PRINTED: 03/26/2018 FORM APPROVED OMB NO. 0938-0391

AND BLAN OF CORRECTION IN IDENTIFICATION NUMBER:		` '		DNSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495339	B. WING _	B. WING		02	/08/2018
	ROVIDER OR SUPPLIER ANOR NURSING HOME			2003	EET ADDRESS, CITY, STATE, ZIP CODE COBB STREET RMVILLE, VA 23901	, <u>v</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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
E 009 SS=C	survey was conducted required for compliant Requirement for Lon Local, State, Tribal CCFR(s): 483.73(a)(4). [(a) Emergency Plant and maintain an emet that must be reviewed annually. The plant must be reviewed annually.	The [facility] must develop ergency preparedness plan ed, and updated at least must do the following:] If for cooperation and cal, tribal, regional, State, and preparedness officials' efforts ated response during a cy situation, including e facility's efforts to contact	E	009			3/25/18
	planning efforts. * [For ESRD facilities Include a process for collaboration with loc Federal emergency to maintain an integr disaster or emergency documentation of the contact such officials participation in collab planning efforts. The the local emergency least annually to con of the dialysis facility emergency.	s only at §494.62(a)(4)]: (4)					
LABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		TITLE		(X6) DATE

Electronically Signed 02/27/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495339	B. WING		02/08/2018		
	ROVIDER OR SUPPLIER ANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901	7 32.00.20.10		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION		
E 009	review it was detern have a complete em The facility staff faile cooperation and col regional, State, and preparedness officia integrated response emergency situation the facility's efforts twhen applicable, of collaborative and	eview and facility document nined the facility staff failed to hergency preparedness plan. The detail to include a process for laboration with local, tribal, rederal emergency als' efforts to maintain an during a disaster or an including documentation of the contact such officials and, an interview was alst #1 (Administrative Staff nistrator, and a review of the preparedness plan was of the facility's emergency failed to evidence policies and ding a process for laboration with local, tribal, rederal emergency als' efforts to maintain an during a disaster or an including documentation of the contact such officials and,	E 00	1) Identified area of concern recogni 2) The facility consulted with the Cen Va. Healthcare Coalition for a full face emergency and disaster plan development. 3) CVHC is reviewing and revising the facility Emergency Preparedness plat accordance with regulatory guideline Upon completion plan will be fully implemented. 4) The Emergency Procedure and Procedures will be reviewed annually the QA Committee and revised accordingly. 5) Complete date: March 25, 2018	tral llity e n in s.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495339	B. WING	B. WING		02/08/2018	
	ROVIDER OR SUPPLIER ANOR NURSING HOME			20	TREET ADDRESS, CITY, STATE, ZIP CODE 103 COBB STREET ARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 009	Continued From page he felt the collaboration	on existed.	E	009			
E 013 SS=C		n was obtained prior to exit. olicies and Procedures	E	013			3/25/18
	develop and impleme policies and procedur plan set forth in paraga and the communication this section. The policies and updated *Additional Requirem Facilities: *[For PACE at §460.8 procedures. The PAC develop and impleme policies and procedur plan set forth in paraga assessment at paraga and the communication this section. The policies and procedures, includir equipment, power, or emergencies; and nathreaten the health or staff, or the public. The must be reviewed and *[For ESRD Facilities procedures. The dialy implement emergencies.	ents for PACE and ESRD 4(b):] Policies and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
495339 B.		B. WING		02/08/2018	
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE
forth in paragraph (a) assessment at paragraph (a) assessment at paragraph (b) assessment at paragraph (b) assessment at paragraph (b) assessment at paragraph (c) reviewed and updated emergencies include, equipment or power for emergencies, water is natural disasters likely geographic area. This REQUIREMENT by: Based on staff intervitation review it was determined have a complete emergency emergency policies developed based on the community-based risk communication plan, approach. The findings include: On 2/6/18 at 1:36 p.m interview of the facility plan conducted with A Member), the Administ emergency preparedron the facility- and conducted assessment and community-based risk communication plan, approach and procedure on the facility- and conducted with A Member), the Administ emergency preparedron the facility- and conducted with A Member) and procedure on the facility and conducted with A Member and communication plan, approach and communication plan approach and commun	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. These but are not limited to, fire, ailures, care-related upply interruption, and y to occur in the facility's is not met as evidenced ew and facility document ned the facility staff failed to regency preparedness plan. It to evidence the Emergency and procedures were he facility- and assessment and utilizing an all-hazards It during a review and of the facility's emergency preparedness as M #1 (Administrative Staff estrator, review of the facility's eness plan failed to evidence es were developed based mmunity-based risk munication plan, utilizing an all-hazard the documentation.		1) Identified area of concern recogn 2) The facility consulted with the Ce Va. Healthcare Coalition for a full fa emergency and disaster plan development. 3) CVHC is reviewing and revising t facility Emergency Preparedness pl accordance with regulatory guidelin Upon completion plan will be fully implemented. 4) The Emergency Procedure and Procedures will be reviewed annual the QA Committee and revised accordingly. 5) Complete date: March 25, 2018	ntral cility he an in es.	2/25/49
Folicies/Frocedures-V	volunteers and stailing	E 0.	- 		3/25/18
	CORRECTION ROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page forth in paragraph (a) assessment at paragrand the communication this section. The policy reviewed and updated emergencies include, equipment or power face emergencies, water is natural disasters likely geographic area. This REQUIREMENT by: Based on staff intervictive in the section of the facility staff failed. Preparedness policies developed based on the facility plan conducted with A member), the Administic emergency preparedre policies and procedure on the facility- and con assessment and com all-hazards approach. No further information	ANOR NURSING HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to evidence the Emergency Preparedness policies and procedures were developed based on the facility- and community-based risk assessment and communication plan, utilizing an all-hazards approach.	ROVIDER OR SUPPLIER NOR NURSING HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to evidence the Emergency Preparedness policies and procedures were developed based on the facility- and community-based risk assessment and communication plan, utilizing an all-hazards approach. The findings include: On 2/6/18 at 1:36 p.m. during a review and interview of the facility's emergency preparedness plan conducted with ASM #1 (Administrative Staff Member), the Administrator, review of the facility's emergency preparedness plan failed to evidence policies and procedures were developed based on the facility- and community-based risk assessment and community-based risk	A BUILDING 495339 ROWIDER OR SUPPLIER SUMMARY STATE-BIFT OF DEFICIENCIES (EACH DEFICIENCY) MIST BE PRECEDED BY YULL REGULATORY OR LSO IDENTIFYING INFORMATION) Continued From page 3 forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined the facility and community-based risk assessment and communication plan, utilizing an all-hazards approach. ASM # 1 (Administrative Staff Member), the Administrator, review of the facility's emergency preparedness plan flexible to evidence policies and procedures were developed based on the facility's emergency preparedness plan failed to evidence policies and procedures were developed based on the facility's emergency preparedness plan failed to evidence policies and procedures were developed based on the facility's emergency preparedness plan failed to evidence policies and procedures were developed based on the facility and community-based risk assessment and community-base	A BUILDING A 495339 B. WING STREETADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY PULL. RESULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 3 forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. The facility staff failed to evidence the Emergency Preparedness policies and procedures were developed based on the facility, and community-based risk assessment and communication plan, utilizing an all-hazards approach. The findings include: The findings include: The facility's emergency preparedness plan failed to evidence policies and procedures were developed based on the facility- and community-based risk assessment and ocommunication plan, utilizing an all-hazards splan failed to evidence policies and procedures were developed based on the facility- and community-based risk assessment and communication plan, utilizing an all-hazards approach. ASM #1 stated the facility and community-based risk assessment and communication plan, utilizing an all-hazards approach. ASM #1 stated the facility did not have the documentation. No further information was obtained prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		495339	B. WING _		02/08/2018		
	ROVIDER OR SUPPLIER ANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901	,		
(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 CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE COMPLETION		
E 024 SS=C	develop and implem policies and procedures. (6) The emergency.	cedures. The [facilities] must ent emergency preparedness ures, based on the emergency agraph (a) of this section, risk graph (a)(1) of this section, risk graph (a)(1) of this section, cion plan at paragraph (c) of icies and procedures must be ed at least annually. At a es and procedures must g:] as noted above] The use of ergency or other emergency including the process and role the and Federally designated onals to address surge needs	EC	, , , , , , , , , , , , , , , , , , ,			
	review it was determ have a complete em The facility staff faile policies and procedu and other staffing st preparedness plan. The findings include	view and facility document nined the facility staff failed to dergency preparedness plan. In the develop and ensure we are for the use of volunteers rategies in the emergency		1) Identified area of concern reco 2) The facility consulted with the O Va. Healthcare Coalition for a full emergency and disaster plan development. 3) CVHC is reviewing and revising facility Emergency Preparedness accordance with regulatory guidel Upon completion plan will be fully implemented. 4) The Emergency Procedure and Procedures will be reviewed annual.	Central facility g the plan in lines.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495339	B. WING	B. WING		02/08/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION DATE
E 024	plan conducted with A Member), the Adminis emergency prepared policies and procedur and other staffing stra	y's emergency preparedness ASM #1 (Administrative Staff strator, review of the facility's ness plan failed to evidence res for the use of volunteers ategies in the emergency ASM # 1 stated that the	E	024	the QA Committee and revised accordingly. 5) Complete date: March 25, 2018		
E 026 SS=C	[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section,		E	026			3/25/18
	this section. The polici reviewed and updated minimum, 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 rwaiver declared by the	, or (9)] The role of the er declared by the Secretary, ection 1135 of the Act, in the treatment at an alternate emergency management 3.748(b):] Policies and ole of the RNHCI under a e Secretary, in accordance					
	at an alternative care management officials	Act, in the provision of care site identified by emergency is not met as evidenced					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED			
		495339	B. WING	 	02/08/2018		
	ROVIDER OR SUPPLIER ANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET 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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION		
E 029 SS=C	by: Based on staff interv review it was determined have a complete emet. The facility staff failed procedures in the emethe facility's role in procedures in the emethe facility's role in procedures include: On 2/6/18 at 2:14 p.m. interview of the facility plan conducted with A Member), the Administ emergency prepared policies and procedur that describe the facility and treatment at alterwaiver. ASM # 1 state have it. No further information Development of Com CFR(s): 483.73(c) (c) The [facility] must emergency prepared that complies with Fe and must be reviewed annually. This REQUIREMENT by: Based on staff interview it was determined.	iew and facility document need the facility staff failed to orgency preparedness plan. I to develop policies and ergency plan that describe oviding care and treatment nder an 1135 waiver. In during a review and y's emergency preparedness ASM #1 (Administrative Staff strator, review of the facility's ness plan failed to evidence es in the emergency plan ity's role in providing care ed care sites under an 1135 ed that the facility did not	E 02	1) Identified area of concern recogni. 2) The facility consulted with the Cen Va. Healthcare Coalition for a full faci emergency and disaster plan development. 3) CVHC is reviewing and revising the facility Emergency Preparedness plan accordance with regulatory guidelines. Upon completion plan will be fully implemented. 4) The Emergency Procedure and Procedures will be reviewed annually the QA Committee and revised accordingly. 5) Complete date: March 25, 2018	tral lity e n in s. by 3/25/18 zed. tral		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495339	B. WING		02/	08/2018
	ROVIDER OR SUPPLIER ANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET 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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 030 SS=C	The findings include: On 2/6/18 at 2:18 p.m interview of the facility plan conducted with A Member), the Administ emergency prepared policies and procedur for a written communication plan. facility did not have it. No further information Names and Contact I CFR(s): 483.73(c)(1) [(c) The [facility, excetransplant centers, armaintain an emergen communication plant State and local laws a updated at least annuplan must include all (1) Names and contact following: (i) Staff.	at to develop policies and en communication plan. a. during a review and y's emergency preparedness ASM #1 (Administrative Staff strator, review of the facility's ness plan failed to evidence es in the emergency plan location plan and all the ts of a written ASM # 1 stated that the a was obtained prior to exit. The remarks of the facility's ness plan failed to evidence es in the emergency plan location plan and all the ts of a written ASM # 1 stated that the a was obtained prior to exit. The remarks of the formation for the following:] The communication of the following:] The services under arrangement. The services under arrangement.	E 02	development. 3) CVHC is reviewing and revising the facility Emergency Preparedness plar accordance with regulatory guidelines Upon completion plan will be fully implemented. 4) The Emergency Procedure and Procedures will be reviewed annually the QA Committee and revised accordingly. 5) Complete date: March 25, 2018	n in S.	3/25/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495339	B. WING	B. WING		02/08/2018	
	ROVIDER OR SUPPLIER ANOR NURSING HOME			20	TREET ADDRESS, CITY, STATE, ZIP CODE 003 COBB STREET ARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 030	(iii) Next of kin, guard (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.4 plan must include all (1) Names and conta following: (i) Staff. (ii) Entities providing: (iii) Patients' physicial (iv) Volunteers. *[For Hospices at §41 communication plan refollowing: (1) Names and conta following: (1) Hospice employee (ii) Entities providing: (iii) Patients' physicial (iv) Other hospices. *[For OPOs at §486.3 plan must include all (1) Names and conta following: (i) Staff. (ii) Entities providing: (iii) Volunteers. (iv) Other OPOs.	services under arrangement. ian, or custodian. 5(c):] The communication of the following: et information for the services under arrangement. ns. 18.113(c):] The must include all of the et information for the services under arrangement. ns. 60(c):] The communication of the following: et information for the services under arrangement. ns.	E	030			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495339	B. WING		02	2/08/2018
	ROVIDER OR SUPPLIER ANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET 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			(X5) COMPLETION DATE
E 030	This REQUIREMENT by: Based on staff intervireview it was determined have a complete eme. The facility staff failed procedures for a writt. Therefore the facility arequired facility contacommunication plan. The findings include: On 2/6/18 at 2:21 p.m. interview of the facility plan conducted with A Member), the Administ emergency prepared policies and procedur for a written communication plan. failed to include that a are included in the constant of the facility No further information Emergency Officials (CFR(s): 483.73(c)(2) [(c) The [facility] must emergency prepared that complies with Fernand must be reviewed.	ew and facility document ned the facility staff failed to rgency preparedness plan. It to develop policies and en communication plan. also failed to include that all cts are included in the cts are included in the staff strator, review of the facility's ness plan failed to evidence es in the emergency plan cation plan and all the ts of a written Therefore the facility also all required facility contacts mmunication plan. ASM # ty did not have it.	E 03	1) Identified area of concern recogn 2) The facility consulted with the Ce Va. Healthcare Coalition for a full far emergency and disaster plan development. 3) CVHC is reviewing and revising the facility Emergency Preparedness placcordance with regulatory guidelin Upon completion plan will be fully implemented. 4) The Emergency Procedure and Procedures will be reviewed annual the QA Committee and revised accordingly. 5) Complete date: March 25, 2018	ntral cility he an in es.	3/25/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495339	B. WING		02/08/2018		
	ROVIDER OR SUPPLIER ANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901	, 02.00.2010		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION		
E 031	Continued From page	e 10	E 03	1			
	(2) Contact information (i) Federal, State, the emergency prepared (ii) Other sources of	ribal, regional, and local ness staff.					
	information for the fol (i) Federal, State, trib emergency prepared (ii) The State Licensin	al, regional, or local ness staff. ng and Certification Agency. State Long-Term Care					
	emergency prepared (ii) Other sources of a (iii) The State Licensi (iv) The State Protect This REQUIREMENT by:	lowing: al, regional, and local ness staff. assistance. ng and Certification Agency. tion and Advocacy Agency. is not met as evidenced					
	review it was determi have a complete eme	riew and facility document ned the facility staff failed to ergency preparedness plan.		1) Identified area of concern recogn 2) The facility consulted with the Cer Va. Healthcare Coalition for a full face emergency and disaster plan development.	ntral		
	procedures for a writt	en communication plan. also failed to include all Officials contacts are		 CVHC is reviewing and revising the facility Emergency Preparedness plates accordance with regulatory guideline Upon completion plan will be fully implemented. 	an in		
	interview of the facility plan conducted with A	n. during a review and y's emergency preparedness ASM #1 (Administrative Staff		4) The Emergency Procedure and Procedures will be reviewed annuall the QA Committee and revised accordingly. 5) Complete date: March 25, 2018	y by		
	Member) the Adminis	strator review of the facility's					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			20	TREET ADDRESS, CITY, STATE, ZIP CODE 003 COBB STREET ARMVILLE, VA 23901		
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E 031	policies and procedur for a written communi necessary componen communication plan. failed to include all re contacts are included ASM # 1 stated that the	ness plan failed to evidence es in the emergency plan cation plan and all the ts of a written Therefore the facility also quired Emergency Officials in the communication. he facility did not have it.	E	031			
E 032 SS=C	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 communicating with the communication w	he following: val, regional, and local	E	032			3/25/18
	local emergency man This REQUIREMENT by: Based on staff interv review it was determin have a complete eme	· · · · · · · · · · · · · · · · · · ·			 Identified area of concern recognize The facility consulted with the Central Va. Healthcare Coalition for a full facility emergency and disaster plandevelopment. CVHC is reviewing and revising the 	al	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY
		495339	B. WING _			02/	08/2018
	ROVIDER OR SUPPLIER			200	REET ADDRESS, CITY, STATE, ZIP CODE 03 COBB STREET IRMVILLE, 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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 032	Therefore the facility ensure the communication plan. The findings include: On 2/6/18 at 2:30 p.m interview of the facility plan conducted with A Member), the Administ emergency prepared policies and procedur for a written communication plan. failed to include and eplan includes primary communicating with fatribal, regional and locagencies. ASM # 1 st have it. No further information Methods for Sharing CFR(s): 483.73(c)(4)-[(c) The [facility] must emergency prepared that complies with Fe and must be reviewed.	also failed to include and ration plan includes primary for communicating with State, tribal, regional and agement agencies. a. during a review and y's emergency preparedness ASM #1 (Administrative Staff strator, review of the facility's ness plan failed to evidence es in the emergency plan facation plan and all the ts of a written Therefore the facility also ensure the communication and alternate means for accility staff, Federal, State, cal emergency management atted that the facility did not in was obtained prior to exit.		032	facility Emergency Preparedness plan accordance with regulatory guidelines. Upon completion plan will be fully implemented. 4) The Emergency Procedure and Procedures will be reviewed annually be the QA Committee and revised accordingly. 5) Complete date: March 25, 2018		3/25/18
	documentation for pa	ing information and medical tients under the [facility's] vith other health providers to					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495339	B. WING		02/08/2018	
	ROVIDER OR SUPPLIER ANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901	1 02/03/2010	
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
E 033	release patient infor CFR 164.510(b)(1)(in required for HHAs under §485.68(c), an §491.12(c).] (6) [(4) or (5)]A mean about the general compatients under the [funder 45 CFR 164.5] *[For RNHCIs at §44 sharing information patients under the Riving information information information information information and location information informati	event of an evacuation, to mation as permitted under 45 ii). [This provision is not nder §484.22(c), CORFs and RHCs/FQHCs under ondition and location of acility's] care as permitted and care documentation for and care documentation for exHCl's care, as necessary, to maintain the continuity of written election statement	E 03	1) Identified area of concern recogniz 2) The facility consulted with the Cen Va. Healthcare Coalition for a full faci emergency and disaster plan development. 3) CVHC is reviewing and revising the	tral lity	
	ensure the commun method for sharing i	also failed to include and ication plan includes 1) a nformation and medical atients under the facility's		facility Emergency Preparedness plan accordance with regulatory guidelines Upon completion plan will be fully implemented.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	' '	E SURVEY PLETED
		495339	B. WING		02	/08/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
E 033	maintain the continuit communication plan; procedures that addrawill use to release pathe general condition the written communication. The findings include: On 2/6/18 at 2:31 p.m. interview of the facility plan conducted with Amember), the Adminiemergency prepared policies and procedure for a written communication plan. failed to include and plan includes 1) a meand medical document facility's care, as neceproviders to maintain written communication procedures that addrawill use to release pathe general condition the written communication on an onsite server a Regarding the document of the facility maintains on an onsite server a Regarding the document of the general condition the document of the server and the serv	with other health providers to by of care in the written and 2) policies and less the means the facility tient information to include and location of patients in cation plan. In during a review and y's emergency preparedness ASM #1 (Administrative Staff strator, review of the facility's mess plan failed to evidence res in the emergency plan ication plan and all the lats of a written Therefore the facility also ensure the communication entation for patients under the lessary, with other health the continuity of care in the less the means the facility tient information to include and location of patients in cation plan. ASM #1 stated the electronic health records	E 03	,	lly by	
E 034 SS=C	the facility did not have No further information Information on Occup CFR(s): 483.73(c)(7)	n was obtained prior to exit.	E 03	34		3/25/18

