident #80 was 4/17/15 with a readiagnoses that incolood pressure, distroke, depression cognitive communative community co	If failed to provide evidence that or his RP (responsible party) then notification of the bed hold if a bed hold when he was hospital on 8/7/17, 12/17/17 admitted to the facility on dission date on 1/5/18 with clude but not limited to high fficulty speaking following a notificulty swallowing and ideation deficit. Dest recent MDS (minimum data assessment with an ARD rence date) of 2/3/18, coded accoring a six out of a possible 15 interview for mental status), sident #80 is severely and with decisions of daily living.	F 625		
	did not reveal any his RP was offere above referenced An end of day me at 5:01 p.m. With member) #1, the adirector of nursing training. ASM #1 made aware of th	evidence that Resident #80 or d a bed hold at the time of the transfers to the hospital. eting was conducted on 2/21/18 ASM (administrative staff administrator, ASM #2, the I, ASM #5, the administrator in ASM #2 and ASM #5 were a above concerns. A policy was time for facility-initiated transfer			

PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391 (X3) OATE SURVEY

	ATEMENT OF OEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION D PLAN OF CORRECTION IOENTIFICATION NUMBER: A. BUILDING			SURVEY PLETEO		
					•	С
NAME OF D	novioca oa evidajira	495249	B. WING		02	/ 2 3/ 20 1 <u>8</u>
	ROVIOER OR SUPPLIER E REHABILITATION	& HEALTH CARE CENTER LLC	l ¹⁵⁷⁵	EET AOORESS, CITY, STATE, ZIP COOE S SCOTT ORIVE ROUTE 5 RMVILLE, VA 23901		
(X4) IO PREFIX TAG	(EACH OEFICIE	STATEMENT OF OEFICIENCIES ENCY MUST BE PRECEOEO BY FULL OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCEO TO THE AF OEFICIENCY)	HOULO BE	(X5) COMPLETION OATE
F 625	conducted with OS admissions director the process followinformation to the at the time of a fact acute care hospital after the transfer, I the resident is doin about a bed hold. explain the process associated with it.' conversation is do not have document the electronic med nowhere to document to do, a bed I and signs a form a admissions office. actually started by transfer; they should OSM #2 was asked bed hold was offer 12/17/17 and 1/2/17. No further informate and of the survey 2. The facility staff Resident #6 and of were provided writt policy, and offered	is p.m., an interview was SM (other staff member) #2, the or. OSM #2 was asked about ed for providing bed hold residents and family members illity-initiated transfer to an I. OSM #2 stated, "The day contact the RP and ask howing and then ask at that point If they want one or not. I is, how it works and the costs "When asked where the cumented OSM #2 stated, "I do tation privileges in (name of ical record program) so I have ent. If the resident RP does nold then the family comes in and I keep that in a folder in the The bed hold conversation is nursing at the time of the ald document that at that time." It do provide evidence that a sed to Resident #80 on 8/7/17, I.S. It is a provided prior to the process. If failed to provide evidence that a real real responsible party) the notification of the bed hold a bed hold when she was	F 625			
	Resident #60 was	nospital on 2/8/18. admitted to the facility on mission on 2/14/18 with				

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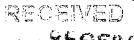
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION		TE SURVEY MPLETED	
		495249	B. WING			С
NAME OF PROVIDER OR SUPPLIER FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC		st 1 ¹⁵	REET ADDRESS, CITY, STATE, ZIP CODE 75 SCOTT DRIVE ROUTE 5 RMVILLE, VA 23901		0 2/23/2 01 <u>8</u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION OATE
F 625	Continued From pa	ge 89	F 625			
	psychosis, Parkinso	ded, but not limited to, n's disease, high blopd oma (a degenerative disease				
	set), a quarterly ass (assessment refere Resident #60 as be questions on the Bl status). The staff as	t recent MDS (minimum data essment with an ARD noce date) of 12/23/17, coded ing unable to answer the MS (brief interview for mental essessment coded Resident ely impaired to make daily				
		at #60's clinical record at she had been transferred to tal on 2/8/18.				:
	did not reveal any e her RP were offered	esident #60's clinical record vidence that Resident #60 or I a bed hold at the time of the ansfer to the hospital.			·	
	at 5:01 p.m. With Almember) #1, the addirector of nursing, training. ASM #1, Almade aware of the	ing was conducted on 2/21/18 SM (administrative staff ministrator, ASM #2, the ASIM #5, the administrator in ASM #2 and ASM #5 were above concerns. A policy was ne for facility-initiated transfer				
,	conducted with OSI admissions director the process followe information to the reat the time of a facil	p.m., an interview was If (other staff member) #2, the COSM #2 was asked about If or providing bed hold If or providing bed members If or providing the memb				

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Event ID: 62X711

Facility ID: VA0080

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STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495249 NAME OF PROVIDER OR SUPPLIER FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC			(X2) MULTIPLE (A. BUILOING	ONSTRUCTION	СОМІ	E SURVEY PLETEO
		I 157	REET AOORESS, CITY, STATE, ZIP CO 'S SCOTT ORIVE ROUTE 5 RMVILLE, VA 23901	02	C /23/201 <u>8</u>	
(X4) IO PREFIX TAG	(EACH OEFICIE)	STATEMENT OF OEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCEO TO TH OEFICIENCY	ON SHOULO BE HE APPROPRIATE	IX5) COMPLETION OATE
F 625	after the transfer, I the resident is doing about a bed hold. I explain the process associated with it." conversation is doon not have document the electronic medinowhere to docume want to do, a bed hand signs a form an admissions office. actually started by it transfer; they shoul OSM #2 was asked bed hold was offere. No further informatiend of the survey p 3. The facility staff in 113 or the resident notification of the bresident was transf 10/27/17. Resident # 113 was 10/10/14 with a readiagnoses that inclusubarachnoid hemotheart failure (3) dys diabetes mellitus (5). Resident # 113's medata set), a signification of cognitication of cogniti	contact the RP and ask how g and then ask at that point of they want one or not. I how it works and the costs When asked where the umented OSM #2 stated, "I do ation privileges in (name of cal record program) so I have ent. If the resident RP does old then the family comes in and I keep that in a folder in the The bed hold conversation is nursing at the time of the did document that at that time." It to provide evidence that a end to Resident #60 on 2/8/18. It on was provided prior to the rocess. Failed to provide Resident #65 representative written and hold policy when the perred to the hospital on the did but were not limited to prhage (1), hypertension (2), phagia (4), and type II	F 625			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
		495249	B. WNG		С
NAME OF P	ROVIDER OR SUPPLIER	400240		EET ADDRESS, CITY, STATE, ZIP CODE	02/ 23/201<u>8</u>
FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC		I	SCOTT DRIVE ROUTE 5 MV/LLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 625	Continued From pa	•	F 625		
	activities of daily liv	ring.			
	Resident # 113 door Restorative aide re Observed resident drooping and slurre (emergency room) services). Resider	ress Notes" dated 10/27/17 for cumented, "11:04 a.m. turned resident to unit. and noted right sided face ed speech. Contacted ER and EMS (emergency medical at sent to ER for evaluation. r) and RP (responsible party)			
	evidence that the r party was provided	ical record failed to reveal any esident and/or responsible with a copy of the "Bed Hold" urs of transfer to the hospital.			
	OSM (other staff m director. When ask regarding resident stated, "If the resid family or RP (respoundate. I explain thold the bed and e is discharged, nurs initiate contact the hold." When asked contact with the Fahold OSM # 2 state anywhere. I don't	O p.m., in an interview with ember) #2, the admissions ed to describe her role in transfers discharges OSM # 2 ent is transferred I contact the onsible party) and give an one process if they choose to explain the costs. If the resident ing should document and family or RP regarding the bed about documenting her mily or RP regarding the bed ed, "I don't document it have access rights to PCC the electronic health record its records)."			
	OSM (other staff m director. When asi Resident # 113's fa	0 a.m., in an interview with ember) #2, the admissions ked if a bed hold was offered to imily or RP for her asfer to the emergency room			•

STATEMENT OF OEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT AND PLAN OF CORRECTION (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT A. BUILDING			[SURVEY PLETEO		
		495249	B. WING			C
	ROVIOER OR SUPPLIER	HEALTH CARE CENTER LLC	l ¹⁵⁷	REET AOORESS, CITY, STATE, ZIP CODE 5 SCOTT DRIVE ROUTE 5 RMVILLE, VA 23901	02	/23/201 <u>8</u>
(X4) IO PREFIX TAG	(EACH OEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEOEO BY FULL R LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCEO TO THE AF OEFICIENCY)	HOULO BE	IX5) COMPLETION DATE
F 625	on 10/27/17, OSM # offered but the fami When asked for doc offer of the bed hold have any and further have any document was offered." On 02/22/18 at 5:00 staff member) # 1, the director of nursing administrator in traing above concerns. No further information in the authin tissues that covicalled the subarach was obtained from the https://medlineplus. 2. High blood press obtained from the whitps://www.nlm.nihessure.html. 3. A condition in whit to pump oxygen-riclefficiently. This cause throughout the body obtained from the whitps://medlineplus. 4. A swallowing discobtained from the whitps://medlineplus.	# 2 stated, "The bed hold was by refused due to finances." cumentation to support the I, OSM # 2 stated she did not er stated, "Because I don't ation I can't say the bed hold I p.m. ASM (administrative he administrator, ASM # 2, ang, and ASM # 5, aning were made aware of the on was provided prior to exit. The abetween the brain and the er the brain. This area is noid space. This information he website: I gov/ency/article/000701.htm. I sure. This information was rebsite: I gov/medlineplus/highbloodproces symptoms to occur I this information was rebsite: I gov/ency/article/000158.htm. I prior to finances." I p. m. ASM (administrative he administrator and the result of the body sees symptoms to occur I this information was rebsite: I gov/ency/article/000158.htm.	F 625			

	OF DEFICIENCIES CORRECTION	V-7		(X3) DATE SURVEY COMPLETED	
	ROVIDER OR SUPPLIER LE REHABILITATION & H	495249 EALTH CARE CENTER LLC	I 1	TREET ADDRESS, CITY, STATE, ZIP CODE 575 SCDTT DRIVE ROUTE 5 ARMV LLE, VA 23901	C 02/23/201 <u>8</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 625	5. A chronic disease i regulate the amount of	n which the body cannot of sugar in the blood. This	F 625		
		ned from the website: ov/medlineplus/ency/article/ ents	F 641		
	resident's status. This REQUIREMENT by: Based on staff intervi and clinical record rev facility staff failed to c	is not met as evidenced ew, facility document review riew, it was determined the omplete an accurate f 30 residents in the survey			
	urinary catheter on a	to capture Resident #94's significant change MDS ssessment with an ARD se date) of 1/24/18.			
	1/02/09 and readmitted that included but were depression, Schizoph hyperplasia (enlarged most recent MDS (minassessment was a sign assessment with an Adate) of 1/24/18. Respecting moderately imp	renia, and Benign prostatic prostate). Resident #94's nimum data set)			

	OF OEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA F CORRECTION IDENTIFICATION NUMBER:	1	E CONSTRUCTION (X	(3) DATE SURVEY COMPLETED
	495249	B WING		С
NAME OF P	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	0 2/23/2 01 <u>8</u>
TVAIVIL OT F	NOVIDEN ON GOFFEIEN		1575 SCOTT DRIVE ROUTE 5	
FARMVILI	LE REHABILITATION & HEALTH CARE CENTER LLC	1	FARMVILLE, VA 23901	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH OEFICIENCY 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 OEFICIENCY)	IX5) COMPLETION DATE
F 641	Continued From page 94	F 641	F641	
-	(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.		 Resident #94's Minimum Data (MDS) was modified on 3/12/1 include coding for urinary cath. The MDS Director will complet audit of the current MDS assessments by 3/14/18 to vali accuracy of coding related to urinary catheters. 	8 to eter. e an
	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):		3. The MDS Director and Coordina will be re-educated by the Corporate Clinical Reimbursem Specialist regarding accuracy of assessments by 3/14/18.	ent
	"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.		4. The MDS Director will audit 5 M assessments on each unit week for 4 weeks and monthly for 2 months to ensure MDS assessments on the store of the second o	nents
	Further review of Section H (Bladder and Bowel) documented the following under section H0300.		Completion date: 3/30/18	

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STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		DATE SURVEY COMPLETED
	495249	B. WING			C
NAME OF PROVIDER OR SUPPLIER FARMVILLE REHABILITATION & HEAD		-	STREET ADDRESS, CITY, STATE, Z 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901	ZIP CODE	0 2/2 3/201 <u>8</u>
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCEO DEFICI	ACTIDN SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
had a catheter in place, output for the entire 7 da Review of Resident #49's that at no point was his of the look back period. On 2/22/18 at 8:33 a.m., conducted with RN (regis MDS coordinator. RN #2 who filled out Section Howas out sick and was no asked about the process of the MDS, RN #2 state resident's ADL record, in and interview staff and/oresident's urinary needs MDS assessment. When had an indwelling catheted did. RN #2 stated, "He hot time and it wasn't remove 1/24/18 MDS was coded H0100. When asked what reference when completions."	Urinary incontinence- that best describes the ent d a catheter (indwelling, or no urine output for ing that the resident either ostomy, or had no urine ys. s clinical record revealed eatheter removed during an interview was stered nurse) #2, the 2 stated the MDS nurse of Resident #94's MDS t doing well. When for filling out section H d she would check the continence information, or the resident on the prior to filling out the n asked if Resident #94 er, RN #2 stated that he has had one for some ed." RN #2 stated his I incorrectly in section at was used as a point of ing the MDS ed the MDS staff use the ent Instrument) manual	F 6-	41		

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Event ID: 62X711

Facility ID: VA0080

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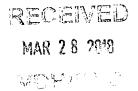
STATEMENT OF OEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA ANO PLAN OF CORRECTION IOENTIFICATION NUMBER:		1, ,	E CONSTRUCTION		(X3) OATE SURVEY COMPLETEO	
		495249	B. WING			C //23/2018
NAME OF P	ROVIOER OR SUPPLIER			STREET AOORESS, CITY, STATE, ZIP COOR		120/2010
				1575 SCOTT DRIVE ROUTE 5		
FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC		HEALTH CARE CENTER LLC		FARMVILLE, VA 23901		
(X4) IO PREFIX TAG	(EACH OEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDEO BY FULL LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A OEFICIENCY)	SHOULO BE	[X5) COMPLETION DATE
F 641	Continued From page	e 96	F 641			
	staff member) #1, the DON (Director of Nur	.m., ASM (administrative e administrator, ASM #2, the rsing) and ASM #3, the ector of Nursing) were made concerns.				
	-	ssessment Instrument) 3.0 ne following for Section H:				
	information on the us appliances, the use of toileting programs, us bowel training progra Each resident who is developing incontine assessed, and provid treatment (medication and/or devices) and	ns in this section is to gather se of bowel and bladder of and response to urinary rinary and bowel continence, ams, and bowel patterns. incontinent or at risk of nce should be identified, ded with individualized ns, non-medicinal treatments services to achieve or elimination function as				
	urinary or bowel appl Review the medical rebowel records, for do past use of urinary or Coding Instructions Check next to each a any time in the past a above if none of the the past 7 days. ·H0100A, indwelling suprapubic catheter ·H0100B, external ca	t to note the presence of any liances. record, including bladder and ocumentation of current or r bowel appliances. appliance that was used at 7 days. Select none of the appliances A-D were used in catheter (including and nephrostomy tube)				

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Event IO:62X711

Facility IO: VAD080

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ANO PLAN OF CORRECTION (X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		. O.	CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
	495249	B. WNG		C 0 2/23/20 18
NAME OF PROVIDER OR SUPPLIER FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC		c. l ^{1.}	STREET AOORESS, CITY, STATE, ZIP COOE 1575 SCOTT ORIVE ROUTE 5 FARMVILLE, VA 23901	
(X4) I PREF TAG	X (EACH OFFICIENCY MUST BE PRECEOEO BY FU		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH OEFICIENCY	N SHOULO BE COMPLETION DATE
F6	41 Continued From page 97 and colostomy) ·H01 0 0D, intermittent catheterization	F 641		
	H0100Z, none of the above Coding Tips and Special Populations Suprapubic catheters and nephrostomy tube should be coded as an indwelling catheter (H0100A) only and not as an ostomy (H0100 [1] A suprapubic catheter (tube) drains urine your bladder. It is inserted into your bladder through a small hole in your belly. You may reactheter because you have urinary incontin (leakage), urinary retention (not being able to urinate), surgery that made a catheter necessor another health problem. This information obtained from The National Institutes of Heal https://wwwqa.nlm.nih.gov/medlineplus/275/epatientinstructions/000145.htm. Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered CPlanning §483.21(a) Baseline Care Plans §483.21(a) (1) The facility must develop and implement a baseline care plan for each resithat includes the instructions needed to provieffective and person-centered care of the resithat meet professional standards of quality cathet meet professional standards of a resident admission. (ii) Include the minimum healthcare informatinecessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders.	from need nence o sary, was th. ency/ F 655 are dent ide sident are. tt's	1. Resident #268's response was assessed on 2/2 Assistant Director of no distress noted. Resident #268 oxygete adjusted to 4 liters possident #268 care possident #268 care possident #268's physonotified on 2/22/18 limited on 2/23/18. Resident #268's physonotified on 2/22/18 limited on 2/22/18 limited on 2/22/18 limited on 2/22/18 limited on 2/22/18 limited on 2/22/18 and administered at the distribution. No new order setting. No new order on 2/22/18 and audit residents on oxygen oxygen setting were settings as required, and Assistant Director reviewed all current plan for oxygen on 2/29 plan for oxygen	2/18 by the Nursing with In flow rate was er minute by 2/22/18. Dan was exygen on Sician was by the Unit en not being ordered ers noted. Or of Nursing er completed of current to ensure on correct Unit Manager or of nursing residents' care

STATEMENT OF OEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ANO PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	ROVIOER OR SUPPLIER LE REHABILITATION &	495249 HEALTH CARE CENTER LLC	J 15	TREET AOORESS, CITY, STATE, ZIP COOE 575 SCOTT DRIVE ROUTE 5 ARMVILLE, VA 23901	C 0 2/23/2 01 <u>8</u>	
(X4) IO PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
F 655	§483.21(a)(2) The ficomprehensive care plan if the comprehensive care care plan if the composition (i) Is developed with admission. (ii) Meets the require (b) of this section). §483.21(a)(3) The resident and their resident and their resident and their resident and their resident and their resident and their resident and their resident and their resident and their resident and their resident and their resident and their resident and their resident and their resident and their resident and their resident in the factive in the	mendation, if applicable. acility may develop a e plan in place of the baseline aprehensive care plan- hin 48 hours of the resident's ements set forth in paragraph excepting paragraph (b)(2)(i) of facility must provide the expresentative with a summary e plan that includes but is not of the resident. The resident me resident's medications and and treatments to be expressed facility and personnel acting fility. Formation based on the details we care plan, as necessary. AT is not met as evidenced review, facility document and review, it was determined and to implement a baseline and residents in the survey #268. The detail of the plan for oxygen.	F 655	3. Charge Nurse was re-educate the Staff Development Coord on 2/23/18 related to ensurin oxygen is administered as ord and care planned. The Licensed Nurses will be reeducated by the Staff Develop Coordinator by 3/14/18 relate ensuring oxygen orders are followed according to plan of 4. The Assistant Director of Nurand the Unit Manager will coan audit of 5 current resident each unit weekly for 4 weeks monthly for 2 months to ensuoxygen is administered as ordered and care planned. The Staff Development Coordinator wis submit a report to the Quality Assurance Committee month months. The Director of Nurs be responsible for the monitor and follow up. Completion date: 3/30/18	inator ng dered lered care. sing mplete ts on and ure dered ll y ly for 3 ing will	
	The facility staff fail 268's baseline care	ed to implement Resident # plan for oxygen.				

