	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPLE	CONSTRUCTION			
) PLAN OF	CORRECTION	IDENTIFICATION NUMBER:					
		495249	B. WING		of this rolle component rolle Care stitute an he acts the statement lbmitted ements d on the ge nurse ere elopment ed to sed when		7
AME OF PF	ROVIDER OR SUPPLIER	••••••••••••••••••••••••••••••••••••••	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
	E REHABILITATION & H	IEALTH CARE CENTER LLC	1	575 SCOTT DRIVE ROUTE 5			
			F.	ARMVILLE, VA 23901			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIO	1	(X	
TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		DA'	
F 000	INITIAL COMMENTS		F 000				
				Preparation and submission of t	his		
	An unannounced Me	dicare/Medicaid standard		plan of correction by Farmville)		
		d 1/4/17 through 1/6/17.		Rehabilitation and Health Ca	re		
		investigated during the		Center, LLC, does not constitu	ite an		
		re required for compliance Federal Long Term Care		admission or agreement by the			
re su TI 11	requirements. The Lil			provider of the truth of the facts			
	survey/report will follo			alleged or the correctness of the			
				conclusions set forth on the stat	ement		
		Certified bed facility was		of deficiencies. The plan of			
	consisted of 19 curren	survey. The survey sample		correction is prepared and subm			
		h #19) and 7 closed record		solely pursuant to the requireme	ents		
	reviews (Residents #2	- ·		under state and federal laws.	-		
1	483.10(h)(1)(3)(i); 483		F 164				
SS=D	PRIVACY/CONFIDEN	TIALITY OF RECORDS		F164			
	483.10						
		includes accommodations,		1. Resident #18's open and			
	medical treatment, wri	•		unattended MAR was closed or	n the		
1	communications, personnectings of family and	onal care, visits, and I resident groups, but this		medication cart by the charge r	urse		
		cility to provide a private		on 1/4/17.			
				The LPN #7 and LPN #5 were			
1	(h)(3)The resident has	-		reeducated by the Staff Develo	pment		
	confidential personal a	ind medical records.		Coordinator on 1/6/17 related to	\sim	Second and	
	(i) The resident has the	e right to refuse the release		ensuring that MARs are closed	when 🔽	denter de la competition de la	
	of personal and medic			unattended to maintain confider	ntiality	E Star	
	provided at			of records.	0	Formal Street	· · · · · · · · · · · · · · · · · · ·
		applicable federal or state			5		
	laws.			2. The Assistant Director of Nu	rsing ष 🖡		
8	§483.70			and the Unit Managers complet	ed an		
((i) Medical records.			audit on 1/24/17 to ensure			
	(2) The facility must ke			confidentiality of the medical re	ecords		
i	ntormation contained i	n the resident's records,		is maintained as required.			

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.

		ND HUMAN SERVICES			PRINTED: 01/17/201
		MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495249	B. WING		C 01/06/2017
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	01/06/2017
FARMVIL	LE REHABILITATION & H	EALTH CARE CENTER LLC		1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
	regardless of the form records, except when (i) To the individual, o representative where (ii) Required by Law; (iii) For treatment, pay operations, as permitt with 45 CFR 164.506; (iv) For public health a neglect, or domestic v activities, judicial and law enforcement purpo purposes, research pur medical examiners, fur a serious threat to hea by and in compliance v This REQUIREMENT by: Based on observation document review and o was determined that fa confidentiality of record the survey sample, Res The facility staff left Re 2017 MAR (medication unattended on the med medication list. The findings include: Resident #18 was admi 7/18/2013 with diagnos not limited to high choice	n or storage method of the release is- r their resident permitted by applicable law; ment, or health care ed by and in compliance activities, reporting of abuse, iolence, health oversight administrative proceedings, oses, organ donation proses, or to coroners, neral directors, and to avert lth or safety as permitted with 45 CFR 164.512. is not met as evidenced , staff interview, facility clinical record review, it incility staff failed to maintain ds for one of 26 residents in sident #18. sident #18 ' s January administration) open and lication cart exposing her	F 16	 3. The nursing staff were reeduca on 1/6/17 by the Staff Developme Coordinator related to ensuring the confidentiality of the medical rec is maintained as required. 4. The Assistant Director of Nurs or the Unit Managers will complet an audit weekly for 4 weeks and monthly for 2 months to ensure confidentiality of medical records maintained as required. The Dire of Nursing will submit a report to Quality Assurance Committee monthly for 3 months. The Direc of Nursing will be responsible for monitoring and follow up. Completion date: 	ent nat ords ing etc is ctor the tor

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Facility ID: VA0080

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PRINTED: 01/17/2017

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		ND HUMAN SERVICES					RM APPROVI NO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		495249	B. WING				C 1/06/2017
NAME OF P	ROVIDER OR SUPPLIER		I	STREET ADD	RESS, CITY, STATE, ZIP CODE	<u>I</u>	1100/2017
FARMVIL	LE REHABILITATION &	HEALTH CARE CENTER LLC			DRIVE ROUTE 5 E, VA 23901		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	I		PROVIDER'S PLAN OF CORR	ECTION	(26)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SH ROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 164	Continued From pag	ae 2	F1	164			
		was a quarterly assessment					
		sment reference date) of					
		#18 was coded as being					
		he ability to make daily					
		out of 15 on the BIMS (Brief Status) exam. Resident #18					
		ing extensive assistance					
	from staff with transf	ers and dressing; total					
		with hygiene and bathing,					
	and independent wit	h meals.					
	On 1/4/17 at 7:20 a.r	n., an observation of a					
		ing one was conducted.					
4 YO 10 () 10 ()		(Medication Administration					
		d open and unattended,					
5 M - 10		tion list, diagnoses; name th). The nurse assigned to					
		ew of the medication cart.					
		n., a facility staff member					
	walked by the cart ar	nd open MAR. On 1/4/17 at					
		aide walked by the open					
		on cart. On 1/4/17 at 7:45					
	no nurse within view	MAR was still left open and of the cart.					
	Povious of Popidant #	191- January 2017 MAD					
		18's January 2017 MAR ration record) revealed that					
	she was on the follow	•					
	[1] Colace Capsule 1	00 mg (milligrams) Give 100					
	mg by mouth two time constipation.						
	•	et 2 MG (Loperamide HCL)					
)		as needed for loose stools					
1		after each loose stool.					
		20 mg by mouth one time a					
1	day related to Edema	mg Give 40 mg by mouth in					
	the evening related to		-	and the second se			

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Facility ID: VA0080

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	RS FOR MEDICARE &	MEDICAID SERVICES			FORM APPROVI OMB NO. 0938-03	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	1 · · ·	TE SURVEY MPLETED
		495249	B. WING			C
IAME OF F			ST	REET ADDRESS, CITY, STATE, ZIP CODE		1/06/2017
		EALTH CARE CENTER LLC	15	75 SCOTT DRIVE ROUTE 5		
		EACTH CARE CENTER LLC	FA	RMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 164	cholesterol) [5] Robitussin Chest C (Guaifenesin) Give 20 hours as needed for c [6] Tylenol Tablet 325 650 mg by mouth eve (headache/Fever) [7] Vitamin D Tablet- C time a day for Vitamin (tablets) every day. On 1/4/17 at 12:00 p.r conducted with LPN (I When asked how staff resident records durin pass, LPN #1 stated th the Resident's MAR of up the MAR. When as to cover the resident's "Because of HIPAA (T Portability and Accoun protect their privacy. T When asked if she was LPN #1 stated, "No. La On 1/4/17 at 12:05 p.m conducted with LPN #1 Resident #18 on that s maintain confidentiality medication administrat "Keep the record (MAF don't want to see perso	Congestion Syrup 10 mg by mouth every 4 ough. mg (Acetaminophen) Give ry 4 hours as needed for HA Give 1000 unit by mouth one D deficiency. Give 2 tabs m., an interview was icensed practical nurse) #1. maintains confidentiality of g medication administration hat she would either close r use a clipboard to cover sked why it was important MAR, LPN #1 stated, he Health Insurance tability Act) [8]. You have to heir chart belongs to them." s Resident #18's nurse, am not her nurse." h., an interview was 7, the nurse assigned to hift. When asked how to o of resident records during ion pass, LPN #7 stated, R) closed because you onal information. That LPN #7 stated that she was se before 8 a.m. Resident	F 164			

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Facility ID: VA0080

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CENTE	RS FOR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES					RM APPROVE 10. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY
		495249	B. WING	B. WING		0.	C 1/06/2017
	PROVIDER OR SUPPLIER	HEALTH CARE CENTER LLC		1575	EET ADDRESS, CITY, STATE, ZIP CODE 5 SCOTT DRIVE ROUTE 5 2 MVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	IX X	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
	 interview was conduct who was assigned to on 1/4/17. He denied working with the reside On 1/5/17 at 5:59 p.m member) #1, the adm DON (Director of Nurse the above concerns. The facility policy title Policy and Procedure protecting confidentia administration. No further information [1] Colace Capsule-Us of stool. This information was obtained for 442. [2] Imodium -controls a information was obtain Institutes of Health. https://dailymed.nlm.n gXsl.cfm?setid=76a97 5544fd4 [3] Lasix 20 mg- used (excess fluid) in patien impairment or kidney of was obtained from Davis (2000) [4] Lovastin Tablet-use 	 cted with LPN #5, the nurse Resident #18 until 8:00 a.m. d that he was the nurse dent on that shift. n., ASM (Administrative staff ninistrator and ASM #2, the sing) were made aware of d, "HIPAA Security Rules s Summary" did not address I records during medication e was presented prior to exit. sed to soften the passage tion was obtained from r Nurses, 11th edition, p. symptoms of diarrhea. This hed from The National ih.gov/dailymed/fda/fdaDru 6d5-8bee-4158-a94d-7fbfc to decrease edema ts with heart failure, liver disease. This information vis's Drug Guide for 	F	164			

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Facility ID: VA0080

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3[™] 2017
 3[™]/OLC

	MENT OF HEALTH AN				FORM	: 01/17/20 APPROVE . 0938-039	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE S COMPL	SURVEY ETED	
		495249	B. WING		C 01/06/2017		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		0.2011	
FARMVIL	E REHABILITATION & H	EALTH CARE CENTER LLC		1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 164	Continued From page	5	F 16	4			
	from the chest when y the cold or flu. It work phlegm in the lungs. T obtained from The Na https://www.ncbi.nlm.r T0010512/?report=de [6] Tylenol Tablet 325 Treats minor aches ar fever. This information National Institutes of H	o clear mucus and phlegm ou have congestion from s by thinning the mucus and this information was tional Institutes of Health. hih.gov/pubmedhealth/PMH tails. mg (Acetaminophen) - d pains and also reduces h was obtained from The					
	vitamin that is naturally added to others, and a supplement." This info The National Institutes	/itamin D is a fat-soluble / present in very few foods, vailable as a dietary prmation was obtained from					
F 167	Accountability Act (HIF comprehensive Federa of personal health info was obtained from The	uleandresearch.nih.gov/. GHT TO SURVEY	F 167	F 167			
	(g)(10) The resident ha (i) Examine the results of the facility conducted	of the most recent survey		1. The survey binder was up include three years of survey on 1/6/17 by the Administra	y results		

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Facility ID: VA0080

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VDH/OLC

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES			PRINTED: 01/17/20
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			FORM APPROV OMB NO. 0938-03
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495249	B. WING		C 01/06/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				1575 SCOTT DRIVE ROUTE 5	
		EALTH CARE CENTER LLC		FARMVILLE, VA 23901	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETIO
	surveyors and any pla respect to the facility; (g)(11) The facility mu (i) Post in a place read and family members a residents, the results of the facility. (ii) Have reports with r certifications, and corr respecting the facility of years, and any plan of respect to the facility of years, and any plan of respect to the facility that accessible to the public (iv) The facility shall not information about com This REQUIREMENT by: Based on observation determined that the fac notice for and failed to the survey results were A Notice was not poster responsible parties that three years of survey re corrections, were availa- request. Review of the revealed the book cont	an of correction in effect with and ist dily accessible to residents, and legal representatives of of the most recent survey of respect to any surveys, aplaint investigations made during the 3 preceding f correction in effect with available for any individual t; and availability of such reports in at are prominent and c. of make available identifying plainants or residents. is not met as evidenced and staff interview, it was cility staff failed to post a ensure that three years of e available upon request. ed to the residents and t the results of the previous esults, with the plan of able for review upon	F 16	 2. The Administrator complete audit on 1/6/17 to ensure surve binders included three years of results as required. 3. The Administrator will be reeducated by the Regional Nu Consultant on 1/31/17 related ensuring three years of survey are maintained in the survey b required. 4. The Administrator or Direct Nursing will complete an audit facility survey binders weekly weeks and monthly for 2 mont ensure survey binders continue include three years of survey re as required. The Administrato submit a report to the Quality Assurance Committee monthly months. The Administrator wi responsible for monitoring and up. Completion date: 	ey f survey f survey urse to results inder as tor of t of the for 4 ths to e to e sults or will / for 3 ill be
	ending on 1/6/16, an al	bbreviated survey ending ee years of survey results			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED	
		495249	B. WING		0	C 1/06/2017	
NAME OF I	PROVIDER OR SUPPLIER	• • • • • • • • • • • • • • • • • • •		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	100/2011	
		EALTH CARE CENTER LLC		1575 SCOTT DRIVE ROUTE 5			
FARIVIVIL		EALTH CARE CENTER LLC		FARMVILLE, VA 23901			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORE	RECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETIC DATE	
F 167	Continued From page as required.	97	F 167	7			
	as required.						
	The findings include:						
	in the front lobby on 1 was located under the Results." The book in survey results and pla annual survey ending abbreviated survey er An interview was cond (administrative staff m administrator, on 1/7/1 asked who is responsi results, ASM #1 stated When asked which su the residents and resp stated, "The last annus surveys." When asked regulations that went in #1 stated, "I'm not awa have not received any that." A policy on the p	the pocket contained the n of corrections from the on 1/6/16 and an iding on 1/28/16. Aucted with ASM ember) #1, the 7 at 10:50 a.m. When ble for posting the survey d, "The administrator." rveys were to be posted for onsible parties, ASM #1 al and any complaint if he was aware of the new not effect on 11/28/16, ASM are of any new regulations, I					
	don't have one." The administrator and were made aware of th at 12:35 p.m.	the director of nursing le above concern on 1/6/17					
F 278 SS=D	No further information 483.20(g)-(j) ASSESSI ACCURACY/COORDII		F 278				
	(g) Accuracy of Assess	ments. The assessment					