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495339	B. WING		02/08/2018
	ROVIDER OR SUPPLIER ANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901	1 02/06/2010
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
E 034	emergency prepared that complies with Fe and must be reviewe annually.] The comm all of the following: (7) [(5) or (6)] A mean about the [facility's] o ability to provide assi having jurisdiction, the Center, or designee. *[For ASCs at 416.54 providing information its ability to provide a having jurisdiction, the Center, or designee. *[For Inpatient Hospic of providing informatiin inpatient occupancy, provide assistance, to	t develop and maintain an ness communication plan deral, State and local laws d and updated at least unication plan must include ans of providing information ccupancy, needs, and its stance, to the authority e Incident Command (c)]: (7) A means of about the ASC's needs, and ssistance, to the authority e Incident Command ce at §418.113:] (7) A means on about the hospice's needs, and its ability to the authority having	E 03		
	designee. This REQUIREMENT by: Based on staff interv review it was determi have a complete eme The facility staff failed procedures for a writt Therefore the facility the communication p			1) Identified area of concern recogni 2) The facility consulted with the Cen Va. Healthcare Coalition for a full faci emergency and disaster plan development. 3) CVHC is reviewing and revising th facility Emergency Preparedness pla accordance with regulatory guideline Upon completion plan will be fully implemented. 4) The Emergency Procedure and	e n in

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495339	B. WING _			02/	/08/2018
	ROVIDER OR SUPPLIER ANOR NURSING HOME			20	REET ADDRESS, CITY, STATE, ZIP CODE 03 COBB STREET ARMVILLE, 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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 034	Continued From page	e 16	EO	34			
	communication plan i	designee; and 2) that the ncludes a means of about their occupancy.			Procedures will be reviewed annually be the QA Committee and revised accordingly. 5) Complete date: March 25, 2018	iy	
E 035 SS=C	On 2/6/18 at 2:35 p.m interview of the facility plan conducted with A Member), the Adminis emergency preparedres policies and procedur for a written communication plan. failed to include 1) the includes a means of puthe facility's needs, an assistance, to the autilicident Command C that the communication providing information ASM # 1 stated the facility and ICF/IID Share CFR(s): 483.73(c)(8) [(c) The [LTC facility and maintain an emergency plan, that	y's emergency preparedness ASM #1 (Administrative Staff strator, review of the facility's ness plan failed to evidence es in the emergency plan faction plan and all the ts of a written Therefore the facility also at the communication plan aroviding information about and its ability to provide hority having jurisdiction, the enter, or designee; and 2) on plan includes a means of about their occupancy. Inclifity did not have it. In was obtained prior to exit. Fing Plan with Patients and ICF/IID] must develop regency preparedness hat complies with Federal, and must be reviewed and itally.] The communication	ΕO	035			3/25/18

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495339	B. WING			02/08/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET 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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
E 035	by: Based on staff interview it was determined have a complete emet. The facility staff failed procedures for a writt. Therefore the facility communication plant is sharing information for residents or clients at representatives. The findings include: On 2/6/18 at 2:39 p.m. interview of the facility plan conducted with A Member), the Adminiemergency prepared policies and procedure for a written communication planthe facility admission preparedness information preparedness information in the facility admission preparedness information without a written communication planthe facility admission preparedness information without a written communication planthe facility admission preparedness information without a written communication planthe	iew and facility document ned the facility staff failed to ergency preparedness plan. It to develop policies and en communication plan. also failed to include that the ncludes a method for om the emergency plan with not their families or In. during a review and y's emergency preparedness ASM #1 (Administrative Staff estrator, review of the facility's ness plan failed to evidence res in the emergency plan ication plan and all the its of a written ASM #1 evidenced from packet, what emergency ation is disseminated to the lies and representatives, but munication plan, this refore also not included in atted that the facility did not	E 03	1) Identified area of concern re 2) The facility consulted with the Va. Healthcare Coalition for a femergency and disaster plantevelopment. 3) CVHC is reviewing and revisfacility Emergency Preparedne accordance with regulatory guilly Upon completion plan will be fuimplemented. 4) The Emergency Procedure a Procedures will be reviewed arthe QA Committee and revised accordingly. 5) Complete date: March 25, 26	e Central ull facility sing the ss plan in delines. illy and inually by		
E 041 SS=C	Hospital CAH and LT CFR(s): 483.73(e)	C Emergency Power	E 04	41		3/25/18	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495339	B. WING		02/08/2018
	ROVIDER OR SUPPLIER ANOR NURSING HOME	•		STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901	,
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION
E 041	hospital must implen power systems base forth in paragraph (a policies and proceduparagraphs (b)(1)(i) §483.73(e), §485.62 (e) Emergency and s [LTC facility and the emergency and stanthe emergency planthis section. §482.15(e)(1), §483. Emergency generate must be located in a requirements found Code (NFPA 99 and Amendments TIA 12 12-5, and TIA 12-6), and Tentative Interim 12-2, TIA 12-3, and when a new structur structure or building 482.15(e)(2), §483.7 Emergency generate [hospital, CAH and L the emergency power and maintenance red Health Care Facilitie Safety Code. 482.15(e)(3), §483.7 Emergency generate LTC facilities] that m	standby power systems. The ment emergency and standby and on the emergency plan set of this section and in the plan set forth in and (ii) of this section. 5(e) Standby power systems. The CAH] must implement dby power systems based on set forth in paragraph (a) of set forth in paragraph (a) of coordinate with the location in the Health Care Facilities Tentative Interim 1-2, TIA 12-3, TIA 12-4, TIA Life Safety Code (NFPA 101 in Amendments TIA 12-1, TIA TIA 12-4), and NFPA 110, in se is built or when an existing	E 04		

	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		ISTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495339	B. WING_			02/	08/2018
	ROVIDER OR SUPPLIER ANOR NURSING HOME		·	2003 (ET ADDRESS, CITY, STATE, ZIP CODE COBB STREET IVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
E 041	Continued From page for how it will keep er operational during the evacuates. *[For hospitals at §48 and CAHs §485.625(The standards incorp section are approved reference by the Dire Federal Register in a 552(a) and 1 CFR pa material from the sou inspect a copy at the Center, 7500 Security or at the National Arc Administration (NAR/availability of this mat 202-741-6030, or go http://www.archives.g_federal_regulations/If any changes in this incorporated by refer document in the Fedethe changes. (1) National Fire Prot Batterymarch Park, Quincy, MA 02169, w 1.617.770.3000.	nergency power systems e emergency, unless it 2.15(h), LTC at §483.73(g), g):] orated by reference in this for incorporation by ctor of the Office of the ccordance with 5 U.S.C. rt 51. You may obtain the rces listed below. You may CMS Information Resource y Boulevard, Baltimore, MD hives and Records A). For information on the terial at NARA, call to: pov/federal_register/code_of ibr_locations.html. edition of the Code are ence, CMS will publish a eral Register to announce		041			
	NFPA 99, issued Aug (iii) TIA 12-3 to NFPA (iv) TIA 12-4 to NFPA (v) TIA 12-5 to NFPA (vi) TIA 12-6 to NFPA	amendment (TIA) 12-2 to ust 11, 2011. .99, issued August 9, 2012. .99, issued March 7, 2013. .99, issued August 1, 2013. .99, issued March 3, 2014. .afety Code, 2012 edition,					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION		DATE SURVEY COMPLETED	
		495339	B. WING	 		02/08/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901		32/00/23 13	
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
E 041	Continued From page		E 04	11			
	2011. (ix) TIA 12-2 to NFPA 2012. (x) TIA 12-3 to NFPA 2013. (xi) TIA 12-4 to NFPA 2013. (xii) NFPA 110, Stand Standby Power System TIAs to chapter 7, isseminated to the second standby Power System TIAs to chapter 7, isseminated to the second standby Power System TIAs to chapter 7, isseminated to the second standby Power System TIAs to chapter 7, isseminated to the second standby Power System TIAs to chapter 7, isseminated to the second standby Power System TIAs to chapter 7, isseminated to the second standby Power System TIAs to chapter 7, isseminated to the second standby Power System TIAs to chapter 7, isseminated to the second standby Power System TIAs to chapter 7, isseminated to the second standby Power System TIAs to chapter 7, isseminated to the second standby Power System TIAs to chapter 7, isseminated to the second standby Power System TIAs to chapter 7, isseminated to the second standby Power System TIAs to chapter 7, isseminated to the second standby Power System TIAs to chapter 7, isseminated to the second standby Power System TIAs to chapter 7, isseminated to the second standby Power System TIAs to chapter 7, isseminated to the second standby Power System TIAs to chapter 7, isseminated to the second standby Power System TIAs to chapter 7, isseminated to the second standby Power System TIAs to chapter 7, isseminated to the second standby Power System TIAs to NFPA 2013.	is not met as evidenced iew and facility document ned the facility staff failed to ergency preparedness plan. If to evidence that the lness policies and eloped to include a plan for erator operational during an		1) Identified area of concern recordingly. 1) The facility consulted with the Va. Healthcare Coalition for a emergency and disaster plan development. 3) CVHC is reviewing and revifacility Emergency Preparednaccordance with regulatory gully Upon completion plan will be fimplemented. 4) The Emergency Procedure Procedures will be reviewed at the QA Committee and revised accordingly. 5) Complete date: March 25, 2	he Central full facility ising the ess plan in tidelines. fully and annually by d		
F 000	include a plan for how operational during an plan to evacuate. AS did not have this doct	v to keep the generator emergency, unless they SM # 1 stated that the facility umented in the plan.	F 00	00			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495339	B. WING			02/	08/2018
	ROVIDER OR SUPPLIER		•	20	TREET ADDRESS, CITY, STATE, ZIP CODE 003 COBB STREET ARMVILLE, VA 23901		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000 F 550 SS=D	survey was conducted 2/8/18. Corrections at with the following 42 of Long Term Care required code survey/report with the census in this 12 104 at the time of the consisted of 22 current (Residents #74, 411, 23, 14, 35, 106, 15, 6410) and two closed of #109 and 110). Resident Rights/Exert CFR(s): 483.10(a)(1)(a) §483.10(a) Resident The resident has a right sident sident	dicare/Medicaid standard d from 2/6/18 through re required for compliance CFR Part 483 of the Federal irements. The life safety II follow. O certified bed facility was survey. The survey sample nt resident reviews 12, 46, 76, 27, 93, 31, 45, 4, 29, 65, 24, 63, 40, 42 and record reviews (Residents cise of Rights (2)(b)(1)(2)		550			3/25/18
	access to persons an outside the facility, incomplete the facility, incomplete the facility and this section. §483.10(a)(1) A facility with respect and dignoresident in a manner promotes maintenancher quality of life, recomplete the rights of the facility of the facility access to quality care severity of condition, must establish and must practices regarding to	d services inside and cluding those specified in by must treat each resident ity and care for each and in an environment that the or enhancement of his or ognizing each resident's ity must protect and					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495339	B. WING		02/08/2018	
	ROVIDER OR SUPPLIER ANOR NURSING HOME	1	2	STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 550	rights as a resident of or resident of the Universident of the Universident can exercise interference, coercio from the facility. §483.10(b)(2) The refree of interference, reprisal from the facility and to be supplexercise of his or he subpart. This REQUIREMENT by: Based on observation interview, staff interview, it was determensure two of 24 resident #24, were addining. 1. On 2/7/18 during the dining room the faciling Resident #46 her meseated at her table her meal to be served. 2. On 2/7/18 during Atkins dining room the Resident #24 her meseated at her table her meal to be served.	of Rights. e right to exercise his or her of the facility and as a citizen ited States. acility must ensure that the e his or her rights without in, discrimination, or reprisal esident has the right to be coercion, discrimination, and lity in exercising his or her ported by the facility in the rights as required under this as required under this on, resident interview, family riew and facility document nined the facility staff failed to idents, Residents #46 and treated with dignity during the lunch service in the Atkins ity staff failed to serve eal until after the residents and been served and eaten in the table of the service of the Atkins ity staff failed to serve eal until after the residents and been served and eaten in the table of the service in the Atkins ity staff failed to serve eal until after the residents and been served and eaten in the table of the service in the Atkins ity staff failed to serve eal until after the residents and been served and eaten in the service in the Atkins ity staff failed to serve eal until after the residents and been served and eaten in the service in the Atkins ity staff failed to serve eal until after the residents and been served and eaten in the service in the Atkins ity staff failed to serve eal until after the residents and been served and eaten in the service in the Atkins ity staff failed to serve eal until after the residents and been served and eaten in the service in the Atkins ity staff failed to serve eal until after the residents and the service in the Atkins ity staff failed to serve eal until after the residents and the service in the Atkins ity staff failed to serve eal until after the residents and the service in	F 550	 Resident #46 and Resident #24, whoth provided meals as soon as the defin meal service was recognize. No other residents were identified be affected. Training was provided to dining roservers as to restaurant style dining. Orders will be taken as residents are seated at the table and meals served patable. The dining service manager will monitor the meal service process and provide staff education as observations are made of delay in meal service. Ongoing concerns will be reported to the facility QA committee for recommendations. Complete date: March 25, 2018 	to om er	

D2/08/2018 E, ZIP CODE AN OF CORRECTION VE ACTION SHOULD BE OD TO THE APPROPRIATE ICIENCY) (X5) COMPLETION DATE
AN OF CORRECTION (X5) PE ACTION SHOULD BE COMPLETION DATE
/E ACTION SHOULD BE COMPLETION DO TO THE APPROPRIATE COMPLETION DATE