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STATEMENT OF OEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA ANO PLAN OF CORRECTION (DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION . A. BUILOING		(X3) OATE SURVEY COMPLETEO		
	·	495249	B. WING			C 2 3/ 201 <u>8</u>
	ROVIOER OR SUPPLIER	EALTH CARE CENTER LLC	l ¹⁵	TREET ACORESS, CITY, STATE, ZIP COCE 575 SCOTT DRIVE ROUTE 5 ARMVILLE, VA 23901		
(X4) IO PREFIX TAG	(EACH OEFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCEO TO THE APPROPRI OEFICIENCY)	BE.	(X5) COMPLETION DATE
F 655	01/26/18 with a readn diagnoses that includ- kidney failure, hyperte	admitted to the facility on nission on 02/14/18 with ed but were not limited to: ension (2), dementia (3), apse (4) gastroesophageal	F 655			
	assessment was not survey. Review of the Evaluation dated 02/1 revealed he was orier and situation. Reside	S (minimum data set) due at the time for the e facility's "Readmission 15/18 for Resident # 268 ntated to person, place time ent # 268 was documented with ADLs (activities of				
	p.m., revealed Reside sitting in his wheelche observed receiving ox (plastic tube placed in oxygen) connected to Observation of the flo concentrator revealed	acted on 02/21/18 at 1:55 ent # 268 was in his room air. Resident #268 was exygen by nasal cannula in the nostrils to deliver of an oxygen concentrator. w meter on the oxygen of the oxygen flow rate was a half liters and five liters				
	p.m. revealed Reside sitting in his wheelcha oxygen by nasal cann meter on the oxygen	ucted on 02/21/18 at 2:48 Int # 268 was in his room Initiality are air, and was receiving Inula. Observation of the flow It concentrator revealed the It set between four and a half It is reminute.	,			
	a.m. revealed Reside	ucted on 02/22/18 at 7:50 nt # 268 was in his room air and was receiving oxygen				

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Event IO: 62X711

Facility O: VA0060

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ANO PLAN OF CORRECTION INTERPRETATION		1 1	CONSTRUCTION	(X3) OATE SURVEY COMPLETED		
		495249	B. WNG		C	
	ROVIOER OR SUPPLIER	HEALTH CARE CENTER LLC	l 15	REET ADORESS, CITY, STATE, ZIP CODE 175 SCOTT DRIVE ROUTE 5 ARMVILLE, VA 23901	02/2	3 /201 <u>8</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEOED BY FULL LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP OEFICIENCY)	OULO BE	(X5) COMPLETION OATE
F 655	by nasal cannula. Of on the oxygen conce flow rate was set bett and five liters per min. The physician's order for Resident # 268 dd (four liters per minute all times every shift for Order Date: 02/15/20. The eMAR (electronic record) dated Februar "Oxygen at 4lpm (four nasal cannula at all ti (short of breath). Order Turther review of the 268 received oxygen 02/21/18 on the day, on 02/22/18 on the day, on 02/22/18 on the draws not due at the tir Resident # 268's bass 2/14/18, documented (four liters per minute 02/15/18)." On 02/23/18 at 8:25 conducted with ASM member) # 3, assistal asked to describe the ASM # 3 stated, "It g for resident." After both observations of Resident end.	pservation of the flow meter intrator revealed the oxygen ween four and a half liters rute. I dated Feb (February) 2018 poumented, "Oxygen at 4lpm or SOB (short of breath). 18. Start Date: 02/15/2018." I decided Feb (February) 2018 poumented, "Oxygen at 4lpm or SOB (short of breath). 18. Start Date: 02/15/2018." I decided Feb (February) 2018 poumented, "I liters per minute on the severy shift for SOB per Date: 02/15/2018." Per Mar revealed Resident # at four liters per minute on evening and night shift and the say shift. Per plan for Resident # 268 per of survey. Review of the line care plan dated per plan dated per plan dated per plan dated per purpose of the care plan, wides the care and treatment the purpose of the care plan, wides the care and treatment per plan formed of the dent # 268's oxygen flow rate	F 655			
	# 268, ASM # 3 was	seline care plan for Resident asked if the care plan was ASM # 3 stated, "No."				

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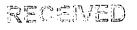
STATEMENT OF CEFICIENCIES ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILOING		
NAME OF PI	ROVIOER OR SUPPLIER	495249		REET AOORESS, CITY, STATE, ZIP COO	C 02/23/201 <u>8</u> E	
FARMVILI	E REHABILITATION &	HEALTH CARE CENTER LLC		5 SCOTT DRIVE ROUTE 5 RMVILLE, VA 23901		
(X4) IO PREFIX TAG	(EACH OEFICIENC	TATEMENT OF OEFICIENCIES CY MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCEO TO THE OEFICIENCY)	SHOULO BE COMPLETION	
F 655	conducted with ASM member) # 2, the dirasked to describe the ASM # 2 stated, "To care for the resident observations of Resi and reviewing the bar # 268, ASM # 2 was being implemented. On 02/22/18 at 5:00 staff member) # 1, the director of nursin administrator in train above concerns. No further information. References: (1) If you have asthman nebulizer as treatmental as metered-dose inhomographic familiar pocket-sized easier to use than M who aren't old enough adults with severe as liquid medicine into a asthman. They come versions. They come versions. They come versions as to a table and made up of a base that container for that connects the air container. Above the mouthpiece or mask	a.m., an interview was (administrative staff ector of nursing. When e purpose of the care plan, have a written document of " After being informed of the dent # 268's oxygen flow rate iseline care plan for Resident asked if the care plan was ASM # 2 stated, "No." p.m., ASM (administrative te administrator, ASM # 2, g, and ASM # 5, ing were made aware of the on was provided prior to exit. a., your doctor may prescribe the nent or breathing therapy. The same types of medication alers (MDIs), which are the inhalers. Nebulizers may be DIs, especially for children gh to properly use inhalers, or esthma. A nebulizer turns a mist to help treat your in electric or battery-run in both a portable size you and a larger size that's meant plug into a wall. Both are nat holds an air compressor, liquid medicine, and a tube compressor to the medicine medicine container is a you use to inhale the mist.	F 655			
	container. Above the mouthpiece or mask	e medicine container is a				

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Event IO: 62X7 t1

Facility IO: VA0080

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STATEMENT OF OEFICIENCIES IX1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) OATE SURVEY COMPLETEO	
	ROVIDER OR SUPPLIER LE REHABILITATION (495249 & HEALTH CARE CENTER LLC		EET AODRESS, CITY, STATE, ZIP CODE 5 SCOTT DRIVE ROUTE 5	C 02/23/201 <u>8</u>
			FAR	MVILLE, VA 23901	
(X4) IO PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IOENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 655 F 656 SS=D	er-machine. (2) High blood presobtained from the whttps://www.nlm.nihessure.html. (3) A group of sympaffect the brain. The from the website: https://www.nlm.nihml. (4) A cancer that be white blood cell. The immune system, where we from germs and oth time, myeloma cell and in the solid part was obtained from https://medlineplus.Develop/Implement CFR(s): 483.21(b) (1) The implement a complex care plan for each resident rights set is \$483.10(c)(3), that objectives and time medical, nursing, a	ine.com/health/asthma-nebuliz sure. This information was vebsite: n.gov/medlineplus/highbloodpr btoms caused by disorders that his information was obtained n.gov/medlineplus/dementia.ht egins in plasma cells, a type of lese cells are part of your hich helps protect the body her harmful substances. In s collect in the bone marrow ts of bones. This information the website: .gov/multiplemyeloma.html. t Comprehensive Care Plan	F 655		
	describe the follow	omprehensive care plan must ing - It are to be furnished to attain			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY
				······································	•	c
 -		495249	8. WING		02/	23/2018
NAME OF P	ROVIDER OR SUPPLIER		Ş	STREET ADDRESS, CITY, STATE, ZIP CODE		-
FARMVILL	LE REHABILITATION 8	HEALTH CARE CENTER LLC	1	575 SCOTT DRIVE ROUTE 5		
		THE TENTE OF THE T		FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	.D 8E	(X5) COMPLETION OATE
F 656	physical, mental, ar required under §48 (ii) Any services that under §483.24, §48 provided due to the under §483.10, inclutreatment under §4 (iii) Any specialized rehabilitative service provide as a result recommendations. findings of the PAS rationale in the resident's represent (A) The resident's periode desired outcomes. (B) The resident's pure discharge. Fawhether the resider community was assolical contact agence entities, for this pure (C) Discharge plans plan, as appropriate requirements set for section. This REQUIREMENT by: Based on staff intereview, clinical recomprehensive can in the survey sample #104.	dent's highest practicable and psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required (3.25 or §483.40 but are not resident's exercise of rights uding the right to refuse (83.10(c)(6)). services or specialized es the nursing facility will of PASARR (If a facility disagrees with the ARR, it must indicate its dent's medical record. With the resident and the tative(s)-locals for admission and preference and potential for acilities must document att's desire to return to the desire to return to the desire and/or other appropriate cose. If in accordance with the right in paragraph (c) of this acility document are review, it was determined detected to develop and implement a deplan for three of 30 residents et, Residents #15, #80 and	F 656	· · · · · · · · · · · · · · · · · · ·		
	1. The facility staff care plan for Reside	failed to implement the pain ent # 51.				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495249	B. WING		C 02/23/2	2018
	ROVIDER OR SUPPLIER LE REHABILITATION & H	HEALTH CARE CENTER LLC	l ¹⁵	REET ADDRESS, CITY, STATE, ZIP CODE 575 SCOTT DRIVE ROUTE 5 ARMVILLE, VA 23901	32,23,,	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE C	JX5) DMPLETION OATE
F 656	Continued From page 2. The facility staff fa		F 656			
	comprehensive care					
	3. The facility staff fa #104's comprehensiv administration of oxyg					
	The findings include:					
	The facility staff facare plan for Residen	iled to implement the pain t # 51.				
	04/10/2017with diagn not limited to kidney f	Imitted to the facility on oses that included but were ailure, diabetes mellitus (1), hypertension (2), and				
	set), a quarterly asse (assessment reference Resident # 51 as sco # 51 was unable to co for mental status (BIM coded as being mode on the "Staff Assessin Resident # 51 was co	recent MDS (minimum data ssment with an ARD ce date) of 12/21/17, coded ring a 99 indicating Resident complete the brief interview IS). Resident # 51 was rately impaired of cognition nent for Mental Status." ded as requiring total ff member for activities of				
	# 51 dated "Feb (Feb "Acetaminophen Sup	order Sheet) for Resident ruary), 2018 documented, pository (4) - 650 MG one) suppository rectally				

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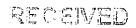
	STATEMENT OF OEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA NO PLAN OF CORRECTION IOENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILOING		(X3) OATE SURVEY COMPLETEO	
		495249	B. WING			C 2/23/2018	
	ROVIOER OR SUPPLIER LE REHABILITATION 8	HEALTH CARE CENTER LLC	i 15	TREET AOORESS, CITY, STATE, ZIP COOE 575 SCOTT DRIVE ROUTE 5 ARMVILLE, VA 23901		<u> </u>	
(X4) IO PREF∤X TAG	(EACH OEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEOEO BY FULL R LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCEO TO THE APPR OEFICIENCY)	JLO BE	(X5) COMPLETION DATE	
F 656	every 8 (eight) hour 4 (four) grams in 24 10/19/2017. Start I The eMAR (electror record) dated Dece "Acetaminophen So suppository rectally grams in 24 hours. Further review of th administration of Ac 650 MG on 12/03/1 6:00 a.m., 12/08/17 6:00 a.m., 12/10/17 a.m., and 12/31/17 Review of the facilit 12/01/17 through 12 failed to evidence d administration of Ac	rs for pain NTE (not to exceed) thours. Order Date: Date: 10/19/2017." Inic medication administration Imber, 2017 documented, Impository - 650 MG. Insert 1 In every 8 hours for pain NTE 4 In Order Date: 10/19/2017." In ee MAR failed to evidence the extaminophen Suppository - That 6:00 a.m., 12/04/17 at at 6:00 a.m., 12/04/17 at at 6:00 a.m.; 21/21/17 at 6:00 at 6:00 a.m. The region of the missing extaminophen Suppository -	F 656				
	6:00 a.m., 12/08/17	7 at 6:00 a.m., 12/04/17 at f at 10:00 p.m., 12/09/17 at f at 6:00 a.m.; 21/21/17 at 6:00 f at 6:00 a.m.					
	with a revision date "Focus: Alteration ir disease process. D Under "Intervention medications as order and effectiveness, side effects. Notify indicated. Date initial						
	conducted with ASM member) # 3, the as	5 a.m., an interview was M (administrative staff ssistant director of nursing, cribe the purpose of the care					

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Eveni IO:62X711

Facility (O: VA0080

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MAR 28 2018

STATEMENT OF OEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILOING	E CONSTRUCTION	(X3) OATE SURVEY COMPLETEO	
	ROVIOER OR SUPPLIER LE REHABILITATION (495249 & HEALTH CARE CENTER LLC	i 1	STREET AOORESS, CITY, STATE, ZIP COOE 575 SCOTT DRIVE ROUTE 5	C 0 2/ 2 3/ 2 01 <u>8</u>
(X4) IO PREFIX	(EACH OEFICIE	STATEMENT OF OEFICIENCIES NCY MUST BE PRECEOEO BY FULL	IO PREFIX	PROVIDER'S PLAN OF CORRECTIO	, ···
TAG	REGULATORY (OR LSC IOENTIFYING INFORMATION)	TAG	CROSS-REFERENCEO TO THE APPROP	RIATE DATE
F 656	•	•	F 656		
	treatment for reside eMAR, progress no	ed, "It guides the care and ent." After reviewing the otes and care plan for Resident ed, "The care plans was not			
	conducted with AS member) # 2, the d asked to describe t	0 a.m., an interview was M (administrative staff lirector of nursing. When the purpose of the re plan, ASM # 2 stated, "To			
	have a written docu After reviewing the	ument of care for the resident." eMAR, progress notes and ent # 51, ASM # 2 stated, "The			
	staff member) # 1, the director of nurs	0 p.m. ASM (administrative the administrator, ASM # 2, ing, and ASM # 5, ining were made aware of the			
	No further informat	ion was provided prior to exit.			
 	References:				
	regulate the amour goal of treatment a blood glucose leve prevent complication to treat and managactive and eating hwas obtained from	se in which the body cannot of sugar in the blood. The trist is to lower your high l. Long-term goals are to ons. The most important way to type 2 diabetes is by being ealthy foods. This information the website: .gov/ency/article/000313.htm.			
	obtained from the v	ssure. This information was website:			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	•		(X3) DATE SURVEY COMPLETED	
		495249	B. WING		n.	C
	ROVIDER OR SUPPLIER	HEALTH CARE CENTER LLC	1 1575	EET ADDRESS, CITY, STATE, ZIP CODE S SCOTT DRIVE ROUTE 5 RMVILLE, VA 23901		2/23/201 <u>8</u>
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE , DEFICIENCY)	SHOULD BE	IX5) COMPLETION OATE
F 656	website: https://www.nlm.nih #summary. (4) Used to relieve headaches, muscle colds and sore thro and reactions to vareduce fever. Aceta to relieve the pain of caused by the brea joints). Acetaminop medications called antipyretics (fever rithe way the body so body. This information website: https://medlineplus.tml. (5) Stomach content the esophagus and was obtained from https://www.nlm.nih (6) The rapid (less to kidneys' ability to refluids and electrolytics.	mation was obtained from the a.gov/medlineplus/anxiety.html mild to moderate pain from aches, menstrual periods, ats, toothaches, backaches, ccinations (shots), and to aminophen may also be used of osteoarthritis (arthritis kdown of the lining of the hen is in a class of analgesics (pain relievers) and educers). It works by changing enses pain and by cooling the tion was obtained from the gov/druginfo/meds/a681004.h ats to leak back, or reflux, into irritate it. This information the website: a.gov/medlineplus/gerd.html.	F 656			
	https://medlineplus. 2. The facility staff comprehensive care	tained from the website: gov/ency/article/000501.htm. failed to develop a e plan that addressed betes and treatment with				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	ROVIDER DR SUPPLIER LE REHABIL TAT ON	495249 & HEALTH CARE CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		C 02/23/201 <u>8</u>	
(X4) ID PREFIX TAG	(EACH DEFICE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IOENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 656	Resident #80 was 4/17/15 with a rea diagnoses that inc blood pressure, di stroke, depressior cognitive commun	admitted to the facility on dmission date on 1/5/18 with clude but not limited to high fficulty speaking following a n, difficulty swallowing and	F 656			
	set), a quarterly a (assessment refer Resident #80 as s on the BIMS (briet indicating that Resolutions)	essessment with an ARD ence date) of 2/3/18, coded coring a six out of a possible 15 interview for mental status), sident #80 is severely ed with decisions of daily living.				
	reveal, in part, the [1] (insulin to treat (protamine) & (and 100 UNIT/ML (mill subcutaneously (u for DM (diabetes r Lispro Suspension	ent #80's physician orders following order: "Insulin Lispro high blood sugar) Prot d) Lispro Suspension (75-25) iliters) Inject 12 unit under the skin) in the evening mellitus). Insulin Lispro Prot & a (75-25) 100 UNIT/ML Inject 12 sly in the morning for DM."				
	plan dated 1/5/18	ent #80's comprehensive care did not have any garding treatment with insulin				
	conducted with RI MDS coordinator. the purpose of the try to foresee any put interventions i happens we try to When asked who	4 p.m. an interview was N (registered nurse) #2, the RN #2 was asked to describe care plans. RN #2 stated, "To problems that may occur and nto place. Once something prevent it happening again." was responsible for developing				

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Event ID: 62X711

Facility ID: VA0080

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STATEMENT OF OEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA NO PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILOING		(X3) OATE SURVEY COMPLETEO		
		405240			•	c ļ
NAME OF D	ROVIOER OR SUPPLIER	495249	B. WING		02/	23/201 <u>8</u>
		3 HEALTH CARE CENTER LLC	l 1	BTREET ADORESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		
(X4) IO PREFIX TAG	(EACH OEFICIE	STATEMENT OF OEFICIENCIES NCY MUST BE PRECEOEO BY FULL DR LSC IOENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROPR OEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	plans. Once devel team) reviewed an needed. When ask completed for Res and diabetes, RN in plan and stated sh writer. On 2/23/18 at approprieting was conducted administrator, ASM and ASM #5, the at #1, ASM #2 and ASM above concern at the requested for the comprehensive call. No further informate and of the survey produced by the before the blood into used for energy. It producing more surobtained from the survey producing more surbtained from the survey producing from the survey producing from the survey producing from the survey producing from the survey producing from the survey producing from the survey producing from the survey producing from the survey producing f	velop the comprehensive care oped the IDT (interdisciplinary drevised the care plans as ed if a care plan had been dent #80's insulin treatments 2 was unable to locate a care would get back with this example with ASM #1, the 1 #2, the director of nursing, dministrator in training. ASM 6M #5 were made aware of the his time and a policy was evelopment of a e plan. In was provided prior to the process. Insulin lispro is a short-acting, of human insulin. Insulin lispro the insulin that is normally only and by helping move sugar other body tissues where it is also stops the liver from gar. This information was	F 656			
		failed to implement Resident sive care plan for the				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					STRUCTION	(X3) DATE SURVEY COMPLETED	
		495249	B. WING				0
NAME OF P	ROVIDER OR SUPPLIER		•		T ADDRESS, CITY, STATE, ZIP CODE	02/	23/2018
FARMV LI	LE REHABILITATION & H	EALTH CARE CENTER LLC			COTT DRIVE ROUTE 5 VILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 656	Continued From page administration of oxyg		F	656			
	4/6/17 and readmitted diagnoses of but not li encephalopathy, chro pressure ulcer, high b bladder, dysphagia, hheart disease, and an recent MDS (Minimum resident as being cogmake daily life decision coded as requiring exareas of activities of diagrams." A review of the physicidated 1/24/18 for "Oxycannula" A review of the reside for "I have altered resident breathing r/t (related the require the use of oxydated 1/3/18. The interior properties of the properties of the resident of the r	mited to metabolic nic kidney disease, lood pressure, neurogenic ypothyroidism, diabetes, xiety disorder. The most n Data Set) coded the nitively intact in ability to ns. The resident was tensive assistance for all aily living. ian's orders revealed one ygen at 2 liters via nasal nt's care plan revealed one piratory status/difficulty on my disease process and I gen." This care plan was erventions included, kygen) as ordered." This					
	and 2/22/18 at 3:04 p. was observed set at 3 2/22/18 at 3:04 p.m., I Nurse) stated the resi at 2 liters. LPN #6 ch	m., 2/21/18 at 2:32 p.m., m., Resident #104's oxygen .5 liters per minute. On LPN #6 (Licensed Practical dent's oxygen should be set ecked Resident #104's unit and stated that it was at the incorrect setting.					
	On 2/23/18 at 8:16 a.r conducted with LPN #	•					