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DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES			FORM A	01/17/2017 PPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. (
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SL COMPLE	
		495249	B. WING		C 01/06	/2017
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FARMVILI	LE REHABILITATION & H	EALTH CARE CENTER LLC		575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 278	must accurately reflect	8 .t the resident's status.	F 278	F278 1. Resident #10 had a pain intervie	ew	
	 (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. 			completed by the MDS Coordinate and modified the MDS with ARD 11/29/16 on 1/23/17. Resident #9's quarterly assessmen	or of	
				with ARD 11/11/16 section K was modified by the MDS Coordinator 1/4/17.		
		o completes a portion of the and certify the accuracy of essment.		2. The MDS Coordinators will complete an audit of the current resident's MDS by 1/30/17 to ensu	ire	
	(j) Penalty for Falsifica(1) Under Medicare an who willfully and know	d Medicaid, an individual		MDS assessments are completed accurately as required.		
	resident assessment is penalty of not more that assessment; or (ii) Causes another inc	ividual to certify a material		3. The Clinical Reimbursement Specialist will reeducate the MDS Coordinators on 1/27/17 related to ensuring MDS assessments are completed accurately as required.		
	and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment.			4. The MDS Coordinators will aud MDS assessments on each unit weekly for 4 weeks and monthly for	or 2	
	material and false state This REQUIREMENT by: Based on staff intervie review, it was determin complete an accurate f	is not met as evidenced w and clinical record ed that the facility failed to MDS (minimum data set)		months to ensure MDS assessment continue to be completed accuratel as required. The MDS Coordinator will submit a report to the Quality Assurance Committee monthly for months.	y rs	
	complete an accurate I	MDS (minimum data set) 26 residents in the survey		-		

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Facility ID: VA0080

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PRINTED: 01/17/2017

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		ID HUMAN SERVICES MEDICAID SERVICES			FC	TED: 01/17/2017 DRM APPROVED
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) D.	NO. 0938-0391 ATE SURVEY DMPLETED
		495249	B. WING _			C 01/06/2017
NAME OF P	ROVIDER OR SUPPLIER	L	/	STREET ADDRESS, CITY, STAT		01/06/2017
				1575 SCOTT DRIVE ROUTE	5	
FARIVIVILI		IEALTH CARE CENTER LLC		FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TVE ACTION SHOULD BE CED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page	9	F 2	78		
	interview before the A date) on Resident # 1 Data Set) assessmen 2. The facility staff co quarterly assessment 11/11/16, in Section K Concerns, as having a weight loss regimen, v loss that was not phys The findings include: 1. Resident # 10 was 12/6/07 with a readmis diagnoses that include dysphagia (1), anxiety disorder (3), aphasia (- Swallowing/Nutritional a physician prescribed when he was having weight sician prescribed. admitted to the facility on ssion on 8/15/16 with ed but not limited to: (2), obsessive compulsive		The Director of N responsible for me up. Completion date:	lursing will be onitoring and follow	02/03/17
	data set), an annual as (assessment reference the resident as scoring interview for mental sta - 15, one being severe Resident # 10 was coo dependent of one staff daily living. Section BC Understood" coded Re understood" and sectio Understand Others" co "Sometimes understan to simple, direct comm	atus (BIMS) of a score of 0 ly impaired of cognition. led as being totally member for activities of 0700 "Makes Self sident # 10 as "Sometimes on B0800 "Able To ded Resident # 10 as ds - responds adequately				

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Facility ID: VA0080

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JAN 10 2017

VDH/OLC

	NE DEELCIENCIES						<u>10. 0938-03</u>
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONS			TE SURVEY MPLETED
							С
		495249	B. WING			01/06/2017	
NUL OF FI	OVIDER OR SOFFLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARMVILL	E REHABILITATION & H	EALTH CARE CENTER LLC			ILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 278	Continued From page	10	E0	278			
	annual MDS assessm			270			
		, "Should Pain Assessment					
	Interview be Conducted	ed? - Attempt to conduct					
		. If resident is comatose,					
		ess of Breath (dyspnea)."					
4 y		n J0200 contained a dash s J0300 "Pain Assessment					
		n Frequency", J0500 "Pain					
	Effect on Function" an	d J0600 "Pain Intensity"					
	revealed dashes in all						
	indicating that the inte	rview was not attempted.					
	On 1/5/17 at 8:55 a.m.	. an interview was					
	conducted with RN (re	gistered nurse) # 2, the					
		# 2 was asked to review					
1		ssessment Interview" of I MDS assessment with an					
		en asked why the interview					
		in Assessment Interview"					
		N # 2 stated, "The pain					
		ve been completed It was					
1		ther staff member) # 9],					
	clinical reimbursement	specialist.					
1	On 1/5/17 at 11:05 a.m						
		other staff member) # 9,					
		specialist. OSM # 9 was n J0200 "Pain Assessment		and the second se			
	Interview" of Resident						
		RD of 11/29/16. When					
		w for Section J0200, "Pain					
1		was not completed, OSM		4 101			
1		er the ARD to help out and utted. At that time there					
	was no pain information						
(dashes. The pain asse	essment should have been					
0	done by the MDS coord	dinator."					
	On 1/5/17 at 12:00 a.m						

Event ID: 095F11

Facility ID: VA0080

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44 CEIVED 44 38 2017 49 H/OLC

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/17/20 FORM APPROVI OMB NO. 0938-03		
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SUR COMPLETE	VEY	
		495249	B. WING		C 01/06/2	017	
	ROVIDER OR SUPPLIER	IEALTH CARE CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP COI 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		.017	
(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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE CO E APPROPRIATE	(X5) MPLETION DATE	
	coordinator. When as interview information done for the pain asse annual MDS, RN # 3 completed (OSM # 9) information." When a follow for completing t # 3 stated, "We use th assessment instrument The RAI (Resident As manual documented," 1. Determine whether at least sometimes. R (A1100), to determine or wants an interprete of fan interpreter is new effort should be made present for the MDS c the interview if the resunderstood and an inter required. •Code 0, no: if the resi understood and an inter available. Skip to Indic Pain item (J0800). •Code 1, yes: if the resi understood and an inter required. Continue to F (J0300).	egistered nurse) # 3, MDS sked about the pain that OSM # 9 stated was not essment of Resident # 10's stated, "The interview was failed to ask for the sked what guidance they the MDS assessments, RN he RAI (resident nt) manual." sessment Instrument) ' Steps for Assessment the resident is understood eview Language item whether the resident needs r. eded or requested, every to have an interpreter linical interview. Complete ident is at least sometimes erpreter is present or not cators of Pain or Possible sident is at least sometimes erpreter is present or not Pain Presence item	F 2	78			

Event ID: 095F11

Facility ID: VA0080

If continuation sheet Page 12 of JZD RECEIVED JAN 30 2017 VDH/OLC

	MENT OF HEALTH AN					FC	TED: 01/17/201 DRM APPROVEI NO: 0938-039	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION	(X3) D	ATE SURVEY OMPLETED	
		495249	B. WING				C 01/06/2017	
	ROVIDER OR SUPPLIER	EALTH CARE CENTER LLC	L	1575	EET ADDRESS, CITY, STATE, ZIP CODE SCOTT DRIVE ROUTE 5 MVILLE, VA 23901	I	01706/2017	
(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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
	infections. Pain significantly adv quality of life and is tig diminished self-confid well as an increase in particularly for cognitiv Some older adults lim avoid having pain. The frequency may reflect more than it reflects ad Planning for Care Directly asking the rest information or relying of significantly improves Resident self-report is for assessing pain. Pain assessment prov treatment need, and re- Assessing whether pain activities provides addifiunctional impact of pain planning implications. Assessment of pain pri- Pain assessment provides addifiunctional impact of pain planning implications. Assessment of pain pri- Pain assessment provides addifiunctional impact of pain planning implications. Consistent use of a starsing a starsing a starsing a starsing a starsing Scale improves the vali	r of Life ved pain impact the functional decline, obility, skin breakdown and ersely affects a person ' s phtly linked to depression, ence and self-esteem, as behavior problems, vely-impaired residents. hit their activities in order to eir report of lower pain their avoidance of activity dequate pain management. sident about pain rather ident to volunteer the on clinical observation the detection of pain. the most reliable means vides a basis for evaluation, esponse to treatment. in interferes with sleep or tional understanding of the in and potential care rovides insight into the og of pain interventions to referred activities. hypts discussion about	F 2	778				

Facility ID: VA0080

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DA	<u>10. 0938-03</u> TE SURVEY
NU PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	6	COL	MPLETED
		495249	B. WING			С
		495249	D. WING	STREET ADDRESS, CITY, STATE, ZIP C		1/06/2017
				1575 SCOTT DRIVE ROUTE 5	ODE	
FARMVILI	_E REHABILITATION & H	IEALTH CARE CENTER LLC		FARMVILLE, VA 23901		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETIO DATE
F 278	Continued From page	9 13	F 27	8		
	settings may improve continuity of care. Pain intensity scales allow providers to evaluate					
		nding to pain medication				
	regimen(s) and/or nor intervention(s).	i-pnarmacological				
	Steps for Assessment					
	Instructions for Pain A (J0300-J0600)	ssessment Interview				
		ent not screened out by the				
	Should Pain Assessm					
	Conducted? item (J02					
		ent Interview for residents				
	Presence item (J0300	the primary question Pain				
	•	ency item (J0400); Pain				
	Effect on Function iten					
		If the resident is unable to				
		estion on Pain Presence Staff Assessment for Pain				
		ors of Pain or Possible Pain				
	item (J0800).					
	3. The look-back perio	d on these items is 5 days.				
	Because this item asks	s the resident to recall pain				
		, this assessment should				
	be conducted close to	the end of the 5- day erably on the day before, or				
		his should more accurately				
1		that occur during the 5-day				
1	look-back period.					
	 Conduct the intervie Be sure the resident 					
1		can near you. g impairment should be				
	tested using their usua					
	devices/techniques, as	applicable.				
1		ve device (headphones or				
	hearing amplifier) if yoι	استعمامه المستعمان المستعمان		1		1

Facility ID: VA0080

If continuation sheet Page 14 of 171

		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 01/17/2017 RM APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495249	B. WING				C 1/06/2017
	ROVIDER OR SUPPLIER	EALTH CARE CENTER LLC		157	REET ADDRESS, CITY, STATE, ZIP CODE 5 SCOTT DRIVE ROUTE 5 RMVILLE, VA 23901		1100/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG			ILD BE	(X5) COMPLETION DATE
F 278	Minimize glare by dire from the resident's fac 7. Give an introductio interview. Suggested you some questions a asking these question often you have pain, h pain affects your daily to develop the best play your pain." 8. Directly ask the rest through J0600 in the of 'Use other terms for p if the resident seems of report that they "hurt." terms such as "aching pain. 9. If the resident chood particular item, accept and move on to the ne 10. If the resident is un pain occurred in the 5- the resident to think all episode of pain and the occurred within the lood On 1/5/17 at approxim (administrative staff m administrator, and ASI were made aware of th No further information References: (1) A swallowing disord obtained from the web	d noise. lent can see your face. lecting light sources away ce. In before starting the language: "I'd like to ask about pain. The reason I am is is to understand how how severe it is, and how activities. This will help us an of care to help manage ident each item in J0300 order provided. ain or follow-up discussion unsure or hesitant. Some i the term "pain" but may Residents may use other " or "burning" to describe ses not to answer a his/her refusal, code 9, ext item. hsure about whether the day time interval, prompt bout the most recent y to determine whether it bk-back period." ately 6:00 p.m. ASM ember) # 1 the M # 2, director of nursing, he findings. was provided prior to exit.	F	278			

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STATEMENT		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY COMPLETED		
				****	C		
LULUE OF S		495249	B. WING		01/06/2017		
	ROVIDER OR SUPPLIER	IEALTH CARE CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CO 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901	P CODE		
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE COMPLE DE APPROPRIATE DATE		
 F 278 Continued From page 15 sorders.html. (2) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary. (3) A common, chronic and long-lasting disorder in which a person has uncontrollable, reoccurring thoughts (obsessions) and behaviors (compulsions) that he or she feels the urge to repeat over and over. This information was obtained from the website: http://www.nimh.nih.gov/health/topics/obsessive-c ompulsive-disorder-ocd/index.shtml. (4) A disorder caused by damage to the parts of the brain that control language. It can make it hard for you to read, write, and say what you mean to say). This information was obtained from the website: (5) A mental disorder that makes it hard to tell the difference between what is real and not real. This information was obtained from the website: https://medlineplus.gov/ency/article/000928.htm. (6) A swelling caused by fluid in your body's tissues. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/edema.html. 		e 15	F 278				
	website: https://www.nlm.nih.gov/medlineplus/anxiety.html						
	the brain that control I hard for you to read, w mean to say). This inf	anguage. It can make it vrite, and say what you					
	difference between wh information was obtain	nat is real and not real. This ned from the website:					
	tissues. This informat website:	ion was obtained from the					
	regulate the amount o information was obtain	n which the body cannot f sugar in the blood. This ned from the website: pv/medlineplus/ency/article/					