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495339	B. WING	 	02/08/2018
	ROVIDER OR SUPPLIER	:		STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, 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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION
F 550	observed starting to were plated in the k individual plate to earlie between 11:17 a.m. residents seated with their meals. At 11:35 a.m., 11 of dining room had not had started to hand process of finishing did not observe faci residents who had the servers did not receiving her meal. On 02/08/18 at 08:5 conducted with OSI dietary server. OS the process for the reconducted with OSI dietary server. OS the process for the reconducted with osI dietary server. OS the process for the reconducted with osI dietary server. OS the process for the reconducted with osI dietary server. OS the process for the reconducted with osI dietary server. OS the process for the reconducted with osI dietary server. OS the process for the reconducted with osI dietary server. OS the process for the reconducted with osI dietary server. OS the process for the reconducted with osI dietary server. OS the process for the reconducted with osI dietary server. OS the process for the reconducted with osI dietary server. OS the process for the reconducted with osI dietary server. OS the process for the reconducted with osI dietary server. OS the process for the reconducted with osI dietary server. OS the process for the reconducted with osI dietary server. OS the process for the reconducted with osI dietary server.	a.m., the facility staff was serve meals. Lunch plates itchen and a server took the	F 5	50	
	had assigned seatir choose to sit where	ng. OSM #8 stated, "Residents wer they like. When residents if irst come first serve basis. If			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495339	B. WING			02/	08/2018
	ROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 003 COBB STREET ARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	time then we try to more sidents on one table same time." OSM #8 serve people at the serve people people serve people serve people serve people people serve people serve people people serve people	a table around the same ake sure that all the e have their food at the was asked why they tried to ame table at the same time. good customer service, I to have to wait too long and not get their food. We don't had at all." OSM #8 was when she noticed someone OSM #8 stated, "I walk up sure she gets her food and . Normally that never be so slow coming out." the delay, OSM #8 stated the e sure it (the food) is perfect thange. OSM #8 was asked and aware of what each anch. OSM #8 stated, "We have to the kitchen as the end on a first come, first was asked how it would be were at a restaurant with her served to everyone else stated, "I would be upset." If she remembered Resident we done something. I must all already ate." OSM #8 was asked recident #46 did not have her "I didn't catch that we done something. I must all already ate." OSM #8 was asked Resident #46 about her	F	550			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495339	B. WING			02/	08/2018
	ROVIDER OR SUPPLIER ANOR NURSING HOME		•	20	TREET ADDRESS, CITY, STATE, ZIP CODE 203 COBB STREET ARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	asked to describe the process. OSM #7 st tickets to me with the as to what the reside asked if the tickets a order. OSM #7 state come first served." (kitchen staff make su food at the same tim at their table. OSM # (certified nursing assinto the dining room together so they can servers let me know in the kitchen who m first." OSM #7 was a lunch service observed did not get their food others seated at their wasn't here yesterd who gets the food who was not here yesterd asked how she woulfamily and they got the	I #7, the cook. OSM #7 was e dining room / kitchen ated, "The servers bring the choices already checked offents want." OSM #7 were re presented in any kind of d, "They bring them in first OSM #7 was asked how the ure the residents get their e as other residents seated for stated, "When the CNAs sistants) bring the residents they will try to seat them be served together. The and we have a dietary aide asked, in reference to the ration on 2/7/18, why people is served at the same time as retables. OSM #7 stated, "I hay. The aide that makes sure then the residents are seated day either." OSM #7 was dieel if she were out with her their food and she did not. build feel insulted, and I would	F	550			
	conducted with OSM services. OSM #2 w observed the lunch s dining room. OSM # OSM #2 was asked the ensure residents were osm #2 stated, "We servers get the ticket resident and then bri	9 a.m., an interview was 1 #2, the director of dining was asked whether he service on 2/7/18 in Atkins #2 stated, "Yes I popped in." to state the process to be served their meals timely. In have restaurant seating, the stand fill them out with the ling the tickets to the kitchen.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495339	B. WING			02/	/08/2018
	ROVIDER OR SUPPLIER ANOR NURSING HOME	1	'	2003	EET ADDRESS, CITY, STATE, ZIP CODE COBB STREET RMVILLE, VA 23901	<u>, v-</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	residents have a spellonger." OSM #2 was ensured residents se served around the sa "They (the tickets) shout the problem is the to slow it (the process asked how long a sperved, OSM #2 state minutes." OSM #2 vobserved not to have others were eating and check on the food OSM #2 stated, "Yes service, which is our (the residents) live." was aware that resident was aware that resident food is being se running." OSM #2 stated was not. OSM #2 we for someone to wait served, and finished was not. OSM #2 we made the residents feat while they were well as the was a severed food when other that food is being se running." OSM #2 we for someone to wait served food when other served, and finished was not. OSM #2 we made the residents feat while they were well as the was request regarding the dining. On 2/8/18 at 11:15 a orientation agenda for agenda provided information agenda for agenda provided information as saked if there were was asked if there were was a sked if there were was asked if there were was a sked if the was	ause it is pre-prepared. If the exialty request it takes a little as asked how the dining staff eated at the same table are ame time. OSM #2 stated, nould be grouped together, e specialty order, that seems is) down." OSM #2 was recialty item would take to be red "No more than 10 was asked if a resident was a her food at a table where should the servers go back and to see what the delay is. Is, that is good customer goal. We work where they OSM #2 was asked if he lents had not been served ables with people who were red, "I did not notice that. It is dining room I make sure reved and that everything is was asked if it is acceptable an extended period to be hers at the table have been their meal. OSM #2 stated it as asked how he thought it feel to have to watch others waiting on their food. OSM ting not to be served timely."	F	550			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495339	B. WING		02/08/2018		
	ROVIDER OR SUPPLIER ANOR NURSING HOME	<u> </u>	:	STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETION		
F 550	the agenda was all orientation agenda services. On 2/8/18 at 3:58 p with ASM (administrator, and Acompliance. ASM # aware of the above requested at this tin On 2/8/18 at 1:05 p conducted with Resasked if she remem Resident #46 stated asked if she remem extended period be Resident #46 said t #46 stated, "They jumy lunch." When a be seated at the tabwere eating and har received her food, Fher mad and disgus staff working in the her meal, Resident asked me anything. brought me my food me my lunch." No further informati end of the survey processing the survey processi	ed timely, OSM #2 stated that he had. A review of the did not reference dining .m., a meeting was conducted rative staff member) #1, the ASM #2, the director of #1 and ASM #2 were made findings. A policy was he regarding dignity. .m., an interview was ident #46. Resident #46 was bered lunch on 2/7/18. If she did. Resident #46 was bered having to wait an fore she was served lunch. That it was terrible. Resident was terrible. Resident was to be with other residents who did finished by the time she resident #46 stated it made with the dining room had checked on #46 stated, "They never I just waited and they finally the time she was provided prior to the limited to the with other and hour to bring the con was provided prior to the limited was provided was provided prior to the limited was provided prior to the limited was provided was provided was provided prior to the limited was provided was	F 550				
	Resident #24 her m seated at her table	heal until after the resident had been served and eaten #24 waited 40 minutes for her					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495339	B. WING		02/08/2018		
	ROVIDER OR SUPPLIER ANOR NURSING HOM	E		STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
F 550	6/1/07 with readmis diagnoses that inclusions that inclusions that inclusions the control of the	admitted to the facility on ession on 11/28/16 with ude, but are not limited to high mentia, heart failure, chronic d difficulty with swallowing. Set recent MDS (minimum data essessment with an ARD ence date) of 1/16/18, coded foring a four out of a possible Resident #24 is severely d with decisions regarding daily 4 is also coded as requiring	F 55	0			
	the Atkins dining ro 11:00 a.m.,. Reside Atkins dining room 11:05 a.m., for toile room at 11:15 a.m. was seated with on being assisted with was served his mea a.m.,. Resident #2 her meal was not s resident seated at I and had been remontherapist at 11:50 a	at #24 was observed seated in om for lunch at approximately ent #24 was removed from the by an aide at approximately ting and returned to the dining for her lunch. Resident #24 the other resident who was his meal by a therapist; he all at approximately 11:20 the had been provided a drink, erved until 11:57 a.m.,. The there table had finished his meal by the a.m.,. The staff server was not on Resident #24's meal.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495339	B. WING			02/	08/2018
	ROVIDER OR SUPPLIER ANOR NURSING HOME		•	2	TREET ADDRESS, CITY, STATE, ZIP CODE 003 COBB STREET ARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550		e 30 a.m., an interview was (other staff member) #8, a	F	550			
	dietary server. OSM the process for the re OSM #8 stated, "We tickets, we take their	#8 was asked to describe sident's dining experience. greet them, we have their ticket to the table and ask					
	selections of meals o they want." OSM #8 had assigned seating	to drink and then tell them n the ticket and ask what was asked if the residents i. OSM #8 stated, "Residents er they like. When residents					
	people are seated at time then we try to m residents on one tabl	e have their food at the					
	serve people at the s OSM #8 stated, "It is don't want someone	was asked why they tried to ame table at the same time. good customer service, I to have to wait too long and					
	want them upset or masked what she did what had not been served.	not get their food. We don't nad at all." OSM #8 was /hen she noticed someone OSM #8 stated, "I walk up					
	apologize for the wait happens. Food can l	sure she gets her food and t. Normally that never be so slow coming out." the delay, OSM #8 stated the					
	and the tickets can check how the kitchen is ma	e sure it (the food) is perfect nange. OSM #8 was asked ade aware of what each unch. OSM #8 stated, "We					
	just take the tickets to residents are seated.						
	the tickets are submit served basis. OSM #	same time. OSM #8 stated tted on a first come, first #8 was asked how it would were at a restaurant with her					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495339	B. WING		02/08/2018	
	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION	
F 550	except her. OSM #OSM #8 was asked #24 seated at the ta OSM #8 stated that if she noticed Residence of the rood, OSM #8 state otherwise I would have thought that swas asked whether about her food. OSM #8 at OSM ON OSM PETER ON OSM ON OSM PETER ON OSM	s served to everyone else s sarved to everyone else s stated, "I would be upset." If she remembered Resident able with one other resident, she did. OSM #8 was asked dent #24 did not have her d, "I didn't catch that ave done something. I must he had already ate." OSM #8 she asked Resident #24 SM #8 stated she did not. IS a.m., an interview was A (certified nursing assistant) sked if she remembered the ins dining room on 2/7/18. Tas assisting a resident with s cueing." CNA #2 was asked the waiting a while to be served the stated, "Sometimes, yes." CNA #2 stated, "I think it t is not that way, and the a lack of staff members. The way their the kitchen." CNA #2 was table should be given to the the time if all residents are CNA #2 stated, "Yes." CNA tit is important to present the the same time. CNA #2 the same time. CNA #2 tryone can eat at the same asked if she noticed residents s where food had been served to others during the 2/7/18 the stated, "Yes." CNA #2	F 55			
	tickets for a table at stated, "So that eve time." CNA #2 was were sitting at table to some and not the lunch service. CNA was asked if she no for a long time to re	the same time. CNA #2 eryone can eat at the same asked if she noticed residents s where food had been served e others during the 2/7/18				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495339	B. WING			02/0	08/2018
	ROVIDER OR SUPPLIER ANOR NURSING HOME	:	1	STREET ADDRESS, CITY, STA 2003 COBB STREET FARMVILLE, VA 23901	TE, ZIP CODE	, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORREC' CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 550	at 11:45a.m., elever dining room) were constated, "I didn't notice that there were asked if she remem seated at the table of food. CNA #2 stated dining area early but back to her room for was in the dining room 10 minutes, she wasticket." When asked for her food, CNA #2 asked if any of the sabout her food, CNA #3 asked if any of the sabout her food, CNA #3 asked to describe the process. OSM #7 stickets to me with the asto what the residd asked if the tickets a order. OSM #7 stated come first served." kitchen staff make so food at the same tin at their table. OSM (certified nursing as into the dining room together so they can servers let me know in the kitchen who mist." OSM #7 was lunch service obsertid dinot get their food others seated at the	d 11:15 a.m. When informed a residents (out of 30 in the observed without food, CNA #2 be the exact number but I did are quite a few." CNA #2 was bered Resident #24 who was beside her, did not have her d, "She was originally in the tone of the aides took her a incontinence care so she om a little later, maybe about as there enough time to do her dif Resident #24 had to wait 2 stated she did. When servers asked Resident #24 A #2 stated, "Not that I recall." 88 a.m., an interview was M #7, the cook. OSM #7 was the dining room / kitchen tated, "The servers bring the e choices already checked off ents want." OSM #7 was are presented in any kind of ed, "They bring them in first OSM #7 was asked how the sure the residents get their the as other residents seated #7 stated, "When the CNAs sistants) bring the residents they will try to seat them in be served together. The vand we have a dietary aide makes sure who gets the food asked, in reference to the vation on 2/7/18, why people diserved at the same time as tir tables. OSM #7 stated, "I ay. The aide that makes sure	F	550			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	LE CONSTRUCTION		TE SURVEY MPLETED	
		495339	B. WING			02/08/2018	
	ROVIDER OR SUPPLIER ANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 550	was not here yesterd asked how she would family and they got the OSM #7 stated, "I wo complain." On 02/08/18 at 09:39 conducted with OSM services. OSM #2 we the lunch service on OSM #2 stated, "Yes asked what the processidents are served stated, "We have residents are served stated, "We have residents choose the is quick because it is residents choose the is quick because it is residents have a spelonger." OSM #2 was ensured that people is served around the sa "They (the tickets) shout the problem is the to slow it (the processaked how long a speserved, OSM #2 stateminutes." OSM #2 was others were eating shand check on the foo OSM #2 stated, "Yes service, which is our (the residents) live." was aware that residents	ay either." OSM #7 was defeel if she were out with her heir food and she did not. build feel insulted, and I would defeel insulted,	F 55				
	and were seated at to eating. OSM #2 state						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495339	B. WING			02/	08/2018
	ROVIDER OR SUPPLIER ANOR NURSING HOME			20	TREET ADDRESS, CITY, STATE, ZIP CODE 003 COBB STREET ARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	running." OSM #2 was for someone to wait a served food when oth served, and finished that it was not. OSM thought that it made the watch others eat while food. OSM #2 stated served timely." A politime regarding the direction of the contentation agenda for agenda provided informs asked if there we the dining experience residents were served the agenda was all he orientation agenda dieservices. On 2/8/18 at 3:38 p.m with ASM (administration, and ASM)	wed and that everything is as asked if it is acceptable in extended period to be ers at the table have been heir meal. OSM #2 stated #2 was asked how he he residents feel to have to be they were waiting on their in, "It is upsetting not to be acy was requested at this aining experience. In OSM #2, provided an in review. When asked if this remation about the dining ed that it did not. OSM #2 are any policies regarding and the process to ensure at timely OSM #2 stated that the had. A review of the did not reference dining In a meeting was conducted the staff member) #1, the of the did ASM #2 were made	F	5550			
F 623 SS=B	end of the survey pro- Notice Requirements	n was provided prior to the cess. Before Transfer/Discharge (6)(8) before transfer. fers or discharges a	F	623			3/25/18

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495339	B. WING		02/08/2018	
NAME OF PROVIDER OR SUPPLIER HOLLY MANOR NURSING HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIES		:	STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901)E		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 623	the reasons for the nanguage and manner facility must send a corepresentative of the Long-Term Care Om (ii) Record the reason discharge in the residuaccordance with paragraph (c)(5) of the \$483.15(c)(4) Timing (i) Except as specified (c)(8) of this section, discharge required unade by the facility a resident is transferred (ii) Notice must be more before transfer or dischargered under this section; (B) The health of indicates be endangered, under this section; (C) The resident's heallow a more immediated under paragraph (c)(0) An immediate transfer paragraph (c)(1) (E) A resident has not days.	and the resident's he transfer or discharge and nove in writing and in a er they understand. The copy of the notice to a Office of the State budsman. Ins for the transfer or dent's medical record in agraph (c)(2) of this section; dice the items described in his section. If of the notice. If in paragraphs (c)(4)(ii) and the notice of transfer or nder this section must be at least 30 days before the d or discharged. ade as soon as practicable charge when- viduals in the facility would ar paragraph (c)(1)(i)(C) of ividuals in the facility would er paragraph (c)(1)(i)(D) of ealth improves sufficiently to ate transfer or discharge, 1)(i)(B) of this section;	F 623			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495339	B. WING		02/08/2018	
	ROVIDER OR SUPPLIER ANOR NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901			
(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 CORRECT (EACH CORRECTIVE ACTION SHOUNDER OF THE APPROPRIES OF THE	JLD BE COMPLETION	
F 623	must include the foll (i) The reason for tr (ii) The effective dat (iii) The location to v transferred or discha (iv) A statement of th including the name, and telephone number receives such reque to obtain an appeal completing the form hearing request; (v) The name, addre telephone number of Long-Term Care On (vi) For nursing facil and developmental disabilities, the maili telephone number of the protection and a developmental disabilities, the maili telephone number of the protection and a developmental disabilities, the maili telephone rumber of the protection and a developmental disabilities, the maili telephone number of the protection and a developmental disabilities, the maili telephone rumber of the protection and a developmental disabilities, the maili telephone number of the protection and a developmental disabilities, the maili telephone number of the protection and a developmental disabilities, the maili telephone number of the protection and a developmental disabilities, the maili telephone number of the protection and a developmental disabilities, the maili telephone number of the protection and a developmental disabilities, the maili telephone number of the protection and a developmental disabilities, the maili telephone number of the protection and a developmental disabilities, the maili telephone number of the protection and a developmental disabilities, the maili telephone number of the protection and a developmental disabilities, the maili telephone number of the protection and a developmental disabilities, the maili telephone number of the protection and a developmental disabilities, the maili telephone number of the protection and a developmental disabilities, the maili telephone number of the protection and a developmental disabilities, the maili telephone number of the protection and a developmental disabilities, the maili telephone number of the protection and a developmental disabilities, the maili telephone number of the protection and a developmental disabilities, the maili telephone	aragraph (c)(3) of this section owing: ansfer or discharge; e of transfer or discharge; which the resident is arged; he resident's appeal rights, address (mailing and email), ber of the entity which ists; and information on how form and assistance in and submitting the appeal ess (mailing and email) and f the Office of the State inbudsman; ity residents with intellectual disabilities or related ing and email address and if the agency responsible for dvocacy of individuals with collities established under Part intal Disabilities Assistance to f 2000 (Pub. L. 106-402, 15001 et seq.); and lity residents with a mental disabilities, the mailing and elephone number of the for the protection and als with a mental disabilities with a mental disabilities with a mental disabilities.	F 62	3		