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

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(X3) DATE SURVEY COMPLETED

					С
	495249	B. WING			02/23/2018
	ROVIDER OR SUPPLIER LE REHABILITATION & HEALTH CARE CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		75 SCOTT DRIVE ROUTE 5	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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	356		
F 657 SS=D	•	F	857		

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _

(X1) PROVIOER/SUPPLIER/CLIA

STATEMENT OF OFFICIENCIES

PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

(X3) OATE SURVEY

NO FLAIN OF	CORRECTION IDENTIFE	CATION NOMBER:	A, BUILOING	3		COMPL	EIEO
		495249	B. WING			O 2 /3	: ! 3/2 018
NAME OF PI	ROVIOER OR SUPPLIER			STREET	AOORESS, CITY, STATE, ZIP COOE	02/2	3/2018
					OTT DRIVE ROUTE 5		
FARMVILL	E REHABILITATION & HEALTH CAR	E CENTER LLC			ILLE, VA 23901		;
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF C (EACH OEFICIENCY MUST BE PRI REGULATORY OR LSC IOENTIFYING	ECEOEO BY FULL	IO PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROPR DEFICIENCY)	BE	(X5 COMPLETION DATE
F 657	Continued From page 112		F 65	57	F657		
1 007	the resident and the resident's re An explanation must be included medical record if the participation and their resident representative not practicable for the developmer resident's care plan. (F) Other appropriate staff or prodisciplines as determined by the or as requested by the resident. (iii)Reviewed and revised by the team after each assessment, including comprehensive and quarterly reviassessments. This REQUIREMENT is not met by: Based on staff interview, facility review, clinical record review, it with facility staff failed to review a comprehensive care plan for one in the survey sample, Resident # The facility staff failed to review a Resident #319's comprehensive discontinuation of a chair pad alase. The finding include: Resident #319 was admitted to the survey and readmitted on 1/26 #319 was also discharged from the 2/1/18 and readmitted on 2/8/18. #319's diagnoses included but we seizures, high blood pressure and insufficiency. Resident #319's modern (minimum data set), a five day Massessment with an ARD (assest date) of 2/1/18, coded the reside intact.	in a resident's of the resident is determined ent of the fessionals in resident's needs interdisciplinary luding both the few as evidenced document was determined and revise the of 30 residents in and revise care plan for the facility on the facility on Resident ere not limited to do pancreatic fest recent MDS ledicare sment reference	F 68	2.	Resident #319's orders were updated to include a Chair al. 3/10/18. The Assistant Director of Nur and the Unit Manager compl an audit on 2/26/18 to ensur alarms had physician's order were reflected correctly on the plan as required. The Licensed Nurses will be reducated on the review and revising of care plans as required. 3/14/18.	sing eted e all and ne care e-	
RM CMS-256	37(02-99) Previous Versions Obsolete	Event IO: 62X711	t	Facility IO	: VA0080 If continu	ation sheet F	age 113 of 185

(X2) MULTIPLE CONSTRUCTION

RECEIVED MAK 28 2018

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495249	8. WING			C /23/2018	
	ROVIDER OR SUPPLIER	HEALTH CARE CENTER LLC	_[1	STREET ADDRESS, CITY, STATE, ZIP CODE 575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		23/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULO BE	(X5) COMPLETION DATE	
F 657	Resident #319's com revised on 1/22/18 d FOR FALL RELATED WITH A CHAIR PAD On 2/21/18 at 12:35 observed propelling wheelchair in the hal observed in the resident of the cord dangling, attached to a box to 2/21/18 at 1:40 p.m., observed in a wheelchair in the wheelchair in the wheelchair station. The observed in the wheelchair station. The observed in the wheelchair gard allow make the alarm function of 2/22/18 at 1:45 pmember) #3 (the assignormation sheet, per chair pad alarm was required for the resident withospital. On 2/22/18 at 1:58 pmursing) stated Resident withospital. On 2/22/18 at 1:58 pmursing) stated Resident withospital. On 2/22/18 at 2:28 pmursing) stated Resident withospital.	prehensive care plan ocumented, "I AM AT RISK O INJURIESPROVIDE ME ALARM" p.m., an employee was Resident #319 in a I. A chair pad alarm was Itent's wheelchair with the end The end of the cord was not make the alarm function. On Resident #319 was chair in an alcove near the chair pad alarm was elchair with the end of the as not attached to a box to tion. .m. ASM (administrative staff sistant director of nursing) 319's nurse aide's er this surveyor's request. A not documented as being Itent. ASM #3 stated the not ordered by the physician as readmitted from the .m., ASM #2 (the director of dent #319 had no current a chair pad alarm and the een resolved from the care .m. ASM #1 (the SM #2 were made aware of	F 657	4. The Assistant Director of and the Unit Manager will an audit of 5 current reside each unit to ensure care previewed and revised for weekly for 4 weeks and m2 months. The Staff Deve Coordinator will submit a the Quality Assurance Commonthly for 3 months. The of Nursing will be responsimentationing and follow up Completion date: 3/30/18	Il complete dents on plans are alarms nonthly for lopment report to mmittee e Director sible for		

PRINTED: 03/09/2018

		ID HUMAN SERVICES MEDICAID SERVICES	FORM APPR OMB NO. 0938			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495249 NAME OF PROVIDER OR SUPPLIER FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC		1	E CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED C 02/23/2018	
		1	STREET ADDRESS, CITY, STATE, ZIP COO 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULO BE	(X5) COMPLETION DATE
F 658 SS=D	ongoing and care plainformation about the condition change" No further information Services Provided McCFR(s): 483.21(b)(3) §483.21(b)(3) Composition Composit	essments of residents are no are revised as resident and the resident's awas presented prior to exit. Let Professional Standards i) chensive Care Plans d or arranged by the facility, apprehensive care plan,	F 65			
	contact the Hospice p administration of Ativa Resident #27. 2. The facility staff ac Resident #66 on five	an [1] 0.5 mg (milligrams) to				

FORM CMS-2567(02-99) Previous Versions Obsolete

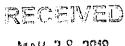
The findings include:

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

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Facility ID: VA0080

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES	,		OMB NO. 0938-0391
	OF OEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
NAME OF PROVIOER OR SUPPLIER FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC (X4) IO SUMMARY STATEMENT OF OEFICIENCIES PREFIX (EACH OEFICIENCY MUST BE PRECEOEO BY FULL TAG REGULATORY OR LSC IOENTIFYING INFORMATION)			B. WING	C 02/23/201 <u>8 </u>	
F 658	Continued From page pressure, colon cancer disease. Resident #2 (minimum data set) a assessment with an Adate) of 12/9/17. Resident scoring a 06 out of pointerview for Mental Swas coded as being is supervision only with meals and ambulation from one staff member personal hygiene and coded in section O "(Sprocedures, and Progedures, and Progedures) and Progedures and Signed by through 12/2017 doct "Lorazepam (Ativan) Give 1 tablet as every AnxietyCall HOSPIG BEFORE USE!" This 1/4/18. Review of Resident # (medication administration Resident #27 receives 3:17 a.m., and 11:44 p.m.	e 115 er, and atherosclerotic heart 17's most recent MDS ssessment was a quarterly 1RD (assessment reference sident #27 was coded as ed in cognitive function resible 15 on the BIMS (Brief status) exam. Resident #27 Independent and requiring bed mobility, transfers, in; and extensive assistance er with dressing, bathing, I toileting. Resident #27 was Especial Treatments, grams)" as receiving 27's physician order sheets the physician on 9/2017 Imented the following order: Tablet 0.5 mg (milligrams) I d hours as needed for DE MD (medical doctor) order was discontinued on 27's September 2017 MAR ation record) revealed that d Ativan 0.5 mg on 9/3/17 at p.m., and 9/13/17 at 5:14	F 658	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCEO TO THE APPRODE OFFICIENCY) F658 1. On 2/19/18, a physician's was obtained to disconting Ativan for resident # 27. 2. The Medical Director was 2/23/18 that resident #66 receiving insulin without physician's order. 3. LPN's # 8 was re-educated Staff Development Coord on 2/23/18 related to foll physician orders and obtain physician orders for a challon condition of a resident. The Licensed Nurses will educated by Staff Development Coordinator regarding physician and obtaining from a physician by 3/14/	s prder nue s notified 6 was a d by the linator lowing aining inge in be re- pment sysician g orders
		nt #27 received Ativan 0.5 p.m., and 11/17/17 at 5:49			

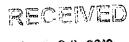
FORM CMS-2567(02-99) Previous Versions Obsolete

The following note was documented on 9/3/17 at 3:17 a.m.: "Lorazepam Tablet 0.5 mg every 4

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Facility IO: VA0080

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	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION	(X3)) DATE SURVEY COMPLETED
		495249	B. WING				C
NAME OF D	ROVIDER OR SUPPLIER	430243	D. VMNO.				02/23/2018
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	!	
FARMVILI	E REHABILITATION &	HEALTH CARE CENTER LLC			S75 SCOTT DRIVE ROUTE 5 ARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	IX5) COMPLETION OATE
F 658	hours as needed for before use! Ativan 0. mouth as ordered for The next note dated documented the follonotified made aware mouth administered Further review of Redated September 20 failed to evidence the PRIOR to the administration of the following at 9:36 a.m. facility nurse), calling (Name of nurse) admat 0300 (3:00 a.m.). call Hospice before glorazepam. (Name sleeping now. Notifier (medical doctor) pati anxiety. No visit need. No further hospice in administration could record. On 2/22/18 at 9:33 a conducted with RN (hospice nurse. RN # process followed pricadministering prn Ati stated that nursing sthe need for Ativan, trying other methods prior to administering	Anxietycall Hospice MD 5 mg (milligrams) given by r increased anxiety." 9/3/17 at 4:04 a.m. pwing: "(Name of Hospice) of Ativan 0.5 mg 1 tablet by as ordered for anxiety." sident #27's nursing notes 17 through November 2017 at hospice was notified stration of Ativan. I 9/3/17 documented the .: "Phone call from: (Name of stating patient anxious. ninistered Lorazepam 0.5 mg (Name of nurse) unaware to giving initial dose of of nurse) stated patient d (Name of Hospice) MD ent received Lorazepam for ded at this time." otes regarding Lorazepam be found in the clinical .m., an interview was registered nurse) #5, the 45 was asked about the	F	658	4. The Assistant Director and the Unit Manager medical records weekl weeks and monthly fo to ensure physician not and physician orders a as required. The Staff Development Coordin submit a report to the Assurance Committee for 3 months. The Director Nursing will be response monitoring and follow Completion date: 3/30/18	will audit's ly for 4 or 2 months otification are in place stator will e Quality e monthly ector of ensible for	5

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A BUILDING

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495249	B. WNG _		C 0 2/23/2 018
NAME OF PROVIDER OR SUPPLIER FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901	V2 20/20 IV
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR X (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPLETION
F 658	contact hospice pinitial dose of Ativ nursing staff to ac without notifying haven asked the motify hospice price dose of Ativan, RI and the hospice pithe behaviors that RN #5 stated hos nursing staff are a #5 confirmed the administered Ativanotified hospice. made aware after the order was not stated she had no notes of nursing sprior to the admin 11:44 p.m., 9/13/1 p.m. and 11/17/17 staff did not have the Ativan order s #5 stated again the notify hospice after given. On 2/22/18 at: 12 conducted with LF When asked if she Ativan order, LPN hospice prior to gwould call hospice or just for the first "Every time I wouthe order says." On 2/23/18 at 8:5	page 117 rior to administering the first an. RN #5 stated that it is ok for Iminister other doses of Ativan riospice after the first initial dose, rationale for nursing staff to or to administering the first initial N #5 stated the hospice staff, rhysician, need to be aware of the warrant the need for Ativan. Pice needs to be aware that ridministering Ativan as well. RN rurse working on 9/3/17 ran to Resident #27 before she RN #5 stated hospice was administration. RN #5 stated followed that morning. RN #5 rodocumentation in her hospice rtaff notifying them (hospice), ristration of Ativan on 9/3/17 at 7 at 5:14 p.m., 11/9/17 at 9:59 rat 5:49 p.m., but that nursing to notify them. RN #5 stated rhould have been clarified. RN re nursing does not have to re the first initial dose has been ref. 3 p.m., an interview was ref. (licensed practical nurse) #5. re could interpret the above ref. 5 stated she would call riving Ativan. When asked if she re every time Ativan was needed ritial dose, LPN #5 stated. Id call before use. That is what	F	558	

STATEMENT OF OEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA ANO PLAN OF CORRECTION IOENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILOING		
<u>.</u>		495249	B. WING		C 0 2/23/2 018
	ROVIOER OR SUPPLIER LE REHABILITATION & I	HEALTH CARE CENTER LLC	I 157	REET AOORESS, CITY, STATE, ZIP CO 5 SCOTT DRIVE ROUTE 5 RMVILLE, VA 23901	OE .
(X4) IO PREFIX TAG	(EACH OEFICIENC	TATEMENT OF OEFICIENCIES OF MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCEO TO THI DEFICIENCY)	IN SHOULO BE COMPLÉTION DATE
F 658	LPN #8 stated she w supposed to notify he Ativan to Resident #2 remember if she had administering Ativan On 2/22/18 at 5:01 p staff member) #1, the DON (Director of Nur ADON (Assistant Dir aware of the above of Ativan is a benzodiaz central nervous system obtained from The N https://www.ncbi.nlm T0010988/?report=d 2. The facility staff a Resident #66 on five	istered Ativan on 11/9/17. It is not sure if she was espice prior to administering 27. LPN #8 could not notified hospice prior to on 11/9/17. I.m., ASM (administrative administrator, ASM #2, the rsing) and ASM #3, the ector of Nursing) were made concerns. It can symptoms of anxiety. It is information was ational Institutes of Health. Inih.gov/pubmedhealth/PMH	F 658	DEFICIENCY	
	9/6/17 with a readmis diagnoses that including diabetes, end stage is heart failure and dem Resident #66's most set), a quarterly asse (assessment referen Resident #66 as scoon his BIMS (brief integrals).	recent MDS (minimum data essment with an ARD ce date) of 1/3/18, coded ring a 10 out of a possible 15 erview for mental status) ent #66 is moderately			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC		8. WING	ST 15	TREET ADDRESS, CITY, STATE, ZIP CODE 575 SCOTT DRIVE ROUTE 5 ARMVILLE, VA 23901		C 23/201 <u>8</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPR DEFICIE NC Y)	3E	JX5) COMPLETION DATE
F 658	A review of Resident revealed, in part, the "NovoLOG [1] (insulin administration) Solution ML (milliliters) Inject a = 0 UNITS; 150 - 199 UNITS; 250 - 299 = 3 UNITS; 350 - 400 = 5 (beneath the skin) be related to TYPE 2 DIADIABETIC CHRONIC A review of Resident (medication administr part, the following ent Solution Pen - Injecto per sliding scale: If 0 = 1 UNIT; 200-249 = 3 UNITS; 300 = 349 = 4 UNITS; 300 = 349 = 4 UNITS, subcutaneous bedtime related to TYMELLITUS WITH DIADISEASE." On the fithe blood sugars were than 400 and a dose as given: - 1/8/18; 4:30 p.m. bloomsulin administered - 1/10/18; 11:30 a.m. b insulin administered - 1/10/18; 4:30 p.m. b insulin administered	#66's clinical record following physician order; a) FlexPen (method of on Pen-Injector 100 UNIT / as per sliding scale: If 0-149 = 1 UNIT; 200- 249 = 2 UNITS; 300 - 349 = 4 UNITS, subcutaneously fore meals and at bedtime ABETES MELLITUS WITH KIDNEY DISEASE." #66's February MAR ation record) revealed, in ries; "NovoLOG FlexPen r 100 UNIT / ML Inject as -149 = 0 UNITS; 150 - 199 2 UNITS; 250 - 299 = 3 4 UNITS; 350 - 400 = 5 sly before meals and at	F	658			
	reveal any documenta been notified about th	#66's progress notes did not ation that the physician had e blood sugars being vidence of an order received					

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STATEMENT OF OEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILOING		(X3) OATE SURVEY COMPLETEO		
		495249	B. WING			C
NAME OF PROVIOER OR SUPPLIER FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC		STREET AOORESS, CITY, STATE, ZIP COOE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901				
(X4) IO PREFIX TAG	(EACH OEFICIEN	STATEMENT OF OEFICIENCIES NCY MUST BE PRECEOEO BY FULL R LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCEO	N OF CORRECTION ACTION SHOULO BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION OATE
F 658	A review of Resider plan dated 12/30/17 following document DM (diabetes mellit times (refusing to he Date Initiated: 10/13/2/21/2018. Interver ORDERED, ACCU NOTIFY MD (medic FINDINGS. MONIT HYPO/HYPERGLY) INDICATED Date In 10/17/17." On 2/23/18 at 7:59 conducted with LPN LPN #9 was asked if a resident's blood sliding scale param blood sugar is within the doctor then I wo outside of the parar there was no ordere blood sugar and no be aware and could orders for the insulin sugar 30 minutes for make sure that the effective." LPN #9 document this inform progress notes."	ge 120 ar of greater than 400. at #66's comprehensive care revealed, in part, the ation; "Focus: HX (history) of us) with refusal of care at ave blood sugar checked) r/2017 Revision on: ations: INSULIN AS CHECKS AS ORDERED, ald doctor) FOR ABNORMAL TOR FOR SX (symptoms) of CEMIA, NOTIFY MD AS atitiated 10/17/17. Revision on: a.m., an interview was I (licensed practical nurse) #9. to describe what she would do sugar was outside of the eter. LPN #9 stated, "If the in the parameters provided by ould give the ordered insulin. If meters, I would document that ed coverage for the recorded tify the doctor so that he would I give orders. If he gives in I would recheck the blood bllowing administration to treatment provided was was asked where she would mation, LPN #9 stated, "In the a.m., a telephone interview	F 658			
	was conducted with documented Reside					

LPN #8 was asked to describe the process

(X1) PROVIOER/SUPPLIER/CLIA

STATEMENT OF OFFICIENCIES

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	OF OEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
		495249	B. WING _		C 0 2/2 3/ 2 01 8
NAME OF PROVIOER OR SUPPLIER FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC			STREET AOORESS, CITY, STATE, ZIP COOR 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		
(X4) IO PREFIX TAG	(EACH OEFICIE	STATEMENT OF OEFICIENCIES NCY MUST BE PRECEOEO BY FULL OR LSC IOENTIFYING INFORMATION)	ID PREFIX TAG	PROVIOER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCEO TO THE OEFICIENCY)	SHOULO BE COMPLETION
F 658	scale. LPN #8 stat the insulin as order obtained. LPN #8 blood sugar was grovided, for exam sliding scale only with she would call the her to do. When a additional order, LF write the order and talked with the doc was." LPN #8 was Resident #66, LPN #8 was provided the results in February and asked if she reductor about the retalked to the doctor do not remember to whether or not I cashe would have dowith the doctor, LP notes." On 2/23/18 at 9:05 conducted with AS member) #4, the masked if a resident addresses blood signal and so with the doctor and the saked if a resident addresses blood signal and so with the masked if a resident addresses blood signal and so with the doctor.	stering insulin on a sliding ed that she would administer ed based on the accu check was asked what she did if the reater than the sliding scale ple greater than 400 if the rent to 400. LPN #8 stated that doctor and ask what he wanted sked if she would get an PN #8 stated, "Yes, I would include in my notes that I had for and what the new order asked if she took care of #8 stated that she did. LPN e dates and the accu check that were greater than 400 membered contacting the sults. LPN #8 stated, "If I I would have documented it. I hat far back. So I can't say led him." When asked where cumented her conversation N #8 stated, "In the progress a.m., an interview was M (administrative staff edical doctor. ASM #4 was is on a sliding scale that ugars up to 400 what should blood sugar is greater than	F 6	58	
	of the parameters to contact me and treat that incident." that Resident #66 this MAR on five on were greater than 4	ed, If the blood sugar is outside then I expect the nursing staff would give a specific order to When asked if he was aware had blood sugars recorded on casions in February 2018 that 100, ASM #4 stated, "I was ood sugars were that high. I			