Event ID: 095F11

Facility ID: VA0080

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PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CTP STRE_2P CODE FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC STREET ADDRESS, CTP STRE_2P, CODE Image: Comparison of the strength of the st			495249	B. WING		0	
FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC FARMVILLE, VA 2391 (M) ID TAG SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY WST ETERMENT OF DEFICIENCES REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDENT ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRATE DEFICIENCY F 278 Continued From page 16 (B) The term "sciure" is often used interchangeably with "comvulsion." A secure is the physical findings or changes in behavior that occur after an episode of abnormal electrical activity in the brain. This information was obtained from the website: https://medlineplus.gov/ency/article/003200.htm. F 278 2. The facility staff coded Resident #9 on the quarterly assessment, with an ARD of 11/11/16, in Section K - Swallowing/Nutritional Concerns, as having a physician prescribed weight loss regime, when he was having weight loss that was not physician prescribed weight loss depression, anxiety, seizures, high blood pressure and traumatic brain injury with cranitory and lobedromy. The most recent MDS (minimum data set) assessment, aquarterly assessment, with an assessment, aquarterly assessment, with an assessment reference date (ARD) of 11/11/16, coded the resident as socing a five on the BIMS (brief interview for mental status) scale, indicating he was severely impaired to make daily cognitive decisions. The resident was coded as being totally dependent on one or more staff members for all of his activities of daily living. In Section K - Swallowing/Nutritional Concerns, Resident #9 was coded as having had a weight loss of five	NAME OF P				STREET ADDRESS, CITY, STATE, ZIP CODE	<u>~</u>	
Processor (EACH OPERICENCY NOLISE TRE PRECEDED BY FULL REGULATORY OR LSC DENTEYING INFORMATION) PRETX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 16 F 278 F 278 Continued From page 16 F 278 (8) The ferm "seizure" is often used interchangeably with "convulsion." A seizure is the physical findings or changes in behavior that occur after an episode of abnormal electrical activity in the brain. This information was obtained from the website: https://medlineplus.gov/ency/article/003200.htm. F 278 2. The facility staff coded Resident #9 on the quarterly assessment, with an ARD of 11/11/16, in Section K - Swallowing/Nutritional Concerns, as having a physician prescribed weight loss that was not physician prescribed. Resident #9 was admitted to the facility on 10/02/4/12 with diagnoses that included but were not limited to: concussion, hypothyroid, diabetes, depression, anviety, seizures, high blood pressure and traumatic brain injury with craniotomy and lobectomy. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date (ARD) of 11/11/16, coded the resident as scoring a five on the BIMS (brief interview for mental status) scale, indicating he was severely impaired to make daily cognitive decisions. The resident was coded as bleing totally dependent on one or more staff members for all of his activities of daily living. In Section K - Swallowing/Nutritional Concerns, Resident #9 was coded as having had a weight loss of five	ARMVILI	LE REHABILITATION & H	HEALTH CARE CENTER LLC				
 (8) The term "seizure" is often used interchangeably with "convulsion." A seizure is the physical findings or changes in behavior that occur after an episode of abnormal electrical activity in the brain. This information was obtained from the website: https://medlineplus.gov/ency/article/003200.htm. 2. The facility staff coded Resident #9 on the quarterly assessment, with an ARD of 11/11/16, in Section K - Swallowing/Nutritional Concerns, as having a physician prescribed weight loss regimen, when he was having weight loss that was not physician prescribed. Resident #9 was admitted to the facility on 10/24/12 with diagnoses that included but were not limited to: concussion, hypothyroid, diabetes, depression, anxiety, seizures, high blood pressure and traumatic brain injury with cranictomy and lobectomy. The most recent MDS (minium data set) assessment, a quarterly assessment, with an assessment reference date (ARD) of 11/11/16, coded the resident as scoring a five on the BIMS (brief interview for mental status) scale, indicating he was severely impaired to make daily cognitive decisions. The resident was coded as being totally dependent on one or more staff members for all of his activities of daily living. In Section K - Swallowing/Nutritional Concerns, Resident #9 was coded as having had a weight loss of five 	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	(X5) COMPLETIO DATE
of 10% or more in last six months. Resident #9 was coded as a "1. Yes, on physician-prescribed weight-loss regimen."	F 278	 (8) The term "seizure interchangeably with the physical findings occur after an episod activity in the brain. obtained from the we https://medlineplus.gr 2. The facility staff conquarterly assessment Section K - Swallowir having a physician pregimen, when he wawas not physician pregimen, when he wawas not physician pregimen, when he wawas not physician pregimen, anxiety, spressure and traumate craniotomy and lobed. The most recent MDS assessment, a quarter assessment reference coded the resident as (brief interview for me he was severely impadecisions. The reside totally dependent on of for all of his activities Swallowing/Nutritiona was coded as having percent or more in hes was coded as a "1. Yee the severe as a severe of the severe of the severe as a severe of the severe of the severe as a severe of the severe as a severe of the severe of the	" is often used "convulsion." A seizure is or changes in behavior that le of abnormal electrical This information was absite: ov/ency/article/003200.htm. add Resident #9 on the t, with an ARD of 11/11/16, in ng/Nutritional Concerns, as rescribed weight loss as having weight loss that escribed. hitted to the facility on ses that included but were sion, hypothyroid, diabetes, seizures, high blood tic brain injury with ctomy. S (minimum data set) erly assessment, with an e date (ARD) of 11/11/16, a scoring a five on the BIMS ental status) scale, indicating aired to make daily cognitive nt was coded as being one or more staff members of daily living. In Section K - I Concerns, Resident #9 had a weight loss of five e last month or a weight loss t six months. Resident #9 es, on physician-prescribed	F 278			

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		ID HUMAN SERVICES MEDICAID SERVICES			FO	ED: 01/17/201 RM APPROVE
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DA	NO. 0938-03 TE SURVEY MPLETED
		495249	B. WING		0	C 01/06/2017
	ROVIDER OR SUPPLIER	EALTH CARE CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CC 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		1100/2017
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 278	documented in part, " therapeutic diet r/t (re risk for impaired nutrit (history) of swallowing fluctuations, short atte meals. Family is awa feeding)." An interview was cond nurse) #3, the MDS of p.m. When asked to r quarterly MDS assess 11/11/16, RN #3 state error. He's not on a p loss program, he's los doesn't want a tube fer reference she uses to assessments, RN #3 assessment instrument The RAI manual, Octor "Section K - K0300: C physician-prescribed v resident has experient more in the past 30 da last 180 days, and the and pursuant to a phy where a resident has a in 30 days or 10% or r results of any physicial expected weight loss of physician orders for di coded as 1. Code 2, y prescribed weight-loss has experienced a weight the past 30 days or 10	Focus: I require a lated to) disease process, tion secondary to a hx g difficulty, recent weight ention span, aspiration at re, does not desire TF (tube ducted with RN (registered bordinator, on 1/4/17 at 3:33 eview Section K on the sment, with an ARD of d, "Well, that was coded in hysician prescribed weight ing weight and his mother weding." When asked what complete the MDS stated, "The RAI (resident nt) manual." bber 2016, documented, ode 1, yes on weight-loss regimen; if the ced a weight loss of 5% or ays or 10% or more in the weight loss of 5% or more nore in 180 days as a n ordered diet plan or due to loss of fluid with uretics, K 0300 cane be es, not on physician - a regimen; if the resident ight loss of 5% or more in % or more in the last 180 poss was not planned and	F 2'	78		

Facility ID: VA0080

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TATEMENT (S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		C
		495249	B. WING		01/06/2017
NAME OF P			S	STREET ADDRESS, CITY, STATE, ZIP CODE	
FARMVILI	E REHABILITATION & H	EALTH CARE CENTER LLC	1	575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLET
F 278	The administrator and	e 18 d director of nursing were bove concern on 1/4/17 at	F 278		
F 279 SS=E		·	F 279	F279	
	assessments complet months in the residen results of the assessr	st maintain all resident ted within the previous 15 t's active record and use the nents to develop, review nt's comprehensive care		 Resident #1 was discharged f the facility on 1/17/17 Resident # 2 psychotropic medi care plan from the CAA on 10/2 significant change MDS was completed on 1/24/17 by the M Coordinator. 	cation 25/16
	 (b) Comprehensive C (1) The facility must d comprehensive perso each resident, consist set forth at §483.10(c) includes measurable to meet a resident's m and psychosocial nee 	evelop and implement a n-centered care plan for tent with the resident rights)(2) and §483.10(c)(3), that objectives and timeframes nedical, nursing, and mental ds that are identified in the sment. The comprehensive		Resident #25 was discharged of 3/21/16. Resident #15's care plan was u related to the 10/21/16 incident MDS Coordinator on 1/23/17. Resident #8 care plan was revide and updated related to the 10/2 incident by the MDS Coordinator	pdated by the ewed 1/16
	or maintain the reside physical, mental, and required under §483.2 (ii) Any services that v	re to be furnished to attain nt's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and vould otherwise be required 25 or §483.40 but are not		1/23/17.	

Facility ID: VA0080

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	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	СОМ	E SURVEY PLETED	
		495249	B. WING		1	1/06/2017	
		J		STREET ADDRESS, CITY, STATE, ZIP CODE			
FARMVILL	E REHABILITATION & H	EALTH CARE CENTER LLC		1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 279	Continued From page	e 19	F 27	79			
		ding the right to refuse		Resident #10 care plan wa for the CAA triggered area	a of vision		
r p	(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the			on the annual assessment v 11/29/16 on 1/23/17 by the Coordinator.	with ARD		
	findings of the PASA rationale in the reside	ARR, it must indicate its	urrent				
	resident's representa			ensure care plans are deve updated to reflect the resid	loped and lent's		
	desired outcomes.			current condition and need required.	ls as		
	future discharge. Fac whether the resident'	eference and potential for ilities must document s desire to return to the ssed and any referrals to		3. The MDS Coordinators interdisciplinary team will	l be		
		s and/or other appropriate		reeducated by the Clinical Reimbursement Specialist related to ensuring care pl	t on 1/27/17		
p ru S T b	plan, as appropriate, requirements set fortl section.	n the comprehensive care in accordance with the h in paragraph (c) of this		developed and updated to resident's current condition as required.	reflect the		
	by:	 is not met as evidenced iew, facility document cord review, it was 		4. The MDS Coordinators current residents' care pla unit weekly for 4 weeks a	ins on each		
	determined that facilit comprehensive care	ty staff failed to develop a plan for five of 26 residents Resident #1, #2, #25, #15,		for 2 months to ensure can continue to be developed to reflect the resident's cu condition and needs as red	re plans and updated irrent		
		led to develop a hospice dent #1 was admitted under			4		

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STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		NSTRUCTION	OMB NO. 0938-035 (X3) DATE SURVEY COMPLETED		
		495249	B. WING			C 01/06/2017		
	ROVIDER OR SUPPLIER	EALTH CARE CENTER LLC		1575	ET ADDRESS, CITY, STATE, ZIP CODE SCOTT DRIVE ROUTE 5 MVILLE, VA 23901	1 0	1100/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	TIVE ACTION SHOULD BE COMP CED TO THE APPROPRIATE D/		
F 279	triggered CAA (care a on Resident #2's 10/2 MDS (minimum data 3. The facility staff fai for discharge planning 4. The facility staff fai following the 10/21/16 #15 was kicked by Re 5. The facility staff fai for the CAA (care are area of vision on Res assessment with an A date) of 11/29/16. The findings include: 1. The facility staff fail care plan when Resid hospice services on 1 Resident #1 was adm 4/28/16 with diagnose limited to protein-calo hypothyroidism, blindr and Dementia with Le Resident #1's most re set) was a quarterly a (assessment referenc Resident #1 was code cognitively impaired in decisions, scoring 03	led to develop a ion care plan from the area assessment summary) 25/16 significant change set) assessment. led to develop a care plan g for Resident #25. led to develop a care plan 5 incident when Resident esident #8. led to develop a care plan a assessment) triggered ident #10's annual RD (assessment reference left to develop a hospice fent #1 was admitted under 0/28/16. itted to the facility on es that included but were not rie malnutrition, dysphagia, ness, muscle weakness, wy Body [1]. cent MDS (minimum data ssessment with an ARD e date) of 11/10/16.	F	279	A report will be submitted to th Quality Assurance Committee monthly for 3 months. The Di of Nursing will be responsible monitoring and follow up. Completion date:	rector	02/03/17	

Event ID: 095F11

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							<u>10. 0938-03</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					TE SURVEY MPLETED
		405040					С
		495249	B. WING			0	1/06/2017
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
FARMVIL	LE REHABILITATION & H	HEALTH CARE CENTER LLC			MVILLE, VA 23901		
(X4) ID	1	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	x	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR(DEFICIENCY)		DATE
F 279	Continued From page	e 21	F	279			
	was coded as requiri	ng extensive assistance with					
		s, dressing, eating, toileting,					
	Review of Resident #	1's physician telephone					
		rder for Hospice Services on					
		1's clinical record revealed care plan from the hospice					
		1's care plan dated 5/17/16 8/2/16, failed to reveal a m the nursing facility.					
	#1's hospice care plan of day meeting with A	nately 4:33 p.m., Resident n was requested at the end SM (administrative staff inistrator and ASM #2 the sing).					
	Resident #1's facility h presented with an ons						
	related to protein calo of Behavioral Disturba	receiving hospice services rie malnutrition, Dementia ance, falls, HTN IsionsGoal/Target date:					
	Hospice nurse/staff ar palliative support and	and facility staff will provide care x 92 daysEffective will be provided x (for) 92					
	Provide comfort meas	lospice services as ordered. ures every shift. Observe rt each shift. Administer					
	pain medication routin Provided non-pharmad	ely/as needed as ordered. cological interventions for I fluid volume deficit may					

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Facility ID: VA0080

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				RM APPROVE 10. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION	(X3) DA1	TE SURVEY MPLETED
		495249	B. WING		C 01/06/2017	
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	i	
FARMVIL	LE REHABILITATION & I	HEALTH CARE CENTER LLC		5 SCOTT DRIVE ROUTE 5 RMVILLE, VA 23901		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES			OTION	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 279	Continued From page	e 22	F 279			
	experienced. Monito					
	-	diet, fluids and supplements				
	as ordered. Skin brea	akdown may occur. Turn and				
		(every) two hours and as				
		axatives as needed for				
	•	age family/resident to talk r feelings about death.				
		it. Social services/Hospice to				
		religious support. Notify MD				
	(medical doctor) as n	• • • •				
	On 1/6/17 at 8:50 a.m	n. an interview was				
		Registered Nurse) #2, the				
	•	sked what would be in the				
		ident was on hospice, RN				
		hould be hospice orders,				
		n from the hospice provider.				
	placed under a separ	se documents would be				
arrow automation and		asked if the nursing facility				
		hospice care plan for the				
		d, "We do put a care plan				
		t type of interventions would				
	•	e plan, RN #2 stated that it				
	would look similar to t					
		#2 stated that the care plan				
		tc. When asked who was				
		ng a hospice care plan when				
		nder hospice services, RN				
	#2 stated, "Probably N	ADS. MDS does it all."				
	On 1/4/17 at 4:33 p.m	., ASM #1, the administrator				
		I were made aware of the				
	concern that a hospic	•				
	-	dent #1 was admitted under				
	hospice services on 1					
	information was prese	inted phor to exit.				