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCT		(X3) DATE SURVEY COMPLETED			
		495339	B. WING		02/08/2018	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901		02/00/2010	
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	
F 623	In the case of facility the administrator of the written notification prito the State Survey A State Long-Term Car the facility, and the rewell as the plan for the relocation of the residus. This REQUIREMENT by: Based on staff intervand clinical record refacility staff failed to prior to a facility initial residents in the surve Resident #40 and Reference on the surve state of the resident and	in advance of facility closure closure, the individual who is he facility must provide or to the impending closure gency, the Office of the e Ombudsman, residents of esident representatives, as e transfer and adequate lents, as required at § is not met as evidenced liew, facility document review view, it was determined the provide required notifications ted transfer for three of 24 by sample, Resident #93, sident #45. illed to provide written incing Resident #93, the insible party) and the liffied in writing when insferred to the hospital on illed to provide written incing, Resident #40, the enable many was transferred to 117. led to provide written incing, Resident #45, the tive and the ombudsman gwhen she was transferred in gwhen she was transferred.	F 623	1) Written notification regarding transf of Resident # 93 (hospital transfer 1/13/18), Resident #40 (Hospital transf 11/17/17), Resident #45 (hospital transf 11/29/17) provided to the ombudsman and RP. 2) The facility notified the Ombudsman office that they would be sending regul updates for facility transfers/discharge despite their direction not to send voluntary transfer discharge data. All notifications from Nov to present date were sent for transfers for resident currently in the facility. 3) The facility will send written notifications for transfer in addition to it normal process of calling the RP. Writt communication with the Ombudsman's office resumed. 4) Medical records will complete rando audit of 10% of transfers for written notification of transfers. Ongoing concerns will be reported to the facility committee for recommendations. 5) Complete date: March 25, 2018	fer sfer s's sar	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		' '	(X3) DATE SURVEY COMPLETED	
	495339	B. WING			02/08/2018	
			STREET ADDRESS, CITY, STATE, ZIP COI 2003 COBB STREET FARMVILLE, VA 23901			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
Continued From page	e 38	F 62	3			
10/21/11 with a readr diagnoses that including irregular heartbeat, he failure, low blood preserved. Resident #93's most set), a 14 day schedu ARD (assessment recoded Resident #93 and interview of mental stopossible 15, indicatin cognitively intact with A review of Resident revealed, in part, the "1/13/2018 12:12 PM (out of facility) to (nareval (evaluation) @ (secondary) to elevat (complaint of) feeling over." Daughter in accompany res to EFF urther review of Resident reveal any do ombudsman, the resimplification of emergency room. On 2/8/18 at 8:10 a.m. conducted with LPN of the action of the	mission on 1/15/18 with led, but are not limited to an leart failure, respiratory ssure and shortness of recent MDS (minimum data luled assessment with an ference date) of 1/29/18, las having a BIMS (brief latus) score of 13 out of a g that Resident #93 is lecision of daily living. #93's clinical record following progress note; least Resident #93) OOF least (Resident					
	ROVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENC REGULATORY OR I Continued From page The findings include: 1. Resident #93 was 10/21/11 with a readr diagnoses that includi irregular heartbeat, h failure, low blood pre- breath. Resident #93's most set), a 14 day schedu ARD (assessment re- coded Resident #93 a interview of mental st possible 15, indicatin cognitively intact with A review of Resident revealed, in part, the "1/13/2018 12:12 PM (out of facility) to (nar eval (evaluation) @ (i (secondary) to elevat (complaint of) feeling over." Daughter in a doctors) order to sen accompany res to ER Further review of Res did not reveal any do ombudsman, the resi written notification of emergency room. On 2/8/18 at 8:10 a.n conducted with LPN i a floor nurse. LPN #	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 38 The findings include: 1. Resident #93 was admitted to the facility on 10/21/11 with a readmission on 1/15/18 with diagnoses that included, but are not limited to an irregular heartbeat, heart failure, respiratory failure, low blood pressure and shortness of breath. Resident #93's most recent MDS (minimum data set), a 14 day scheduled assessment with an ARD (assessment reference date) of 1/29/18, coded Resident #93 as having a BIMS (brief interview of mental status) score of 13 out of a possible 15, indicating that Resident #93 is cognitively intact with decision of daily living. A review of Resident #93's clinical record revealed, in part, the following progress note; "1/13/2018 12:12 PM. Res (Resident #93) OOF (out of facility) to (name of emergency room) for eval (evaluation) @ (at) 1140am (11:40 a.m.) sec (secondary) to elevated temp, (temperature), c/o (complaint of) feeling "weak with body aches all over." Daughter in agreement with MD's (medical doctors) order to send for eval and will accompany res to ER (emergency room)." Further review of Resident #93's clinical record did not reveal any documentation evidencing the ombudsman, the resident, and RP were provided written notification of the transfer to the	A BUILDING A95339 ROVIDER OR SUPPLIER ANOR NURSING HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 38 The findings include: 1. Resident #93 was admitted to the facility on 10/21/11 with a readmission on 1/15/18 with diagnoses that included, but are not limited to an irregular heartbeat, heart failure, respiratory failure, low blood pressure and shortness of breath. Resident #93's most recent MDS (minimum data set), a 14 day scheduled assessment with an ARD (assessment reference date) of 1/29/18, coded Resident #93 as having a BIMS (brief interview of mental status) score of 13 out of a possible 15, indicating that Resident #93 is cognitively intact with decision of daily living. A review of Resident #93's clinical record revealed, in part, the following progress note; "1/13/2018 12:12 PM. Res (Resident #93) OOF (out of facility) to (name of emergency room) for eval (evaluation) @ (at) 1140am (11:40 a.m.) sec (secondary) to elevated temp, (temperature), c/o (complaint of) feeling "weak with body aches all over." Daughter in agreement with MD's (medical doctors) order to send for eval and will accompany res to ER (emergency room)." Further review of Resident #93's clinical record did not reveal any documentation evidencing the ombudsman, the resident, and RP were provided written notification of the transfer to the emergency room. On 2/8/18 at 8:10 a.m., an interview was conducted with LPN (licensed practical nurse) #1, a floor nurse. LPN #1 was asked what type of	ROWIDER OR SUPPLIER ANDRING NURSING HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 38 The findings include: 1. Resident #93 was admitted to the facility on 10/21/11 with a readmission on 1/15/18 with diagnoses that included, but are not limited to an irregular heartbeat, heart failure, respiratory failure, low blood pressure and shortness of breath. Resident #93's most recent MDS (minimum data set), a 14 day scheduled assessment with an ARD (assessment reference date) of 1/29/18, coded Resident #93's clinical record interview of mental status) score of 13 out of a possible 15, indicating that Resident #93 is cognitively intact with decision of daily living. A review of Resident #93's clinical record revealed, in part, the following progress note; "1/13/2018 12:12 PM. Res (Resident #93) OOF (out of facility) to (name of emergency room) for eval (evaluation) @ (at) 1140am (11:40 a.m.) sec (secondary) to elevated temp, (temperature), c/o (complaint of) feeling "weak with body aches all over." Daughter in agreement with MD's (medical doctors) order to send for eval and will accompany res to ER (emergency room)." Further review of Resident #93's clinical record did not reveal any documentation evidencing the ombudsman, the resident, and RP were provided written notification of the transfer to the emergency room. On 2/8/18 at 8:10 a.m., an interview was conducted with LPN (licensed practical nurse) #1, a floor nurse. LPN #1 was asked what type of	A BUILDING 495339 ROYDER OR SUPPLIER NOR NURSING HOME SUMMARY STATEMENT OF DEPICIENCIES GEACH DEPICENCY MILENT OF DEPICIENCIES GEACH CORRECTION RESULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 38 The findings include: 1. Resident #93 was admitted to the facility on 10/2/1/11 with a readmission on 1/1/5/1/8 with diagnoses that included, but are not limited to an irregular heartbeat, heart failure, respiratory failure, low blood pressure and shortness of breath. Resident #93's most recent MDS (minimum data set), a 14 day scheduled assessment with an ARD (assessment reference date) of 1/29/18, coded Resident #93 as having a BIMS (brief interview of mental status) score of 13 out of a possible 15, indicating that Resident #93 is cognitively intact with decision of daily living. A review of Resident #93's clinical record revealed, in part, the following progress note; "1/1/3/20/18 1/21/2 PM. Res (Resident #93) OOF (out of facility) to (name of emergency room) for eval (evaluation) @ (at) 1/14/0/20/18 (1/20/18)	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495339	B. WING		02/08/2018
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		200	REET ADDRESS, CITY, STATE, ZIP CODE 03 COBB STREET .RMVILLE, VA 23901		
PRÉFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETION
F 623	transferred to the honotify the resident and document that the When asked if she wonotification of the transferred to the transferred to the combudsman, LPN # During an interview ASM (administrative director of compliant their practice to sensitive when a Resident transfer discharges April 2017, was proved a prior to exit ASM #2 notifying the ombudent of April 2017. On 2/8/18 at 3:58 p. with ASM (administrator, and Acompliance. ASM #1 responsible to send resident, RP and on was transferred to the they had not been dunderstood that was written notifications ASM #2 was made and asked to provide and discharges. An interview was cop.m. with OSM (other social worker. OSM responsible for provide and discharges.	pspital. LPN #1 stated, "I and the RP of what is occurring hey have been notified." would send a written ansfer to the resident, RP and 1 stated she would not. on 2/8/18 at 10:00 a.m. with a staff member) # 2 (the	F 623		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	` '	(X3) DATE SURVEY COMPLETED	
		495339	B. WING _			02/08/2018
	ROVIDER OR SUPPLIER ANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901	•	
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 623	Continued From pag	ge 40	F 6	23		
	resident was transfe stated nursing was r notifications.	erred to the hospital. OSM #1 responsible for such				
	Discharge Transfethe hospital ER" revidocumentation; "12. include: Reason for effective date of the location to which the or discharged."	ty policy titled "Transfer and er to a medical facility such as ealed, in part, the following A letter of transfer shall transfer or discharge. b. The transfer or discharge. C. The eresident is to be transferred on was provided prior to the				
	documentation evidencesident's RP and the	failed to provide written encing, Resident #40, the le ombudsman were notified dent #40 was transferred to				
	9/10/11 with a readr diagnoses that inclu pressure ulcer, nutri sclerosis [1] (a disat spinal cord (central	dmitted to the facility on nission on 11/24/17 with ded, but are not limited to, tional deficiency, multiple oling disease of the brain and nervous system). and disease (poor circulation in				
	set), a significant ch ARD (assessment ro coded Resident #40 interview of mental s possible 15, indicati	t recent MDS (minimum data ange assessment with an eference date) of 12/8/2017, as having a BIMS (brief status) score of eight out of a ng that Resident #40 is ely impaired with decisions of				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	RIPLE CONSTRUCTION NG	(>	(3) DATE SURVEY COMPLETED
		495339	B. WING_			02/08/2018
	ROVIDER OR SUPPLIER ANOR NURSING HOME		·	STREET ADDRESS, CITY, STATE, ZIP 2003 COBB STREET FARMVILLE, VA 23901	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN C X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 623	revealed, in part, the "11/17/2017 10:10 P rescue squad to (nai room) at 5:30 PM, popt B/P (blood pressustatus. Her sister Popt notified of transfer, a Further review of Redid not reveal any doombudsman, the reswith written notification of 2/8/18 at 8:10 aux conducted with LPN a floor nurse. LPN # notifications are comtransferred to the homotify the resident ar and document that the When asked if she with notification of the transferred to the tr	at #40's clinical record of following progress note; M. Pt (patient) transferred via me of hospital emergency er MD (medical doctor) order. are) low, change in mental DA (power of attorney) as well as her husband." sident #40's clinical record ocumentation evidencing the added and RP were provided on of the transfer to the ER. m., an interview was (licensed practical nurse) #1, the was asked what type of apleted when a resident was appital. LPN #1 stated, "I and the RP of what is occurring the have been notified."	F	523		
	ASM (administrative director of compliand their practice to send when a Resident training Then in April of 2017 they only send notific transfers/discharges April 2017, was proven Prior to exit ASM # 2	on 2/8/18 at 10:00 a.m. with staff member) # 2 (the se), ASM # 2 stated it was an email to the ombudsman insferred to the hospital. 7, the ombudsman requested cation for involuntary . A copy of this email, dated ided to the survey team. 2 presented copies of emails sman prior to the ombudsman				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY LETED
		495339	B. WING			02/	08/2018
	ROVIDER OR SUPPLIER ANOR NURSING HOME		•	2	STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAN DEFICIENCY)		(X5) COMPLETION DATE
F 623	email of April 2017. On 2/8/18 at 3:58 p.m with ASM (administrator, and AS compliance. ASM #2 responsible to send a resident, RP and omb was transferred to the they had not been do understood that was a written notifications had ASM #2 was made awand asked to provide and discharges. An interview was comp.m. with OSM (other social worker. OSM # responsible for provide the resident, RP and resident was transferrestated nursing was renotifications. A review of the facility Discharge Transfer the hospital ER" reveated ocumentation; "12. A include: a. Reason for The effective date of the location to which transferred or discharger.	a., a meeting was conducted tive staff member) #1, the M #2, the director of was asked who was written notification to the budsman when a resident to hospital. ASM #2 stated ing that, and had not a requirement and the ad not been completed. Ware of the above findings a policy regarding transfer ducted on 2/9/18 at 3:25 staff member) #1, the #1 was asked who was ing written notifications to the ombudsman when a red to the hospital. OSM #1 sponsible for such a policy titled "Transfer and to a medical facility such as aled, in part, the following A letter of transfer or discharge. C. the resident is to be ged."	F	623			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
	495339	B. WING		02/08/2018
NAME OF PROVIDER OR SUPPLIER HOLLY MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901	
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
ultiple-sclerosis/symp 3. The facility staff fa documentation evide representative and the in writing when she we hospital on 11/29/17. Resident # 45 was as 11/21/15 and readmit diagnoses that include dementia, hypertensis disease, diabetes, his peripheral vascular demential va	nic.org/diseases-conditions/m otoms-causes/syc-20350269 illed to provide written incing Resident # 45's ne ombudsman were notified was transferred to the dimitted to the facility on tted on 12/2/17 with died but were not limited to ion, gastroesophageal reflux gh cholesterol, and lisease. It recent MDS (minimum data assment with an ARD ce date) of 12/17/17 coded ing cognitively impaired. It record for Resident # 45 bysician's order dated in the order documented, ame of local hospital) due to a congested cough." It ransfer form dated 11/29/17 documented, "Reason for riness with increased cough. BP (blood pressure) in 100.2, pulse: 114, pain, alert, lethargic, (name arty) was notified." Signed by call nurse) # 2.	F 62	23	

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING ———————————————————————————————————		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495339	B. WING		02/08/2018	
	ROVIDER OR SUPPLIER ANOR NURSING HOME	:	STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 623	114 (pulse) - 24 (respressure)." Signed to pressure)." Signed to pressure it is signed to the signed and signed and the signed	I signs): 100.2 (temperature) - spirations) - 144/95 (blood by LPN # 2. e clinical record for Resident # e documentation that the esident # 45's representative ification of Resident # 45's ital. on 2/8/18 at 9:15 a.m. with ember) # 1 (the social ras asked who was rying, in writing, the e responsible party of the etital. OSM # 1 stated, "Will ryou I'm not sure about that e to get back to you." A was made for any If # 1 could provide notice having been given to d the responsible party for resfer to the hospital. on 2/8/18 at 10:00 a.m. with e staff member) # 2 (the ce), ASM # 2 stated it was d an email to the ombudsman referred to the hospital. Then ombudsman requested they in for involuntary s. A copy of this email, dated wided to the survey team. 2 presented copies of emails sman prior to the ombudsman	F 623			

	OF DEFICIENCIES CORRECTION			(X3) DATE SURVEY COMPLETED			
		495339	B. WING			02/	08/2018
	ROVIDER OR SUPPLIER		•	20	TREET ADDRESS, CITY, STATE, ZIP CODE 003 COBB STREET ARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	that the ombudsman been given written no transfer as outlined in On 2/8/18/18 at 3:50	yone in the facility indicating or the responsible party had tification of a resident the new regulations.	F	623			
F 645 SS=D	PASARR Screening f CFR(s): 483.20(k)(1)- §483.20(k) Preadmiss	c(3) sion Screening for ntal disorder and individuals	F	645			3/25/18
	or after January 1, 19 (i) Mental disorder as (i) of this section, unlea uthority has determined performed by a persormed by a	and mental evaluation in or entity other than the uthority, prior to admission, the physical and mental dual, the individual requires provided by a nursing facility; quires such level of individual requires or ty, as defined in paragraph					

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495339	B. WING	<u>.</u>		02/08/2018
	ROVIDER OR SUPPLIER ANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CO 2003 COBB STREET FARMVILLE, 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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 645	and (B) If the individual reservices, whether the specialized services is \$483.20(k)(2) Except section- (i)The preadmission is paragraph(k)(1) of this for determinations in to a nursing facility of being admitted to the transferred for care in (ii) The State may chepreadmission screen paragraph (k)(1) of the to a nursing facility of (A) Who is admitted thospital after received hospital, (B) Who requires nur condition for which the hospital, and (C) Whose attending before admission to the is likely to require less facility services. §483.20(k)(3) Definition section- (i) An individual is condisorder defined in 48 (ii) An individual is conditional disorder defined in 48 (iii) An individual is conditional disability in the services in the individual is conditional disability in the services in the individual is conditional disability in the services in the individual is conditional disability in the services in the individual is conditional disability in the services in the individual is conditional disability in the services	equires such level of a individual requires for intellectual disability. Itions. For purposes of this secreening program under its section need not provide the case of the readmission of an individual who, after an unusing facility, was an a hospital. It oose not to apply the ing program under his section to the admission of an individual-to the facility directly from a neg acute inpatient care at the section in the individual received care in physician has certified, the facility that the individual is than 30 days of nursing for. For purposes of this insidered to have a mental unal has a serious mental and as defined in §483.102(b)(3)	F 64	45		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495339	B. WING		02/08/2018
	ROVIDER OR SUPPLIER ANOR NURSING HOME	,	2	STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901	,
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 645	by: Based on staff intervand clinical record rethe facility staff failed (Preadmission Scree was complete for one survey sample, Resident Facility staff failed PASARR was completed was evaluated and rethe most integrated stresident's needs. The findings include: Resident # 63 was as 12/30/15 with diagnon to limited to: psychologoric valve stenosis, gastroesophageal retheressure, peripheral dementia with behavior recent MDS (minimum an ARD (assessment coded the resident as	O of this chapter. I is not met as evidenced view, facility document review view, it was determined that to ensure a PASARR ning and Resident Review) of 24 residents in the dent # 63. If to ensure Resident # 63's tet to ensure the resident ecciving care and services in tetting appropriate for the dmitted to the facility on ses that included but were tic disorder with delusions,	F 645	,	xit. all ey ds. ded of erral rces, a not nen if
	paper and electronic; resident's PASARR, of concerning the PASA On 2/7/18 at 2:35 p.m was requested via a via) failed to reveal the or any documentation			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495339	B. WING _			02/08/2018	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET 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 O ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 645	On 2/7/18 at approxin 63's PASARR dated 2 During an interview of (other staff member); # 1 was asked who w PASARR. OSM # 1 s PASARR but that the was responsible. During an interview of 9:30 a.m. with OSM # 0SM # 5 was asked who were completing the PASAR request them from the provide them then it is admission. There is a from the hospital but who was asked who were sident comes to the OSM # 5 stated, "It is PASARR. If they do not do the PASARR." review Resident # 63' why the Re	mately 4:00 p.m. Resident # 2/7/18 was presented. In 2/8/18 at 9:15 a.m. OSM # 1, the social worker, OSM as responsible to do the tated she did not do the Admissions Coordinator In 2/8/18 at approximately # 5 (admission coordinator), what the process was for RR. OSM # 5 stated, "We hospital and if they do not a something that is done on a problem with getting them we do the PASARR." OSM as responsible if the facility without a PASARR. my responsibility to get the not have it, I am responsible OSM # 5 was asked to s PASARR and was asked 8's PASARR was completed stated, "Can I get back with to talk with (name of ASM # e on 2/7/18." In an interview with ASM # e on 2/7/18." In an interview with ASM # 2 stated they PASARRs were to be done - nem from the hospital. ASM en the PASARRs were staff was instructed to do a	Fé	345			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495339	B. WING_		02	/08/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTIC X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 645 F 656 SS=D	ASM #1 (the administ of compliance) were refindings. The facility policy title "ADMISSION/TRANS documented, Under "Prospective admissio years of age, unless a state agency. Preadr be completed, such a No further information	n 2/8/18/18 at 3:50 p.m., crator), ASM #2 (the director made aware of the above d, sFER/DISCHARGE" Procedure:4a. ns should be older than 18 a lower age is allowed by the mission screenings should		656		3/25/18	
	§483.21(b) Comprehe §483.21(b)(1) The faci implement a comprehe care plan for each respective resident rights set for §483.10(c)(3), that into objectives and timeframedical, nursing, and needs that are identifiassessment. The condescribe the following (i) The services that are or maintain the reside physical, mental, and required under §483.2 (ii) Any services that under §483.24, §483.2 provided due to the residence of the provided due to	cility must develop and lensive person-centered sident, consistent with the sthat §483.10(c)(2) and cludes measurable armes to meet a resident's mental and psychosocial led in the comprehensive aprehensive care plan must personal led in the comprehensive are to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse .10(c)(6).					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495339	B. WING		02/08/2018
	ROVIDER OR SUPPLIER ANOR NURSING HOME			1 02/00/2010	
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F 656	provide as a result of recommendations. If findings of the PASAI rationale in the reside (iv)In consultation wit resident's representa (A) The resident's go desired outcomes. (B) The resident's prefuture discharge. Fact whether the resident's community was asselocal contact agencie entities, for this purpor (C) Discharge plans in plan, as appropriate, requirements set fortisection. This REQUIREMENT by: Based on observation interview, facility docurecord review, it was failed to implement a care plan for two of 2 sample, Residents #1. The facility staff fail Resident #106's care assessment of the resident #42's computered includes. The findings include:	s the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. In the resident and the tive(s)-als for admission and eference and potential for eference and potential for eference and any referrals to seed and effect of the entire propriate lose. In the comprehensive care in accordance with the entire paragraph (c) of this effect of the facility staff and follow the comprehensive the residents in the survey 106 and #42. It is included the facility staff and follow the comprehensive the sident's dialysis access site. It is the survey staff the sident's dialysis access site.	F 65	1)Resident's #106's care plan for A monitoring was added to the nursin interventions prior to exit of the surteam. Resident #42's care plan for DM treatment was reviewed with the nuduty as well as the requirement to administer medications per MD ord prior to the exit of the survey. 2)No other resident identified witho nursing interventions to monitor AV other residents identified with post insulin administration based on meconsumption. 3)Random 10% audits will be compof dialysis residents with AVFs to en	g vey irse on ers ut F. No meal al