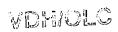
ORM CMS-2567(02-99) Previous Versions Obsolete

Event IO: 62X711

Facility IO: VA0080

If continuation sheet-Rage 122 of 185

MAR 28 2018



PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCES (X1) PROVIDER/SUPPLIER/CLIA ANO PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DA	(X3) DATE SURVEY COMPLETED		
	ROVIOER OR SUPPLIER LE REHABILITATION & H	495249 EALTH CARE CENTER LLC	B. WING S	TREET AODRESS, CITY, STATE, ZIP CODE 575 SCOTT DRIVE ROUTE 5 ARMVILLE, VA 23901	. 0	C 2/23/201 <u>8</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 658	should get called by the address appropriately. On 2/23/18 at approximeeting was conducted administrator, ASM #2 and ASM #5, the administrator, and #5, the administrator, and #6, the administrator at this which standard of practice and an administrator at this which standard of practice and ards of practice. No further information and of the survey process a rapid analog indicated to imadults and children with information was obtain website; https://dailymed.nlm.r.	mately 10:00 a.m., a sed with ASM #1, the 2, the director of nursing, inistrator in training. ASM #5 were made aware of the time. ASM #2 was asked ctice the facility nursing staff ted that they followed the set forth by the Virginia	F 658			
F 684 SS=D	Patricia A. Potter and Inc; Page 419 "The p directing medical trea obligated to follow phy	Nursing" 6th edition, 2005; Anne Griffin Perry; Mosby, hysician is responsible for tment. Nurses are vsician's orders unless they in error or would harm	F 684			

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AD LEWIS OF	, IDENTIFICATION NOWBER.	A. BUILDING		COMPLETED
	495249	B. WING		C 02 /2 3/ 2 018
NAME OF PI	ROVIDER OR SUPPLIER	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	0212312010
			575 SCOTT DRIVE ROUTE 5	
FARMVILL	E REHABILITATION & HEALTH CARE CENTER LLC	į.	ARMVILLE, 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 OATE
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:	F 684	The Medical Director was notified 2/23/18 that resident #66 was receivinsulin without a physician's order. 2. Unit Manager and Assistant Director 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	ing or is
	The facility staff administered insulin to Resident #66 on five occasions when his blood sugar was greater than 400 without a physician order.		orders from a physician by 3/14/18.	_
,	Resident #66 was admitted to the facility on 9/6/17 with a readmission on 12/30/17 with			

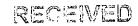
(X2) MULTIPLE CONSTRUCTION

ORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 62X711

Facility ID: VA0080

If continuation sheet Page 124 of 185



STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	[CONSTRUCTION		(X3) OATE SURVEY COMPLETEO	
		495249	B. WING		02/	C 23/20 1 <u>8</u>	
	ROVIOER OR SUPPLIER	& HEALTH CARE CENTER LLC	15	FREET AOORESS, CITY, STATE, ZIP COOE 575 SCOTT ORIVE ROUTE 5 ARMVILLE, VA 23901	:		
(X4) IO PREFIX TAG	(EACH OEFICI	Y STATEMENT OF OEFICIENCIES ENCY MUST BE PRECEOEO BY FULL OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCEO TO THE A OEFICIENCY)	SHOULO BE	(X5) COMPLETION OATE	
F 684	diabetes, end stage heart failure and of heart failure and of the resident #66's meset), a quarterly a (assessment refer Resident #66 as son his BIMS (brief indicating that Resimpaired with dec A review of Resider revealed, in part, "NovoLOG [1] (insuministration) Some ML (milliliters) Injection of the skin; related to TYPE 2 DIABETIC CHRO A review of Resident (medication administration) A review of Resident (medication administration) and the following Solution Pen - Injection Pen - Inje	cluded but were not limited to ge kidney disease, congestive	F 684	4. The Assistant Director of the Unit Manager will aud records weekly for 4 week monthly for 2 months to e physician notification and orders are in place as requisionability. Staff Development Coordi submit a report to the Quantitation and months. The Director of N responsible for monitoring up. Completion date: 3/30/18	lit 5 medical as and ensure physician uired. The inator will ality nthly for 3 lursing will be g and follow		

ANO PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) OATE SURVEY COMPLETEO		
	ROVIOER OR SUPPLIER LE REHABILITATION &	495249 HEALTH CARE CENTER LLC	15	TREET AOORESS, CITY, STATE, ZIP COOE 575 SCOTT ORIVE ROUTE 5 ARMVILLE, VA 23901	02/:	23/201 <u>8</u>
(X4) IO PREFIX TAG	(EACH OEFICIEN	TATEMENT OF OEFICIENCIES CY MUST BE PRECEOEO BY FULL R LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO B CROSS-REFERENCEO TO THE APPROPRIA OEFICIENCY)		(X5) COMPLETION DATE
F 684	insulin administered - 1/10/18; 4:30 p.m. insulin administered - 1/19/18; 9/19/19/19/19/19/19/19/19/19/19	blood sugar 411 5 units of blood sugar 436 5 units of blood sugar 491 5 units of	F 684			

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF OFFICIENCIES

PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILOII	۷G			COMPL	LETED
							C	
·		495249	B. WING _				02/2	23/2 018
NAME OF P	ROVIDER OR SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP CODE			
FARMVIII	F REHABILITATION & HE	ALTH CARE CENTER LLC	I	157	75 SCOTT DRIVE ROUTE 5			
				FA	RMVILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH OEFICIENCY N	MENT OF DEFICIENCIES JUST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFI TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE		(X5) COMPLETION DATE
F 684	sugar 30 minutes follow make sure that the treat effective." LPN #9 was document this informati progress notes." On 2/23/18 at 8:52 a.m. was conducted with LP documented Resident # insulin treatment on 2/8 LPN #8 was asked to d followed for administeri scale. LPN #8 stated the insulin as ordered to obtained. LPN #8 was blood sugar was greated provided, for example gold sliding scale only went she would call the doctor her to do. When asked additional order, LPN # write the order and inclutal ked with the doctor a was." LPN #8 was ask Resident #66, LPN #8 #8 was provided the daresults in February that and asked if she remend doctor about the results talked to the doctor I will whether or not I called she would have documents.	rould recheck the blood ing administration to ment provided was asked where she would on, LPN #9 stated, "In the ", a telephone interview N #8. LPN #8 66's blood sugar and /18, 2/10/18 and 2/19/18. escribe the process ag insulin on a sliding that she would administer asked on the accu check asked what she did if the rethan the sliding scale reater than 400 if the to 400. LPN #8 stated that for and ask what he wanted if she would get an 8 stated, "Yes, I would used in my notes that I had and what the new order end if she took care of stated that she did. LPN tes and the accu check were greater than 400 abered contacting the LPN #8 stated, "If I buld have documented it. I ar back. So I can't say nim." When asked where	F	684				
	On 2/23/18 at 9:05 a.m conducted with ASM (a							

PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

	OF OEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CO		СОМІ	(X3) OATE SURVEY, COMPLETEO	
		495249	B. WING			C // 2 3/ 20 1 <u>8</u>	
	ROVIOER OR SUPPLIER LE REHABILITATION	& HEALTH CARE CENTER LLC	1575	ET AOORESS, CITY, STATE, ZIP COO SCOTT DRIVE ROUTE 5 MVILLE, VA 23901)E		
(X4) IO PREFIX TAG	(EACH OEFICIE	STATEMENT OF OEFICIENCIES ENCY MUST BE PRECEOEO BY FULL OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCEO TO THE OEFICIENCY)	N SHOULO BE E APPROPRIATE	X5 COMPLETION DATE	
F 684	asked if a resident addresses blood s the nurses do if the 400. ASM #4 state of the parameters to contact me and treat that incident, that Resident #66 his MAR on five of were greater than unaware that his behalf get called the address appropriated address appropriated ASM #5, the affective and ASM #5, the affective and ASM #2 and Ash above concern at which standard of followed. ASM #2 standards of pract Board of Nursing. No further informated of the survey [1] Novolog is a manalog indicated the adults and childred information was of website; https://dailymed.n.	nedical doctor. ASM #4 was is on a sliding scale that ugars up to 400 what should be blood sugar is greater than ed, If the blood sugar is outside then I expect the nursing staff I would give a specific order to When asked if he was aware had blood sugars recorded on casions in February 2018 that 400, ASM #4 stated, "I was lood sugars were that high. I by the nursing staff so that I can tely." Toximately 10:00 a.m., a ucted with ASM #1, the M #2, the director of nursing, administrator in training. ASM SM #5 were made aware of the this time. ASM #2 was asked practice the facility nursing staff stated that they followed the ide set forth by the Virginia	F 684				

(X1) PROVIOER/SUPPLIER/CLIA

IOENTIFICATION NUMBER:

TATEMENT OF OFFICIENCIES

NO PLAN OF CORRECTION

PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

(X3) OATE SURVEY

COMPLETEO

IO PLAN OF	CORRECTION IOENTIFICATION NUMBER:	A. BUILOING		COMPLETEO
				C
·	495249	B. WING		02/23/2018
	ROVIOER OR SUPPLIER LE REHABILITATION & HEALTH CARE CENTER LLC	1575	ET AOORESS, CITY, STATE, ZIP COOE SCOTT DRIVE ROUTE 5 MVILLE, 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
F 684	Continued From page 128	F 684		
	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 AnxietyCall 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.			

(X1) PROVIOER/SUPPLIER/CLIA

STATEMENT OF OFFICIENCIES

PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

(X3) OATE SURVEY

NO PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILOIN	IG		COMPLETED
						С
		495249	B. WING _			0 2 /2 3 /2018
NAME OF P	ROVIOER OR SUPPLIER			STREE	ET AOORESS, CITY, STATE, ZIP COOE	
EA DMM/ILL	E DEHABILITATION & H	EALTH CARE CENTER LLC	1	1575 \$	SCOTT ORIVE ROUTE 5	
LVIZIMIAICE	LE REMABILITATION & TH	EACH CARE CERTER CEC		FARI	//VILLE, VA 23901	
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG		PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETION E DATE
F 684	Continued From page	129	F 6	84		
	revealed that Residen	27's November 2017 MAR t #27 received Ativan 0.5 p.m., and 11/17/17 at 5:49				
	3:17 a.m.: "Lorazepar hours as needed for A	s documented on 9/3/17 at n Tablet 0.5 mg every 4 nxietycall Hospice MD mg (milligrams) given by increased anxiety."				
	notified made aware of	/3/17 at 4:04 a.m. ving: "(Name of Hospice) of Ativan 0.5 mg 1 tablet by s ordered for anxiety."				
		•				
	following at 9:36 a.m. facility nurse), calling (Name of nurse) adm at 0300. (Name of nu before giving initial do nurse) stated patient (Name of Hospice) M	9/3/17 documented the "Phone call from: (Name of stating patient anxious. inistered Lorazepam 0.5 mg rse) unaware to call Hospice use of Lorazepam. (Name of sleeping now. Notified D (medical doctor) patient for anxiety. No visit needed				
		tes regarding Lorazepam se found in the clinical				
	Review of Resident # dated 9/13/17 docum	27's psychotropic care plan ented the following				

(X1) PROVIOER/SUPPLIER/CLIA

PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

	OF OEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) OATE SURVEY COMPLETEO	
	ROVIOER OR SUPPLIER	495249 & HEALTH CARE CENTER LLC	l ¹⁵⁷	EET AOORESS, CITY, STATE, ZIP COOE 5 SCOTT DRIVE ROUTE 5 RMVILLE, VA 23901	C 02/23/201 <u>8</u>	
(X4) IO PREFIX TAG	(EACH OEFICII	Y STATEMENT OF OEFICIENCIES ENCY MUST BE PRECEOEO BY FULL OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCEO TO THE API OEFICIENCY)	OULO BE COMPLETION	
F 684	on 2/22/18 at 9:33 conducted with RN hospice nurse. W should be done pradministering prostated that nursing the need for Ativat trying other methoprior to administer for every hospice contact hospice prinitial dose of Ativat nursing staff to adwithout notifying h When asked the motify hospice, prinitial dose of Ativat staff, and the hospaware of the behat Ativan. RN #5 stated hospice was administration. R followed that morn no documentation staff notifying ther Ativan on 9/3/17 at 9.m., 11/9/17 at 9.p.m., but that nurs them. RN #5 stated hove also been climated.	dered by the physician." 3 a.m., an interview was N (registered nurse) #5, the hen asked the process; what ior to nursing staff Ativan for Resident #27, RN #5 a staff should first be assessing in, checking vital signs, and ids such as tolleting the resident ing Ativan. RN #5 stated that patient, nursing staff must rior to administering the first in an. RN #5 stated that it is ok for minister other doses of Ativan iospice after the first initial dose, ationale for nursing staff to or to administering the first in, RN #5 stated the hospice bice physician, need to be exiors that warrant the need for sted the hospice staff needs to sing staff are administering the first in the nurse administered Ativan to one she notified hospice. RN #5 is made aware after N #5 stated the order was not ning. RN #5 stated that she had in her hospice notes of nursing in prior to the administration of at 11:44 p.m., 9/13/17 at 5:14 is p.m., and 11/17/17 at 5:49 sing staff did not have to notify ed that the Ativan order should arified. RN #5 stated again that have to notify hospice after the	F 684			

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

TATEMENT OF DEFICIENCIES

IND PLAN OF CORRECTION

PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

COMPLETED

ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	1G		COMPL	ETED
		495249	B. WING				; 23/ 2 018
NAME OF RE	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	02/2	3/2010
					S SCOTT DRIVE ROUTE 5		
FARMVILL	E REHAB LITAT ON & HEAL	TH CARE CENTER LLC		FAI	RMV LLE, VA 23901		;
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION OATE
F 684	Continued From page 13	1	F6	84			
	On 2/22/18 at 9:47 a.m., p.m. attempts were made administered the first initi 9/3/17. This nurse could interview.	to reach the nurse who al dose of Ativan on		in			
	On 2/22/18 at 5:01 p.m., staff member) #1, the add DON (Director of Nursing ADON (Assistant Directo aware of the above concentrat the facility used The Nursing professional star standard to guide nursing	ministrator, ASM #2, the) and ASM #3, the r of Nursing) were made erns. ASM #2 stated Virginia Board of udards as a professional					
	In "Fundamentals of Nurs Patricia A, Potter and And Inc; Page 419. "The phy directing medical treatme obligated to follow physic believe the orders are in clients. Therefore all ord one is found to be errone clarification from the physic	ne Griffin Perry; Mosby, sician is responsible for ent. Nurses are iian's orders unless they error or would harm ers must be assessed if eous or harmful further					
F 690	T0010988/?report=detail Bowel/Bladder Incontine	ne that depresses the This information was hal Institutes of Health, gov/pubmedhealth/PMH s.	F	690			
SS=D	§483.25(e) Incontinence §483.25(e)(1) The facility						

(X1) PROVIOER/SUPPLIER/CLIA

IOENTIFICATION NUMBER:

TATEMENT OF OFFICIENCIES

NO PLAN OF CORRECTION

PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

(X3) OATE SURVEY

COMPLETEO

NO PLAN OF	CORRECTION	IOENTIFICATION NUMBER:	A. BUILOING _	CC	MPLETEO
					С
		495249	B. WNG		02/23/2018
	ROVIOER OR SUPPLIER LE REHABILITATION & H	EALTH CARE CENTER LLC	l 15	TREET AOORESS, CITY, STATE, ZIP COOE 575 SCOTT ORIVE ROUTE 5 ARMVILLE, VA 23901	, , , ,
(X4) IO PREFIX TAG	(EACH OEFICIENC)	TEMENT OF OEFICIENCIES 'MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY	X5 COMPLETION OATE
F 690	admission receives so maintain continence use condition is or become not possible to maintain §483.25(e)(2) For a reincontinence, based of comprehensive assessensure that— (i) A resident who entindwelling catheter is resident's clinical concatheterization was note (ii) A resident who en indwelling catheter or is assessed for removas possible unless the demonstrates that caund (iii) A resident who is receives appropriate prevent urinary tractic continence to the ext §483.25(e)(3) For a rincontinence, based comprehensive asseensure that a resider receives appropriate restore as much nor possible. This REQUIREMENT by: Based on staff intenticality document reverview, it was determined to the condition of 29 residence of 29 residential conditions.	ervices and assistance to unless his or her clinical es such that continence is ain. sident with urinary on the resident's asment, the facility must ers the facility without an not catheterized unless the dition demonstrates that eccessary; ters the facility with an subsequently receives one val of the catheter as soon the resident's clinical condition theterization is necessary; incontinent of bladder treatment and services to infections and to restore ent possible.	F 690	 Resident #94's Subra Pubic cathete 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 reash was noted. 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 a required. The Licensed Nurses will be reeducated by 3/14/18 related to the care and treatment of catheters as required. 	e o

STATEMENT OF OFFICIENCIES

TATEMENT OF OEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (OF PLAN OF CORRECTION (OF PLAN OF CORRECTION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILOING			(X3) OATE SURVEY COMPLETEO		
		495249	B. WING				C 23/ 2 018
		& HEALTH CARE CENTER LLC	IO	15	TREET AODRESS, CITY, STATE, ZIP COOE 575 SCOTT DRIVE ROUTE 5 ARMV LLE, VA 23901 PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		ENCY MUST BE PRECEOED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI TAG	×	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCEO TO THE APPROPRI DEFICIENCY)	3E	COMPLÉTION DATE
F 690	leaking catheter o Hospice did not co until 2/7/18 (10 da The findings include Resident #94 was 1/02/09 and readn that included but v depression, Schiz hyperplasia (enlar most recent MDS assessment, was assessment with a date) of 1/24/18. being moderately daily decisions so (Brief Interview for Resident #94 was assistance from o mobility, transfers total dependence independent with in section O "(Spe and Programs)" a Review of Reside the following activ "Suprapubic cathe Change prn (as ni physician for occle Review of the nur	documented as having a in 1/29/18 at 10:26 p.m. ome in to change his catheter ys later). de: admitted to the facility on nitted on 7/2/17 with diagnoses were not limited to manic ophrenia, and Benign prostatic ged prostate). Resident #94's (minimum data set) a significant change an ARD (assessment reference Resident #94 was coded as impaired in the ability to make oring 08 out of 15 on the BIMS or Mental Status) exam. coded as requiring extensive me staff member with bed in toileting, personal hygiene; on staff with bathing, and meals. Resident #49 was coded exial Treatments, Procedures, is receiving Hospice Care. Int #94's clinical record revealed de order dated 11/29/17: exter 24 fr (french) 10 cc bulb. deeded) or as ordered by usive BPH."	F	590	4. The Assistant Director of Nursand Unit Manager will audit 5 residents on each unit weekly weeks and monthly for 2 monensure the treatment and carcatheters are carried out as required. The Staff Developme Coordinator will submit a report the Quality Assurance Commimonthly for 3 months. The Director of Nursing will be responsible the monitoring and follow up. Completion date: 3/30/18	for 4 ths to e of ent ort to ttee rector for	
	the following: "Re Catheter[1] leakir	ed 1/29/18, that documented s, (Resident) Supra-pubic ng (Name of Hospice) RN from (Name of Hospice group)		:			

PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

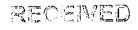
	TATEMENT OF OEFICIENCIES NO PLAN OF CORRECTION (X1) PROVIOER/SUPPLIEI IOENTIFICATION NUM		(X2) MULTIPLE CO	ONSTRUCTION	(X3) OATE SURVEY COMPLETEO	
	ROVIOER OR SUPPLIER	495249 & HEALTH CARE CENTER LLC	I 1575	EET AOORESS, CITY, STATE, ZIP COOE SCOTT DRIVE ROUTE 5 MVILLE, VA 23901	C 0 2/2 3/201 <u>8</u>	
(X4) IO PREFIX TAG	(EACH OEFIC	Y STATEMENT OF OEFICIENCIES ENCY MUST BE PRECEOEO BY FULL OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCEO TO THE AF OEFICIENCY)	SHOULO BE COMPLETION	
F 690	Hospice group) w The next note dat following: "Hospic catheter. Rash not Referred to MD (r Review of Reside revealed the follow "Hydrocortisone or rash to abdomen This rash was done 2/16/18. Review of the Jar hospice notes revealed the following rash to abdomen This rash was done 2/16/18. Review of the Jar hospice notes revealed the following note dat assessed? Yes, It assessment finding Indicate location of Resident #94's carevised 8/14/17 dateration in elimin R/T (related to) B foley (suprapublic On 2/22/18 at 8:4 conducted with L and the nurse where the resident's indwelling resident's indicate resident's indicate resident's indicate resident's indicate resident	stated someone from (Name of ill come in and change it." ed 2/8/17 documented the eRN in to change suprapubic ted to waist due to leakage. medical doctor)." nt #94's physician orders wing order dated 2/9/18, cream 1 % (percent): Apply to topically every shift for 7 days." cumented as "Resolved" on auary and February 2018 realed that hospice changed uprapubic catheter on 2/7/18. k was identified). the hospice notes revealed the ed 2/8/18: "Was integumentary andicate integumentary and selection industrial i	F 690			

ORM CMS-2567(02-99) Previous Versions Obsolete

Event IO: 62X711

Facility IO: VA0060

If continuation sheet Page 135 of 185



MAK 28 2018

STATEMENT OF OFFICIENCIES

ANO PLAN OF CORRECTION

PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

TATEMENT OF OEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILOING		(X3) OATE SURVEY COMPLETEO		
		•				C	
		495249	B. WING			02/2	23/2018
NAME OF P	ROVIOER OR SUPPLIER			\$T	REET AOORESS, CITY, STATE, ZIP COOE		<u></u>
EA DMANUL I	E DELIABILITATION 9 L	JEALTH CARE CENTER 11.0	1	15	75 SCOTT DRIVE ROUTE 5		
PARIVIVILL	E REMABILITATION & F	HEALTH CARE CENTER LLC		FA	ARMVILLE, VA 23901		
(X4) IO	SUMMARY ST	ATEMENT OF OEFICIENCIES	10		PROVIOER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	•	Y MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULO E CROSS-REFERENCEO TO THE APPROPRI OEFICIENCY)		COMPLETION OATE
F 690	Continued From page	e 13 5	F	590			
		determine if she would					
	_	atheter. LPN #7 stated she		- 1			1
	-	the order to change the					
		ging the catheter. LPN #7					
		s have to be sent out to		ĺ			
ļ		change especially those					
		theter. When asked if it was					
ļ	• •	ays to change a leaking					
		ed, "No that is not ok. That				i	
	should be done earlie	•					
		ing to change a leaking					
		ed the resident could					
Ì	•	like skin breakdown. When					i
	•	call when Resident #94's					
:	catheter was leaking	on 1/29/18, LPN #7 stated					
		stated that only Hospice					
	was allowed to chang	ge Resident #94's catheter.					
	LPN #7 stated she co	ould not recall when Hospice				:	
	came in to change th	e catheter. LPN #7 could					
	not recall where the	catheter was leaking, and					
	how big the leak was	. LPN #7 stated she did not					
		esident #94. When asked					
		do if a resident's catheter					
		some time and hospice had					
		e it, LPN #7 stated that she					
		ian to get an order to either					
	_	or send the resident out for a		i			
	_	en asked if Resident #94					
		noticed the catheter was					
		PN #7 stated that she did		ŀ			
	not notice any skin is	sues.					
	00/00/40 1.0.50						
		.m., an interview was					
	,	registered nurse) #4, the					
		n asked who was allowed to					
		l's suprapubic catheter, RN					
		only. The facility's policy is		İ			
		uprapubic." RN #4 stated					
	sne recalled Resider	t #94's catheter leaking					

STATEMENT OF DEFICIENCIES

PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		405240	B WING		•	С
	ROVIDER OR SUPPLIER	495249 HEALTH CARE CENTER LLC	15	TREET ADDRESS, CITY, STATE, ZIP CODE 575 SCOTT DRIVE ROUTE 5 ARMVILLE, VA 23901		2/23/2 01 <u>8</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 690	changed the cathete RN #4 wasn't sure if date. RN #4 stated a should be document leaking catheter should be document leaking catheter should be document leaking catheter should be deaked. "Right away. #4 stated should be cause hit. When asked if should eake a lot because hit. When asked if should eake a lot because hit. When asked if should change on 2/7/18, Right rash on his siditching. RN #4 state rash being caused be asked about the conton change a leaking resident could develoinfection. On 2/22/18 at 1:17 producted with LPN the unit manager and note on 2/8/18. When the unit manager and note on 2/8/18. When the unit manager and note on 2/8/18. When the unit manager and note on 2/8/18. When the unit manager and note on 2/8/18. When the unit manager and note on 2/8/18. When a period to wait for character, LPN #1 stated it was didn't think the leak was didn't think the leak was stated she did not resident and the catheter.	anuary. RN #4 stated she r but could not recall when. she had documented the every visit from hospice ed. RN #4 was asked when a uld be changed. RN #4 As soon as possible." RN ally at the facility 5 days a that Resident #94's catheter he has a tendency to pull on the could recall a rash to men after the catheter N #4 stated she did recall a res from him scratching or dothat she does not recall the sy the catheter leaking. When sequence of waiting ten days catheter, RN #4 stated the pop skin breakdown or an how which is the could recall a respectively to the catheter leaking. When sequence of waiting ten days catheter, RN #4 stated the pop skin breakdown or an how which is leaking, ret nursing should try to maked what nursing should try to make the physician should be structions. When asked who anging Resident #94's	F 690			

STATEMENT OF OEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILOING			(X3) DATE SURVEY COMPLETED		
		495249	B MNG			С	
	ROVIDER OR SUPPLIER LE REHABILITATION & HEAL		STREET AODRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901			02/2	23/201 <u>8</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFI) TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCEO TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION OATE
F 695 SS=E	sent to urology if the cathe and there was no follow ure and there was no follow ure at the stated she could recall a rash on his abdomen or not recall specifically it was leaking. When LPN #1 was written on 2/8/18, LPN #1 that he was leaking from the stated the leak had to have for the rash to appear on abdomen. On 2/22/18 at 5:01 p.m., A staff member) #1, the adm DON (Director of Nursing) ADON (Assistant Director aware of the above concerns and the further information was preceded in the further information was preceded in the state of the same and the further of the cause you have catheter because you hav	eter continued to leak p from Hospice. LPN that Resident #94 had a 2/8/18. LPN #1 could s related to his catheter s shown her note stated, "My thinking is he stoma site." LPN #1 e been from the stoma the sides of his ASM (administrative ninistrator, ASM #2, the and ASM #3, the of Nursing) were made rns. Suprapubic Catheter above concerns. No esented prior to exit. (tube) drains urine from into your bladder ur belly. You may need ave urinary incontinence in (not being able to e a catheter necessary, . This information was al Institutes of Health. //medlineplus/275/ency/ 5.htm. / Care and Suctioning re, including	F	90			
	The facility must ensure the						

STATEMENT OF OEFICIENCIES (X ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
		•	1 A. Baicon	<u> </u>	' C
		495249	B. WNG _		02/23/2018
NAME OF P	ROVIOER OR SUPPLIER	•		STREET AOORESS, CITY, STATE, ZIP (
54 BAR 41 1	E DELLA DU TATION	A HEALTH GARE GENTER III A	1	1575 SCOTT ORIVE ROUTE 5	
FARMVILI	E REHABILITATION	& HEALTH CARE CENTER LLC	.	FARMVILLE, VA 23901	
(X4) IO PREFIX TAG	(EACH OEFICIE	STATEMENT OF OEFICIENCIES CNCY MUST BE PRECEOEO BY FULL OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCEO TO OEFICIENC	TION SHOULO BE COMPLETION THE APPROPRIATE
·				F695	
F 695	Continued From p	age 138	F 6	95	·
	needs respiratory care and tracheal	care, including tracheostomy suctioning, is provided such		1. Resident #104's resp	iratory status
		ith professional standards of prehensive person-centered		was assessed on 2/22/1	· I
		dents' goals and preferences,		Assistant Director of Nu	1
	and 483.65 of this			distress noted.	
	by:			Resident #104 oxygen f	low rate was
		ation, staff interview, and clinical		adjusted to 4 liters per	
	staff failed to admi	as determined that the facility inister oxygen at the physician		Unit Manager on 2/22/	- I
		ate for two of 30 residents in the survey residents #104 and #268.		Resident #104's Physicia on 2/22/18 by the Unit	
		failed to administer Resident		oxygen not being admir ordered setting.	nistered at the
	ordered rate. Durii Resident #104's o set at 3.5 liters pe	accordance with the physician ng multiple observations xygen flow rate was observed r minute. The physician's ad the oxygen flow rate should		Resident #268's nebuliz covered on 2/22/18 by Nurse.	•
		off failed to keep Resident # ask (1) covered when not in		Resident #268's oxygen adjusted to the physicia on 2-22-2018. Resident status was assessed on	n ordered rate s respiratory
		off failed to administer Resident ecording to the physician's		ADON no issues were no was notified on 2-22-20 manager that oxygen ha	oted. Physician 18 by the unit
	The findings inclu-	de:		administered at the ord	
	#104's oxygen in a ordered rate, Duri Resident #104's o set at 3.5 liters pe	f failed to administer Resident accordance with the physician ng multiple observations oxygen flow rate was observed or minute. The physician's ed the oxygen flow rate should		the Staff Development (2/26/18 related to oxyg followed as required an equipment is stored wh	Coordinator on en orders are d nebulizer

ANO PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1''	PLE CONSTRUCTION 3	(X3) OATE SURVEY COMPLETEO	
	1070.40			C	
NAME OF D	495249	B. WING		0 2/2 3/ 2 01 <u>8</u>	
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP	CODE	
FARMVILL	LE REHAB)L)TATION & HEALTH CARE CENTER LLC		1575 SCOTT DRIVE ROUTE 5		
			FARMVILLE, VA 23901		
(X4) IO 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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION THE APPROPRIATE DATE	
F 695	Continued From page 139	F 69	95 2. The Assistant Directo	r of Nursing and	
	be at 2 liters.		the Unit Manager com		
	D 11 17404 1 17 1 1 1 1 1 1 1 1		2/22/18 an audit of all		
	Resident #104 was admitted to the facility on 4/6/17 and readmitted on 1/24/18 with the		oxygen orders to ensur	e oxygen setting	
	diagnoses of but not limited to metabolic		were on correct setting	s as required as	
	encephalopathy, chronic kidney disease,		required.		
	pressure ulcer, high blood pressure, neurogenic		,	_	
	bladder, dysphagia, hypothyroidism, diabetes,		The Assistant Director		
	heart disease, and anxiety disorder. The most recent MDS (Minimum Data Set) coded the		Unit Manger complete		
	resident as being cognitively intact in ability to		2/22/18 of current res	idents with	
	make daily life decisions. The resident was		nebulizer treatments t	o ensure	
	coded as requiring extensive assistance for all		equipment was stored	appropriately	
	areas of activities of daily living.		while not in use.		
	A review of the physician's orders revealed one		3. Charge Nurse was re	-educated by the	
	dated 1/24/18 for "Oxygen at 2 liters via nasal		Staff Development Coo	ordinator on	
	cannula"		2/23/18 related to ens		
	A review of the resident's care plan revealed one		administered as ordere		
	for "I have altered respiratory status/difficulty				
i	breathing r/t (related to) my disease process and I		The Licensed Nurses w	ill be re-educated	
	require the use of oxygen." This care plan was		by the Staff Developm	ent Coordinator	
	dated 1/3/18. The interventions included, "Administer my O2 (oxygen) as ordered." This		by 3/14/18 related to	ensuring oxygen	
	intervention was dated 1/3/18.		orders are followed as	required and	
	, , , , , , , , , , , , , , , , , , ,		storing nebulizer equip	oment	
	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		appropriately when no	ot in use.	
	was observed set at 3.5 liters per minute. On		LPN #6 and LPN #4 we	re re-educated by	
	2/22/18 at 3:04 p.m., LPN #6 (Licensed Practical		the Staff Development	Coordinator on	
	Nurse) stated the resident's oxygen should be set at 2 liters. LPN #6 checked Resident #104's		2/26/18 related to oxy		
	oxygen concentrator unit and stated that it was at		followed as required a	•	
	3.5 liters and this was the incorrect setting.		equipment is stored w		
			- darbinous o stored M		
	On 2/22/18 at 5:16 p.m., at the end of day meeting, the Administrator (ASM #1				

STATEMENT OF OEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILOING _	CONSTRUCTION	(X3) OATE SURVEY COMPLETED	
	SUMMAR) (EACH OEFICIE	495249 & HEALTH CARE CENTER LLC Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEOEO BY FULL OR LSC IOENTIFYING INFORMATION)	B. WING STREET AOORESS, CITY, STATE, ZIP COOE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901 ID PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPLOATED TO TH		DRRECTION (X5) N SHOULO BE COMPLETION EAPPROPRIATE CATE
F 695	Administrative Sta Nursing (ASM #2) findings. A facility oxygen therapy/se written list of need provided to the fac meeting on 2/22/1 the written list of n by the facility, and for oxygen service was no policy for t No further informa the survey. 2a. The facility sta 268's nebulizer ma use. Resident # 268 wa 01/26/18 with a re diagnoses that inc kidney failure, hyp multiple myeloma reflux disease (5) Resident # 268's f not due at the time	ff Member) and Director of were made aware of the policy on the provision of ervices was requested via a ed documents. This list was cility at the end of the end of day 8. On 2/23/18 at 08:00 a.m., eeded documents was returned next to the request for policy as, was documented that there	F 695	4 .The Assistant Director of the Unit Manager will con audit of 5 current residen weekly for 4 weeks and months to ensure oxygen administered as ordered a equipment is stored approwhen not in use. The Staff Coordinator will submit a Quality Assurance Commit for 3 months. The Directo will be responsible for the and follow up. Completion date: 3/30/18	of Nursing and inplete an its on each unit conthly for 2 is and nebulizer opriately if Development report to the itee monthly in of Nursing monitoring
	for Resident # 268 person, place time was documented a ADLs (activities of Observations condum, 02/21/18 at 2 a.m., revealed Resitting in his whee	revealed he was orientated to and situation. Resident # 268 as being independent with			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
	ROVIDER OR SUPPLIER LE REHABILITATION & H	495249 SEALTH CARE CENTER LLC	157	EET ADDRESS, CITY, STATE, ZIP CODE 5 SCOTT DRIVE ROUTE 5 RMVILLE, VA 23901	C 0 2/23/201<u>8</u>
(X4) IO PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IOENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 695	lying on top of small of The physician's order for Resident # 268 dr Solution 0.5-2.5 MG (one) inhalation orally needed for SOB (sho 02/21/18. Start Date On 02/22/18, an inter 11:15 a.m. with LPN 4. When asked abouresident's nebulizer of 4 stated it should be have a response who observations of Resident's network in a On 02/23/18, an inter a.m. with ASM (admindirector of nursing. V procedure for storing when not in use ASM placed in a bag when of the observations of mask not covered, As aware of it. On 02/22/18 at 5:00 staff member) # 1, the director of nursing administrator in training above concerns. No further information References:	dresser uncovered. dated Feb (February) 2018 cumented, "DuoNeb (Ipratropium-Albuterol [7]) 1 vevery 4 (four) hours as rt of breath). Order Date: c02/21/18." view was conducted at (Icensed practical nurse) # tt the procedure for storing a nask when not in use LPN # covered. LPN # 4 did not en informed of the above dent # 268's nebulizer mask bag. view was conducted at 9:30 nistrative staff member) # 2, Vhen asked about the a resident's nebular mask # 2 stated, "It should be a not in use." When informed of Resident # 268's nebular SM # 2 stated she was not o.m. ASM (administrative e administrator, ASM # 2,	F 695		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILOING		(X3) DATE SURVEY COMPLETEO		
	NAME OF PROVIDER OR SUPPLIER FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901	02/2	23/201 <u>8</u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		JX5) COMPLETION DATE
F 695	The device delivers as metered-dose inh familiar pocket-sized easier to use than M who aren't old enough adults with severe as liquid medicine into a asthma. They come versions. They come can carry with you a to sit on a table and made up of a base that a small container for that connects the air container. Above the mouthpiece or mask This information was https://www.healthlirer-machine. (2) High blood press obtained from the whitps://www.nlm.nih.essure.html. (3) A group of symplaffect the brain. This from the website: https://www.nlm.nih.ml. (4) A cancer that be white blood cell. The immune system, wh from germs and other sizes and in the case of the container of the container.	the same types of medication halers (MDIs), which are the linhalers. Nebulizers may be DIs, especially for children to properly use inhalers, or sthma. A nebulizer turns a mist to help treat your in electric or battery-run in electric or battery-run at in both a portable size you and a larger size that's meant plug into a wall. Both are that holds an air compressor, iliquid medicine, and a tube are compressor to the medicine elemedicine container is a a you use to inhale the mist. In obtained from the website: The com/health/asthma-nebuliz there. This information was	F 695			
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN) REGULATORY OF REGU	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL (LSC IDENTIFYING INFORMATION) THE 142 THE 142 THE 142 THE 142 THE 145 THE 146 THE 147	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		col

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	STATEMENT OF OEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETEO	
		495249	B. WING		0.0	C
	ROVIOER OR SUPPLIER LE REHABILITATION &	HEALTH CARE CENTER LLC	STREET AOORESS, CITY, STATE, ZIP COI 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		02/23/201 <u>8</u> DDE	
(X4) IO PREFIX TAG	JEACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF JEACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE 'HE APPROPRIATE	(X5) COMPLETION DATE
F 6 9 5	Continued From pag	ge 143	F 695			
	was obtained from t https://medlineplus.	he website: gov/multiplemyeloma.html,				
	the esophagus and was obtained from t	ts to leak back, or reflux, into irritate it. This information he website: gov/medlineplus/gerd.html.				
	kidneys' ability to re fluids and electrolyte information was obt	han 2 days) loss of your move waste and help balance es in your body. This alned from the website: gov/ency/article/000501.htm.				
	is used to prevent we chest tightness, and chronic obstructive group of diseases the airways) such as che air passages the	of albuterol and ipratropium heezing, difficulty breathing, coughing in people with pulmonary disease (COPD; a lat affect the lungs and ronic bronchitis (swelling of at lead to the lungs) and				
	lungs). Albuterol and used by people who controlled by a sing Albuterol and ipratrol medications called lipratropium combinationening the air pass	ge to the air sacs in the dipratropium combination is use symptoms have not been to einhaled medication. Soplum are in a class of coronchodilators. Albuterol and sation works by relaxing and sages to the lungs to make his information was obtained				
	from the website:	gov/druginfo/meds/a601063.h				
	# 268's oxygen acco	failed to administer Resident ording to the physician's				

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Event ID:62X711

Facility tO: VA0080

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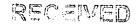
STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILOING		(X3) OATE SURVEY COMPLETEO	
		495249	B. WING		C 02/23/2018
	ROVIOER OR SUPPLIER	& HEALTH CARE CENTER LLC	STREET AOORESS, CITY, STATE, ZIP COOE 1575 SCOTT ORIVE ROUTE 5 FARMVILLE, VA 23901		
(X4) IO PREFIX TAG	(EACH OEFICI	Y STATEMENT OF OEFICIENCIES ENCY MUST BE PRECEOEO BY FULL OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROP OEFICIENCY)	BE COMPLETION
F 695	his wheelchair in a nasal cannula (plato deliver oxygen) on the oxygen corflow rate was set and five liters per An observation cop.m., revealed Resitting in his whee observed receiving (plastic tube place oxygen) connecte Observation of the concentrator revesset between four aper minute. An observation cop.m. revealed Resitting in his whee oxygen by nasal cannula oxygen flow rate valuers and five liters and five liters and flow rate was set and five liters per The physician's or	sident # 268 was sitting up in his room receiving oxygen by stic tube placed in the nostrils. Observation of the flow meter acentrator revealed the oxygen between four and a half liters minute. Inducted on 02/21/18 at 1:55 sident # 268 was in his room lichair. Resident #268 was goxygen by nasal cannula din the nostrils to deliver did to an oxygen concentrator. If the flow meter on the oxygen alled the oxygen flow rate was and a half liters and five liters inducted on 02/21/18 at 2:48 sident # 268 was in his room lichair, and was receiving annula. Observation of the flow en concentrator revealed the was set between four and a half is per minute. Inducted on 02/22/18 at 7:50 sident # 268 was in his room lichair and was receiving oxygen Observation of the flow meter incentrator revealed the oxygen observation four and a half liters between four and a half liters	F 695		
	(four liters per min	to the state of th			

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Event IO:62X711

Facility IO: VAD080

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MAK 2 8 2018

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
						С
		495249	B. WNG)2/2 3 /201 <u>8</u>
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CO	DDE	
FARMVILL	E REHABILITATION &	HEALTH CARE CENTER LLC	l 1	575 SCOTT DRIVE ROUTE 5		
			F	ARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 695	Continued From pag	ge 145	F 695			
	Order Date: 02/15/2	018. Start Date: 02/15/2018."				
	record) dated Febru "Oxygen at 4lpm (for nasal cannula at all (short of breath). Or Further review of the 268 received oxyge 02/21/18 on the day on 02/22/18 on the day on 02/22/18 on the day on 02/22/18 on the day on 02/22/18, an interest of the comprehensive was not due at the transition of the comprehensive w	aic medication administration ary 2018 documented, ur liters per minute) via (by) times every shift for SOB order Date: 02/15/2018." e eMAR revealed Resident # or at four liters per minute on the evening and night shift and day shift. care plan for Resident # 268 or a seline care plan dated Daygen: 4L N.C. 2/15 (four nasal cannula, 02/15/18)." erview was conducted at a seline of survey. Review of seline care plan dated Daygen: 4L N.C. 2/15 (four nasal cannula, 02/15/18)." erview was conducted at a seline of year flow rate for N # 4 stated, "Four liters per ed how often the flow rate of year is checked, LPN # 4 hift." When asked if it was ing of his shift, LPN # 4 forning I check his O2 uration) and gave him a seline of the experimental process of the room, LPN # 4 was expending the room, LPN # 4 was expending the room, LPN # 4 further orrectly and proceeded to flow rate. When asked how LPN # 4 stated, "The liter				
	mark should pass th	nrough the center of the ball."				