Event ID: 095F11

Facility ID: VA0080

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	S FOR MEDICARE & OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CC	DNSTRUCTION	(X3) DAT	<u>O. 0938-03</u> e survey
PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		495249	B. WNG		C 01/06/2017	
ME OF PI	ROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP CODE		106/2017
RMVILL	E REHABILITATION & H	EALTH CARE CENTER LLC		SCOTT DRIVE ROUTE 5 MVILLE, 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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 279	Continued From page	23	F 279			
		nentals of Nursing Made				
		ncott Williams and Wilkins, 65: "A written care plan				
	serves as a communi	cation tool among health				
	care team members t	hat helps ensure the e care plan is developed on				
	admission and include					
- or other states and the states and	problems and is revie	wed and revised as				
*******************	necessary" [1] Lewy Body- "LBD is a disease associated with					
	abnormal deposits of	a protein called				
		brain. These deposits, ffect chemicals in the brain				
	whose changes, in tur	n, can lead to problems				
	with thinking, moveme LBD is one of the mos	ent, behavior, and mood.				
	dementia, after Alzhei	mer's disease and vascular				
	disease." This information of the National Institutes	ation was obtained from				
1		v/alzheimers/publication/le				
	wy-body-dementia/bas	sics-lewy-body-dementia.				
	2. The facility staff faile	ed to develop a				
	psychotropic medication	on care plan from the				And a second s
		ea assessment summary) 5/16 significant change				
	MDS (minimum data s					
	Resident #2 was admi	•				
1	-	s that included but were not				
	limited to GERD (gastr disease), major depres	oesopnageal reflux				
\ \	without behavioral dist	urbance, high blood				
	pressure, atrial fibrillati shortness of breath, ar					
	STOLLESS OF DEALE AF	id difficulty walking				

If continuation sheet Page 24 of 171

TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING		(X3) DA	NO. 0938-039 TE SURVEY MPLETED
		495249	B. WING		C 01/06/2017	
	ROVIDER OR SUPPLIER	HEALTH CARE CENTER LLC	1575	EET ADDRESS, CITY, STATE, ZIP CODE 5 SCOTT DRIVE ROUTE 5 2 MVILLE, 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) COMPLETIO DATE
F 279	set) was a quarterly a (assessment reference Resident #2 was cod cognitively impaired i decisions scoring 00 (Brief Interview for Me Resident #2 was cod assistance with all AE Resident #2's most re was a significant char ARD of 10/25/16. "Pe an area triggered in S Assessment Summar This area was also ch #2's care plan. Review of Resident # and updated 8/23/16 psychotropic drug use Review of Resident # (physician order shee was placed on "Reme by mouth at bedtime r Disorder." This order On 12/28/16 the order decreased to 30 mg p night) for depression. On 1/6/17 at 8:50 a.m conducted with RN (re MDS nurse. RN #2 st a psychotropic care pl asked why it would be psychotropic medicati that it would be import	assessment with an ARD ce date) of 12/4/16. ed as being severely n the ability to make daily (zero) out of 15 on the BIMS ental Status) exam. ed as requiring extensive DLS (activities of daily living). ecent comprehensive MDS nge assessment with an sychotropic Drug Use" was Section V (CAA) Care Area y of the 10/25/16 MDS. necked to be on Resident 2's care plan dated 9/2/15 failed to reveal a e care plan. 2's December 2016 POS tt) revealed that Resident #2 eron [1] 45 mg (milligrams) related to Major Depressive was initiated on 11/11/2016. r for Remeron was bo (by mouth) qhs (every	F 279			

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DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					MAPPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					D. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		495249	B. WING_			1	C / 06/2017
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					1575 SCOTT DRIVE ROUTE 5		
FARIVIVILI		EALTH CARE CENTER LLC			FARMVILLE, VA 23901		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	Х	(EACH CORRECTIVE ACTION SHOULD I		COMPLETION DATE
TAG	REGULAIORI ORI	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	AIE	Diric
F 279	Continued From page	25	-	~~~			
1 210			F 2	275			
		asked who was responsible					
	RN #2 stated that MD	n from the triggered CAAs,					
		. When asked if Resident					
		chotropic care plan in place,					
		CAA says you are going to					
		care planned." RN #2					
	stated, "I know I did o	ne and I thought I attached					
		o it." RN #2 stated that she					
	-	nt Assessment Instrument)					
		completing a care plan from					
	the triggered CAAs.						
	On 1/6/17 at 1:16 nm	ASM (administrative staff					
	-	., ASM (administrative staff nistrator was made aware					
	of the above concerns						
		•					
	The RAI (resident ass	essment instrument) 3.0					
	manual documents the	e following:					
		MDS constitutes the core					
	of the required State-s	•					
	Assessment Instrumer	t, the MDS identifies actual					
	-	oncern. The remainder of					
	-	orts the efforts of nursing					
	home staff, health prot						
	•	assess these triggered					
		der to identify, to the extent					
	possible, whether the						
		ng further intervention, as					
		I risk factors related to the					
	00	der assessment. These					
		de the basis for developing					
	an individualized care	plan for each resident.					
	CAA documentation.						
	e. staboanionadon.						

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN O	F CORRE CTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		495249	B. WING		0	1/06/2017
NAME OF P	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE		
FARMVIL	LE REHABILITATION & H	HEALTH CARE CENTER LLC		SCOTT DRIVE ROUTE 5 RMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 279	CAA documentation in the care plan by show (interdisciplinary tear underlying causes, care factors were related the aspecific resident; for documentation shoul decisions, why the fir intervention, and the specific interventions comprehensive assest resident and/or the red determine the areas to intervention(s) and det the individualized care [1] Remeron- REMEF are indicated for the the depressive disorder. obtained from The Na https://dailymed.nlm.rm?setid=010f9162-9f 3. The facility staff fai for discharge planning Resident #25 was ad 1/21/16 and discharge diagnoses included b chronic obstructive publood pressure, cereta acidosis, hypothermia and a The most recent MDS assessment, a chang	helps to explain the basis for wing how the IDT m) determined that the ontributing factors, and risk to the care area condition for or example, the d indicate the basis for these nding(s) require(s) an rationale(s) for selecting . Based on the review of the ssment, the IDT and the esident's representative that require care plan evelop, revise, or continue e plan." RON (mirtazapine) Tablets treatment of major This information was ational Institutes of Health. hih.gov/dailymed/drugInfo.cf 77-4b6d-a6e4-4f832f26f38 led to develop a care plan g for Resident #25. mitted to the facility on ed on 3/21/16. His ut were not limited to: JImonary disease, high oral infarction, metabolic a, vascular dementia, ttrial fibrillation.	F 279			

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EPARTMENT	OF HEALTH	AND HUMAN	SERVICES
ENTEDO FOD			

	MENT OF HEALTH AN				FORM	D: 01/17/2017 MAPPROVED D: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495249	B. WING			C 06/2017
	ROVIDER OR SUPPLIER	EALTH CARE CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 279	decisions. He was con for bed mobility, trans The Care Plan, printe There was nothing ad related to discharge p An interview was cond member (OSM) #3 on #13 was asked when starts for a resident. Of during admission. Wr the social work assists set up a meeting in 72 phone." When asked be on the care plan, Of anything with the care reviewed with OSM #3 see anything on the care discharge planning." An interview was cond nurse) #3, the MDS co 10:12 a.m. When asked develop a discharge of am." When asked if al discharge planning ca don't do a care plan if term care." When ask resident was to stay lo on the care plan too, F resident triggers on th community, then it is of don't do a discharge of term care."	ded as being independent fers, eating and toilet use. d on 2/5/16, was reviewed. dressed on the care plan lanning. ducted with other staff 1/5/17 at 9:50 a.m. OSM the discharge planning OSM #3 stated, "It starts nen a resident is admitted, ant or I contact the family to 2 hours in person or on the if discharge planning should OSM #3 stated, "I don't do plan." The care plan was 3. OSM #3 stated, "I don't are plan regarding ducted with RN (registered pordinator, on 1/5/17 at ed who is responsible to are plan, RN #3 stated, "I I residents should have a re plan, RN #3 stated, "We they are going to stay long ed if it was noted the ong term care should that be	F 27	79		

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DEPART	MENT OF HEALTH AN	D HUMAN SERVICES				FORM	APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495249	B. WING				06/2017
NAME OF P	ROVIDER OR SUPPLIER		1	STI	REET ADDRESS, CITY, STATE, ZIP CODE		
FARMVILI	E REHABILITATION & H	EALTH CARE CENTER LLC			75 SCOTT DRIVE ROUTE 5 RMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 279	should have a dischar stated, "Yes." When a staying long term care should have a care pl The administrator and of the above findings No further information 4. The facility staff fail following the 10/21/16 #15 was kicked by Re Resident #15 was adm 12/5/13 and readmitted diagnoses that include pain, diabetes, demer and weakness. The most recent MDS quarterly assessment reference date) of 11/ having short term and problems and as mod in making daily decisie coded as requiring as activities of daily living coded the resident as after tray set up. Review of the facility r 10/22/16 documented had wheeled his chair Resident #8 kicked Re residents were separa was assessed. There injury to the leg. Review of the social s 10/21/16 documented director) visited (name	rge care plan, ASM #2 sked even if the resident is e, ASM #2 stated, "Yes, they an for discharge planning." ASM #2 were made aware on 1/5/17 at 6:00 p.m. was provided prior to exit. ed to develop a care plan incident when Resident iscident #8. mitted to the facility on id on 7/25/15 with ed but were not limited to: ntia, high blood pressure 6 (minimum data set), a , with an ARD (assessment 10/16 coded the resident as long term memory erately impaired cognitively ons. The resident was sistance from staff for all g except for eating which independently performed eported incident dated on 10/21/16 Resident #15 in front of Resident #8. esident #15 in the leg. The net and Resident #15's leg was no apparent physical ervices progress note dated	F	279			

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Facility ID: VA0080

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		AND HUMAN SERVICES & MEDICAID SERVICES			
ATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
			A, BUILDI	NG	C
		495249	B. WING_		01/06/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	
				1575 SCOTT DRIVE ROUTE 5	
	LE REMADILITATION &	HEALTH CARE CENTER LLC		FARMVILLE, VA 23901	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES	ID PREFI>	PROVIDER'S PLAN O (EACH CORRECTIVE AC	TION SHOULD BE COMPLETIO
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO DEFICIEN	
F 279	Continued From page	ge 29	F 2	279	
	no visual signs of di	stress or trauma. He doesn't			
	understand SSD @	(sic) I asked "Are you okay,			
		yone? (") (Name of resident			
	1	orted, I don't know what your			
		anked him for his time and			
		D to follow up on 10/22/16."			
	1	services progress note dated			
		ed, "(Name of resident tinues to wander with			
		it process. He has Dx			
		ntia. Resident does not			
		ies and personal space of			
		signs of distress. He is			
		CNA [certified nursing			
		ling as usual. No changes in			
4.4444444444444444444444444444444444444	his mood/behavior."				
	Review of the nurse'	s notes dated 10/21/16 to			
	10/30/16 did not evid	dence documentation			
	regarding the incider				
		#15's care plan did not			
		ation regarding the incident.			
		nducted on 1/4/16 at 3:45			
		ered nurse) #2, the MDS			
		sked who uses the care			
	plans for the residen	was then asked when a care			
	• •	#2 stated, "Pretty for much			
		asked why the care plans			
		2 stated, "Hopefully we try to			
	-	actual problems to help them			
	from happening agai				
		nducted with RN #3, the MDS			
		sked why a resident had a			
	care plan, RN #3 sta	ted, "It dictates the care of			
		asked who used the care			
		Anybody taking care of the			
		ed if a care plan would be			
	-	lent to resident altercation,			
	RN #3 stated, "If it's s	significant yes it should be			

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Facility ID: VA0080

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AF: CEIVED

		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 01/17/2017 RM APPROVED NO: 0938-0391	
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DA	(X3) DATE SURVEY COMPLETED	
	495249		B. WING				C 1/06/2017	
NAME OF P		I		STF	REET ADDRESS, CITY, STATE, ZIP CODE	<u>I</u> ¥	1100/2017	
FARMVILI	LE REHABILITATION & H	IEALTH CARE CENTER LLC			5 SCOTT DRIVE ROUTE 5 RMVILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 279	practical nurse) #3. W staff when there was altercation, LPN #3 st signs (blood pressure give first aid if needed party), the doctor and An interview was com a.m. with CNA #4. Wf a resident had been s CNA #4 stated, "I wou nurse." When asked incidents between Re CNA #4 stated she was of the residents are at I keep her separated An interview was com a.m. with CNA #I. Wh there had been a resi CNA #1 stated, "I would asked if she was awa been aggressive towas stated she was not. An interview was com (other staff member) # director. When asked when there was a resi OSM #3 stated, "Ever immediately separate then to the nurse's stati injury). I check on their make sure they are not their safety." When as assess, OSM #3 state changes in their behat had ate (sic) for that d	ducted with LPN (licensed Vhen asked what process a resident to resident tated, "We check their vital pulse and respirations), d. Notify the RP (responsible social services." ducted on 1/6/17 at 10:50 hen asked how staff knew if struck by another resident, uld get a report from the if she was aware of any sident #8 and Resident #15, as not but did state, "Some fraid of her (Resident #8) so (from the other residents)." ducted on 1/6/17 at 11:00 en asked how staff knew if dent to resident altercation, uld expect that what when on know what to do." When re that Resident #8 had ards Resident #15, CNA #1 ducted on 1/6/17 with OSM #3, the social services the process staff followed ident to resident altercation, yone intervenes. We the residents and send ation to be assessed (for m for the next day or two to ot in distress, not in fear of iked what behaviors they	F2	279				

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/17/20 FORM APPROV OMB NO. 0938-03
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
	495249 B. WING			C 01/06/2017	
NAME OF PI	ROVIDER OR SUPPLIER	.	STR	EET ADDRESS, CITY, STATE, ZIP CODE	·····
FARMVILL	E REHABILITATION & H	EALTH CARE CENTER LLC		SCOTT DRIVE ROUTE 5	
	CLIMMA DV CT	ATEMENT OF DEFICIENCIES	I	- 	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO
F 279	Continued From page	e 31	F 279		
		for a resident who had been	1 270		
		ident, OSM #3 stated, "I			
	have never heard of t	hat. Only do (a care plan)			
		behavioral management but			
	-	en asked why a care plan			
	-	ed for the recipient, OSM #3			
		ed about care plans as a I'm supposed to do the			
		nly. The MDS coordinator			
		p a care plan)." When			
	•	nportant to have a care plan			
		incident, OSM #3 stated,			
	"Yes." When asked a				
		and Resident #15, OSM #3			
		now any better." When how to keep Resident #15			
		B, OSM #3 stated, "We try to			
	redirect (name of Res	-			
	An interview was cond	-			
	(administrative staff m	nember) #2, the director of			
	•	what process staff followed			
	when there was an alt				
	residents, ASM #2 sta	÷			
		s and have them assessed for any injury. The nurses			
	•	for a few days and follow up			
		hen asked if there would be			
		for the resident who had			
	been kicked, ASM #2	stated "If the resident had a			
		here (on the care plan)."			
		f would know to keep the			
	stated, "They (the staf	other resident, ASM #2 f) would get it through			
	report."				
	On 1/6/17 at 11:30 a.n				
	the findings.	1 #2 was made aware of			
		was provided prior to exit.			