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CON AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING				(X3) DATE SURVEY COMPLETED		
		495339	B. WING		02	2/08/2018
	ROVIDER OR SUPPLIER ANOR NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901			
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F 656	Resident #106 was r facility on 1/11/18. R included but were no blood pressure and e Resident #106's mos data set), a 14 day M ARD (assessment recoded the resident at O documented Resident #106's comproblem onset date or "DialysisObserve L access) site for presesswelling as indicated to MD (medical doctor Resident #106's Jani 2018 MARs (medical TARs (treatment adm 2/7/18) failed to rever Resident #106's left assessed. Review of through 2/6/18 (excefailed to reveal document #106's left arm shund On 2/7/18 at 4:21 p.r in the bedroom. The site located on the recovered with a dress	e plan regarding the esident's dialysis access site most recently admitted to the desident #106's diagnoses at limited to diabetes, high end stage renal disease. Set recent MDS (minimum dedicare assessment with an afference date) of 1/25/18, as cognitively intact. Section dent #106 received dialysis. Apprehensive care plan with a set 12/12/17 documented, deft Arm Shunt (dialysis ence of bruit (2), redness or and report negative findings for) accordingly" Review of duary 2018 and February tion administration records)/ ininistration records) (prior to all documentation that farm shunt site was a finurses' notes from 1/11/18 president site was assessed. The plant regarding the dialysis access of the plant regarding the site was assessed.	F 656		rvations of in identify oractice. It pass the reported to	
	don't think they do he dialysis." Resident #	Resident #106 stated, "I ere so much as they do at 106 stated she goes to week and the staff there				

AND DUAN OF CORRECTION INTEREST IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION	OATE SURVEY OMPLETED		
		495339	B. WING	 		02/08/2018
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(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 656	the dressing. On 2/7/18 at 4:30 p.n conducted with RN (r was asked to describ provided to a residen #1 stated the facility arm that contains the site). RN #1 stated the under impaired mobil plan. RN #1 was ask done. RN #1 stated, down to nursing interextremity and note or was asked if nurses and bruit. RN #1 stated the nurses bruit every shift. On 2/7/18 at 5:21 p.n member) #1 (the adn director of compliance above findings. On 2/8/18 at 7:40 a.n physician order list did documented, "Nursin dialysis shunt for bruishift. Monitor for pos Notify MD (medical documented with LPN regarding the care the resident receiving dia a fistula there is a bruwant to make sure the	n., an interview was registered nurse) #1. RN #1 re the care that should be the twho receives dialysis. RN staff protects the resident's residual (a type of access his is noted on the care plan rity or in a separate care read if anything else should be "I want to say that translates ventions. We protect the high the MAR or TAR." RN #1 should assess for thrill (3) red, "We do that. Yes." RN should assess for thrill and high ASM (administrative staff hinistrator) and ASM #2 (the re) were made aware of the high the color of abnormal findings."	F 65	56		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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F 656	can hear it." When done, LPN #1 stated used. When asked done, LPN #1 stated When asked how of area needs to be as #1 stated this inform during the shift chard documented on the was asked the purpose of staff how to take calplans were on the coneeded to follow res #1stated, "You shout The facility documented on the coneeded to follow res #1stated, "You shout The facility documented plan to each problem identification regularly to address interventions necessing interventions necessing all discipling coordinate efforts to service has the over care among all disciplinated plant to send the stablished goals" No further information (1) "A vascular accellifeline. A vascular accellifeline. A vascular accellifeline is a treatment for kid machine to send the filter, called a dialyzing a state of the filter, called a dialyzing a state of the filter, called a dialyzing a state of the filter.	ed, "Feel it and make sure you asked how this should be d a stethoscope should be how often this should be d she would have to check. her nurses would know the sessed and how often, LPN nation should be relayed age report and should be treatment record. LPN #1 cose of a care plan. LPN #1 of a care plan was to inform re of the patient and care computer. When asked if staff sidents' care plans, LPN and follow the care plan." Int titled, "Resident PLAN DOCUMENTATION amented, "Develop a provide appropriate care for fied. It should be updated changes in status and sary to meet the resident's es involved in care should ward the same goal. Nursing reall responsibility to coordinate plines to achieve the	F 656				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 656	The blood goes throu at a time. The blood that takes it to the did blood flows through the wastes and extra fluir filtered blood to the blood to the blood to the blood to filter as much blood treatment" This infilter website: https://www.niddk.nifey-disease/kidney-faccess (2) "When blood flow sometimes makes a bruit." This information website: https://www.niddk.nifey-disease/renal-arter (3) "How does a patien vascular accessChevery day. The thrill in person can feel over information was obta https://www.niddk.nifey-disease/kidney-faccess 2. The facility staff facomprehensive care diabetes.	and during hemodialysis. Igh a needle, a few ounces then travels through a tube alyzer. Inside the dialyzer, the hin fibers that filter out d. The machine returns the rody through a different tube. Its large amounts of blooding hemodialysis treatments d as possible per formation was obtained from an	F 65	6		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
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F 656	weakness, reflux dises chronic kidney disease chronic kidney disease. Resident #42's most set), a quarterly asse (assessment reference Resident #42's BIMS status) score as sever indicating that Reside cognitively impaired who was a sever indicating that Reside cognitively impaired who was a sever indicating that Reside cognitively impaired who was a sever indicating that Resident plan dated 8/2/17 revident and a sever indicating that Resident plan dated 8/2/17 revident for the signs and syptoms (starough next review. Accuchecks (blood signs and syptoms (starough next review. Accuchecks (blood signs and pringent for the substantial planting and pringent for the several planting in part, the treatment of diabetes - "9/19/17. Novolog to treat diabetes) 1000 Inject 10 units subcut immediately after lundoes not eat 75% of	but not limited to muscle case, shortness of breath, se and diabetes. recent MDS (minimum data ssment with an ARD ce date) of 12/13/17, coded (brief interview of mental en out of a possible 15, ent #42 is severely with decisions of daily living. #42's comprehensive care realed, in part, the following blem / Need. Risk for (high/low blood sugar) r/t Goal & Target Date: 42) will remain free from ici) of hyper/hypoglycemia Approaches. Perform ugar checks) as ordered by a needed) if you suspect r. May follow standing it occurs. Administer d by physician."	Fé	556			
	scheduled dose)." - "9/4/17. Novolog 10	00 unit/ml vial inject 1-16					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 656	Sliding scale if BS: 2 units, 250 - 299 = 350 - 399 = 8 units, (greater) = 12 units On 2/7/18 at 10:45 nurse) #4, a floor nurse accucheck from administering Novol accucheck was mereviewed the MAR (record) and stated to Resident #42 would units plus Resident 10 units of Novolog drew up 16 units of administered the inselft upper stomach accucheck was mereviewed 12:45 p.m. with OSI dietary staff, OSM # residents on the Learooms. OSM # 3 st dining room is serve floor (Lee Unit) are Lunch trays were not any time on 12/7/18 on 2/7/18 at 2:15 producted with LPN describe the process medications to a residents of the medication as in to review Residents state what the order	y 3 times daily before meals. 150 -199 = 1 unit, 200 - 249 = 4 units, 300 - 349 = 6 units, 400 - 450 = 10 units, 450 or > & call MD (medical doctor)." a.m. LPN (licensed practical urse, was observed obtaining Resident #42 and log insulin. Resident #42's asured at 324. LPN #4 then imedication administration that for an accucheck of 324 receive sliding scale insulin 6 #42 had a scheduled order for three times per day. LPN #4 Novolog insulin and sulin to Resident #42 in her area. on 2/7/18 at approximately M (other staff member) # 3, # 3 was asked at what time the en Unit are served lunch in their ated when everyone in the end then the residents on the	F 650		

	OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495339	B. WING			02/08/2018
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F 656	lunch." When asked 10 units today, LPN # lunch, at 10:45 a.m." time the Novolog 10 to stated, "12:30 PM." Administered the Novoscheduled Novolog a stated, "I read it wron When asked if Reside prior to administering LPN #4 stated that should be conducted with ASM member) #3, the direwas asked what a nuadministering medicanurse should check the dothe five rights of mASM #3 was informed was asked if LPN #4 rights of medication administering the two same time to Resider did not know, as she administered. ASM # checked the order, shup." At this time this the documentation for conducted (and obse at 10:57 a.m. and at asked why or how the insulin were documentation for the second order as the second orde	g 10 units immediately after when she gave the Novolog 44 stated, "I gave it before LPN #4 was asked what units was due. LPN #4 When asked why she olog sliding scale and at the same time, LPN #4 g, it is two separate orders." ent #42 had eaten lunch the two doses of Novolog, he had not. a., an interview was (administrative staff ctor of nursing. ASM #3 rese should do prior to tions. ASM #3 stated, "The he orders, check the patient, edication administration." d of the above concern and had conducted the five	F 69	56		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
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F 656	On 2/8/18 at 8:10 a.m conducted with LPN awas asked to describ comprehensive care know how to take car specifics are (for care she would know what #1 stated, "The care we have knowledged there and how to care asked if the nursing scomprehensive care you should follow the At a meeting conduct staff member) #1, the the director of complithe above concerns verificating policy for follow requested at this time. No further information end of the survey profully in the survey profull	was actually administered. I., an interview was #1, a floor nurse. LPN #1 #2 the purpose of the plan. LPN #1 stated, "It is to #2 of the patient, what their #3." LPN #1 was asked how was on the care plan. LPN plans are on the computer, #4 why the residents are #5 for them." LPN #1 was #5 taff should follow the plan. LPN #1 stated, "Yes, plane on 2/8/18 at 3:58 p.m. #6 with ASM (administrative #6 administrator, and ASM #2, #6 ance on 2/8/18 at 3:58 p.m. #6 was presented prior to the plans are plan was #6 the state of the prior to the #6 presented prior to the #6	F 65			3/25/18
SS=D	CFR(s): 483.25 § 483.25 Quality of ca Quality of care is a fu	are ndamental principle that				

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F 684	facility residents. Ba assessment of a rest that residents received accordance with propractice, the compression of a rest that residents received accordance with propractice, the compression of the resident and the resident review as determined that follow the physician in the survey sample. The facility staff failing Resident #42's as a compression of the resident resident resident resident resident resident resident references (assessment references resident resident resident references resident resident resident references resident resident resident references resident resident references resident resident resident references resident resident references resident resident resident references resident re	ent and care provided to ased on the comprehensive sident, the facility must ensure we treatment and care in ofessional standards of ehensive person-centered esidents' choices. AT is not met as evidenced ion, staff interview, facility and clinical record review, it at the facility staff failed to orders for one of 24 residents e, Resident #42. Bed to administer insulin to ordered by the physician. Be: Admitted to the facility on mission on 8/2/17 with g, but not limited to muscle sease, shortness of breath, ase and diabetes. But recent MDS (minimum data dessment with an ARD noce date) of 12/13/17, coded S (brief interview of mental oven out of a possible 15, dent #42 is severely	F 684	1)Resident #42's insulin orders were reviewed with the nurse on duty during survey at the time the error was recognized. 2)No other residents in the facility had insulin orders for post meals based on consumption. 3)Unannounced med pass observation will be made for 10% of the nurses administering insulin will be complete identify deviations from standards of practice. 4)Ongoing concerns from med pass observations of will be reported to the facility QA committee for recommendations. 5)Complete date: March 25, 2018	าร		
	A review of Resider plan dated 8/2/17 re documentation: "Pr hyper/hypoglycemia	It #42's comprehensive care evealed, in part, the following roblem / Need. Risk for a (high/low blood sugar) r/t s. Goal & Target Date:					

AND BLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION	l` '	(X3) DATE SURVEY COMPLETED		
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F 684	signs and symptoms through next review. Accuchecks (blood s physician and prn (as abnormal blood suga orders if hypoglycem medication as ordered. A review of Resident revealed, in part, the treatment of diabetes - "9/19/17. Novolog to treat diabetes) 100 Inject 10 units subcurimmediately after lundoes not eat 75% of (is less than) 100* (If scheduled dose)." - "9/4/17. Novolog 10 units subcutaneously Sliding scale if BS: 12 units, 250 - 299 = 2350 - 399 = 8 units, 24 (greater) = 12 units 80 On 2/7/18 at 10:45 a nurse) #4, a floor nur an accucheck from Radministering Novolog accucheck was meas reviewed the MAR (mecord) and stated th Resident #42 would units plus Resident #	(sic) of hyper/hypoglycemia Approaches. Perform ugar checks) as ordered by s needed) if you suspect ur. May follow standing ia [2] occurs. Administer d by physician." #42's physician orders following order related to the s: [1] (a fast acting insulin used 0 unit/ml (milliliters) vial. taneously (under the skin) ch. *Hold dose if patient meal or if BS (blood sugar) < BS 100-130 give 1/2 of 00 unit/ml vial inject 1-16 a 3 times daily before meals. 50 -199 = 1 unit, 200 - 249 = 4 units, 300 - 349 = 6 units, 100 - 450 = 10 units, 450 or > 5 call MD (medical doctor)." 1.m. LPN (licensed practical use, was observed obtaining usesident #42 and ug insulin. Resident #42's sured at 324. LPN #4 then medication administration at for an accucheck of 324 receive sliding scale insulin 6 42 had a scheduled order for hree times per day. LPN #4	F 68				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	IPLE CONSTRU		(X3) DATE SURVEY COMPLETED				
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	PROVIDER OR SUPPLIER ANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 684	administered the insuleft upper stomach and left upper stomach and 12:45 p.m. with OSM dietary staff, OSM # residents on the Lee rooms. OSM # 3 state dining room is served floor (Lee Unit) are substituted by the conducted with LPN describe the process medications to a resist the medication as insuled to review Resident # state what the orders medications. LPN # 4 # 42) receives Novolc lunch." When asked to Resident # 42 toda before lunch, at 10:4 what time the Novolc LPN # 4 stated, "12:3 she administered the and scheduled Novolc LPN # 4 stated, "I read orders." When asked lunch prior to administ Novolog insulin, LPN # 4 repeat blood sugar a accompanied LPN # 4 repeat accompanied LPN # 4 repeat blood sugar a accompanied LPN # 4 repeat staff process."	ulin to Resident #42 in her rea. on 2/7/18 at approximately (other staff member) # 3, 3 was asked at what time the Unit are served lunch in their ted when everyone in the d then the residents on the erved lunch. observed on the Lee unit at petween 11 a.m. and noon. n., an interview was #4. LPN #4 was asked to followed when giving dent. LPN #4 stated, "I give structed." LPN #4 was asked 42's orders for insulin and to	F	684					

NAME OF PROVIDER OR SUPPLIER 198339 102/08/2018 STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBS STREET FARMVILLE, VA. 23901 PROJUCT MANOR NURSING HOME 102/08/2018 SUMMAY STATEMENT OF SEPTICENCIES PROVIDER OR SUPPLIER 102/08 COBS STREET FARMVILLE, VA. 23901 PROJUCT OR SUPPLIER 102/08 COBS STREET FARMVILLE, VA. 23901 PROJUCT OR SUPPLIER 102/08 COBS STREET FARMVILLE, VA. 23901 PROJUCT OR SUPPLIER 102/08 COBS STREET FARMVILLE, VA. 23901 PROJUCT OR SUPPLIER FOR SUPPLIER FO	OLIVILIV	OT OIL WILDIO, WE G	WEDIO/ ND CEITTICE				CIVID ITC	7. 0000 000 1
MANDE OF PROVIDER OR SUPPLIER HOLLY MANOR NURSING HOME SUMMARY STATEMENT OF DESPICIACIES (PREFIX TAG) GEAH DEPTICACY MUST BE PRECEDED BY FULL (PARMILLE, VA 23901 F 684 Continued From page 62 obtain the accucheck was 64, LPN #4 offered Resident #42 a soda at this time. On 27/18 at 3.48 p.m., an interview was conducted with ASM (administrative staff member) #3, the director of nursing, ASM #3 was asked what a nurse should of prior to administering medications. ASM #3 stated, "The nurse should of heok the orders, check the patient, do the five rights of medication administration." ASM #3 was asked if LFN #4 had conducted the five rights of medication administration was seed if LFN #4. As we have not there when it was administered. ASM #3 stated, "The patient was administered. ASM #3 stated with a non-ducted (and observed by this writer) on 27/18 at 10.57 a.m. and at 11.30 a.m. ASM #3 was asked why or how the 10 units of scheduled insulin were documented at 11.30 a.m. ASM #3 was asked why or how the 10 units of scheduled insulin were documented at 11.30 a.m. ASM #3 was asked why or how the 10 units of scheduled insulin were documented at 11.30 a.m. ASM #3 was asked why or how the 10 units of scheduled insulin were documented at 11.30 a.m. ASM #3 was asked why or how the 10 units of scheduled insulin were documented at 11.30 a.m. ASM #3 was asked why or how the 10.01 units of scheduled insulin were documented at 11.30 a.m. ASM #3 was asked why or how the 10.01 units of scheduled insulin were documented at 11.30 a.m. ASM #3 was asked with the 6 units sliding scale insulin at 10.57 a.m. ASM #3 stated the nurse had not signed off on the second order at the time the medication was administered as she had forgotten to do it when the medication was administered as he had forgotten to do it when the medication was administered as the had converted as 50 %. ASM #3 was asked if the order for Novolog 10 units should have been administered. ASM #3 presented to this writer a list of Resident #4.2 meal intakes. The 27/18 t			` '	1 ' '				
HOLLY MANOR NURSING HOME DIA DI			495339	B. WING			02/	08/2018
FREETY TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 684 Continued From page 62 obtain the accucheck. The accucheck was 64, LPN #4 offered Resident #42 a soda at this time. On 217/18 at 3.48 p.m., an interview was conducted with ASM (administrative staff member) #3, the director of nursing. ASM #3 was asked what a nurse should do prior to administering medications. ASM #3 stated the order of vigingts of medication administration." ASM #3 was informed of the above concern and was asked if LPN #4 had conducted the five rights of medication administration prior to administering the two doses of insulin at the same time to Resident #42. ASM #3 stated that she did not know, as she was not there when it was administered. ASM #3 stated that she did not know, as she was not there when it was administration for the insulin administration conducted (and observed by this writer) on 27/18 at 10:57 a.m. and at 11:30 a.m. ASM #3 was asked with provide the formal provided insulin were documented at 11:30 a.m. ASM #3 stated the nurse had not signed off on the second order at the time the medication was administering the 10 units of rooting insulin with the 6 unit's sliding scale insulin at 10:57 a.m. ASM #3 stated the nurse had not signed off on the second order at the time the medication was administering the 10 units of rooting insulin with the medication was actually administred. ASM #3 presented to this writer a list of Resident #42 meal intakes. The 27/1/18 unit knows recorded as 50 %. ASM #3 was asked if the order for Novolog 10 units should have been administered, ASM #3 stated that it should not. On 2/8/18 at 8:10 a.m., an interview was				•	20	003 COBB STREET		
obtain the accucheck. The accucheck was 64, LPN #4 offered Resident #42 a soda at this time. On 277/18 at 3:48 p.m., an interview was conducted with ASM (administrative staff member) #3, the director of nursing. ASM #3 was asked what a nurse should do prior to administering medications. ASM #3 stated, "The nurse should check the orders, check the patient, do the five rights of medication administration." ASM #3 was informed of the above concern and was asked if LPN #4 had conducted the five rights of medication administration prior to administering the two doses of insulin at the same time to Resident #42. ASM #3 stated that she did not know, as she was not there when it was administered. ASM #3 stated, "She (LPN #4)-checked the order, she read it, she just messed up." At this time this writer and ASM #3 reviewed the documentation for the insulin administration conducted (and observed by this writer) on 277/18 at 10:57 a.m. and at 11:30 a.m. ASM #3 was asked why or how the 10 units of scheduled insulin were documented at 11:30 a.m. ASM #3 was asked why or how the 10 units of scheduled insulin were documented at 11:30 a.m., when the nurse (LPN #4) was observed administering the 10 units of novolog insulin with the 6 unit's sliding scale insulin at 10:57 a.m. ASM #3 stated the nurse had not signed off on the second order at the time the medication was administered as she had forgothen to do it when the medication was administered as she had forgothen to do it when the medication was administered to this writer a list of Resident #42 meal intakes. The 277/18 lunch was recorded as 50 %. ASM #3 was asked if the order for Novolog 10 units should have been administered, ASM #3 stated that it should not. On 2/8/18 at 8:10 a.m., an interview was	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
conducted with LPN #1, a floor nurse. LPN #1	F 684	obtain the accucheck LPN #4 offered Residence LPN #4 offered Residence LPN #4 offered Residence LPN #3, the dire was asked what a nuadministering medical nurse should check the dother five rights of medication as asked if LPN #4 rights of medication and administering the two same time to Residenshe did not know, as was administered. A #4) checked the order messed up." At this treviewed the docume administration condumeriter) on 2/7/18 at 10 ASM #3 was asked with scheduled insulin were administering the 10 the 6 unit's sliding scandaministered as she the medication was a #3 presented to this with meal intakes. The 2/50 %. ASM #3 was a Novolog 10 units sho ASM #3 stated that it	the accucheck was 64, dent #42 a soda at this time. In., an interview was (administrative staff ctor of nursing. ASM #3 rse should do prior to ations. ASM #3 stated, "The he orders, check the patient, nedication administration." If of the above concern and had conducted the five administration prior to a doses of insulin at the not #42. ASM #3 stated that she was not there when it SM #3 stated, "She (LPN er, she read it, she just time this writer and ASM #3 entation for the insulin cted (and observed by this 0:57 a.m. and at 11:30 a.m. why or how the 10 units of re documented at 11:30 (LPN #4) was observed units of novolog insulin with ale insulin at 10:57 a.m. urse had not signed off on the time the medication was had forgotten to do it when actually administered. ASM writer a list of Resident #42 7/18 lunch was recorded as asked if the order for uld have been administered, should not.	F	684			