	OF OEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) OATE SURVEY COMPLETEO
	ROVIOER OR SUPPLIER LE REHABILITATION & H	495249 EALTH CARE CENTER LLC	157	REET AOORESS, CITY, STATE, ZIP COOE 5 SCOTT DRIVE ROUTE 5 RMVILLE, VA 23901	C 0 2/2 3/201 <u>8</u>
(X4) IO PREFIX TAG	(EACH OEFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCEO TO THE APPROPR OEFICIENCY)	E COMPLETION
F 695	a.m. with ASM (admir director of nursing. What rate for oxygen is rearmark should pass throubble or ball." When observations of Resign flow rate, ASM # 2 statements of the director of nursing administrator in training above concerns.	view was conducted at 9:30 histrative staff member) # 2, //hen asked how the flow d, ASM # 2 stated, "The liter ough the center of the hinformed of the lent # 268's incorrect oxygen ated she was not aware of it. o.m. ASM (administrative e administrator, ASM # 2,	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Manather facility must ensure provided to residents consistent with profess the comprehensive pand the residents' goard the residents' goard the residents' goard the REQUIREMENT by: Based on clinical recinterview, it was deterailed to ensure the reand care in accordant standards of practice person centered care in the survey sample. The facility staff failed	agement. are that pain management is who require such services, esional standards of practice, erson-centered care plan, als and preferences. is not met as evidenced evidenced that the facility staff esident received treatment ce with professional and the comprehensive plan for one of 30 residents Resident # 51.	F 697		

	OF DEFICIENCIES (X1) PROVIDER/SUPI	NII IMRED:		CONSTRUCTION (X3) DATE SURVEY COMPLETED
	495	249 B. WING	G		C 0 2/2 3/ 2 018
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	02/23/2018
	E DELLA DILITATIONI A LIFENI TIL CA DE CENI	TER 11 0	1 1	575 SCOTT DRIVE ROUTE 5	
FARMVILL	LE REHABILITATION & HEALTH CARE CEN	TER LLC	F	ARMVILLE, VA 23901	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIEN (EACH DEFICIENCY MUST BE PRECEDED REGULATORY OR LSC IDENTIFYING INFO	BY FULL PRE	O EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	IX5I COMPLETION OATE
F 697	Continued From page 147		F 697	F 697	
	The findings include:			1. Resident #51 was reassessed f	,
	1.1.0 m.a.m.g. m.e			pain by the Assistant Director	of
	Resident # 51 was admitted to the facil 04/10/2017 with diagnoses that include not limited to kidney failure, diabetes multhout complication (1), hypertension	d but were ellitus		Nursing on 2/23/18.	
	anxiety (3).			Resident #51's physician was	
				notified by the Director of Nurs	sing
	Resident # 51's most recent MDS (min			2/23/18 regarding omissions	
	set), a quarterly assessment with an Af (assessment reference date) of 12/21/	l l		related to Tylenol suppository	in
	Resident # 51 as scoring a 99 indicatin # 51 was unable to complete the brief i	g Resident		December 2017.	
	for mental status (BIMS). Resident # 5			2. The Assistant Director of Nursi	ng
	coded as being moderately impaired of			and the Unit Manager will audi	
	on the "Staff Assessment for Mental St Resident # 51 was coded as requiring	• • • • • • • • • • • • • • • • • • •		current residents medication	t trie
	assistance of one staff member for acti			administration records by 3/14	14.0
	daily living.				
				to ensure medications have be	en
	The POS (Physician's Order Sheet) for # 51 dated "Feb (February), 2018 doct "Acetaminophen Suppository (4) - 650	ımented, MG		documented as required.	
	(milligrams) Insert 1 (one) suppository every 8 (eight) hours for pain NTE (not			3. The Licensed Nurses will be re-	
	4 (four) grams in 24 hours. Order Date			educated by the Staff Developr	nent
	10/19/2017. Start Date: 10/19/2017."			Coordinator by 3/14/18 related	l to
				ensuring medication administra	ation
	The eMAR (electronic medication adm	1		is documented as required.	ition
	record) dated December, 2017 docum "Acetaminophen Suppository - 650 MC				
	suppository rectally every 8 hours for p				
	grams in 24 hours. Order Date: 10/19				
	Further review of the eMAR failed to e	vidence the			-
i	administration of Acetaminophen Supp	•			
	650 MG on 12/03/17 at 6:00 a.m., 12/0				
	6:00 a.m., 12/08/17 at 10:00 p.m., 12/08/17 at 6:00 a.m. 12/10/17 at 6:00 a.m. 21/2:				1
				1	

	OF OEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUL A. BUILOI		E CONSTRUCTION		ATE SURVEY OMPLETED
		495249	B. WING		·		C 0 2/2 3/ 20 18
	ROVIOER OR SUPPLIER LE REHABILITATION &	HEALTH CARE CENTER LLC		1	STREET AOORESS, CITY, STATE, ZIP CODE 575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		02/23/20 10
(X4) IO PREFIX . TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDEO BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	IX5) COMPLETION DATE
F 697	12/0/17 through 12, to evidence docum- administration of Ac 650 MG on 12/03/16:00 a.m., 12/08/17 6:00 a.m., 12/10/17 a.m., and 12/31/17 The care plan for R date of 02/21/2018 Alteration in comfor process. Date initia "Interventions" it do medications as ord and effectiveness. side effects. Notify indicated. Date initia on 02/23/18 at 8:2 conducted with ASI member) # 3, the a When asked to des documenting on the administered ASM the medication a clear for the date the mesome reason them numeric (number) when asked about blank ASM # 3 state wasn't given. Documers's notes." Aft progress notes dat ASM # 3 stated, "L	y's "Progress Notes" dated y'31/17 for Resident # 51 failed entation of the missing cetaminophen Suppository - 7 at 6:00 a.m., 12/04/17 at y at 10:00 p.m., 12/09/17 at y at 6:00 a.m.; 21/21/17 at 6:00	F	697	4. The Assistant Director and the Unit Manager resident's medical recounit weekly for 4 week monthly for 2 months to be documented as restaff Development Coosubmit a report to the Assurance Committeer months. The Director of be responsible for monfollow up. Completion date: 3/30/	will audit 5 ords on each is and ito ensure ition continue equired. The ordinator will Quality monthly for 3 if Nursing will itoring and	3

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	F CORRECTION	IOENTIFICATION NUMBER:	1 ' '	S	COMPLETED
		495249	B. WING		C 0 2/23/2 018
	ROVIDER OR SUPPLIER LE REHABILITATION & H	EALTH CARE CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP COOE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901	
(X4) ID PREFIX TAG	(EACH OEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
F 697	On 02/23/18 at 9:30 a conducted with ASM (member) #2, the dire the administration of t Suppository - 650 MG 12/04/17 at 6:00 a.m., 21/29/17 at 6:00 a.m., for Resident # 51. Aff the progress notes da 12/31/17 ASM # 3 stamedication was given On 02/22/18 at 5:00 p staff member) # 1, the the director of nursing administrator in training above concerns. No further information References: (1) A chronic disease regulate the amount of goal of treatment at fill blood glucose level. L prevent complications to treat and manage the active and eating head was obtained from the https://medlineplus.go.	.m. an interview was administrative staff ctor of nursing regarding he Acetaminophen on 12/03/17 at 6:00 a.m., 12/10/17 at 6:00 a.m.; and 12/31/17 at 6:00 a.m.; and 12/31/17 at 6:00 a.m. er reviewing the eMAR and ted 12/01/17 through ted, "I can't say the" .m. ASM (administrative administrator, ASM # 2, and ASM # 5, ag, were made aware of the awas provided prior to exit. in which the body cannot of sugar in the blood. The rest is to lower your high ong-term goals are to a The most important way the ype 2 diabetes is by being lithy foods. This information is website: by/ency/article/000313.htm. re. This information was	F 69	97	

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Event ID: 62X711

Facility IO: VA0080

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(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

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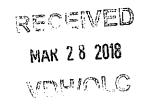
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495249 HEALTH CARE CENTER LLC	1	TREET ADDRESS, CITY, STATE, ZIP CODE 575 SCOTT DRIVE ROUTE 5 ARMVILLE, VA 23901 PROVIDER'S PLAN OF CORRECT	C 02/23/201 <u>8</u> TION (X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 697	website: https://www.nlm.nih. #summary. (4) Used to relieve n	nation was obtained from the gov/medlineplus/anxiety.html nild to moderate pain from	F 697		
F 742 SS=D	colds and sore throat and reactions to vac reduce fever. Acetar to relieve the pain of caused by the break joints). Acetaminoph medications called a antipyretics (fever rethe way the body sebody. This informat website: https://medlineplus.tml. Treatment/Srvcs MeCFR(s): 483.40(b) Based of	analgesics (pain relievers) and educers). It works by changing moses pain and by cooling the ion was obtained from the gov/druginfo/meds/a681004.h	F 742	 Resident #73 no longer resident the facility. An audit of all residents wof Schizoaffective, Schizop Bipolar Disorder, and Intel Disabilities will be conduct 30-2018 by the Social Serv Director to identify addition residents requiring psychia. 	ith a DX phrenia, llectual ted by 3- vice onal atric d or
	that- §483.40(b)(1) A resident who disp mental disorder or p difficulty, or who has post-traumatic stres appropriate treatme assessed problem of practicable mental a This REQUIREMEN by: Based on resident	lays or is diagnosed with sychosocial adjustment is a history of trauma and/or is disorder, receives int and services to correct the forto attain the highest ind psychosocial well-being; IT is not met as evidenced observation, staff interview, view and clinical record		3. The Social Services Director with the clinical team will educated on regulation (C 483.40(b)(1) by 3-30-2018 Administrator. Any future psych evaluations recommend the physician will be refer licensed mental health propassion of the company of the physician will be refer licensed mental health propassions.	be FR(s) by the follow up nended by red to a

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Event ID: 62X711

Facility ID: VA0080

If continuation sheel Page 151 of 185



PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''		(X3) DATE SURVEY COMPLETED
	ı	A. BUILDING		C
	495249	B. WING		02/23/2018
ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP	
LE REHABILITATION	& HEALTH CARE CENTER LLC	FA	ARMVILLE, VA 23901	
SUMMAR'	Y STATEMENT OF DEFICIENCIES	lD ID	PROVIDER'S PLAN OF	CORRECTION (X5)
1		PREFIX TAG	CROSS-REFERENCED TO	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
review, it was dete ensure appropriat provided to addresconcerns for one sample, Resident The facility staff faneed for continues services following and falled to obtain address Resident ordered by the phomograph ordered by the phomograph ordered by the phomograph ordered by the phomograph ordered by the phomograph ordered by the phomograph ordered by the phomograph ordered by the findings inclused intellectual disability and bipolar. Resident #73 was (assessment refered Resident #73 as soon the BIMS (bries indicating that Rewith daily decision Resident #73 was into the facility on a.m. walking up a the staff, stating here.	ermined the facility staff failed to e treatment and services were as mental/psychosocial of 30 residents in the survey #73. alled to assess Resident #73's depsychiatric / psychotherapy her last visit in March 2017; in a psychiatric consult to #73's increased behaviors as ysician on 2/9/2018. de: admitted to the facility on obses that include but not limited we disorder, schizophrenia, lities, schizoaffective disorder ost recent MDS (minimum data assessment with an ARD rence date) of 1/11/18 coded accoring a 14 out of a possible 15 of interview for mental status) esident #73 is cognitively intact ins. sobserved at the time of entry a 2/21/18 at approximately 7:00 and down the hallways yelling at her tooth was hurting. Resident	F 742	4. The Social Services designee will randoresidents with DX of Schizoaffective, Schizoaffective, Schizoaffective, and Disabilities weekly weeks then month any disruptive/mochanges that may evaluation and/or management.	Director or their omly audit of hizophrenia, and Intellectual for the next 4 hily thereafter; for od/behavior need a psych medication
	Summar (EACH DEFICI REGULATORY) Continued From preview, it was detensure appropriat provided to addreconcerns for one sample, Resident The facility staff faneed for continue services following and failed to obtain address Resident ordered by the photomajor depression intellectual disability and bipolar. Resident #73 was intellectual disability and annual as (assessment referes Resident #73 as son the BIMS (brief indicating that Rewith daily decision Resident #73 was into the facility on a.m. walking up at the staff, stating here.	ROVIDER OR SUPPLIER LE REHABILITATION & HEALTH CARE CENTER LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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	ROVIDER OR SUPPLIER LE REHABILITATION & HEALTH CARE CENTER LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 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 2/21/1/8 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	ROVIDER OR SUPPLIER A STREET ADDRESS, CITY, STATE, ZIP 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901 SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY Mush as Percectoes by Full REQULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 151 review, it was determined the facility staff falled 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

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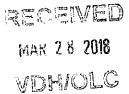
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 7	E CONSTRUCTION	(X3) DATE: COMPI	
	ROVIDER OR SUPPLIER LE REHABILITATION & 1	495249 HEALTH CARE CENTER LLC	i	STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901	0 2 /2	23/201 <u>8</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CDRRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 742	constantly getting up dining room despite in her calm. Resident #73 was ob up and down the hall talking to herself. A review of the physic revealed, in part, the "Psych (psychiatric) behavior, paranola, a time only for 1 Day. Completed. Revision Date 2/9/18." "Geodon [1] (an antimed MG (milligrams) Give times a day related to DISORDER, BIPOLA DEPRESSIVE DISO SCHIZOPHRENIA. 2/9/18. Last Order Efurther review of Redid not reveal that a appointment had been further review of Redid reveal document psychiatric consults 2017 and March 15, documentation regard consultations either in the clinical record. A review of Resident	served talking to herself, and pacing around the he efforts of the staff to keep served on 2/22/18 walking ways throughout the day, cian orders since admission following orders: consult for increased gitation, pacing, stealing one Order Status: Completed. Date 2/9/2018. Last Order psychotic medication) 40 of 1 capsule by mouth two of SCHIZOAFFECTIVE AR TYPE, MAJOR RDER, OTHER Active. Revision Date rate 2/9/18" sident #73's clinical record psychiatric consult on made as ordered. Sident #73's clinical record ation related to two that occurred on January 23, 2017. There was no further ding the plan to continue the on the consultation notes or #73's comprehensive care	F 742			
	plan dated 1/3/17 rev	vealed, in part, the following us: I have an alteration in				:

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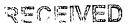
PREFIX TAG (EACH OEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OEFICIENCY) F 742 Continued From page 153 F 742 my behavior Crying out loud, cussing, talking to		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	TIPLE CONSTRUCTION NG	(X3) OATE SURVEY COMPLETEO
NAME OF PROVIDER OR SUPPLIER FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC (X4) IO SUMMARY STATEMENT OF OEFICIENCIES PREFIX REGULATORY OR LSC IOENTIFYING INFORMATION) F 742 Continued From page 153 my behavior Crying out loud, cussing, talking to			495249	B. WING _		1
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 742 Continued From page 153 my behavior Crying out loud, cussing, talking to			3 HEALTH CARE CENTER LLC		1575 SCOTT DRIVE ROUTE 5	
my behavior Crying out loud, cussing, talking to	PREFIX	(EACH OEFICIE	NCY MUST BE PRECEOEO BY FULL	PREFI)	X (EACH CORRECTIVE ACTION CROSS-REFERENCEO TO THE A	SHOULO BE COMPLETION
herself, the walls and an imaginary friend. Interventions: Administer my medications as ordered. Focus: Potential for adverse side effects rit (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.	F 742	my behavior Cryin herself, the walls a Interventions: Adnordered. Focus: Peffects r/t (related medications. Intereval (evaluation) at A review of Resided date of service of following document (Resident #73) was behavioral health of here (at the facility #73) still continues visual hallucination and sometimes gepeople and relative Further review of Failed to reveal any need for continued A review of Resided did not reveal any continuing psychiat treatments. On 2/22/18 at 3:43 conducted with Os director of social swhat she could tel #73's ongoing psy stated, "I would he each quarter and for her to be follow OSM #1 was proving the sould was proving the same provi	g out loud, cussing, talking to and an imaginary friend. Ininister my medications as otential for adverse side to use of psychotropic ventions: Psych (psychiatric) and follow up prn (as needed.)" Int #73's physician note with a 1/5/18 revealed, in part, the tation: "Social History: She is followed by (name of tenter) up until her admission. Assessment: She (Resident is to have some auditory and inside and she does have outbursts its aggressive towards other est." Resident #73's physician notes by documentation regarding the identification of psychiatric services. Int #73's social services notes documentation regarding the identification of the psychiatric services. She (other staff member) #1, the ervices. OSM #1 was asked if this writer about Resident chiatric treatment. OSM #1 was to say that I meet with her there was no recommendation and up by psych (psychiatry)." ided the two psychiatry consult	F 7	742	

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STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION
AND PEAN OF CONNECTION	TOENTH TOATTON WOUNDER.	A. BUILOING

(X3) OATE SURVEY COMPLETEO

495249

B. WING ______

C **02/23/201**8

NAME OF PROVIOER OR SUPPLIER

FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC

STREET AOORESS, CITY, STATE, ZIP COOE 1575 SCOTT DRIVE ROUTE 5

FARMVILLE, VA 23901

			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	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLET CROSS-REFERENCEO TO THE APPROPRIATE OATE DEFICIENCY)	TION
F 742	Continued From page 154	F 74	42	
1	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.		12	
	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			