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		ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 01/17/20 RM APPROVE IO: 0938-039
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495249	B. WING		C 01/06/2017	
NAME OF P			STF	REET ADDRESS, CITY, STATE, ZIP CODE	······································	
FARMVILI	E REHABILITATION & H	IEALTH CARE CENTER LLC		5 SCOTT DRIVE ROUTE 5 RMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 279	Continued From page	e 32	F 279			
	for the CAA (care are area of vision on Res assessment with an A date) of 11/29/16. Resident # 10 was ac 12/6/07 with a readmi diagnoses that includ dysphagia (1), anxiety disorder (3), aphasia edema (6) diabetes m (8). The most recent comp data set), an annual a (assessment reference	ARD (assessment reference Imitted to the facility on ission on 8/15/16 with ed but not limited to: (2), obsessive compulsive (4), schizophrenia (5), nellitus (7) and convulsions orehensive MDS (minimum assessment with an ARD re date) of 11/29/16 coded				
	- 15, one being severe Resident # 10 was co dependent of one staf daily living. Review o Assessment (CAA) Su	atus (BIMS) of a score of 0 ely impaired of cognition. ded as being totally f member for activities of f Section V Care Area				
	plan with a review dat	10's comprehensive care e of 12/01/2016 failed to to address Resident # 10's				
	regarding the CAA are for a care plan care pl reviewing the annual N ARD of 11/29/16 for R	42, the director of nursing a of vision being identified an for Resident # 10. After MDS assessment with an				

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JAF 34 2017 VDH/OLC

		ND HUMAN SERVICES MEDICAID SERVICES					FOR	D: 01/17/2017 MAPPROVEE D: 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		(X3) DATE COMF	SURVEY
		495249	B. WING					C /06/2017
NAME OF P	ROVIDER OR SUPPLIER	1	L	Τ	STREET ADDRESS, CITY, STATE, ZIP CODE			00/2011
FARMVILI	E REHABILITATION & H	IEALTH CARE CENTER LLC			1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 279	plan for vision." On 1/5/17 at 12:00 p. conducted with RN (m coordinator regarding being identified for a d about the process of a the CAA of an MDS, If triggered on the CAA developed according assessment instrume annual MDS assessm 11/29/16 for Resident comprehensive care p 3 stated, "It's not on th should have been dev The facility's policy "P "1. Our facility's Care Team, in coordination family or representative maintains a comprehe resident that identifies functioning the resided attain. 2. The compre- on a thorough assess not limited to, the MDS On 1/5/17 at approxim (administrator, and AS) were made aware of t No further information References:	stated, "There isn't a care m., an interview was egistered nurse) # 3, MDS the CAA area of vision care plan. When asked developing a care plan from RN # 3 stated, "If the area a care plan should be to the RAI (resident nt)." After reviewing the nent with an ARD of # 10 and the Dan dated of 12/1/16, RN # ne care plan. A care plan veloped." lans of Care" documented, Planning/Interdisciplinary with the resident, his/her ve (sponsor) develops and ensive care plan for each to the highest level of nt may be expected to ehensive care plan is based ment that includes, but is S." nately 6:00 p.m. ASM ember) # 1 the M # 2, director of nursing, he findings. was provided prior to exit.	F	27				
	(1) A swallowing disor	der. This information was						

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		ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 01/17/201 RMAPPROVE IO. 0938-039
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		TE SURVEY MPLETED
		495249	B. WING		0	C 1/06/2017
		IEALTH CARE CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901	E	*****
(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
F 279	 obtained from the we <https: www.nlm.nih.<br="">disorders.html>.</https:> (2) Fear. This inform website: https://www.nlm.nih.g #summary. (3) A common, chroni in which a person has thoughts (obsessions (compulsions) that he repeat over and over. obtained from the wel http://www.nimh.nih.g ompulsive-disorder-out (4) A disorder caused the brain that control hard for you to read, w mean to say). This inf the website: <https: www.nlm.nih.<br="">ml>.</https:> (5) A mental disorder difference between wi information was obtai https://medlineplus.got (6) A swelling caused tissues. This informative website: https://www.nlm.nih.g (7) A chronic disease 	bsite: gov/medlineplus/swallowing ation was obtained from the rov/medlineplus/anxiety.html ic and long-lasting disorder a uncontrollable, reoccurring) and behaviors e or she feels the urge to This information was bsite: ov/health/topics/obsessive-c cd/index.shtml. by damage to the parts of language. It can make it write, and say what you formation was obtained from gov/medlineplus/aphasia.ht that makes it hard to tell the hat is real and not real. This ned from the website: ov/ency/article/000928.htm. by fluid in your body's tion was obtained from the ov/medlineplus/edema.html. in which the body cannot of sugar in the blood. This	F 279			

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Facility ID: VA0080

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		ID HUMAN SERVICES			FORM	D: 01/17/201 APPROVE 0.0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495249					(X3) DATE SURVEY COMPLETED	
		B. WING		C 01/06/2017		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 279 F 280 SS=E	https://www.nlm.nih.g 001214.htm. (8) The term "seizure interchangeably with the physical findings of occur after an episod activity in the brain. To obtained from the weat https://medlineplus.go 483.10(c)(2)(i-ii,iv,v)(C PARTICIPATE PLANN 483.10 (c)(2) The right to part and implementation of plan of care, including (i) The right to particip included in the plan request meetings and revisions to the perso (ii) The right to particip expected goals and of amount, frequency, and other factors related to plan of care. (iv) The right to receiv included in the plan of (v) The right to see the right to sign after sign of care.	" is often used "convulsion." A seizure is or changes in behavior that e of abnormal electrical This information was bsite: ov/ency/article/003200.htm. 3),483.21(b)(2) RIGHT TO NING CARE-REVISE CP ticipate in the development of his or her person-centered g but not limited to: oate in the planning process, dentify individuals or roles to nning process, the right to I the right to request n-centered plan of care. pate in establishing the utcomes of care, the type, and duration of care, and any o the effectiveness of the re the services and/or items	F 279		5/17 to ndition evised cately be	

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CENTERS FOR MEDICARE & M STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	IA (X2) MULTIPLE CONSTRUCTION		OMB NO. 0938-0 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:		G		IPLETED
		495249	B. WING			C
				STREET ADDRESS, CITY, STATE, ZIP CO		1/06/2017
FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC				1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	I	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		N SHOULD BE E APPROPRIATE	COMPLETION DATE
F 280	Continued From page	36	F 2	30		
	1 0	nis or her treatment and		Resident #5 comprehens	vive care plan	-
	shall support the resid			was reviewed by the inte		
	planning process mus	st		team on 1/26/17 to refle	• •	
	(i) Epoilitata tha inclus	ion of the regident and/or		resident's current condit		
	(i) Facilitate the inclusion of the resident and/or resident representative.			needs.	ion und	
	(ii) Include an assess	ment of the resident's		Resident #4 comprehens	sive care plan	
	strengths and needs.			was reviewed by the inte		
	(iii) Incorporate the re	sident's personal and		team on 1/26/17 to refle	• •	
	(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.			resident's current condit	ion and	
				needs.		
	483.21					
	(b) Comprehensive C	are Plans		Resident #12 was discha	arged on	
	(2) A comprehensive care plan must be-			1/4/17.		
	(i) Developed within 7	days after completion of		Resident #11's care plar	n was	
	the comprehensive as	sessment.		reviewed and revised by		
	(ii) Duran and have an int			Coordinator on 1/13/17		
	includes but is not lim	erdisciplinary team, that ited to		reflect the use of an AV		
	(A) The attending phy	sician.		Resident #1 was dischar	ged from the	
	(B) A registered nurse resident.	with responsibility for the		facility on 1/7/17.		
	resident.			2. The MDS Coordinato	r will	
	(C) A nurse aide with	esponsibility for the		complete an audit of the	current	
No. of the second s	resident.			residents' comprehensiv	e care plans	
				by 2/1/17 to ensure care	plans have	
	(D) A member of food	and nutrition services staff.		been revised and review	ed by the	
	(E) To the extent pract	icable, the participation of		interdisciplinary team to	reflect the	
		esident's representative(s).		resident's current condit		
	An explanation must b	e included in a resident's		required.		
	medical record if the p	articipation of the resident		•		

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Facility ID: VA0080

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	S FOR MEDICARE &	I CONTRACTOR OF CONTRACTOR		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	OMB NO. 0938-	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495249	B. WING		C 01/06/2017	
IAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ARMVILI	E REHABILITATION & H	IEALTH CARE CENTER LLC		575 SCOTT DRIVE ROUTE 5 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLE	
F 280			F 280			
	not practicable for the resident's care plan. (F) Other appropriate disciplines as determined or as requested by the (iii) Reviewed and revise team after each assess comprehensive and quassessments. This REQUIREMENT by: Based on observation document review and was determined that the review and revise the for eight of 26 resident Residents #6, #9, #14 1. For Resident #6 the evidence that the com	staff or professionals in ined by the resident's needs e resident. rised by the interdisciplinary ssment, including both the uarterly review is not met as evidenced n, staff interview, facility clinical record review, it he facility staff failed to comprehensive care plan its in the survey sample, t, #5, #4, #12, #11 and #1. e facility staff failed to show oprehensive care plan was		 3. The MDS Coordinators and interdisciplinary team will be reeducated by the Clinical Reimbursement Specialist by 1 related to ensuring comprehens care plans are reviewed and reverequired. 4. The MDS Coordinators will comprehensive care plans on ear unit weekly for 4 weeks and me for 2 months to ensure comprehensive care plans continue to reviewed revised as required. The MDS Coordinator will submit a report the Quality Assurance Committed monthly for 3 months. The Dirrof Nursing will be responsible functional processing and follow up. 	1/27/17 sive vised as audit 5 ach onthly hensive d and rt to tee rector	
	 reviewed at each scheduled assessment. 2. The facility staff failed to revise the care plan to accurately reflect Resident #9's type of sleeping arrangements for safety. 3.a. For Resident #14, the facility staff failed to review and revise the care plan after a resident to resident altercation with Resident #14 the recipient of a bruised hand. b. The facility staff failed to review Resident #14's comprehensive care plan at each scheduled 			Completion Date:	02/03/	

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES			FOR	D: 01/17/2017 MAPPROVED D: 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495249	B. WING			C /06/2017
NAME OF PR			STI	REET ADDRESS, CITY, STATE, ZIP CODE		
FARMVILL	E REHABILITATION & H	EALTH CARE CENTER LLC		75 SCOTT DRIVE ROUTE 5 RMVILLE, 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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	the comprehensive ca quarterly for Resident 6. The facility staff fail the comprehensive ca quarterly for Resident	are plan was reviewed #5. ed to show evidence that are plan was reviewed #4. ed to show evidence that are plan was reviewed #12. ed to revise Resident 11's	F 280			
	and update the care p and interventions imp The findings include:	cility staff failed to revise olan to include multiple falls lemented after each fall.				
	the comprehensive ca assessment. Resident #6 was adm 10/13/09 with a recen with diagnoses that in to: multiple sclerosis (in which nerve fibers of lose their myelin cove vascular disease, high neurogenic bladder. The most recent MDS assessment, a quarte assessment reference	t readmission on 9/16/16, cluded but were not limited MS) (a progressive disease of the brain and spinal cord r) (1), dysphagia, peripheral n blood pressure, and				

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	MENT OF HEALTH AN					FO	ED: 01/17/201 RM APPROVED NO: 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		495249	B. WING				C 1/06/2017
NAME OF P	ROVIDER OR SUPPLIER	I	I	STR	EET ADDRESS, CITY, STATE, ZIP CODE		
FARMVIL	FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC				5 SCOTT DRIVE ROUTE 5 RMVILLE, VA 23901		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 280	interview for mental s she was cognitively ir decisions. The reside extensive to being tot staff for most of her a was coded as indepen assistance was provid The following assess 1/22/16 - quarterly as 4/13/16 - annual asse 5/11/16 - significant of 8/1/16 - quarterly ass 9/23/16 - Medicare 90 The active compreher the following: "Probler FULL CODE STATUS Goal & Target Date: M status will be honored (continue) goals." The documented under go "Problem/Need: Impai (related to) Rt (right) g and LFT (left) middle for onset: 10/04/15. Goal healing of arterial ulce show signs of healing area thru next 2 week no dates documented "Problem/Need: Impai episodes of confusion she is still working at a stating that she is sign work and pay (however score), HX (history) of 10/15/12. Goal & Targ	tatus) score, indicating that neact to make daily ent was coded as requiring ally dependent upon the ctivities of daily living. She indent after set up ded for eating. The swere completed: sessment assessment assessment assessment assessment assessment assessment. The set of the set of the sessment assessment assessment. The set of the set of the sessment assessment. The set of the set of the set of the set assessment assessment. The set of the set of the set of the set ass. The set of the set of the set of the set ass. The set of the set of the set of the set assessment of the set of the	F	280			