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
		495339	B. WING			02/	08/2018
	ROVIDER OR SUPPLIER ANOR NURSING HOME			STREET ADDRESS, CITY, 2003 COBB STREET FARMVILLE, VA 2390	· · · ·	1 021	00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	administering a medi stated, "We can give hour before the time time due. If you are to outside of the time panot show up, it will not the screen, it will be to give outside of the give you a warning the could circumvent but LPN #1 was asked hinsulin, when there wapart, before and afte the order states beforwould have to follow LPN #1 was asked the orders of insulin, LPN sugar could drop, and after lunch based on they don't get too mu On 2/8/18 at 3:11 p.m conducted with ASM ASM #4 was asked to #42's blood sugars us orders. ASM #4 state under a tighter control are unpredictable." A expectation was whe orders to nursing. As the orders are followed is difficult to gain comprevent excessive hig regime she is on and is more cause for the Any insulin order requal greater diligence before the support of the state of the support of the suppo	the time parameters for cation to a resident. LPN #1 the medication up to an due and an hour after the rying to give the medication will of "fire" you cannot see it on white. I guess you could try time but it (the system) will not it is not time. I guess you that wouldn't make sense." ow that works when giving the two orders an hour er lunch. LPN #1 stated, "If the and after lunch then you the order as it is written." the risk of combining two the reason for the dose the meal is to make sure ch insulin." In., an interview was #4, the medical doctor. The state the goal for Resident sing his current insulined, "To get her blood sugars of because her eating habits ASM #4 was asked what his in he provided specific insulines of the meal lows. The insulines is not a normal regime, this is not a normal regime, this is not a normal regime, this is nursing staff to be diligent. Luires, by nature of the drug,	F	684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	FIPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
		495339	B. WING			02/08/2018	
	ROVIDER OR SUPPLIER ANOR NURSING HOME		,	STREET ADDRESS, CITY, STATE, ZIP 2003 COBB STREET FARMVILLE, VA 23901	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 684	Mostly due to the reconcerned with hyporal SM #4 was asked meal scheduled order before meals. ASM because of her prevand erratic intake. It her to the have the sof the risk of hypogly what he thought of Fithe pre meal sliding the post meal sched time (prior to the meatheory if she receive the meal it could pot always eats somethic keep her above 80 (not ideal for her." At this time that Reside doses of insulin (the Novolog and post middlessed the nurse to resugar and it was 64. The received an email for stating (name of Resunchtime was 325 at the sliding scale doses ugar re-check was both insulins had be did not indicate the remeal. ASM #4 further contacted another put the stating conducts the stating conducts aff member) #1, the stating conducts the staff member) #1, the staff member) #1, the stating conducts the staff member) #1, the staff member) #1, the stating conducts the staff member) #1, the staff member is the stating conducts the staff member) #1, the staff member is the staff member in the staff mem	int hypoglycemic emergency. Sidents' erratic intake, I am orglycemic events with her." if he would expect the after er of insulin to be given #4 stated that he would not ious "spells" of hypoglycemia if she doesn't eat I don't want scheduled Novolog because ycemia." ASM #4 was asked Resident #42 receiving both scale dose of Novolog and uled Novolog at the same al). ASM #4 stated, "In d both insulin doses prior to entially be too much. She ing so it is unlikely. I want to blood sugar), below that is SM #4 was made aware at ent #42 had received both pre meal sliding scale eal scheduled Novolog) at at 2:27 p.m. this writer had e-check Resident #42's blood ASM #4 stated he had om the nurse on 2/7/18 sident #42's) blood sugar at and the resident was given e, and the three-hour blood 64. The nurse did not state en given prior to lunch, and resident only ate 50% of her er stated, "Perhaps she hysician."	F	684			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495339	B. WING			02/	08/2018
	ROVIDER OR SUPPLIER			2	STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page No further information end of the survey pro	was presented prior to the	F	684			
	work about 15 minute about 1 hour, and kee Insulin is a hormone t	•					
	effect of all insulin the NOVOLOG. Severe h seizures, may lead to life threatening or cau was obtained from the https://dailymed.nlm.r	lypoglycemia can cause unconsciousness may be use death. This information					
F 695 SS=D	or low blood sugar, or glucose in your blood many people with dia 70 milligrams per dec information was obtai website:https://www.r ion/diabetes/overview ood-glucose-hypoglyo	niddk.nih.gov/health-informat r/preventing-problems/low-bl	F	695			3/25/18
		ry care, including Id tracheal suctioning. Ire that a resident who					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		495339	B. WING		02	/08/2018	
	ROVIDER OR SUPPLIER ANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 695	needs respiratory car care and tracheal succare, consistent with practice, the comprehence and 483.65 of this sull This REQUIREMENT by: Based on observation document review and was determined the forespiratory care per the of 24 residents in the #23. The facility staff failed oxygen saturation on physician and failed the forespiratory care per the forespiratory care per the facility staff failed oxygen saturation on physician and failed the forespiratory care per the #23. The facility staff failed oxygen saturation on physician and failed the forespiratory care per the finding include: Resident #23 was add 2/26/2007 and readmed diagnoses that include orthostatic hypotensic standing), iron deficient hypothyroidism and compulmonary disease). MDS (minimum data assessment with an Adate) of 11/12/17. Resident #23 was addity to make daily of 15 on the BIMS (Brief exam. Resident #23	e, including tracheostomy tioning, is provided such professional standards of ensive person-centered tts' goals and preferences, part. It is not met as evidenced In, staff interview, facility clinical record review, it acility staff failed to provide the physician's order for one survey sample, Resident It to monitor Resident #23's room air as ordered by the cassess the residents need curately. In the doubt were not limited to be on (low blood pressure with next anemia, heart failure, copp (chronic obstructive Resident #23's most recent set) was a quarterly uRD (assessment reference esident #23 was coded as nitvely impaired for the ecisions scoring 08 out of Interview for Mental Status) was coded as requiring from one staff member with	F 69	1)Resident #23's oxygen saturation obtained on RA per orders upon realization of concern. 2)Charge Nurse on duty was re-edu on obtaining oxygen saturations on per MD orders. 3)Unannounced med pass observat (during which oxygen checks are dowill be made for 10% of the nurses administering oxygen will be completed identify deviations from standards of practice. 4)Ongoing concerns will be reported the facility QA committee for recommendations. 5)Complete date: March 25, 2018	icated RA ions one) ete to f		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495339	B. WING			02/	08/2018
	ROVIDER OR SUPPLIER ANOR NURSING HOME		•	2	TREET ADDRESS, CITY, STATE, ZIP CODE 003 COBB STREET ARMVILLE, VA 23901	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695	oxygen in place at 2 I cannula connected to These observations w p.m., 2/7/18 at 8:22 a p.m., and 2/8/18 at 8: Review of Resident # (physician order shee orders: 1. "Oxygen via NC (n (liters)/min (minute) a saturation greater that distress or shortness liters/min." This orde 2. "Pulse OX [1] (oxin room air every shift." 1/2/18. Review of Resident # (Medication Administing Resident #23's pulse high 90s on 2/6/18 th The following was do "2/06/18 at 7:00 a.m., 2/06/18 at 3:00 p.m., 2/07/18 at 3:00 p.m., 2/07/18 at 3:00 p.m., 2/07/18 at 7:00 a.m., 2/07/18 at 7:00 a.m., 2/08/18 at 7:00 a.	2/08/18, several ade of Resident #23 with iters/min (minute) via nasal of an oxygen concentrator. were made on 2/6/18 at 2:44 .m., 9:11 a.m., and 4:00 01 a.m., and 9:47 a.m. 23's most recent POS et) documented the following asal cannula) at 2 L s needed to keep 02 in 90 percent for respiratory of breath. May titrate up to 4 r was initiated on 1/2/18. metry): check pulse ox on This order was initiated on 23's February 2018 MAR ration Record) revealed oximetry levels were in the rough 2/8/18 on room air. cumented: , Sp02 [2] levels: 96 percent. Sp02 levels: 97 percent. Sp02 levels: 97 percent. Sp02 levels: 93 percent. Sp02 levels: 97 percent. Sp03 s'activity intolerance"	F	695			

`` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			ATE SURVEY OMPLETED
		495339	B. WING		_	02/08/2018
	ROVIDER OR SUPPLIER ANOR NURSING HOME		•	STREET ADDRESS, CITY, S 2003 COBB STREET FARMVILLE, VA 2390	STATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	conducted with RN (manager. When as oxygen saturations or receives prn (as need the purpose was to maintain high oxyge When asked if oxygoresident who is react on room air and on the resident would not not not reaching high levels who was responsible #2 stated the nurses asked if she was far #2 stated that she would have to compare the resident #23's oxygoshe would have to compare the resident soxygen saturated, "I would check oxygen saturated, "I would check oxygen le room air, LPN #1 standinister oxygen be read it. On 2/08/18 at 11:46 conducted with LPN When asked who was the pulse ox for resident's oxygen be read it.	a.m., an interview was (registered nurse) #2, a unit ked the purpose of checking on room air for a resident who eded) oxygen, RN #2 stated check to see if a resident can n saturation on their own. en would be placed on a hing 02 levels in the high 90s cheir own, RN #2 stated the leed oxygen if they were on their own. When asked e for taking the pulse ox, RN s were responsible. When niliar with Resident #23, RN ras. When asked about leen order, RN #2 stated that	F	695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495339	B. WING		_	02/0	08/2018	
	ROVIDER OR SUPPLIER ANOR NURSING HOME	Ē		STREET ADDRESS, CITY, ST. 2003 COBB STREET FARMVILLE, VA 23901	ATE, ZIP CODE	,		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 695	pulse ox. with the oplace. LPN #3 state (as needed); she we without the oxygen resident's oxygen lepercent on room air oxygen. When asked Resident #23, LPN asked if she knew FLPN #3 stated she chand. LPN #3 stated on." When asked h #23's oxygen saturated she checked saturation with the roxygen on at 2 liters sure of the pulse ox purpose of checking room air, LPN #3 st their baseline is." L sure if the other nur #23's pulse oximetr place or on room air. On 2/08/18 at 3:58 conducted with ASM member) #2, the Dir #2 stated that check air was part of the osee if residents nee stated some resider oxygen in place and changing the orders. On 2/08/18 at 3:58 administrator and A Compliance were more stated some resider oxygen in place and changing the orders.	r oxygen, she would check xygen via nasal cannula in ad if the oxygen order was propould check oxygen saturation in place. LPN #3 stated if a evel were not above 90 to the she would apply the difference of the she was familiar with the stated she was. When Resident #23's oxygen order, could not remember right official difference of the she was it (oxygen) to when the she has it (oxygen) to she has it (oxygen) to when the she has it (oxygen) to she has it (oxygen) to when the she has it (oxygen) to she has i	F	595				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495339	B. WING			02/08/2018	
	ROVIDER OR SUPPLIER		•	20	TREET ADDRESS, CITY, STATE, ZIP CODE 003 COBB STREET ARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 695	documents in part, the resident's response to oximetry as necessar. No further information [1] Pulse Oximmetry-probe attached to the measures the different light by oxygenated a haemoglobin in capilla indicates the percent saturated with oxyger was obtained from The Health.	d, "Oxygen Administration" e following: "13. Monitor o therapy with pulse y." n was presented prior to exit. "The pulse oximeter is a patient's finger that itial absorption of infrared ind deoxygenated aries. The display unit	F	695			
F 698 SS=D	80222/. [2] Sp02 (saturated lewith respiratory disea or above. Supplement for Sp02 levels of lessair. This information National Institutes of https://www.ncbi.nlm.13909/ Dialysis CFR(s): 483.25(I) §483.25(I) Dialysis. The facility must ensurequire dialysis receive with professional stars.	evels of oxygen) in residents sees should be at 90 percent intal oxygen should be used is than 90 percent on room was obtained from The Health. nih.gov/pmc/articles/PMC11 are that residents who be such services, consistent indards of practice, the in-centered care plan, and	F	698			3/25/18

AND DUAN OF CODDECTION IDENTIFICATION NUMBER.		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495339	B. WING		02/08/2018	
	ROVIDER OR SUPPLIER ANOR NURSING HOME	•	2	STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901	,	
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION	
F 698	by: Based on observation interview, facility door record review, it was failed to provide dial residents in the surv. The facility staff failed Resident #106's dial. The findings include Resident #106 was facility on 1/11/18. Fincluded but were not blood pressure and Resident #106's most data set), a 14 day facility on 1/11/18 for coded the resident at O documented Resident #106's most data set). ARD (assessment recorded the resident at O documented Resident #106's most data set) and the resident at the revealed physician at 1/11/18 that docume every Monday, Wed orders failed to document at the resident #106's dial #106's January 2018 (medication administronic 2/7/18) failed to document at the resident with the resident part of the re	on, resident interview, staff cument review and clinical state determined the facility staff sysis care for one of 24 ey sample, Resident #106. Indicate the facility staff sysis care for one of 24 ey sample, Resident #106. Indicate the facility staff sysis care for one of 24 ey sample, Resident #106. Indicate the facility staff sysis vascular access site (1). Indicate the facility staff sysis vascular access site (1). Indicate the facility staff sysis vascular access site (1). Indicate the facility staff sysis vascular access site (1). Indicate the facility staff sysis recent MDS (minimum facility staff sysis) and stage renal disease. Set recent MDS (minimum facility sysis) sheet dated an order for dialysis and staff sysis residues and friday. The	F 698	1)AVF monitoring was added to the nursing interventions for Resident #1 prior to exit of the survey team. 2)All residents with AVFs where audiensure nursing interventions were in for AVF monitoring. 3)The facility will randomly audit 10% residents chart with AVF to ensure ninterventions for AVF monitor are in 4)Ongoing concerns will be reported the facility QA committee for recommendations. 5)Complete date: March 25, 2018	ited to place 6 of ursing blace.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495339	B. WING _			02/	08/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (2003 COBB STREET FARMVILLE, VA 23901	CODE			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIAT		(X5) COMPLETION DATE	
F 698	access site except fo Resident #106's care date of 12/12/17 doct Left Arm Shunt (dialy of bruit, redness or so report negative findin accordingly" On 2/7/18 at 4:21 p.m in the bedroom. The site located on the recovered with a dressi asked if the facility stadialysis access site. don't think they do he dialysis." Resident # dialysis three days a listen to the area with the dressing. On 2/7/18 at 4:30 p.m conducted with RN (rwas asked to describ provided to a residen #1 stated the facility sarm that contains the site). RN #1 stated the under impaired mobil plan. RN #1 stated, down to nursing interextremity and note or was asked if nurses shruit. RN #1 stated, '	Resident #106's dialysis r a note dated 1/11/18. plan with a problem onset umented, "DialysisObserve sis access) site for presence velling as indicated and gs to MD (medical doctor) n., Resident #106 was sitting resident's dialysis access sident's left arm was ng. Resident #106 was aff ever assesses her Resident #106 stated, "I are so much as they do at 106 stated she goes to week and the staff there a stethoscope and check	F	598				
	On 2/7/18 at 5:21 p.m	n. ASM (administrative staff						