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	OF OEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CO	NSTRUCTION		TE SURVEY MPLETEO
		405040	B. WNG			С
		495249				2/23/201 <u>8</u>
NAME OF P	ROVIOER OR SUPPLIER			EET AOORESS, CITY, STATE, ZIP CO	<i>I</i> OE	
FARMVILI	E REHABILITATION	& HEALTH CARE CENTER LLC	1575	S SCOTT ORIVE ROUTE 5		
			FAR	RMVILLE, VA 23901		
(X4) IO PREFIX TAG	(EACH OEFIC	Y STATEMENT OF OEFICIENCIES IENCY MUST BE PRECEOEO BY FULL OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCEO TO TH OEFICIENCY	ON SHOULO BE HE APPROPRIATE	(X5) COMPLETION OATE
F 742	Continued From	page 155	F 742			
	have seen lately. had talked to the psychiatric servic practitioner left. aware of." OSM	t really had the outbursts as we 'OSM #1 was asked if anyone doctor about continuing the es after the psychiatric nurse OSM #1 stated, "Not that I am #1 was unaware about the order a psychiatric consult.				
	conducted with A member) #4, the asked when a repsychiatric / psychiatric / psychiatric / psychiatric and behaviors, not thrive, psychiatric and we don't have a psychiatric and we don't have time." ASM #4 we Resident #73, ASM and recently star medication, Geobehaviors. ASM was in regards to Resident #73. A have the service. When asked if he discussions about psychiatric service practitioner left thad not. ASM #4 the resident on a psychiatric pieces.	SM (administrative was SM (administrative staff medical doctor. ASM #4 was sident would be referred to shotherapy care. ASM #4 stated, slability is an issue. However, con-controllable behaviors, failure tric illness without improvement with the medications that I all be reasons. We used to conurse practitioner but she left anything in the facility at this was asked if he was familiar with SM #4 stated that he was and ted her on some new don, because of her increased #4 was asked what his intention of psychiatric services for SM #4 stated, "I would like to secontinued. She needs them." It had been involved in any at Resident #73 having continued the ses after the psychiatric nurse the facility. ASM #4 stated that he are facility. ASM #4 stated that he are gular basis, I try to cover the because I have been told it is to continue to the effective.				
		:30 a.m., an interview was				

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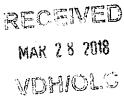
	CORRECTION	IDENTIFICATION NUMBER:	1	S (X3) DATE:	
NAME OF P	ROVIDER OR SUPPLIER	495249	B, WNG	O2/2 STREET ADDRESS, CITY, STATE, ZIP CODE	2 3/201<u>8</u> -
FARMVILL	E REHABILITATION & H	EALTH CARE CENTER LLC		1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 742	Continued From page	e 156	F 74	12	
	ASM #2, the director who was responsible services are made avneeding the service, a services are responsiservices are available was done for Resider services stopped and ASM #1 stated, "I don requested regarding that and behavioral health." No further information end of the survey properovision of Medically CFR(s): 483.40(d). §483.40(d) The facility medically-related soon maintain the highest and psychosocial we this REQUIREMENT by: Based on staff intervand clinical record refacility staff failed to psocial services for on survey sample, Residenced for continued pservices after the psydiscontinued services obtain a psychiatric cophysician on 2/9/18.	of nursing. When asked for ensuring that psychiatric railable to those residents ASM #1 stated that social ble, if the psychiatric to us. When asked what at #73 when her psychiatric were no longer available. If thou, "A policy was he use of antipsychotics a services at this time. In was provided prior to the cess. If Related Social Service If y must provide ital services to attain or practicable physical, mental libeling of each resident. It is not met as evidenced item, facility document review wiew, it was determined the provide medically related to 130 residents in the	F 74	 F745 Resident # 73 no longer resides at the facility. The Social Service Director will complete an audit by 3-30-2018 to identify other residents with psychiatric diagnosis that require psychiatric follow-up. On admission the social services director will review admission documentation and schedule psychiatric follow-up services as needed. The interdisciplinary quality assurance team will monitor for continued compliance monthly for the next three months and quarterly thereafter. 	
	The findings include:			5. Completion date 3-30-2018	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
	49524 9	B. WING		C 02/2 3/ 2018
NAME OF PROVIDER OR SUPPLIER FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMV LLE, 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 CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTION
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,	F 745	DEFICIENCY)	
	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			

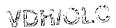
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	OF OEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CO	DNSTRUCTION	(X3) OATE SUR COMPLETI	
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NAME OF P	ROVIOER OR SUPPLIER	495249	B, WŅG	EET AOORESS, CITY, STATE, ZIP COOE	02/2 3/2	2018
		& HEALTH CARE CENTER LLC	1579 FAF			
(X4) IO PREFIX TAG	(EACH OEFICI	Y STATEMENT OF OEFICIENCIES ENCY MUST BE PRECEOEO BY FULL OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCEO TO THE APPROPERTIES OF THE PROPERTIES OF THE APPROPERTIES OF THE APPROPERTIES OF THE PROPERTIES OF T	O BE C	(X5) OMPLETION DATE
F 745	MG (milligrams) Of times a day related DISORDER, BIPO DEPRESSIVE DISSCHIZOPHRENIA 2/9/18. Last Order Further review of did not reveal that appointment had Further review of did reveal documentation reconsultations eith in the clinical reconsultations eith in the clinical reconsultations eith in the clinical reconsultations. "In my behavior Cryherself, the walls Interventions: Acordered. Focus: effects r/t (related medications. Interventions Interventions in the eval (evaluation). A review of Resident #73) when the properties of the following document (Resident #73) when the properties of the propert	antipsychotic medication) 40 Sive 1 capsule by mouth two d to SCHIZOAFFECTIVE DLAR TYPE, MAJOR SORDER, OTHER A. Active. Revision Date er Date 2/9/18" Resident #73's clinical record t a psychiatric consult been made as ordered. Resident #73's clinical record entation related to two lts that occurred on January 23, 15, 2017. There was no further garding the plan to continue the er on the consultation notes or	F 745			

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	OF DEFICIENCIES F CORRECTION	(X1) PRDVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY IPLETED
					'	С
	ROVIDER OR SUPPLIER LE REHABILITATION &	495249 HEALTH CARE CENTER LLC	1575	EET ADDRESS, CITY, STATE, ZIP CODE S SCOTT DRIVE ROUTE 5 RMVILLE, VA 23901	0:	2/23/201 <u>8</u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION OATE
F 745	visual hallucinations and sometimes get people and relative Further review of R did not reveal any or need for continued A review of Resider did not reveal any or continuing psychiat treatments. On 2/22/18 at 3:43 conducted with OS director of social sewhat she could tell #73's ongoing psychiated, "I would have each quarter and the for her to be follow OSM #1 was provivisit notes from Jar OSM #1 was provivisit notes from Jar OSM #1 was asked documentation to a should not continuing stated there was now as a conversation Resident #73's conhealth services. On not. OSM #1 was behavioral service. #73 and was asked evidence that Resineeds were met. On 2/23/18 at 9:45 writer. OSM #1 was writer. OSM #1 was writer. OSM #1 was writer. OSM #1 was writer. OSM #1 was writer.	s and she does have outbursts aggressive towards other s." esident #73's physician notes documentation regarding the psychiatric services. Int #73's social services notes documentation regarding ric / psychotherapy p.m., an interview was M (other staff member) #1, the ervices. OSM #1 was asked this writer about Resident chiatric treatment. OSM #1 we to say that I meet with her here was no recommendation ed up by psych (psychiatry)." ded the two psychiatry consult muary 2017 and March 2017.	F 745			

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

COMPLETED

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	495249	B. WING		02/23/2018
NAME OF PE	ROVIDER OR SUPPLIER	STRE	EET ADDRESS, CITY, STATE, ZIP CODE	· · · · · · · · · · · · · · · · · · ·
		, 1575	SCOTT DRIVE ROUTE 5	
FARMVILL	E REHABILITATION & HEALTH CARE CENTER LLC	FAR	MVILLE, 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)	IX5) COMPLETION DATE
	Continued From page 160 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.	F 745		DATE
	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			

(X2) MULTIPLE CONSTRUCTION

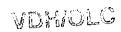
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PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT C AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE	р.		ONSTRUCTION	(X3) DATE : COMPI	
NAME OF PE	ROVIDER OR SUPPLIER	495249	B. WINC	STE	REET ADDRESS, CITY, STATE, ZIP CODE		23/201 <u>8</u>
FARMVILL	E REHABIL TAT ON & F	HEALTH CARE CENTER L	LC		'S SCOTT DRIVE ROUTE 5 RMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATIO		FIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	X5 COMPLETION DATE
F 745	or complications with prescribe, would all bhave a psychiatric nuand we don't have artime." ASM #4 was a Resident #73, ASM #had recently started hedication, Geodon, behaviors. ASM #4 was in regards to psy Resident #73. ASM have the services cowhen asked if he had discussions about Repsychiatric services a practitioner left the fahad not. ASM #4 fur the resident on a reg psychiatric piece becond available, but I can conducted with ASM ASM #2, the director who was responsible services are made an needing the service, services are available was done for Reside services stopped and ASM #1 stated, "I do requested regarding and behavioral health A review of the social states."	illness without improvement the medications that I be reasons. We used to presepractitioner but she have practitioner but she have in the facility at the saked if he was familiar at the stated that he was an her on some new because of her increasons asked what his interpretation of the provided in any sesident #73 having continued. She needs the dependent #73 having continued after the psychiatric nurse acility. ASM #4 stated the ther stated, "I interact would be asis, I try to cover cause I have been told it	left his with id ed ed etion o em." inued se nat he eith the t is and ed niatric nts sial ehat atric ole.	745			
FORM CMS-25	1	r help in locating and	Event ID: 62X711	Fac	cility ID: VA0080	If continuation sheet	Rage 162 of 185

If continuation sheet Rage 162 of 185

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PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495249,	B. WING			C 0 2/23/2 018	
	ROVIDER OR SUPPLIER	HEALTH CARE CENTER LLC		STREET ADDRESS, CIT 1575 SCOTT DRIVE R FARMVILLE, VA 231	OUTE 5	02/20/20 10	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CO	DER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION OATE	
F 745	arranging for service agencies as needed	s of other professionals or	F	745			
F 758 SS=D	end of the survey pro	ychotropic Meds/PRN Use	F	758			
	affects brain activitie processes and beha but are not limited to categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and	chotropic drug is any drug that is associated with mental vior. These drugs include, , drugs in the following					
	sunless the medication	ents who have not used are not given these drugs on is necessary to treat a diagnosed and documented					

drugs;

§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

§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

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY COMPLETED

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	495249	B. WING		02/23/2018
NAME OF P	ROVIDER OR SUPPLIER	ST	REET ADDRESS, CITY, STATE, ZIP CODE	
		, 15	75 SCOTT DRIVE ROUTE 5	ļ
FARMVILL	E REHABILITATION & HEALTH CARE CENTER LLC	FA	ARMVILLE, 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)	IX5) COMPLETION OATE
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	F 758		UATE
	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.		conscion required.	
	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.			
	The facility staff failed to provide a clinical indication for the administration of Seroquel [1] (an antipsychotic medication) to Resident #66.			
	The findings include:			
	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			

(X2) MULTIPLE CONSTRUCTION

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PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		EALTH CARE CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD 8 CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION OATE	
F 758	disease. Resident #2 (minimum data set) at assessment with an Adate) of 12/9/17. Resident scoring a 06 out of politerview for Mental Swas coded as being it supervision only with meals and ambulation from one staff member personal hygiene and coded in section 0 "(Signored Procedures, and Progroup Hospice Care. Review of Resident # dated and signed by through 12/2017 documents and through 12/2017 documents and the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section administration a	er, and atherosclerotic heart 17's most recent MDS sesessment was a quarterly 1RD (assessment reference 1dent #27 was coded as 1RD (assessment reference 1dent #27 was coded as 1RD (assessment reference 1dent #27 was coded as 1RD (assessment reference 1dent #27 was coded as 1RD (Brief 1Status) exam. Resident #27 1Dependent and requiring 1Ded mobility, transfers, 1Ded mobility, tra	F 75	8			

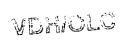
FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 62X711

Facility ID: VA0080

RECCONTINUE TO Sheet Page 165 of 185

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PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

	OF OEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		CONSTRUCTION	(X3) OATE COMF	SURVEY PLETEO
		495249	B. WING			C
	ROVIOER OR SUPPLIER LE REHABILITATION & H	SEALTH CARE CENTER LLC	รา 15	TREET AOORESS, CITY, STATE, ZIP COOE 575 SCOTT DRIVE ROUTE 5 ARMVILLE, VA 23901	02/	23/201 <u>8</u>
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCEO TO THE APPRI OEFICIENCY)	JLO BE	(X5) COMPLETION DATE
F 758	Review of Resident # dated 9/13/17 did not attempt non-pharmach the administration of On 2/22/18 at 9:33 a. conducted with RN (rhospice nurse. When followed prior to nurs Ativan for Resident # staff should first be achecking vital signs, a such as toileting the radministering Ativan. On 2/22/18 at 11:41 aconducted with LPN When asked the about	the administration of Ativan. 27's psychotropic care plan document an intervention to cological intervention prior to prn Ativan. m., an interview was egistered nurse) #5, the nasked about the processing staff administering prn 27, RN #5 stated the nursing essessing the need for Ativan, and trying other methods resident prior to	F 758			
	stated she would atterinterventions such as environment to the remedication. LPN #3 attempted should be (medication administ note. On 2/23/18 at 8:53 a conducted with LPN the nurse who admin occasions. When as followed prior to admin Ativan, LPN #8 state alternative first such intervention. When a non-pharmacologica	empt non-pharmacological sproviding a quiet esident before administering stated interventions documented on the MAR ration record) or in a nursing .m., an interview was (licensed practical nurse) #8, listered Ativan on one of the eked about the process sinistering prn (as needed) d she would try another as a non-pharmacological				

FORM CMS-2587(02-99) Previous Versions Obsolete

Eveni IO:62X711

Facility IO: VA0080

If continuation sheet Page 166 of 185



(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

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A495249 A495249 AMME OF PROVIDER OR SUPPLIER FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC (X4) ID PREFIX TAG CONDITION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) FOR 3 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	AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
NAME OF PROVIDER OR SUPPLIER FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC (XA) ID SUMMARY STATEMENT DF DEFICIENCIES (EACH CORRECTION YEAR) (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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						С
FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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			495249	B. WING		02/2 3/ 20 1 <u>8</u>
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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			EALTH CARE CENTER LLC	l ¹⁵⁷⁵	SCDTT DRIVE RDUTE 5	
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	PREFIX	(EACH DEFICIENC)	Must be preceded by full	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
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/PMH T0010988/?report=details. 2. The facility staff falled 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	LPN #8 stated they she attempted non-phyprior to administering back in November of she could not remember. On 2/22/18 at 5:01 p.i. staff member) #1, the DON (Director of Nurs ADON (Assistant Director of Staff member) #1, the DON (Director of Nurs ADON (Assistant Director of Staff member) #1, the DON (Director of Nurs ADON (Assistant Director of Nurs ADON (Assistant Director of Staff derived in the above of the above of the facility policy title Medication Use" did in concerns. No further prior to exit. [1] Ativan is used to the Ativan is a benzodiaz central nervous syste obtained from The Nathttps://www.ncbi.nlm. T0010988/?report=detector. The facility staff faindication for the admit (an antipsychotic medication for the admit (an antipsychotic	armacological interventions prince Ativan to Resident #27 2017, LPN #8 stated that per. In., ASM (administrative administrator, ASM #2, the sing) and ASM #3, the ctor of Nursing) were made process. In., "Psychopharmacological tot address the above information was presented eat symptoms of anxiety. This information was ational Institutes of Health. In the gov/pubmedhealth/PMH stails. Eled to provide a clinical inistration of seroquel [1] dication) to Resident #66. In the double the facility on sion on 12/30/17 with the double were not limited to idney disease, congestive entia. In the double the facility on sion on 12/30/17 with the double were not limited to idney disease, congestive entia. In the double the facility on sion on 12/30/17 with the double were not limited to idney disease, congestive entia. In the double the facility on sion on 12/30/17 with the double were not limited to idney disease, congestive entia. In the double the facility on sion on 12/30/17 with the double were not limited to idney disease, congestive entia.	F 758		

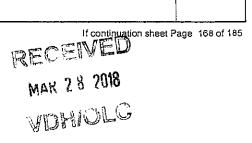
PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

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F 758	revealed, in part, the Fumarate (seroque medication) 100 Mc mouth at bedtime released to the EWY BODIES. A Start Date 12/30/20 A Review of Reside 1/3/18 did not reversible to the Ewy Quetiapine Fur 12/30/17. A review of Reside reveal any docume by Resident #66. A review of Reside plan dated 12/30/1 documentation regular documentation regular documentation regular documentation regular documentation regular disorder or Sometimes I may the provento be resist treatment." ASM #4 stated, "I the provento be resist treatment." ASM #4 demential with Lew Fumarate. ASM #4 resident is having (dystonic movements)." ASM documented the climate is having the company of the Ewy Pumarate. ASM #4 resident is having the Company of the Ewy Pumarate. ASM #4 resident is having the Company of the Ewy Pumarate. ASM #4 resident is having the Company of the Ewy Pumarate. ASM #4 resident is having the Company of the Ewy Pumarate. ASM #4 resident is having t	ions of daily living. Int #66's physician orders e following order: "QUEtiapine I) [1] (an antipsychotic G (milligrams) Give 1 tablet by elated to DEMENTIA WITH ctive. Order Date 12/30/2017. D17." Int #66's physician note dated al any documentation as to marate was started on Int #66's clinical record did not inted behaviors demonstrated Int #66's comprehensive care If did not reveal any arding behaviors. Int #66's comprehensive care If did not reveal any arding behaviors. Int #66's comprehensive care If did not reveal any arding behaviors. Int #66's comprehensive care If did not reveal any arding behaviors. Int #66's comprehensive care If did not reveal any arding behaviors. Int #66's comprehensive care If did not reveal any arding behaviors. Int #66's comprehensive care If did not reveal any arding behaviors. Int #66's comprehensive care If did not reveal any arding behaviors. Int #66's comprehensive care If did not reveal any arding behaviors. Int #66's comprehensive care If did not reveal any arding behaviors. Int #66's comprehensive care If did not reveal any arding behaviors. Int #66's comprehensive care If did not reveal any arding behaviors. Int #66's comprehensive care If did not reveal any arding behaviors. Int #66's comprehensive care If did not reveal any arding behaviors. Int #66's comprehensive care If did not reveal any arding behaviors. Int #66's comprehensive care If did not reveal any arding behaviors Int #66's comprehensive care If did not reveal any arding behaviors Int #66's comprehensive care If did not reveal any arding behaviors Int #66's comprehensive care If did not reveal any arding behaviors Int #66's comprehensive care If did not reveal any Int #66's comprehensive care If did not reveal any Int #66's comprehensive care If did not reveal any Int #66's comprehensive care If did not reveal any Int #66's comprehensive care Int #66's comprehensive care Int #66's comprehensive care Int #66's comprehensive care Int #66's comprehensive care Int #66's comprehensive care In	F 75	58			
		inical indication for the use of ent #66's situation. ASM #4					

FORM CMS-2567(02-99) Previous Versions Obsotete

Event IO: 62X711

Facility IO: VA0080



PRINTED: 03/09/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF OFFICIENCIES (X1) PROVIDER/\$UPPLIER/\$\text{CLIA} (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY ANO PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495249 B. WING _ 02/23/2018 NAME OF PROVIOER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC FARMVILLE, VA 23901 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH OEFICIENCY MUST BE PRECEDEO BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IOENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 758 Continued From page 168 F 758 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 761 Label/Store Drugs and Biologicals F 761 SS=E | CFR(s): 483.45(g)(h)(1)(2)

applicable.

§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

FORM APPROVED

PRINTED: 03/09/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495249 B. WING _ 02/23/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC FARMVILLE, VA 23901 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION OATE (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F761 F 761 Continued From page 169 F 761 1. Medication carts on 100 and §483.45(h) Storage of Drugs and Biologicals 200 were noted locked and §483.45(h)(1) In accordance with State and secure on 2/23/18. 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. 2. An observational audit was conducted on 2/23/18 by §483.45(h)(2) The facility must provide separately Director of nursing to validate locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of that all medication carts were the Comprehensive Drug Abuse Prevention and locked. No negative findings Control Act of 1976 and other drugs subject to were noted. abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can 3. Licensed Nurses were rebe readily detected. educated by the Staff This REQUIREMENT is not met as evidenced Development Coordinator on by: Based on observation, staff interview, and facility 2/23/18 related to locking of document review, it was determined the facility medication storage carts. staff failed to secure medication for two pf 4

medication cart. The findings include:

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was unlocked.

medication carts on the 100 and 200 hall.