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		MEDICAID SERVICES			OMB NO. 093	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.	PLE CONSTRUCTION G	(X3) DATE SURVE COMPLETED	
					с	
		495249	B. WING		01/06/20	17
NAME OF P	ROVIDER OR SUPPLIER	······································	1	STREET ADDRESS, CITY, STATE, ZIP CC	DDE	******
FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC				1575 SCOTT DRIVE ROUTE 5		
	1990 (1994) - The provide states of the second states and the second states of the second states of the second states and the second states of the			FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE COMP IE APPROPRIATE D	(X5) PLETIO MATE
F 280	Continued From page	e 40	F 28	30		
	documented under g		, 200			
	"Problem/Need: Risk					
	decreased mobility, S		14. 19.			
	psychotropic medications, side rail use, resident					
		f assistance with transfers,				
	decreased vision at times (double vision). Goal &					
	Target date: 11/03/09	. Resident will not fall or				
		uires hospitalization r/t to				
		2 days. Cont. goals." There				
	were no dates docum					
		care deficit r/t decreased				
	mobility secondary to					
		get Date: Resident will				
		tivities of choice daily thru goals. Resident will be able				
		nd face each day thru next				
		. Resident will continue to				
		aily thru next 92 days. Cont.				
		dated documented under				
	goals.					
		or anaphylactic reaction r/t				
		TZ (hydrochlorothiazide -				
	used to treat high blo	od pressure (2)) and				
and the second se		treat high blood pressure				
	,	11/03/09. Goal & Target				
**************************************		t experience an allergic				
		bited by) no s/s (signs and				
		tory distress thru next 92				
	days. Cont. goals." T					
	documented under go					
A		or infection (UTI - urinary				
tract infection) r/t indwelling catheter. Proble onset: 10/28/09. Goal & Target date: Reside		•				
		s and symptoms) of UTI i.e.;				
		thru next 92 days. Cont.				
	· · ·	b dated documented under				
	goals.	s dated documented under				
	Problem/Need: Risk f	or Impaired elimination				
					1	

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DEPARTMENT OF HEALTH A				PRINTED: 01/17/201 FORM APPROVED
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
	495249	B. WING		C 01/06/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE
			1575 SCOTT DRIVE ROUTE 5	
FARMVILLE REHABILITATION &	HEALTH CARE CENTER LLC		FARMVILLE, VA 23901	
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION E APPROPRIATE DATE
 will have a soft form thru next 92 days. Of dated documented Problem/Need: Risk secondary to the dis onset: 10/28/10. Ge no complaints of pa no facial grimacing each shift through n state pain level less after intervention fo to 1 hour thru next & were no dated docu Problem/Need: Risk integrity r/t suprapu decreased mobility incontinence of bow Goal & Target date: no skin breakdown body audit thru next were no dated docu Problem/Need: Risk psychotropic medic 2/9/15. Goal & Target from injury from use Cont. Goals." There under goals. Problem/Need: Risk resident may leave weight loss. Goal & consume at least 72 next 92 days. Cont weight thru next 30 were no dated docu The care plan docu (care plan) meeting 	oal & Target date: Resident ned stool q (every) 2-3 days Cont. goals." There were no	F 280		

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DEPARTMENT OF HEALTH AND HUMAN SERV CENTERS FOR MEDICARE & MEDICAID SERV					FORM	: 01/17/20 ⁻ APPROVE . 0938-039
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
495249		B. WING		01/0	;)6/2017	
NAME OF P	ROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP CO		
FARMVILI	LE REHABILITATION & H	EALTH CARE CENTER LLC		SCOTT DRIVE ROUTE 5		
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLTAGREGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE	
F 280	three staff members a An interview was cond nurse) #3 on 1/5/17 at When asked how ofte reviewed, RN #3 state each assessment and #3 was asked to revie Resident #6. Once rev how it is documented reviewed. RN #3 state documented on it." We each resident should H instead of 'continue go an inside issue. Some to write continue goals that it was reviewed by care plan." When asked indicated, RN #3 state there until it changes of revision." When asked that the care plan was "Here on the care plan of signatures on 2/20/7 asked if that was with assessment, RN #3 just An interview was cond (administrative staff me nursing, on 1/5/17 at a ASM #2 was asked wh reviewed. ASM #2 sta quarterly and PRN (as change we update the where the quarterly rev	ignatures," the signatures of and was dated, 2/20/15. ducted with RN (registered t approximately 2:00 p.m. n the care plans are ed, "They are reviewed with 1 updated as needed." RN w the active care plan for viewed, RN #3 was asked that the care plan was ed, "By the dates nen asked if the goals for nave documented date bals,' RN #3 stated, "That is ewhere back we were told s. I agree there is no date ut we have reviewed the ed what continue goals d, "a continue goal is to be or goal is resolved or needs I where it is documented reviewed, RN #3 stated, "She pointed to the dates 15 and 4/21/16. When each scheduled st shook her head. ucted with ASM ember) #2, the director of pproximately 2:30 p.m. nen resident care plans are ted, "Care plans are review needed). If there is a new care plan." When asked	F 280	DEFICIENCY		

Event ID: 095F11

Facility ID: VA0080

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STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DA	NO. 0938-03 TE SURVEY MPLETED
		495249	B. WNG		0	C 1/06/2017
		IEALTH CARE CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 280	be dates there." The facility policy, "C "Policy: An individual plan that includes me timetables to meet th nursing, mental psych for each resident. Gu Care Planning/Interdi coordination with the representative (spons a comprehensive care identified the highest resident may be expe comprehensive care assessment that inclu MDS. 3. Identifying p causes and developin targeted to the reside processes. 4. The re care plan is developed the completion of the assessment (MDS). 5. Assessments of th care plans are revise resident and the reside The Care Planning/In responsible for the re plans." Basic Nursing, Essent (Potter and Perry, 20) reference for care plan a written guideline for promoting continuity of criteria to be used in	buld have dates 2 stated, "Yes, there should are Plans" documented, ized comprehensive care asurable objectives and e resident's medical, hological needs is developed idelines: 1. Our facility's sciplinary Team, in resident, his/her family or sor), develops and maintains e plan for each resident that level of functioning the	F 280			

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		MEDICAID SERVICES			OMB NO. 0938-03		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495249	B. WING		C 01/06/2017		
NAME OF P	ROVIDER OR SUPPLIER	.4		STREET ADDRESS, CITY, STATE, ZIP CO			
FARMVILI	FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC			1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901			
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE COMPLETIN E APPROPRIATE DATE
F 280	Continued From page	e 44	F 28	.0			
	nursing care priorities to other health care			-			
	professionals. The care plan also identifies and						
		s used to deliver nursing					
	care. A correctly formulated care plan makes it easy to continue care from one nurse to another.						
	•	has changed and the					
		d related interventions are					
		e, modify the nursing care					
	plan. An out of date compromises the qua	•					
		SM #1 and ASM #2 were bove findings on 1/5/17 at					
	No further information	n was provided prior to exit.					
	website:						
	T0010584/?report=de						
	(3) This information w website:						
		nih.gov/pubmedhealth/PMH stails					
	-	led to revise the care plan to sident #9's type of sleeping ety.					
		ses that included but were sion, hypothyroid, diabetes,					

Event ID:095F11

Facility ID: VA0080

If continuation sheet Page 45 of 171



.363 3€ 2017 ✓**DH/OLC**

	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT		INSTRUCTION	(X3) DA	TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:					MPLETED
							С
		495249	B. WING				01/06/2017
ME OF PF				STR	EET ADDRESS, CITY, STATE, ZIP CODE		
	E REHABILITATION & H	IEALTH CARE CENTER LLC		1575	SCOTT DRIVE ROUTE 5		
	E REHABIENATION OF			FAR	MVILLE, VA 23901		
X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 280	Continued From page	e 45	F	280			
	pressure and traumat						
	craniotomy and lobec	, .					
	The most recent MDS	2 (minimum data cot)					
		erly assessment, with an					
	assessment reference						
		s scoring a five on the BIMS					
	(brief interview for me						
		aired to make daily cognitive nt was coded as being					
		one or more staff members					
	for all of his activities						
	The comprehensive of	are plan dated, 1/3/17,					
	•	I am at risk for falls/injuries					
		ory) of falls, with multiple					
		ne agitated easily, I can be					
		at times, I use psychotropic					
		have decreased vision, hx					
		n injury) and poor decision or safety awareness, and hx					
	0	Interventions" documented					
	in part, "Low Bed with						
	Observation was mad	le of Resident #9 on 1/4/17					
		as no bed frame in the					
		resident was observed					
		hat was at ground level.					
	There was no sort of I						
		mattress was noted to be					
	toam mats approxima	itely 24 by 24 inches that her. The mattress was up					
		hwise. There was a fall mat					
		on the floor, lengthwise.					
1							
	The review of the nhu	cician orders dated 1/1/17					
		sician orders dated, 1/1/17, cian order for a type of bed.					

Event ID: 095F11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED	
	495249		B. WNG			C 01/06/2017	
	ROVIDER OR SUPPLIER	HEALTH CARE CENTER LLC		1:	TREET ADDRESS, CITY, STATE, ZIP CODE 575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 280	nurse) #3, the MDS of p.m. When asked if a arrangement should RN #3 stated, "We've When asked if it is a mattress on the floor When asked the purp stated, "It's used to of their goals and intervi- asked if the care plan sleeping arrangement stated, "That's what we An interview was com- practical nurse) #2, of asked what kind of sl place for (Resident # low bed with protective that is considered a b what we've called it." An interview was com- (administrative staff m nursing, on 1/5/17 at When asked about R arrangements, ASM ab bed." When asked if the Resident #9, ASM #2 that lies on foam mat- asked if the care plan stated, "I guess it's a where you are coming. The administrator, AS made aware of the ab 6:00 p.m.	coordinator, on 1/5/17 at 1:13 in unusual sleeping be placed on the care plan, e always called it a low bed." "bed," RN #3 stated, "It's a with mats underneath it." pose of the care plan, RN #3 are for the residents with entions in place." When a truly reflects the resident's its for his safety, RN #3 ve've been told to call it." ducted with LPN (licensed in 1/5/17 at 1:32 p.m. When eeping arrangements are in 9), LPN #2 stated, "He has a ve padding." When asked if bed, LPN #2 stated, "That's ducted with ASM nember) #2, the director of approximately 2:30 p.m. esident #9's sleeping #2 stated, "He has a low here was a bed frame, for stated, "There is a mattress is underneath it." When should reflect this, ASM #2 wording issue, but I see	F	280			

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
					С
		495249	B. WNG		01/06/2017
NAME OF P	ROVIDER OR SUPPLIER		The second se	STREET ADDRESS, CITY, STATE, ZIP CC	DDE
				1575 SCOTT DRIVE ROUTE 5	
	FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC			FARMVILLE, VA 23901	
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE COMPLETIO IE APPROPRIATE DATE
F 280	Continued From page	e 47	F 280		
	review and revise the resident altercation wi recipient of a bruised Resident #14 was adr	hand. nitted to the facility on s that included but were not			
	obstructive pulmonary blood pressure. The most recent MDS assessment, a quarter assessment reference the resident as being of	ly assessment, with an date of 10/18/16, coded cognitively intact to make			
	more staff members for living except eating an	esident was coded as ensive assistance of one or or all of her activities of daily id locomotion on the unit as bendent with supervision			
	documented, "Resider into altercation. (Name obtaining scratch to rig obtained bruise to left separated. RP/MD (res	ht arm and (Resident #14)			
	up letter dated, 7/13/10 July 8th 2016 (Name o (Resident #14) were o they got into a verbal a	6, documented in part, "On			

Facility ID: VA0080

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES				FORM): 01/17/20 APPROVE . 0938-039
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPL	SURVEY LETED
	495249	B. WING		C 01/06/2017	
ROVIDER OR SUPPLIER	.	s	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC					
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETIO DATE
		F 280			
stated she was upset cigarettes and (Resid one of hers. (Resider other resident) was tr front of her to go insic residents were monitor altercations occurred, both resident and no behavior were noted, continue to monitor bo with the physician as The "Nurse's Notes" of "Resident assaulted a on patio. Noted L (lef bruised. Tx (treatmen (medical doctor) called left for (name of respon	she didn't have any ent #14) wouldn't give her nt #14) stated that (Name of ying to be rude and cut in de bumping her chairBoth bred and no there (sic) Social Services met with changes in mood or Social Services will oth residents and follow up needed." dated, 7/8/16, documented, and hit by another resident t) hand injury, swollen t) started to monitor. MD d made aware, message onsible party)." There were				
7/8/16, documented, ' assistant) reported that struck resident (Resid (social services direct (Resident #14) to inqu Resident reported, "I w building from the pation struck my hand several Resident (Resident#14 SSD. SSD observed a SSD then apologized behavior. SSD escort (director of nursing) of resident (Resident #14 Progress Notes" dated	CNA (certified nursing at another resident had ent #14) on her hand. SSD or) visited resident ire about the incident. was trying to come in the o and so was she; she al times for no reason. 4) showed her hand to a bruise on resident's hand. for other resident's ed resident to DON fice. DON then spoke with 4)." A "Social Service d, 7/11/16, documented,				
	S FOR MEDICARE & C FOR DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER LE REHABILITATION & H SUMMARY ST (EACH DEFICIENC REGULATORY OR I Continued From page armUpon interview stated she was upset cigarettes and (Reside one of hers. (Resider other resident) was tr front of her to go insic residents were monito altercations occurred. both resident and no behavior were noted. continue to monitor be with the physician as The "Nurse's Notes" of "Resident assaulted a on patio. Noted L (lef bruised. Tx (treatmer (medical doctor) calle left for (name of respon no further nursing note The "Social Service P 7/8/16, documented, ' assistant) reported tha struck resident (Reside (social services directed (Resident #14) to inqu Resident reported, "I w building from the patic struck my hand severa Resident (Resident#14 SSD. SSD observed SSD then apologized behavior. SSD escort (director of nursing) of resident (Resident#14 Progress Notes" date	ROVIDER OR SUPPLIER K1) PROVIDER/SUPPLIER/CLIA IDE DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10ENTIFICATION NUMBER: 495249 495249	SFOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING_ 495249 ROVIDER OR SUPPLIER 495249 B. WING	SFOR MEDICARE & MEDICAID SERVICES PP DEFICIENCIES (X1) PROVIDENSUPPLERCLIA (X2) MULTIPLE CONSTRUCTION A BEXAMPLEX A BUILDING ROWIDER OR SUPPLEX B WING REFEACTORN STREET ADDRESS, CITY, STATE, ZIP CODE IE REHABILITATION & HEALTH CARE CENTER LLC STREET ADDRESS, CITY, STATE, ZIP CODE IE REHABILITATION & HEALTH CARE CENTER LLC STREET ADDRESS, CITY, STATE, ZIP CODE IE ADDRESS, CITY, STATE, ZIP CODE ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR USE DENTIFYING INFORMATION) TAG Continued From page 48 F 280 armUpon Interview (Name of other resident), stated she was upset she didn't have any cagaretites and (Resident #14) wouldn't give her one of hers. (Resident #14) stated that (Name of other resident) was tying to be rude and cut in from for her to go inside bumping her chaiBoth resident were monitor both residents and follow up with the physician as needed." The "Nurse's Notes" dated, 7/8/16, documented, "Resident assaulted and hit by another resident on further nursing notes until 7/18/16. The "Social Service Progress Notes" dated, 7/8/16, documented, "CMA (certified nursing assistant) reported that another resident putied for (name of responsible party)." There were no further nursing notes until 7/18/16. The "Social Service Progress Notes" dated, 7/8/16, documented, 'CMA (certified nursing assistant) reported that another resid	MENT OF HEALTH AND HUMAN SERVICES FORM SIF OR MEDICARE & MEDICALD SERVICES OMB NO IP DEPICIENCIES (N) PROVDERSUPPLERCUA A BULDING IDENTIFICATION NUMBER A BULDING (P) PROVERSUPPLER IDENTIFICATION NUMBER A BULDING (P) PROVERSUPPLER IDENTIFICATION & HEALTH CARE CENTER LLC STREET ADDRESS, CITY, STATE, ZIP CODE 1775 SCOTT DRIVE, ROUTE 5 ROUDERC OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1775 SCOTT DRIVE, ROUTE 5 IDENTIFICATION & HEALTH CARE CENTER LLC PROVICE SCOTT DRIVE, ROUTE 5 SUMMARY STATEMENT OF DEPICIENCIES ID PROVICE ROUTE STATEMENT OF DEPICIENCIES IDENTIFICATION VIST BE PRECEDED BY FULL PROVICE ROUTE STATEMENT OF DEPICIENCIES ID IDENTIFICATION OR LSE DEMINITING INFORMATION PROVICE ROUTE STATEMENT COSSINGERTANIA OF CONRECTION IDENTIFICATION OR LSE DEMINITING INFORMATION PROVICE ROUTE STATEMENT COSSINGERTANIA OF CONRECTION IDENTIFICATION OR LSE DEMINITING INFORMATION PROVICE STATEMENT COSSINGERTANIA OF CONRECTION IDENTIFICATION OR LSE DEMINITING INFORMATION PROVICE ROUTE STATEMENT COSSINGERTANIA OF CONRECTION IDENTIFICATION OR LSE DEMINITING INFORMATION PROVICE ROUTE STATEMENT COSSINGERTANIA OF CONRECTION IDENTIFICATION OR LSE TRANSPORTATE PROVICE ROUTE STATEMENT COSSINGERTANIA OF CONRECTION