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495339	B. WING _			02/	08/2018	
	ROVIDER OR SUPPLIER ANOR NURSING HOME			20	TREET ADDRESS, CITY, STATE, ZIP CODE 103 COBB STREET ARMVILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 698	Continued From page	e 73	F	598				
		ninistrator) and ASM #2 (the e) were made aware of the						
	physician order list da documented, "Nursin dialysis shunt for brui shift. Monitor for pos Notify MD Medical do On 2/8/18 at 8:10 a.m conducted with LPN (regarding the care the resident receiving dia a fistula there is a bru want to make sure the clarify what she mear going," LPN #1 stated can hear it." When a done, LPN #1 stated used. When asked how oth area needs to be ass #1 stated this informaduring the shift change documented on the tropical shift is the modialysis with an documented, "PURPO hemodialysis via an Afistula are at risk for coshunt, dialysis and er facility will monitor the	g Intervention: Assess tt (sic) and thrill q (every) tt dialysis bleeding from site. octor) of abnormal findings." n., an interview was (licensed practical nurse) #1 at should be provided to a allysis. LPN #1 stated, "With uit and thrill and you always at's going." When asked to nt by "to make sure that's d, "Feel it and make sure you sked how this should be a stethoscope should be ow often this should be she would have to check. er nurses would know the essed and how often, LPN ation should be relayed ge report and should be reatment record. ad, "Care of the Resident on AV Shunt or Fistula" OSE: Residents receiving av [ateriovenous] shunt or complications related to the and stage renal disease. The are resident for change in infection, hemorrhage, in overall						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
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F 698	staff may palpate the listen for bruit to mor palpated and/or bruit will be documented in physician will be immodirection and treatment prescribe care instrust appropriate. 9. The dialysis care measure. No further information (1) "A vascular accessifeline. A vascular accessifeline. A vascular accessifeline. A vascular accessis a surgically remove and return book that takes it to the district blood flows through wastes and extra fluifiltered blood to the law accessine flow continuously due to filter as much blood treatment" This into the website: https://www.niddk.nii.ey-disease/kidney-faccessCh	JIREMENTS4. Nursing a shunt or fistula for thrill and nitor patency. If a thrill is not at not heard, the assessment in the nursing notes and the nediately notified for further ent8. The physician will ctions as deemed medically care plan will include other res and precautions" In was presented prior to exit. It is is a hemodialysis patient's coess makes life-saving ents possible. Hemodialysis ney failure that uses a patient's blood through a ter, outside the body. The y created vein used to lood during hemodialysis. ugh a needle, a few ounces then travels through a tube alyzer. Inside the dialyzer, the thin fibers that filter out id. The machine returns the body through a different tube. Its large amounts of blood ring hemodialysis treatments	F6	98		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 698	information was obtain https://www.niddk.nih ey-disease/kidney-fail ccess (3) "When blood flow sometimes makes a water bruit." This information website: https://www.niddk.nih ey-disease/renal-arter Drug Regimen is Free CFR(s): 483.45(d)(1)-\$483.45(d) Unnecess Each resident's drug unnecessary drugs. Adrug when used-\$483.45(d)(1) In exceed duplicate drug therapy: \$483.45(d)(2) For exceed uplicate drug therapy: \$483.45(d)(3) Without use; or \$483.45(d)(5) In the proconsequences which reduced or discontinut.	the vascular access" This ned from the website: .gov/health-information/kidn lure/hemodialysis/vascular-a s through a narrow artery, it whooshing sound, called a on was obtained from the .gov/health-information/kidn ry-stenosis e from Unnecessary Drugs .(6) ary Drugs-General. regimen must be free from An unnecessary drug is any ssive dose (including y); or tessive duration; or t adequate monitoring; or t adequate indications for its presence of adverse indicate the dose should be		757	DEFICIENCY)		3/25/18
	§483.45(d)(5) In the process which reduced or discontinute §483.45(d)(6) Any constated in paragraphs section.	indicate the dose should be ed; or mbinations of the reasons					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	C	(X3) DATE SURVEY COMPLETED	
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(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 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 757	record review, it was failed to ensure one of sample, Resident #42 unnecessary medicate. On 2/7/18 at 10:45 a. nurse) #4 was observinsulin to Resident #4 administration at 12:3 the resident ate great Resident #42 was do % of her lunch on that. The findings include: Resident #42 was ad 2/21/11 with a readmidiagnoses including, weakness, reflux disechronic kidney disease. Resident #42's most set), a quarterly asse (assessment reference (assessment referenc	n, staff interview and clinical determined the facility staff of 24 residents in the survey 2, was free from ions m., LPN (licensed practical red administering a dose of 22 that was ordered for 30 p.m., following lunch, if rer than 75% of the meal. cumented as eating only 50 t day. mitted to the facility on a sission on 8/2/17 with but not limited to muscle rease, shortness of breath, are and diabetes. recent MDS (minimum data assment with an ARD red date) of 12/13/17, coded (brief interview of mental n out of a possible 15, and #42 is severely with decisions of daily living. #42's comprehensive care realed, in part, the following blem / Need. Risk for (high/low blood sugar) r/t	F 7	1)Resident #42's medicatic administration error was ad appropriately after discover survey process 2)The LPN #4 responsible erroneous medication (insu administration was provided and counseling. 3)Unannounced med pass will be made for 10% of the administering insulin will be identify deviations from star practice. 4)Ongoing concerns will be the facility QA committee for recommendations. 5)Complete date: March 25	ddressed ry during the for the ulin) d education observations e nurses e complete to ndards of e reported to		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 757	physician and prn (a abnormal blood sugorders if hypoglycen medication as order. A review of Residen revealed, in part, the treatment of diabete - "9/19/17. Novolog to treat diabetes) 10 Inject 10 units subcuimmediately after luidoes not eat 75% of (is less than) 100* (I scheduled dose)." - "9/4/17. Novolog 1 units subcutaneousl Sliding scale if BS: 2 units, 250 - 299 = 350 - 399 = 8 units, (greater) = 12 units of 10 units subcutaneousl Sliding scale if BS: 2 units, 250 - 299 = 350 - 399 = 8 units, (greater) = 12 units of 10 units of Novolog drew up 16 units of Novolog drew up 16 units of side of 10 units of Novolog drew up 16 units of 10 units	sugar checks) as ordered by as needed) if you suspect ar. May follow standing nia [2] occurs. Administer ed by physician." It #42's physician orders of following order related to the seriol of unit/ml (milliliters) vial. It at acting insulin used of unit/ml (milliliters) vial. It aneously (under the skin) onch. *Hold dose if patient of meal or if BS (blood sugar) < If BS 100-130 give 1/2 of I	F 757			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495339	B. WING _			02/08/2018	
	ROVIDER OR SUPPLIER ANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP COD 2003 COBB STREET FARMVILLE, VA 23901	•	2.00,20.10	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 757	12:45 p.m. with OSM dietary staff, OSM # 3 residents on the Lee rooms. OSM # 3 staft dining room is served floor (Lee Unit) are set. Lunch trays were not any time on 12/7/18 to Con 2/7/18 at 2:15 p.m. conducted with LPN # describe the process medications to a reside the medication as inset to review Resident # state what the orders medications. LPN # 4 # 42) receives Novolo lunch." When asked to Resident # 42 today before lunch, at 10:45 what time the Novolo LPN # 4 stated, "12:30 she administered the and scheduled Novol LPN # 4 stated, "I read orders." When asked lunch prior to administ Novolog insulin, LPN # 42) had not. LPN # 442 permission was obtain obtain the accucheck	n 2/7/18 at approximately (other staff member) # 3, 3 was asked at what time the Unit are served lunch in their ed when everyone in the I then the residents on the erved lunch. observed on the Lee unit at between 11 a.m. and noon. n., an interview was #4. LPN #4 was asked to followed when giving dent. LPN #4 stated, "I give tructed." LPN #4 was asked 12's orders for insulin and to	F7	57			

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OLIVILIY	OT OIL MEDIONILE &	MEDIO/ ND OLIVIOLO				CIVID IV	7. 0000 0001
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495339	B. WING			02/	08/2018
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F 757	was asked what a nuadministering medical nurse should check to the five rights of m ASM #3 was informed was asked if LPN #4 rights of medication and administering the two same time to Reside she did not know, as was administered. A was administered to conduct writer) on 2/7/18 at 1 and ASM #3 was asked was administering the 10 the 6 unit's sliding so ASM #3 stated the nutre second order at the administered as she the medication was a was	n., an interview was (administrative staff ctor of nursing. ASM #3 rse should do prior to ations. ASM #3 stated, "The the orders, check the patient, nedication administration." d of the above concern and had conducted the five administration prior to to doses of insulin at the the that #42. ASM #3 stated that she was not there when it SM #3 stated, "She (LPN the state of the insulin that this writer and ASM #3 that this writer and ASM #3 that this writer and ASM #3 that this writer and at 11:30 a.m. why or how the 10 units of the documented at 11:30 to (LPN #4) was observed units of novolog insulin with that insulin at 10:57 a.m. the time the medication was that forgotten to do it when the time the medication was that forgotten to do it when the time the medication was that forgotten to do it when the time the medication was that forgotten to do it when the time the medication was that forgotten to do it when the time the medication was that forgotten to do it when the time the medication was that forgotten to do it when the time the medication was that forgotten to do it when the time the medication was that forgotten to do it when the time the medication was that forgotten to do it when the time the order for the time t	F	757			
	administering a medi	cation to a resident. LPN #1					

stated, "We can give the medication up to an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495339	B. WING			2/08/2018	
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(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 757	time due. If you are outside of the time not show up, it will the screen, it will be to give outside of the give you a warning could circumvent be LPN #1 was asked insulin, when there apart, before and a the order states betwould have to follow LPN #1 was asked orders of insulin, LF sugar could drop, a after lunch based or they don't get too m. On 2/8/18 at 3:11 p conducted with ASI ASM #4 was asked #42's blood sugars orders. ASM #4 staunder a tighter confare unpredictable." expectation was whorders to nursing. As the orders are following difficult to gain coprevent excessive is regime she is on an is more cause for the Any insulin order rea a greater diligence (hypoglycemia), who of changes to prevent excessive is a greater diligence (hypoglycemia), who of changes to prevent excessive is a greater diligence (hypoglycemia), who of changes to prevent excessive to the real property of the prevent excessive is a greater diligence (hypoglycemia), who of changes to prevent excessive to the prevent excessive to	e due and an hour after the trying to give the medication parameter, the medication will not "fire" you cannot see it on white. I guess you could try ne time but it (the system) will that it is not time. I guess you gut that wouldn't make sense." how that works when giving were two orders an hour offer lunch. LPN #1 stated, "If fore and after lunch then you were the order as it is written." the risk of combining two PN #1 stated, "The blood and the reason for the dose in the meal is to make sure	F	757			

NAME OF PROVIDER OR SUPPLIER **NAME OF PROVIDER OR SUPPLIER **NAME OF PROVIDER OR SUPPLIER **NAME OF PROVIDER OR SUPPLIER **POLICY MANOR NURSING HOME** **SUMMARY STATEMENT OF SEPCIENCES OF THE APPROPRIATE COMPONING THE PROCESSION OF THE APPROPRIATE COMPONING THE APPROPRIATE CO	OLIVILIY	OT OIL MEDIOMILE &	WEDIO/ (ID OLI (VIOLO				CIVID ITC	7. 0000 000 I
NAME OF PROVIDER OR SUPPLIER HOLLY MANOR NURSING HOME ACMINISTRY AND CORRECTION OF STREET PROCESS TREET PROPRIET			1 ' '	` ′			(X3) DATE SURVEY COMPLETED	
HOLLY MANOR NURSING HOME XSUMMARY STATEMENT OF DEFICIENCIES ID PREFIX TAG REQUILATIONY OR LSC IDENTIFYING INFORMATION) TAG REPOWDERS PLAN OF CORRECTION ECACH CONSISTENCY TAG REPOWDERS PLAN OF CORRECTION ECACH CONSISTENCY TAG REPOWDERS PLAN OF CORRECTION CROSS-REPREDENCED TO THE APPROPRIATE CONSISTENCY TAG REPOWDERS PLAN OF CORRECTION CROSS-REPREDENCED TO THE APPROPRIATE CROSS-REPREDENCED TO THE APPROPRI			495339	B. WING			02/	08/2018
FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 757 Continued From page 81 ASM #4 was asked if he would expect the after meal scheduled roter of insulin to be given before meals. ASM #4 stated that he would not because of her previous "spells" of hypoglycemia and erratic intake. If she doesn't earl don't want her to the have the scheduled Novolog because of the risk of hypoglycemia." ASM #4 stated, "In theory if she received both insulin doese prior to the meal it could potentially be too much. She always eats something so it is unlikely. I want to keep her above 80 (blood sugar), below that is not ideal for her." ASM #4 was made aware at this time that Resident #42 had received both doses of insulin (the pre meal sliding scale Novolog) at 10:57 a.m. and then at 2:27 p.m. this writer had asked the nurse to re-check Resident #42's blood sugar and it was \$4. ASM #4 stated he had received a mail from the nurse on 2/7/18 stating (name of Resident #42's blood sugar and it was \$4. ASM #4 stated he had received toose, and the three-hour blood sugar re-check was \$6. The nurse did not state both insulins had been given prior to lunch, and did not indicate the resident only ate 50% of her meal. ASM #4 further stated, "Perhaps she contacted another physician." At a meeting conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of compliance on 2/8/18 at 3:58 p.m. the above concerns were discussed.					2	003 COBB STREET		
ASM #4 was asked if he would expect the after meal scheduled order of insulin to be given before meals. ASM #4 stated that he would not because of her previous "spells" of hypoglycemia and erratic intake. If she doesn't eat I don't want her to the have the scheduled Novolog because of the risk of hypoglycemia." ASM #4 was asked what he thought of Resident #42 receiving both the pre meal sliding scale dose of Novolog and the post meal scheduled Novolog at the same time (prior to the meal). ASM #4 stated, "In theory if she received both insulin doses prior to the meal it could potentially be too much. She always eats something so it is unlikely. I want to keep her above 80 (blood sugar), below that is not ideal for her." ASM #4 was made aware at this time that Resident #42 had received both doses of insulin (the pre meal sliding scale Novolog) and post meal scheduled Novolog) at 10:57 a.m. and then at 2:27 p.m. this writer had asked the nurse to re-check Resident #42's blood sugar and it was 64. ASM #4 stated he had received an email from the nurse on 2/71/18 stating (name of Resident #42's) blood sugar at lunchtime was 325 and the resident was given the sliding scale dose, and the three-hour blood sugar re-check was 64. The nurse did not state both insulins had been given prior to lunch, and did not indicate the resident only ate 50% of her meal. ASM #4 further stated, "Perhaps she contacted another physician." At a meeting conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of compliance on 2/8/18 at 3:58 p.m. the above concerns were discussed.	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
No further information was presented prior to the end of the survey process.	F 757	ASM #4 was asked if meal scheduled orde before meals. ASM # because of her previous and erratic intake. If her to the have the sof the risk of hypoglywhat he thought of Rother previous the post meal schedutime (prior to the meal theory if she received the meal it could pote always eats somethin keep her above 80 (bunot ideal for her." AST this time that Resider doses of insulin (the Novolog and post meals to the nurse to resugar and it was 64. received an email from stating (name of Resilunchtime was 325 and the sliding scale doses sugar re-check was 65 both insulins had beed did not indicate the remeal. ASM #4 further contacted another photographs. We further the director of complition the above concerns we not the sugar and the staff member) #1, the staff member) #1, the director of compliting above concerns we not the sugar and the sugar and the sugar and the sugar and the sugar re-check was 65 both insulins had beed did not indicate the remeal. ASM #4 further contacted another photographs. We further information the sugar re-check was 65 both insulins had beed did not indicate the remeal. ASM #4 further contacted another photographs with the director of compliting the above concerns we have the sugar re-check was 65 both insulins had been did not indicate the remeal. ASM #4 further contacted another photographs with the director of compliting the above concerns we have the sugar re-check was 65 both insulins had been did not indicate the remeal. ASM #4 further contacted another photographs with the director of compliting the above concerns we have the sugar re-check was 65 both insulins had been did not indicate the remeal. ASM #4 further contacted another photographs with the director of compliting the above concerns we have the sugar re-check was 65 both insulins had been did not indicate the remeal was 65 both insulins had been did not indicate the remeal was 65 both insulins had been did not indicate the remeal was 65 both insulins had been did not indicate the remeal was 65 both insulins had been did n	the would expect the after or of insulin to be given the stated that he would not ous "spells" of hypoglycemia she doesn't eat I don't want cheduled Novolog because demia." ASM #4 was asked esident #42 receiving both scale dose of Novolog and alled Novolog at the same all). ASM #4 stated, "In a both insulin doses prior to entially be too much. She ago it is unlikely. I want to blood sugar), below that is so #4 was made aware at an the #42 had received both pre meal sliding scale at 2:27 p.m. this writer had each check Resident #42's blood ASM #4 stated he had me the nurse on 2/7/18 ident #42's) blood sugar at and the resident was given and the three-hour blood state. The nurse did not state an given prior to lunch, and asident only ate 50% of her ar stated, "Perhaps she hysician."	F	757			

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F 757	Continued From page		F 75	7		
	work about 15 minute about 1 hour, and kee Insulin is a hormone of glucose (sugar) in was obtained from the https://www.drugs.co. [2] Hypoglycemia is the effect of all insulin the NOVOLOG. Severe is seizures, may lead to life threatening or cau was obtained from the https://dailymed.nlm.ii	m/novolog.html he most common adverse erapies, including hypoglycemia can cause o unconsciousness may be use death. This information				
F 760 SS=D	or low blood sugar, or glucose in your blood many people with dia 70 milligrams per decinformation was obtain Residents are Free or CFR(s): 483.45(f)(2) The facility must ensure \$483.45(f)(2) Resident medication errors. This REQUIREMENT	f Significant Med Errors	F 76	0	3/25/18	
	record review, it was staff failed to ensure significant medication	on, staff interview and clinical determined that the facility a resident was free from a nerror for one of 24 by sample, Resident #42.		1)LPN #4 responsible for the medicat administration error was provided education and counseling. 2)The facility provided medication administration/Insulin administration	ion	

1 7		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 760	nurse) #4 was observinsulin to Resident #4 administration at 12:3 the resident ate great Resident #42 was do % of her lunch on that to check Resident #4 approximately 2:15 p was 64. The findings include: Resident #42 was ad 2/21/11 with a readm diagnoses including, weakness, reflux disc chronic kidney diseased Resident #42's most set), a quarterly asset (assessment referent Resident #42's BIMS status) score as sever indicating that Reside cognitively impaired was a complete to documentation: "Prohyper/hypoglycemia (related to) diabetes. (Name of Resident # signs and symptoms through next review. Accuchecks (blood sphysician and prn (as	a.m. LPN (licensed practical wed administering a dose of 42 that was ordered for 30 p.m., following lunch, if ter than 75% of the meal. In the documented as eating only 50 at day. Staff were requested 42's blood sugar at 5.m.; the blood sugar reading size on 8/2/17 with but not limited to muscle ease, shortness of breath, se and diabetes. The documented as eating only 50 at day. Staff were requested 42's blood sugar at 5.m.; the blood sugar reading 5.	F	760	in-services for facility charge nurses. 3)Unannounced med pass observation will be made for 10% of the nurses administering insulin will be complete identify deviations from standards of practice. 4)Ongoing concerns will be reported to the facility QA committee for recommendations. 5)Complete date: March 25, 2018	to		