Three residents and on staff nurse, were

1. The facility staff failed to lock the medication

cart on the 200 hall while the cart was not in use.

observed walking by the medication cart while it

2. LPN (Licensed Practical Nurse) #2 failed to

locked while in a resident's room administering medications. Other staff and a resident were observed approximately three feet from the

ensure a medication cart in the 100 hall was fully

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4. The Assistant Director of

Nursing and the Unit Manager

monthly for 2 months to ensure medication carts are locked

will audit medications carts

weekly for 4 weeks and

when not in use or out of

Nurses sight.

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
	ROVIDER OR SUPPLIER LE REHABILITATION	495249 & HEALTH CARE CENTER LLC	B. WING STR	C 0 2/2 3/201 <u>8</u> ≣	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 761	200 hall was condi- parked near room On 2/22/18 at 12:55 nurse) #5 was obs- medication cart an 2/22/18 at 12:53 p. propelling himself i- medication cart. T unlocked at this tin- another resident w- in his wheelchair p 2/22/18 at 12:56 p pbserved ambulati- medication cart. O nurse was observed back to the nurses On 2/22/18 at 12:5 conducted with LP medication cart sh LPN #5 stated the medications lying of if the medication c LPN #5 stated it w was not her medic don't know why sh stated the other nu particular medicati unlocked for abour stated the nurse h least 20 minutes. N for medication cart use, LPN #5 state the cart if not locked	2:51 p.m., observation of the acted. The medication cart 212, was observed unlocked. 2 p.m., LPN (licensed practical erved walking by the dentering into room 212. On .m., a resident was observed in his wheelchair past the he medication cart was still ne. On 2/22/18 at 12:55 p.m., as observed propelling himself ast the medication cart. On .m., a third resident was ng in the hallway passing the ne 2/22/18 at 12:56 p.m., the ed walking out of room 212 and	F 761	The Staff Development Coordinator will submit to the Quality Assurance Committee monthly formonths. The Director of will be responsible formonitoring and follow to Completion date: 3/30/2	it a report ce r 3 f Nursing up.

(X1) PROVIOER/SUPPLIER/CLIA

STATEMENT OF OFFICIENCIES

PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

	OF OEFICIENCIES F CORRECTION	(X1) PROVIOER/SUPPL IOENTIFICATION N			PLE CONSTRUCTION		E SURVEY IPLETEO
		49524	19	B. WING		_	С
NAME OF P	ROVIOER OR SUPPLIER	4002-			STREET AOORESS, CITY, ST		2/23/201 <u>8</u>
TVAINL OF T	NO VIOLITON GOIT LILIN				1575 SCOTT DRIVE ROUT		1
FARMVILI	LE REHABILITATION	& HEALTH CARE CENT	ER LLC		FARMVILLE, VA 23901	- 5	
(X4) IO PREFIX TAG	(EACH OEFIC	Y STATEMENT OF OEFICIENC ENCY MUST BE PRECEOEO (OR LSC IOENTIFYING INFOR	BY FULL	IO PREFIX TAG	(EACH CORREC	PLAN OF CORRECTION CTIVE ACTION SHOULO BE ICEO TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From p	page 171		F 7	61		
	On 2/22/18 at 5:0 staff member) #1 DON (Director of	1 p.m., ASM (administr the administrator, ASM Nursing) and ASM #3, Director of Nursing) we	/I #2, the the				
	Cart" documented securely locked a nurse's view" 2. LPN (Licensed ensure a medicat locked while in a medications. Other	titled, "Security of Med d, "4. Medication carts of t all times when out of d Practical Nurse) #2 fa ion cart in the 100 hall resident's room admini- er staff and a resident mately three feet from ion cart.	must be the iled to was fully stering was		•		
	preparing and adresident was con- medications at the across from the re- lock button on the room. The lock betton the drain the room of the drain the drain the room of the drai	8 p.m. observation of Liministering medications ducted. LPN #2 prepare medication cart in the esident's room then pure cart and entered their attention was not fully pussed as turned from the medications to the form. Two staff members are unlocked medication.	s to a red the hall shed the resident's hed in. utton out tions. lication he s and a eximately cart.				
	was shown the lo that was not fully what should be d medication cart. locked the medic	*******	ation cart us asked ght he				-
FORM CMS-25	67(02-99) Previous Version	s Obsolete	Event IO: 62X711		Facility IO: VA0060	If continuation shee	t Page 172 of 185

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WAY 28 2018

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STATEMENT OF OFFICIENCIES ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) OATE SURVEY COMPLETEO	
NAME OF PI	ROVIOER OR SUPPLIER	495249	B. WNG	STREET AOORESS, CITY, STATE, ZIP COOE	(02/2	2 3 /201 <u>8</u>	
FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC				1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901			
(X4) IO PRÉFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO B CROSS-REFERENCEO TO THE APPROPRI OEFICIENCY)		(X5] COMPLETION OATE	
F 761	interview was conduct was asked what should leaves a medication of should lock the compinformation is visible. When asked how the medications, LPN #1 make sure medication cart and lock the cart the cart to where it is in the room. When a cart, LPN #1 stated, on 2/22/18 at 10:55 staff member) #1 (the director of nursing above findings.	imately 8:00 a.m., an otted with LPN #1. LPN #1 ald be done when a nurse cart. LPN #1 stated nurses outer screen so no and secure the medications. In nurse should secure stated the nurse should ns are not left on top of the LPN #1 stated she turns visible to her when she goes sked if she still locks the	F 76	1			
	Cart" documented, "4 securely locked at all nurse's view" No further informatio Food Procurement, S CFR(s): 483.60(i)(1)(1)(1)(1)(1)(2)(2)(3)(3)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	A. Medication carts must be times when out of the n was presented prior to exit. tore/Prepare/Serve-Sanitary 2) ty requirements. re food from sources red satisfactory by federal, ties. food items obtained directly subject to applicable State	F 81	2			

(X1) PROVIOER/SUPPLIER/CLIA

IOENTIFICATION NUMBER:

STATEMENT OF OFFICIENCIES

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ANO PLAN OF CORRECTION

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(X3) OATE SURVEY

COMPLETEO

NO PLAN OF	CORRECTION IDENTIFICATION NUMBER:	A. BUILDING	СОМ	PLETEO
	495249	B. WING		C .
NAME OF S				/2 3/2 01 <u>8</u>
	ROVIOER OR SUPPLIER LE REHABILITATION & HEALTH CARE CENTER LLC	15	REET AOORESS, CITY, STATE, ZIP COOE	
		F#	ARMVILLE, 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)	X5 COMPLETION DATE
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 falled 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, folding the resident and assistance.	F 812	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.	
	it and folding it and handing it to the resident. On 02/21/18 at approximately 8:12 a.m. a staff			

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(X2) MULTIPLE CONSTRUCTION

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(X1) PROVIOER/SUPPLIER/CLIA

STATEMENT OF OFFICIENCIES

PRINTED: 03/09/2018 FORM APPROVED OMB NO. 0938-0391

(X3) OATE SURVEY

ANO PLAN OF	CORRECTION	IOENTIFICATION NUMBER:	A. BUILOING		COMPLETEO
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NAME OF F	BOVIOED OF SUPELIES	495249	B. WING	TOFFT ADOPTED ONLY OF THE THE	02/ 23 /201 <u>8</u>
	ROVIOER OR SUPPLIER LE REHABILITATION & F	IEALTH CARE CENTER LLC	1 1	TREET AOORESS, CITY, STATE, ZIP COO 575 SCOTT DRIVE ROUTE 5 ARMVILLE, VA 23901	E
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCEO TO THE OEFICIENCY)	SHOULO BE COMPLETION
F 812	member was observed to ast in their bare hard then handing to the resident with CNA (65. When asked if she resident with her bare on it, folded it and processistance to help the bread, CNA # 5 state hands were bare when the resident, CNA # 8 gloves on when I was On 02/21/18 at approinterview with CNA # resident's piece of browhile spreading jelly the resident, CNA # 6 if she held a piece of for a resident while s 6 stated, "Yes." On 02/21/18 at approinterview was conducted as a conductive was conducted as a conductive was conducted as a conductive was conducted as a conductive was conducted as a conductive was conducted as a conductive was conducted as a conductive was conducted as a conductive was conducted as a conductive was conducted as a conductive was conducted as a conductive was conducted as a conductive was conducted as a conductive was conducted as a conductive was conducted as a conductive was conducted as a conductive was conducted as a conductive was conducted as a conductive was conducted as a conductive was conducted as a co	ed holding the resident's ands while buttering it and esident. Eximately 8:21 a.m. an certified nursing assistant) # e held a piece of bread for a e hands while spreading jelly by by by by by by by by by by by by by	F 812	4. The Assistant Director and the Unit Manager weekly audits of dining weekly for 4 weeks and 2 months to ensure prof food by staff. The St Development Coordinates submit a report to the Assurance Committee months. The Director of be responsible for mor follow up. The Staff De Coordinator will submit the Quality Assurance monthly for 3 months. of Nursing will be responsitoring and follow Completion date: 3	will conduct g services d monthly for oper handling aff ator will Quality monthly for 3 of Nursing will nitoring and velopment t a report to Committee The Director onsible for up.

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	OF OEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING COMP		SURVEY LETED		
					(
		495249	8. WING		0 2/ 2	23/2 01 <u>8</u>	
NAME OF PROVIDER OR SUPPLIER FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5				
			FA	ARMVILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES Y MUST BE PRECEDEO BY FULL LSC IOENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	8E	(X5) COMPLETION OATE	
F 812	under §3-302.15 or a this section, FOOD E contact exposed, RE their bare hands and UTENSILS such as o single-use gloves, or	s specified in (D) and (E) of MPLOYEES may not ADY-TO-EAT FOOD with	F 812				
F 842 SS=B	Resident Records - I CFR(s): 483.20(f)(5) §483.20(f)(5) Reside (i) A facility may not resident-identifiable of accordance with a coagrees not to use or except to the extent to do so. §483.70(i) Medical residentifiable of accordance with a coagrees not to use or except to the extent to do so. §483.70(i) Medical residentifiable of accordance with a coagrees not to use or except to the extent to do so. §483.70(i) Medical residentifiable of accordance with a coagrees in a coagree of a	dentifiable Information , 483.70(i)(1)-(5) Int-identifiable information. release information that is to the public. elease information that is to an agent only in contract under which the agent disclose the information the facility itself is permitted ecords. ordance with accepted ds and practices, the facility ral records on each resident mented; ele; and	F 842				
	all information conta regardless of the for records, except whe (i) To the individual,	ined in the resident's records, m or storage method of the n release is- or their resident e permitted by applicable law;					

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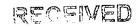
	CORRECTION	IDENTIFICATION NUMBER:	1 -		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495249	B, WING _	,		C 0 2/2 3/ 2 018
	ROVIDER OR SUPPLIER LE REHABILITATION &	HEALTH CARE CENTER LLC	!	15	REET ADDRESS, CITY, STATE, ZIP COOE 75 SCOTT DRIVE ROUTE 5 ARMVILLE, VA 23901	02123/2016
(X4) IO PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDEO BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	·	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE COMPLETION
F 842	operations, as permi with 45 CFR 164.50 (iv) For public health neglect, or domestic activities, judicial and law enforcement pur purposes, research medical examiners, a serious threat to he by and in compliance §483.70(i)(3) The farecord information a unauthorized use. §483.70(i)(4) Medica for- (i) The period of time (ii) Five years from the there is no requirem (iii) For a minor, 3 yelegal age under Staff (iv) The comprehens provided; (iv) The results of an and resident review determinations cond (v) Physician's, nurs professional's progra (vi) Laboratory, radioservices reports as This REQUIREMEN by:	ayment, or health care tted by and in compliance 3; activities, reporting of abuse, violence, health oversight d administrative proceedings, poses, organ donation purposes, or to coroners, funeral directors, and to avert ealth or safety as permitted e with 45 CFR 164.512. cility must safeguard medical gainst loss, destruction, or al records must be retained e required by State law; or he date of discharge when ent in State law; or ears after a resident reaches the law. edical record must contain- tion to identify the resident; esident's assessments; sive plan of care and services my preadmission screening evaluations and fucted by the State; e's, and other licensed	F	342	 Resident #50's representation and physician were notified 2/22/18 of falls without injut hat occurred on 6/12/17, 9/4/17 and 1/5/18 by the UManager. An audit was performed on 2/22/18 by the Unit Manage and Assistant Director of Nursing of all current reside falls within the last 30 days validate resident represent and physician were notified Any identified issues were corrected. Licensed staff will be reeducated by the Staff Development Coordinator 3/14/18 on notification of resident representative and physician after a fall. 	d on ury Unit Diger ent's sto sto stative d.

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Event ID: 62X711

Facility IO: VA0080

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	OF OEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
					С
		495249	8. WNG		0 2/23 /201 <u>8</u>
	FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC (X4) IO SUMMARY STATEMENT OF OEFICIENCIES			STREET AOORESS, CITY, STATE, ZIP COOE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901	
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCEO TO THE AI OEFICIENCY)	HOULO BE COMPLETION
F 842	maintain a complete for one of 30 resident Resident #50. The facility staff failed #50's physician was a sustained falls on 6/1 to document the resident sold 1/5/18. The findings include: Resident #50 was ad 7/1/14. Resident #50 were not limited to tradisorder and depress quarterly MDS (mining (assessment reference the resident's cognition Review of Resident #50 investigations reveal falls on 6/12/17, 9/4/1/17 review of the resident murse's notes) failed physician was notified 6/12/17 and 9/4/17. To reveal Resident #50 interview was conducted for 2/22/18 at approximaterial nurse) #1.	ined the facility staff failed to and accurate clinical record its in the survey sample, If to document Resident notified the resident 2/17 and 9/4/17, and failed dent's representative was sustained falls on 9/4/17 and mitted to the facility on D's diagnoses included but aumatic brain injury, anxiety sion. Resident #50's num data set) with an ARD ce date) of 12/21/17, coded on as severely impaired. #50's clinical record and fall led the resident sustained 17 and 1/5/18. Further t's clinical record (including to reveal the resident's d regarding the falls on The clinical record also failed 50's representative was a falls on 9/4/17 and 1/5/18. Attimately 8:00 a.m., an cited with LPN (licensed LPN #1 stated nurses notify sident representatives	F 84	4. The Assistant Director Nursing and the Unit I will conduct audits invital to ensure notificat resident's representat physician weekly for 4 and monthly for 2 months to the Quality Assurant Committee monthly for months. The Director of will be responsible for monitoring and follow Completion date: 3/30	Manager volving a ion to the ive and weeks oths. t t a report ce r 3 f Nursing

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notification is documented, LPN #1 stated the notification is documented on incident reports

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Facility IO: VA0080

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			TE SURVEY MPLETED
		495249	B. WING		0	C 2/23/201 8
NAME OF PE	ROVIDER OR SUPPLIER		STRI	EET ADDRESS, CITY, STATE, ZIP CODE	-	<u></u> -
CADAWILL	E DELIADO ITATION O L	CALTURA DE CENTER 11 C	1575	SCOTT DRIVE ROUTE 5		
PARIVIVILL	E REHABILITATION & H	IEALTH CARE CENTER LLC	FAR	RMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 842	Continued From page	e 178	F 842			
		that is not part of the clinical				
		es documented in nurses'				
		f the notification should be nical record, LPN #1 asked				
		to this surveyor with an				
	answer.	to this surveyor with an				
	On 2/22/18 at 12:54 r	o.m. LPN#1 presented				
		that were not part of the				
		ing 24-hour reports and				
		ition forms). The forms				
	, ,	n was notified regarding the				
		9/4/17, and Resident #50's				
		otified regarding the falls on PN #1 stated physician and				
ļ		e notification of falls should				
	be documented in the					
	On 2/22/18 at 1:58 p.	m. ASM (administrative staff				
		ctor 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				
		SM #2 were made aware of				
	the above findings.					
	No further information	n was presented prior to exit.				
F 880	Infection Prevention 8	•	F 880			
SS=F	CFR(s): 483.80(a)(1)	(2)(4)(e)(f)				
	§483.80 Infection Cor	ntrol				
		blish and maintain an				
	infection prevention a	and control program	1			1

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diseases and infections.

designed to provide a safe, sanitary and

comfortable environment and to help prevent the development and transmission of communicable

EvenI ID: 62X711

Facility ID: VA0080

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		[X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 -		ISTRUCTION		SURVEY PLETED
		495249	B, WING				C
NAME OF PROVIDER OR SUPPLIER FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC [X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES IEACH DEFICIENCY MUST BE PRECEOED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 dailyClean 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 -	STREET AOORESS, CITY, STATE, ZIP COOE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901				/23/201 <u>8</u>		
PREFIX	[EACH DEFIC	ENCY MUST BE PRECEOED BY FULL	IO PREFI TAG	x	PROVIDER'S PLAN OF COI IEACH CORRECTIVE ACTION CROSS-REFERENCED TO THE OEFICIENCY)	SHOULD BE	IX5) COMPLETI≪⊃∙N OATE
F 880		•	F	880			
	to be dirty, with ta posts, the residue contact with linen to be worn, and he that had dripped all facility linen ca #7 (Other Staff Maccount manager eleven linen carts cleaning or repair Observation of the carts were directly tape on the posts with dirt, and in covers were note a tear of approximus OSM #7 stated the sanitary condition	cky residue from old tape on the was blackened with dirt, and in s, the linen cart cover was noted ad a dried whitish substance down the side of it. At this time, arts were inspected, with OSM ember), the laundry department and the inspection revealed and were unsanitary. The seven identified carts revealed try, with tacky residue from old and the tresidue was blackened contact with linens, the linen cart do be worn, and one cover had mately 6 inches in the top of it.					
	Care of Equipme must be sanitized be free of trash a On 2/22/18 at 5: meeting, the Administrative St Nursing (ASM #2 findings.	nt" documented, "Laundry carts I dailyClean Linen carts must and lint and sanitized daily." 6 PM, at the end of day			·		
	113's wheelchair	aff failed to maintain Resident # armrests free from torn areas, at was unable to be sanitized.			RE	CEIVED	



DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/09/2018, FORM APPROVED OMB NO. 0938-0391

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION (X			SURVEY ETEO
	ROVIOER OR SUPPLIER LE REHABILITATION & H	495249 EALTH CARE CENTER LLC	B. WING _	15	REET AOORESS, CITY, STATE, ZIP COOE 75 SCOTT ORIVE ROUTE 5 ARMVILLE, VA 23901	02/2	23/201 <u>8</u>
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG	ĸ	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO B CROSS-REFERENCEO TO THE APPROPRI OEFICIENCY)		X5 COMPLETION DATE
F 880	reported to maintena asked to accompany 113's room. Upon obwheelchair, LPN #4 vleft armrests were crafoam. LPN #4 stated replaced." When ask properly cleaned LPN debris could be in the be properly cleaned. On 02/22/18 at 5:00 staff member) # 1, the director of nursin administrator in train above concerns. No further information References: 1. Bleeding in the arcthin tissues that cover called the subarachmas obtained from the https://medlineplus.governed.	taff and needed repairs are nce." LPN # 4 was then this surveyor to Resident # serving Resident # 113's rerbally agreed the right and acked, torn and exposing I, "They should have been ed if the arm rests could be IN # stated, "No because the copen areas and could not repair and ASM (administrative e administrator, ASM # 2, g, and ASM # 5, and, were made aware of the er the brain. This area is noid space. This information he website: nov/ency/article/000701.htm.	F	380			
	to pump oxygen-rich efficiently. This caus throughout the body obtained from the we	ch the heart is no longer able blood to the rest of the body es symptoms to occur. This information was ebsite: gov/ency/article/000158.htm.					

PRINTED: 03/09/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILOING С 495249 B. WNG_ 02/23/2018 NAME OF PROVIOER OR SUPPLIER STREET AODRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC FARMVILLE, VA 23901 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION IX5) COMPLETION DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 880 Continued From page 184 F 880 4. A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdi sorders.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. RECEIVED MAR 28 2018

ADHIOLC