Facility ID: VA0080

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				<u>VO. 0938-03</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
					С	
		495249	B. WING			1/06/2017
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		DDE	
FARMVILI	E REHABILITATION &	HEALTH CARE CENTER LLC		1575 SCOTT DRIVE ROUTE 5 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 ((EACH CORRECTIVE ACTI) CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 280	Continued From pag	e 49	F 280			
	asked her how was		. 200			
		ad any concerns. Resident				
		ng fine. I'm just watching TV.'				
	•	her time. There was no				
		No further social services				
	notes until 8/25/16.					
	The active comprehe	ensive care plan dated,				
	12/21/11, was review	-				
	documentation relate	ed to the incident of 7/8/16 or				
		eft hand sustained on 7/8/16.				
		12/21/11, documented,				
		for ineffective protection r/t				
	(related to) treatment thinner)."	t (platelet inhibitor/blood				
		nducted with RN (registered				
		coordinator, on 1/6/17 at 9:45				
	1	here is a resident to resident				
		e care plan be updated to				
		RN #2 didn't respond. When n should have the bruise				
		or healing, RN #2 stated,				
		ne care plan and yes, it's not				
		what was put into place to				
		RN #2 stated, "I'm sure we				
	separated them and	we probably updated the				
	care plan of the aggr	essor."				
	An interview was cor	nducted with other staff				
		he director of social services,				
	on 1/6/17 at 11:25 a.	m. When asked should the				
		for the recipient of a				
		altercation, OSM #3 stated,				
		hat. We usually update the ressor but not the recipient."				
	An interview was cor					
	(administrative staff r	member) #2, the director of				

Facility ID: VA0080

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 01/17/2017 M APPROVED D. 0938-0391
STATEMENT ((X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	СОМ	E SURVEY PLETED
		495249	B. WING			C /06/2017
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP COD	DE	
FARMVILI	E REHABILITATION & H	EALTH CARE CENTER LLC		1575 SCOTT DRIVE ROUTE 5		
				FARMVILLE, VA 23901		1
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 280	nursing, on 1/6/17 at the care plan should resident altercation if bruise, ASM #2 state follow up note in the car guess it should be." The administrator and of the above findings No further information b. The facility staff fai	12:21 a.m. When asked if be updated for a resident to there is an injury such as a ed, "I would expect to see a clinical record." When asked re plan, ASM #2 stated, "I d ASM #2 were made aware on 1/6/17 at 12:35 p.m. h was provided prior to exit. led to review Resident #14's plan at each scheduled e following MDS sessment. essment. sessment.	F 28	30		
	3/8/16, documented t Problem/Need: Smok hazard, injury related health improvement r Problem onset: 05/29 not cause injury to se property related to sm resident's desire for p cessation at each car	ing - Potential for safety to smoking. Potential for elated to smoking cessation. /13. Goal & Target date: Will If or others, or damage to noking. Will discuss				

Facility ID: VA0080

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IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY
	1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPL IDENTIFICATION NUMBER: A. BUILDING		COMPLETED
495249			C 01/06/2017
		STREET ADDRESS, CITY, STATE, ZIP CO	
TH CARE CENTER LLC		1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901	
ENT OF DEFICIENCIES IT BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETIO HE APPROPRIATE DATE
reased hearing. tool & Target date: ability to hear by opriately daily through nothing documented for this care plan. eturn to my home. oal & Target date: I will pportive services." ented and no dates olan. paired comfort; pain r/t of) pain, late effects of dent - stroke) disease. Goal & Target date: r relief in 30 minutes to vas introduced thru othing documented for this care plan. ntractures r/t late aresis, impaired mobility ction with muscle //21/11. Goal & Target ce of decline in current B (as exhibited by) ivities of daily living) as rough next 90 days." ented and no dates lan. paired skin integrity r/t bisodes of sitting in hover round rossed. Problem onset: te: Will not have any documentation on t 90days." There was o dates documented	F2		
	ENT OF DEFICIENCIES BT BE PRECEDED BY FULL ENTIFYING INFORMATION) reased hearing. tooal & Target date: ability to hear by opriately daily through nothing documented for this care plan. eturn to my home. oal & Target date: I will pportive services." ented and no dates olan. paired comfort; pain r/t of) pain, late effects of dent - stroke) disease. Goal & Target date: relief in 30 minutes to vas introduced thru othing documented for this care plan. ntractures r/t late tresis, impaired mobility ction with muscle //21/11. Goal & Target ce of decline in current B (as exhibited by) ivities of daily living) as rough next 90 days." ented and no dates lan. paired skin integrity r/t bisodes of sitting in hover round rossed. Problem onset: te: Will not have any documentation on t 90days." There was	ENT OF DEFICIENCIES ID PREFIC TAG PREFIC ENTIFYING INFORMATION) F 2 reased hearing. ioal & Target date: ability to hear by opriately daily through nothing documented for this care plan. eturn to my home. oal & Target date: I will pportive services." ented and no dates olan. paired comfort; pain r/t of) pain, late effects of dent - stroke) disease. Goal & Target date: relief in 30 minutes to vas introduced thru othing documented for this care plan. ntractures r/t late irresis, impaired mobility ction with muscle //21/11. Goal & Target ce of decline in current B (as exhibited by) ivities of daily living) as rough next 90 days." ented and no dates lan. paired skin integrity r/t isodes of sitting in hover round rossed. Problem onset: te: Will not have any documentation on t 90days." There was o dates documented eficit; toileting,	TH CARE CENTER LLC 1575 SCOTT DRIVE ROUTE 5 ENT OF DEFICIENCIES TAG ID PREFIX TAG PROVIDER'S PLAN OF 4 ENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF 4 example ID PREFIX TAG PROVIDER'S PLAN OF 4 entifying INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF 4 reased hearing. ID COORSE-REFERENCED TO TO DEFICIENC ID DEFICIENC reased hearing. ID F 280 ID PREFIX ID CROSS-REFERENCED TO TO DEFICIENC reased hearing. ID F 280 ID F 280 ID F 280 reased for this care plan. ID F 2014 ID F 2014 ID F 2014 rease of decline in current B (a sexhibited by) ID F 2014 ID F 2014 ID F 2014 ID F 2014

Event ID: 095F11

Facility ID: VA0080

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RECEIVED JAN 30 2017 VDH/OLC

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING C 495249 B WING 01/06/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC FARMVILLE, VA 23901 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) ID (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRFFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 280 Continued From page 52 F 280 dressing, bathing, personal hygiene, ambulation, bed mobility, transfers r/t to decline in health status; extensive hemiparesis, hx (history) of previous stroke. Resident feels she can be more independent that she is. Problem onset: 12/21/11. Goal & Target date: Resident will continue to participate in self-care by brushing hair, washing face, and brushing teeth daily thru review." There was nothing documented and no dates documented for this care plan. Problem/Need: Risk for further falls/injury r/t hx of falls, hemiparesis, decreased mobility, uses electric hover round as primary mode of locomotion, and leans to the left side especially her head with c/o (complaints of) neck pain. Problem onset: 12/21/11. Goal & Target date: Resident will have no injury from fall that requires hospitalization aeb no hospitalization for such thru next 90 days. There was nothing documented and no dates documented for this care plan. Problem/Need: Risk for ineffective protection r/t treatment (platelet inhibitor/blood thinner). Problem onset: 12/21/11. Goal & Target date: Resident will have no evidence of new bleeding such as hematuria, bleeding gums, hematomas, bruises thru next review." There was nothing documented and no dates documented for this care plan. Problem/Need: Risk for vascular congestion r/t vascular insufficiency (HTN - high blood pressure). Problem onset: 12/21/11. Goal & Target date: Resident will have no signs or symptoms of HTN; headache, bloody nose or confusion, thru next 90 days." There was nothing documented and no dates documented for this care plan. Problem/Need: Risk for metabolic imbalance r/t thyroid insufficiency. Problem onset: 12/21/11. Goal & Target date: Resident will have no

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FO	ED: 01/17/20 RM APPROVE NO: 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					TE SURVEY MPLETED	
		495249	B. WING			C 01/06/2017		
NAME OF PR	ROVIDER OR SUPPLIER	1	I	STREET ADDRES	SS, CITY, STATE, ZIP CODE			
FARMVILL	E REHABILITATION & H	IEALTH CARE CENTER LLC		FARMVILLE, V				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EA	PROVIDER'S PLAN OF COR ACH CORRECTIVE ACTION SS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 280	Continued From page	e 53	F	280				
		othyroidism or synthroid						
		pothyroidism (1)) such as						
	c/o cold, weight gain,	• •						
		90 days." There was nothing						
		lates documented for this						
	care plan.	(de net requesitete)						
	Problem/Need: DNR Problem onset: 12/21	/11. Goal & Target date:						
		available necessary medical						
		vent of cardiac or respiratory						
2		ru next 90 days." There was						
		and no dates documented						
	for this care plan.							
		or impaired adjustment r/t . Problem onset: 12/21/11.						
	•	esident will interact with						
	-	3 times a week during the						
		was nothing documented						
		nted for this care plan.						
		with spaces for signatures.						
	The one signature, the							
	•	/17/16. Attached to the care Attendance Record." This						
	•	/16. The top of the form						
		nt's discharge plan has						
		sident/responsible party.						
		ble party desires discharge						
		ted living/another skilled						
	• •	in this facility/other." There						
	-	he MDS coordinator and						
		ant. At the bottom of the d, "Care plan reviewed and						
		on:"						
	This was not filled out							
	An interview was conc							
		ember) #2, the director of						
	nursing, on 1/5/17 at a	approximately 2:30 p.m.						