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		495339	B. WING		02/08/2018	
NAME OF PROVIDER OR SUPPLIER HOLLY MANOR NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
F 760	medication as ordered. A review of Resident revealed, in part, the treatment of diabetes - "9/19/17. Novolog to treat diabetes) 100 Inject 10 units subcut immediately after lundoes not eat 75% of (is less than) 100* (If scheduled dose)." - "9/4/17. Novolog 1 units subcutaneously Sliding scale if BS: 2 units, 250 - 299 = 4 350 - 399 = 8 units, 4 (greater) = 12 units 80 On 2/7/18 at 10:45 anurse) #4, a floor nuran accucheck from Fadministering Novolog accucheck was measureviewed the MAR (record) and stated the Resident #42 would units plus Resident #10 units of Novolog to drew up 16 units of Novolog to administered the insileft upper stomach as subcutaneous part of the state of Novolog to drew up 16 units of Novolog to administered the insileft upper stomach as subcutaneous part of Novolog to drew up 16 units of Novolog to administered the insileft upper stomach as subcutaneous part of Novolog to drew up 16 units of Novolog to administered the insileft upper stomach as subcutaneous part of Novolog to drew up 16 units of Novolog to administered the insileft upper stomach as subcutaneous part of Novolog to drew up 16 units of Novolog to administered the insileft upper stomach as subcutaneous part of Novolog to drew up 16 units of Novolog to drew up 16 un	ia [2] occurs. Administer de by physician." #42's physician orders following order related to the s: [1] (a fast acting insulin used 0 unit/ml (milliliters) vial. taneously (under the skin) ich. *Hold dose if patient meal or if BS (blood sugar) < fBS 100-130 give 1/2 of 00 unit/ml vial inject 1-16 / 3 times daily before meals. 150 -199 = 1 unit, 200 - 249 = 4 units, 300 - 349 = 6 units, 400 - 450 = 10 units, 450 or > 6 call MD (medical doctor)." I.m. LPN (licensed practical rese, was observed obtaining Resident #42 and or insulin. Resident #42's sured at 324. LPN #4 then medication administration in lat for an accucheck of 324 receive sliding scale insulin 6 fe42 had a scheduled order for three times per day. LPN #4 Novolog insulin and ulin to Resident #42 in her	F 760			
	12:45 p.m. with OSM	on 2//18 at approximately I (other staff member) # 3, 3 was asked at what time the				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
495339		B. WING			02/08/2018		
NAME OF PROVIDER OR SUPPLIER HOLLY MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP COI 2003 COBB STREET 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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 760	rooms. OSM # 3 star dining room is served floor (Lee Unit) are self-loor (Lee Unit) are self-loo	Unit are served lunch in their ted when everyone in the dithen the residents on the erved lunch. Tobserved on the Lee unit at petween 11 a.m. and noon. The initial control of the least	F 76	,			
	permission was obtain obtain the accucheck LPN #4 offered Residence On 2/7/18 at 3:48 p.n conducted with ASM member) #3, the direction obtains the accuracy of the conducted with ASM member) #3, the direction obtains the conducted with ASM member) #3, the direction obtains the conducted with ASM member) #3, the direction obtains the conducted with ASM member) #3, the direction obtains the conducted with ASM member) #3, the direction obtains the conducted with ASM member) #3, the direction obtains the conducted with ASM member) #3, the direction obtains the conducted with ASM member) #3, the direction obtains the conducted with ASM member) #3, the direction obtains the conducted with ASM member) #3, the direction obtains the conducted with ASM member) #3, the direction obtains the conducted with ASM member) #3, the direction obtains the conducted with ASM member) #3, the direction obtains the conducted with ASM member) #3, the direction obtains the conducted with ASM member) #3, the direction obtains the conducted with ASM member) #3, the direction obtains the conducted with ASM member) #3, the direction obtains the conducted with ASM member) #4, the direction obtains the conducted with ASM member) #4, the direction obtains the conducted with ASM member with the conducted with the conducted with ASM member with the conducted with t						

02:1:2:10:0:1	MEDIO, II LE G	WEDIO/ ND OLIVIOLO				CIVID ITC	7. 0000 0001
STATEMENT OF DEFICI AND PLAN OF CORREC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495339	B. WING			02/	08/2018
NAME OF PROVIDER HOLLY MANOR N			•	2	TREET ADDRESS, CITY, STATE, ZIP CODE 003 COBB STREET FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
admin nurse do the ASM # was as rights admin same she di was au #4) ch messe review admin writer) ASM # sched a.m., vadmin the 6 u ASM # the se admin the me #3 pre meal i 50 %. Novolo ASM # On 2/8 condu was as admin stated hour b time do outsid	should check to five rights of metals and informed sked if LPN #4 of medication a istering the two time to Resided do not know, as dministered. A secked the ordered up." At this wed the docume istration conduit on 2/7/18 at 10 and a secked the nurse istering the 10 unit's sliding so a stated the nurse istering the 10 unit's sliding so a stated the nurse istering the 10 unit's sliding so a sected as she edication was a sected to this word and a stated that it istered as the edication was a sected to this word as a stated that it is a stated with LPN is sked to state the istering a media, "We can give the fore the time ue. If you are the of the time passed to the time passed in the sked to the time passed in the time passed	ations. ASM #3 stated, "The he orders, check the patient, nedication administration." d of the above concern and had conducted the five administration prior to o doses of insulin at the nt #42. ASM #3 stated that she was not there when it SM #3 stated, "She (LPN er, she read it, she just time this writer and ASM #3 entation for the insulin cted (and observed by this 0:57 a.m. and at 11:30 a.m. why or how the 10 units of re documented at 11:30 a.m. why or how the 10 units of re documented at 11:30 a.m. urise had not signed off on the time the medication was had forgotten to do it when actually administered. ASM writer a list of Resident #42 7/18 lunch was recorded as asked if the order for ould have been administered,	F	760			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
495339		B. WING			2/08/2018		
NAME OF PROVIDER OR SUPPLIER HOLLY MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP 2003 COBB STREET FARMVILLE, VA 23901				
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 760	to give outside of the give you a warning could circumvent by LPN #1 was asked insulin, when there apart, before and a the order states betwould have to follow LPN #1 was asked orders of insulin, LF sugar could drop, a after lunch based of they don't get too m. On 2/8/18 at 3:11 pconducted with ASI ASM #4 was asked #42's blood sugars orders. ASM #4 staunder a tighter contare unpredictable." expectation was whorders to nursing. As the orders are follow is difficult to gain corprevent excessive in the orders are following difficult to gain corpression of the concerned with hypoglycemia), who of changes to prevent excessive in the orders are followed in the concerned with hypoglycemia. As the concerned with hypoglycemia is concerned with hypoglycemia. As the was asked meal scheduled or before meals.	white. I guess you could try the time but it (the system) will that it is not time. I guess you ut that wouldn't make sense." how that works when giving were two orders an hour fter lunch. LPN #1 stated, "If fore and after lunch then you w the order as it is written." the risk of combining two PN #1 stated, "The blood and the reason for the dose n the meal is to make sure	F	760			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	495339		B. WING				02/08/2018	
NAME OF PROVIDER OR SUPPLIER HOLLY MANOR NURSING HOME			2003 CO	ADDRESS, CITY, STATE, ZIP CODE BB STREET ILLE, VA 23901		02/00/2010		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 760	her to the have the sof the risk of hypogly what he thought of F the pre meal sliding the post meal sched time (prior to the me theory if she receive the meal it could pot always eats someth keep her above 80 (not ideal for her." A this time that Reside doses of insulin (the Novolog and post m 10:57 a.m. and then asked the nurse to r sugar and it was 64 received an email for stating (name of Relunchtime was 325 at the sliding scale dos sugar re-check was both insulins had be did not indicate the real. ASM #4 furth contacted another p At a meeting conducts aff member) #1, the director of comp the above concerns No further informatic end of the survey present the survey present about 15 minutes.	f she doesn't eat I don't want scheduled Novolog because vemia." ASM #4 was asked Resident #42 receiving both scale dose of Novolog and uled Novolog at the same al). ASM #4 stated, "In d both insulin doses prior to entially be too much. She ing so it is unlikely. I want to blood sugar), below that is SM #4 was made aware at ent #42 had received both pre meal sliding scale eal scheduled Novolog) at at 2:27 p.m. this writer had e-check Resident #42's blood ASM #4 stated he had om the nurse on 2/7/18 sident #42's) blood sugar at and the resident was given e, and the three-hour blood 64. The nurse did not state en given prior to lunch, and resident only ate 50% of her er stated, "Perhaps she hysician."	F	760				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED	
		495339	B. WING		_	02/	08/2018
	ROVIDER OR SUPPLIER ANOR NURSING HOME			STREET ADDRESS, CITY, STA 2003 COBB STREET FARMVILLE, VA 23901	ATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	of glucose (sugar) in was obtained from the https://www.drugs.co. [2] Hypoglycemia is the effect of all insulin the NOVOLOG. Severe is seizures, may lead to life threatening or cau was obtained from the https://dailymed.nlm.im?setid=3a1e73a2-3c5 [2] Hypoglycemia, also or low blood sugar, or glucose in your blood many people with dia 70 milligrams per decinformation was obtain website:https://www.rion/diabetes/overview ood-glucose-hypoglycemia. Several is decirated in the facility must - \$483.60(i)(1) - Procurate proved or consider state or local authorit (i) This may include for from local producers, and local laws or regulii) This provision does	that works by lowering levels the blood. This information e following website: m/novolog.html the most common adverse erapies, including hypoglycemia can cause of unconsciousness may be use death. This information is website: hih.gov/dailymed/drugInfo.cf 1009-40d0-876c-b4cb2be56f so called low blood glucose ccurs when the level of aldrops below normal. For abetes, that means a level of colitier (mg/dL) or less. This ined from the hiddk.nih.gov/health-informat hypreventing-problems/low-blucemia tore/Prepare/Serve-Sanitary 2) ty requirements. The food from sources are food from sources are distincted by federal, ites. The food from sources are food items obtained directly subject to applicable State		760			3/25/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495339	B. WING		02/08/2018
NAME OF PROVIDER OR SUPPLIER HOLLY MANOR NURSING HOME			:	STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901	,
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 812	safe growing and for (iii) This provision do from consuming food \$483.60(i)(2) - Store serve food in accord standards for food s This REQUIREMEN by: Based on observati document review, it staff failed to store a manner in one of two on the Jefferson unit rooms (the Atkins di 1. The facility staff facontainer of chicken the Jefferson unit. 2. The facility staff facontainer of chicken the Jefferson unit. 2. The facility staff vindividual desert booduring the 2/7/18 lurdining room. The findings include 1. The facility staff facontainer of chicken the Jefferson unit. Observation of the faconducted on 2/6/18 11:51 a.m., an expirind umplings was foun of the Jefferson kitch container had a "creen serve food in accord standards for the Jefferson kitch container had a "creen serve food in accord standards for the Jefferson kitch container had a "creen serve food in accord standards for the serve food in accord standards for the Jefferson kitch container had a "creen serve food in accord standards for the serve food in accord standards for the Jefferson kitch container had a "creen serve food in accord standards for the serve food in accord standards fo	compliance with applicable od-handling practices. Des not preclude residents distribute and lance with professional ervice safety. T is not met as evidenced on, staff interview and facility was determined the facility was determined the facility and serve food in a sanitary of facility kitchens (the kitchen at) and one of two dining ning room). Tailed to discard an expired dumplings in the kitchen on was observed serving will in an unsanitary manner nich service in the Atkins Ealled to discard an expired dumplings in the kitchen on	F 812	1)The facility promptly discarded the of date dumplings. The facility dining room server (OSM) was in-serviced on proper handling or bowls when serving food. 2)No other out of date food items identified. No other staff observed improperly handling& serving food. 3)Unannounced kitchen inspections who be provided on a monthly basis to instead for dating and discarding of products. 4)Ongoing concerns will be reported the facility QA committee for recommendations. 5)Complete date: March 25, 2018	¢6) f vill pect

NAME OF PROVIDER OR SUPPLIER HOLLY MANOR NURSING HOME SIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST SER PECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 812 Continued From page 91 by" date of 2/4/18. On 2/08/18 at 11:59 a.m., an interview was conducted with OSM (other staff member) #6, the cook. When asked who was responsible for checking the refrigerator for expired items, OSM #6 stated he checked the refrigerator every night. When asked if the container of chicken dumplings was expired, OSM #6 stated that the chicken dumpling expired on 2/4/18. OSM #6 stated with OSM 22, the Director of Dining Services. When asked who was responsible for ensuring the refrigerator was free from expired food items, OSM #2 stated any staff member should be checking to see fifth is out." On 2/08/18 at approximately 9:00 a.m., an interview was conducted with OSM #2, the Director of Dining Services. When asked who was responsible for ensuring the refrigerator was free from expired food items, OSM #2 stated any staff member should be checking to see if this was done. When asked why the kitchen refrigerator should be free from expired food items, OSM #2 stated residents could get sick if they eat expired food items. On 2/08/18 at 3:58 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the Director of Compliance were made aware of the above findings. The facility policy titled, "Food Storage"	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
MANE OF PROVIDER OR SUPPLIER HOLLY MANOR NURSING HOME SUMMARY STATEMENT OF DESCRIPCIONES CAPTION SUMMARY STATEMENT OF DESCRIPCIONES CAPTION SUMMARY STATEMENT OF DESCRIPCIONES CAPTION CAPTION SUMMARY STATEMENT OF DESCRIPCIONES CAPTION C			495339	B. WING		02/08/2018	
FREEIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 812 Continued From page 91 by" date of 2/4/18. On 2/06/18 at 11:59 a.m., an interview was conducted with OSM (other staff member) #6, the cook. When asked who was responsible for checking the refrigerator for expired items, OSM #6 stated he checked the refrigerator every night. When asked if the container of chicken dumplings was expired, OSM #6 stated, "I'll throw this out." On 2/06/18 at approximately 9:00 a.m., an interview was conducted with OSM #2, the Director of Dining Services. When asked who was responsible for ensuring the refrigerator was free from expired food items, OSM #2 stated any staff member should be checking the refrigerator daily. OSM #2 stated the kitchen menanger should also be checking to see if this was done. When asked why the kitchen refrigerator should be free from expired food items, OSM #2 stated residents could get sick if they eat expired food items. On 2/08/18 at 3:58 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the Director of Compliance were made aware of the above findings.					2003 COBB STREET	•	
by" date of 2/4/18. On 2/06/18 at 11:59 a.m., an interview was conducted with OSM (other staff member) #6, the cook. When asked who was responsible for checking the refrigerator for expired items, OSM #6 stated he checked the refrigerator every night. When asked if the container of chicken dumplings was expired, OSM #6 stated that the chicken dumpling expired on 2/4/18. OSM #6 stated, "I'll throw this out." On 2/08/18 at approximately 9:00 a.m., an interview was conducted with OSM #2, the Director of Dining Services. When asked who was responsible for ensuring the refrigerator was free from expired food items, OSM #2 stated any staff member should be checking the refrigerator daily. OSM #2 stated the kitchen manager should also be checking to see if this was done. When asked why the kitchen refrigerator should be free from expired food items, OSM #2 stated residents could get sick if they eat expired food items. On 2/08/18 at 3:58 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the Director of Compliance were made aware of the above findings.	PRÉFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE COMPLET	
documents in part the following,"All foods should be covered, labeled and dated. All foods will be checked to assure that foods (including leftovers) will be consumed by their safe use dates, or frozen (where applicable), or discarded." 2. The facility staff was observed serving	F 812	by" date of 2/4/18. On 2/06/18 at 11:59 conducted with OSN cook. When asked checking the refrige #6 stated he checked When asked if the complings was expichicken dumplings was expichicken dumpling estated, "I'll throw this On 2/08/18 at approinterview was conducted Director of Dining S was responsible for free from expired for staff member should also be checked when asked why the pree from expired residents could get items. On 2/08/18 at 3:58 staff member) #1, the Director of Compute above findings. The facility policy tit documents in part the covered, labeled checked to assure the will be consumed by frozen (where applied to the consumed by frozen to the consumed by frozen the consumer th	a.m., an interview was M (other staff member) #6, the who was responsible for rator for expired items, OSM and the refrigerator every night. Container of chicken red, OSM #6 stated that the expired on 2/4/18. OSM #6 sout." Examinately 9:00 a.m., an acted with OSM #2, the ervices. When asked who ensuring the refrigerator was not items, OSM #2 stated any do be checking the refrigerator and the kitchen manager ching to see if this was done. We kitchen refrigerator should a food items, OSM #2 stated sick if they eat expired food D.m., ASM (administrative ne administrator and ASM #2, pliance were made aware of the following, "All foods should and dated. All foods will be that foods (including leftovers) of their safe use dates, or cable), or discarded."	F 812			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
495339		B. WING	·····	0	2/08/2018			
NAME OF PROVIDER OR SUPPLIER HOLLY MANOR NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901				
(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 API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 812	during the 2/7/18 lundining room. On 2/7/18 lunch, ser 11:00 a.m. and 12 nd At 11:35 a.m. OSM (dining room server, uncovered, individual tray by picking up eafinger, in a pinching thumb was inside eawearing gloves durin On 2/8/18 at 8:55 a.r. conducted with OSM how she should serven.	vice was observed between con in the Atkins dining room. other staff member) #8, the was observed serving I portions of desert from a ch bowl using her thumb and motion, from the tray. Her ch bowl and she was not g the service. m., an interview was 1 #8. OSM #8 was asked e an uncovered container of	F 8:	12				
	pick up at the base a asked if it was approtechnique at the lip of thumb into the bowl wastated that it was not asked if she remember the residents during the Atkins dining roo remember and she rebowls with her thumbowls with her thumbowls with her thumbowls with OSM services. OSM #2 was correct manner of se of food to the resider Serve Safe recommended aware of the oatkins dining room of the containers from the containers							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495339	B. WING)2/08/2018
	ROVIDER OR SUPPLIER ANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIF 2003 COBB STREET FARMVILLE, VA 23901	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 812	using a pinching motiniside the bowl. OSM OSM #2 was made at made on 2/7/17 durin Atkins dining room. Oprovide the Serve Sat regarding serving ope On 2/8/18 at 11:15 a. writer and stated he wreference on how to servidents in a sanitary On 2/8/18 at 3:58 p.m member) #1, the adm Director of Compliance above findings.	on in which the thumb was 1 #2 stated that it was not. ware of the observation g the lunch serving in the DSM #2 was asked to fe recommendation en containers of food. m., OSM #2 approached this was unable to locate any serve bowls of food to manner. a. ASM (administrative staff inistrator, and ASM #2, the se were made aware of the	F8	312		