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		ND HUMAN SERVICES			FOI	ED: 01/17/20 RM APPROVE IO: 0938-03	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		495249	B. WING		C 01/06/2017		
NAME OF P			STRI	EET ADDRESS, CITY, STATE, ZIP CODE			
ARMVILI	E REHABILITATION & H	HEALTH CARE CENTER LLC		SCOTT DRIVE ROUTE 5 MVILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 280	Continued From page	e 54	F 280				
	10	en care plans are reviewed,					
		y are reviewed with each					
	· ·	N (as needed) for any					
	change in the resider	nt's treatment or condition."					
	An interview was car	ducted with DN (registered					
		ducted with RN (registered coordinator, on 1/6/17 at 9:45					
		w often the care plan is					
		ed, "With each assessment					
	· · · · · · · · · · · · · · · · · · ·	en asked where it was					
	documented that the	•					
		ed, "It's on the care plan or					
		a new form, so we don't 's note, where everyone					
		an Attendance Record" was					
		. The top paragraph of the					
		liscussed and then the					
		t states the care plan had					
		pdated. When shown the					
		N #2 stated, "I didn't see read the form we are using."					
	that, I guess I better i	read the form we are using.					
	The administrator and	d ASM #2 were made aware					
		on 1/6/17 at 12:35 p.m.					
	No further information	n was provided prior to exit.					
	(1) This information v website:	vas obtained from the					
		.nih.gov/pubmedhealth/PMH					
	T0010926/?report=de						
	4. The facility staff fai	iled to show evidence that					
		are plan was reviewed					
	quarterly for Residen	t #5.					
		mitted to the facility on 1/2/09					
	and most recently on	3/26/16 with diagnoses					
	including, but not limi	ited to: anemia, atrial					

If continuation sheet Page 55 of 171

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/17/2017 M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 01/06/2017	
		495249	B. WING				
	NAME OF PROVIDER OR SUPPLIER FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC			15	IREET ADDRESS, CITY, STATE, ZIP CODE 575 SCOTT DRIVE ROUTE 5 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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	fibrillation, hypertensis benign prostatic hype hyperlipidemia, arthrit schizophrenia (2). Or (minimum data set), a ARD (assessment ref Resident # 4 was cod possible 15 on the BII status) indicating that impaired. The following list of co was provided by RN # 1/28/16 - Annual Asse 4/26/16 - Quarterly As 7/20/16 - Quarterly As 10/20/16 - Resident # care plan documented Under Problem Onset moderate constipation medications. For this documented under Go soft formed stool ever verbalize or indicate fr Hand written under Go (continue) goals" Under Problem Onset impaired comfort. For documented under Go will state decrease in p the pain scale within o	on, coronary artery disease, rtrophy, diabetes, is, bi-polar (1), and in the most recent MDS in annual assessment with erence date) of 12/14/16, ed as scoring an 8 out of a MS (brief interview of mental he was cognitively ompleted MDS assessments assessment assessment assessment assessment assessment assessment assessment bis active comprehensive d the following: : 07/07/2015 I am at in risk related to use of a problem it was bal & Target Date: I will have y two or three days and reedom from discomfort. bal & Target Date: "cont. : 09/05/2012 Risk for this problem it was bal & Target Date: Resident bain of at least one point on ine hour of interventions Hand written under Goal	F	280			

Facility ID: VA0080

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		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 01/06/2017	
		495249	B. WING			
NAME OF P			STREET ADDRESS, CITY, STATE, ZIP CODE		E	********
FARMVILI	E REHABILITATION & F	EALTH CARE CENTER LLC		75 SCOTT DRIVE ROUTE 5 RMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 280	Continued From page	9 56	F 280			
	ineffective protection anticoagulation thera documented under G be hospitalized for oc days. Hand written u "cont. goals" Under Problem Onse Deficit r/t lack of coor poor balance, recent problem it was docum Date: Resident will co thru next 92 days. H Target Date: "cont. go Under Problem Onse impaired Skin Integrit documented under G will have no skin brea	py. For this problem it was oal & Target Date: I will not cult bleeding, thru next 92 under Goal & Target Date: t: 09/05/2012 Self-Care dination, easily fatigued, and decline in health. For this nented under Goal & Target ontinue to comb my hair daily and written under Goal &				
	Risk for alteration in h UTI (urinary tract infe was documented und continue to self acces Will show no signs of evidenced by) a mois under both goals G goals" Under Problem Onse	t mouth daily. Hand written oal & Target Date: "cont. t: 09/05/2012 Risk for For this problem it was				

Facility ID: VA0080

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STATEMENT	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	OMB N (X3) DA	RM APPROVE 10. 0938-039 TE SURVEY
					COMPLETED	
		495249	B. WING		o	1/06/2017
	ROVIDER OR SUPPLIER	HEALTH CARE CENTER LLC	1	TREET ADDRESS, CITY, STATE, ZIP CODE 575 SCOTT DRIVE ROUTE 5 ARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 280	Continued From page Target Date: "cont. go		F 280			
	skills, with receptive a communication defici documented under G make appropriate/pos next review period. Al when offered through written under both G goals" Under Problem Onset injury, r/t hx of fallsF documented under G will have no more tha (AEB) documentation written under Goal & Under Problem Onset ineffective protection of therapy. For this prot under Goal & Target D hospitalized for occult days. Hand written u "cont. goals" Under Problem Onset Decreased Cardiac O dysfunctionFor this p under Goal & Target D s/s (signs and sympto headache, bloody nos	y impairment poor decision and expressive ts. For this problem it was oal & Target Date: I will sitive/safe decisions through ND I will make a choice the next 92 days. Hand Goal & Target Date: "cont. t: 09/05/2012 Risk for For this problem it was oal & Target Date: Resident n 2 falls per month aeb thru next 90 days. Hand Target Date: "cont. goals" t: 06/08/2013 Risk for r/t to anticoagulation olem it was documented Date: I will not be bleeding, thru next 92 inder Goal & Target Date: : 09/05/2012 Risk for utput r/t cardiac problem it was documented Date: Resident will have no				
	Under Problem Onset adverse effects r/t use	: 01/01/2015At risk for of psychotropic				

Event ID:095F11

Facility ID: VA0080

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RECEIVED 348 30 2**017** OH/OLC

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	Т	<u>10. 0938-039</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:				MPLETED
						С
		495249	B. WING		0	1/06/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
CA DBAL(1)	C DELLA DU ITATION &			1575 SCOTT DRIVE ROUTE 5		
FARMVIL	LE REMABILITATION & I	HEALTH CARE CENTER LLC		FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 280	Continued From pag	e 58	F 280)		
		s problem it was documented	1 200			
		Date: Resident will be free of				
	adverse effects from					
	3	t 92 days. Nothing was				
	written under Goal &	Target.				
		e) # 1, the assistant director				
		were discussed. RN # 1				
	-	tant to date when the care				
	-	I # 1 further stated, "If not				
	documented then not	t done."				
	D					
		on 1/5/17 at 2:24 p.m. with DS (minimum data set)				
		was asked about the				
		are plans. RN # 3 stated,				
		with each assessment and				
		RN # 3 reviewed a resident				
	care plan and was as	sked how it is documented				
	-	s reviewed. RN # 3 stated,				
		ented on it." When asked if				
	Ų	sident should have a date				
		tead of 'continue goals' RN # me they did put a date on				
		was reviewed but sometime				
		write 'continue goals'. RN #				
	•	vas no date to indicate when				
		viewed. When RN # 3 was				
	asked about the hand	d written 'continue goals', RN				
		nue goals) indicated that the				
	•	there is a notation that there				
	0	hat the problem is resolved.				
		e would know when the care not the care not there is no date, RN # 3				
	,	o date so staff cannot tell				
		I. RN # 3 further stated that				
		work in progress - they are				
	changing over to the					

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/17/201 FORM APPROVE OMB NO. 0938-039
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495249	B. WING		C 01/06/2017
		IEALTH CARE CENTER LLC		STREET ADDRESS, CITY, STATE, ZIF 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901	P CODE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLETION O THE APPROPRIATE DATE
F 280	nurses. During an interview of ASM (Administrative Director of Nurses, A often care plans shou stated that staff shou quarterly and as need review should be dood that the care plan shou reviewed the care plan done. When asked w plan was, ASM # 2 st know how to take care During the end of dat p.m. with ASM # 1, th 2, the concern about dates was revealed.	on 1/5/17 at 4:30 p.m. with Staff Member) # 2, the SM # 2 was asked how uld be reviewed. ASM # 2 Id review the care plans ded. When asked how this sumented, ASM # 2 stated build have signatures of who an and the date that it was what the purpose of the care tated, "The purpose is that all	F 2	80	
	causes unusual shift levels www.nimh.nih.gov/he ndex.shtml <http: www.nimh.nih<br="">order/index.shtml> (2) Schizophrenia is disorder that affects l and behaves.</http:>	also known as less, is a brain disorder that s in mood, energy, activity ealth/topics/bipolar-disorder/i gov/health/topics/bipolar-dis a chronic and severe mental now a person thinks, feels, ealth/topics/schizophrenia/ind			

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/17/2017 MAPPROVED
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY PLETED
		495249	B. WNG				C /06/2017
NAME OF P	ROVIDER OR SUPPLIER	A		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 01	00/2011
FARMVIL	LE REHABILITATION & H	EALTH CARE CENTER LLC			75 SCOTT DRIVE ROUTE 5 ARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 280	80 Continued From page 60		F	280			
	the comprehensive ca quarterly for Resident Resident # 4 was adm 8/26/15 with diagnose to: hypertension, pres polyneuropathy. On t (minimum data set), a ARD (assessment refe Resident # 4 was code possible 15 on the BIN status) indicating that	#4. hitted to the facility on es including, but not limited sure ulcer, and he most recent MDS quarterly assessment with erence date) of 12/16/16, ed as scoring a 15 out of a MS (brief interview of mental she was cognitively intact. mpleted MDS assessments a 2: essment sessment sment sessment					
	care plan documented Under Problem Onset: for alteration in comfor was documented unde have demonstrate (sic at least one point on th scale within one hour of including non-pharmac	08/28/2015 I am at risk t/pain. For this problem it er Goal & Target Date: Will) a decrease in pain level of ne cognitively impaired of interventions used ceutical and/or medication led. There were no dates					

Event ID: 095F11

Facility ID: VA0080

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DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					ED: 01/17/201	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					RM APPROVE[10. 0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DA1	TE SURVEY MPLETED	
		495249	B. WING			С		
NAME OF P	ROVIDER OR SUPPLIER	1		5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	1/06/2017	-
FARMVILI	E REHABILITATION & H	EALTH CARE CENTER LLC			1575 SCOTT DRIVE ROUTE 5			
				F	FARMVILLE, VA 23901			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 280	Continued From page	61	F:	280				
	Under Problem Onset impaired skin integrity (bowel & bladder) for documented under Go maintain intact skin or issues through next 92 dates documented under Under Problem Onset Resistant to Care Give documented under Go will receive ADL (activi without resistant behar were no dates docume Under Problem Onset: falls/injury r/t hx of falls transfers via Hoyer Lift documented under Go no falls with significant by) no hospitalizations dates documented under Go no falls with significant by) no hospitalizations dates documented under Constipation with use o problem it was docume Date: I will be free from regular BM (bowel mov aeb documentation (sic	 c: 09/10/2015 Risk for r/t incontinent of B & B this problem it was bal & Target Date: Will not develop any new skin 2 days. There were no der goals. c: 09/10/2015 Behavior - erFor this problem it was bal & Target Date: Resident ities of daily living) care viors by 30 days. There ented under goals. c: 09/10/2015 Risk for s, requires assistance with t. For this problem it was al & Target Date: Will have injury AEB (as evidenced for same. There were no der goals. 09/10/2015, I am at risk pattern related to f narcotics. For this ented under Goal & Target in constipation and have vement) q (every) 3 days. b) through next 90 days. 	F	280				
- - -	chosen DO NOT RESL this problem it was doc Target Date: My advan NOT RESUSCITATE) w	08/27/2015 I have JSCITATE STATUS. For umented under Goal & nced directive for DNR (DO vill be honored x 92 days. I on 2/16/16 at the care						

Facility ID: VA0080

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					PRINTED: 01/17/20 FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495249	B. WING		C 01/06/2017
	ROVIDER OR SUPPLIER	HEALTH CARE CENTER LLC		STREET ADDRESS, CITY, STATE, ZI 1575 SCOTT DRIVE ROUTE 5 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 (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
F 280	documented under g Under Problem Onse staff assistance to me transfers via Hoyer li bathing, dressing, an limitations related to this problem it was d Target Date: I will be dressed appropriately of day through next 9 dates documented un Under Problem Onse imbalanced nutrition therapeutic diet, incre d/t (due to) pressure was documented un Resident will consum thru next 30 days. Th 12/1/15 at the care p no other dates docum During an interview of RN (Registered Nurs of nurses, care plans stated that it is impor plan is reviewed. RN documented then not During an interview of RN # 2, an MDS cool discussed. RN # 2 st reviewed with each a	re were no other dates oals. et: 09/10/2015 require aintain personal hygiene, ft with nursing, toileting, id grooming due to functional amputation and pain. For ocumented under Goal & e clean, dry, odor free and y for season, place and time 00 days. There were no inder goals. et: 09/10/2015 Risk for related to refusals, ease need for caloric intake ulcerFor this problem it der Goal & Target Date: ne 75% of two meals daily his goal was reviewed on lan meeting but there were nented under goals. en 1/5/17 at 11:40 a.m. with e) # 1, the assistant director were discussed. RN # 1 tant to date when the care 1 # 1 further stated, "If not : done." en 1/5/17 at 2:46 p.m. with rofinator, this care plan was tated that each care plan is ssessment. RN # 2 further	F 2	80	
	stated that there are a document each revie			Facility ID: VA0080	If continuation sheet Page, 63 of

Facility ID: VA0080

If continuation sheet Page 63 of 171

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLI			ID HUMAN SERVICES			FOR	RM APPROVEI
AND PLAN OF CORRECTION DEMPIRATION NUMBER A BULDING COMPLETED ASS249 B. KING COMPLETED C NAME OF PHONIDER OF SUPPLIER STREET ADDRESS, GITY, STATE, J2P CODE STREET ADDRESS OF TWO FROM CODE FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC STREET ADDRESS OF TWO FROM CODESCIDENCE DO PRETVA SUMMENT'S INTENTION TO BE OF DESCRIPTION OF DE			1			T	
495249 3. WNG O106/2011 NME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE PARMVILLE REHABILITATION & HEALTH CARE CENTER LLC STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE (X4) ID SUMMARY STREMENT OF DEPICIPATION STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE Continued From Selection BY FILL (X4) ID STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE Code (X4) ID STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE Code (X4) ID STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE Code (X4) ID STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE Code (X4) ID STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE Code (X4) ID STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE Code (X4) ID STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE Code (X4) ID STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE Code (X4) ID STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE Code							MPLETED
FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901 (W10) PRETX TAG SUMMARY STATEMENT OF DEPICIENCES (RCH DEPICIENCY WISTER PROCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D F 280 Continued From page 63 them. P230 Review of the "Care Plan Attendance Record" documented at the bottom revealed the following: Care plan reviewed and updated by: On: F 280 Toring an interview on 1/5/17 at 4:30 p.m. with ASM (Administrative Staff Tailed to show widence that the the care plans should be reviewed. ASM # 2 stated that the care plan should have signatures of who reviewed that care plan asked how often care plan should have signature and date were blank. During an interview on 1/5/17 at 4:30 p.m. with ASM (Administrative Staff Thember) # 2, the Director of Nurses, ASM # 2 was asked how often care plan should have signatures of who reviewed that care plan asked how this review who to take care of residents." During the end of day interview on 1/5/17 at 6:00 pm. with ASM # 1, the Administrative Staff The purpose is that all know how to take care of residents." During the end of day interview on 1/5/17 at 6:00 pm. with ASM # 1, the Administrative staff failed to show evidence that the comprehensive care plan review dates was revealed. Prior to exit no further information was provided.			495249	B. WING		0	
FARMVILLE REHABILITATION & HEALTH CARE CENTRE LLC FARMVILLE, VA 23901 (X4) 0 FRETTX TAG SUMMARY STATEMENT OF DEFICIENCIES RESULTORY OR LSC IDENTIFYING INFORMATION D PARMVILLE, VA 23901 F 280 Continued From page 63 them. D Review of the "Care Plan Attendance Record" documented at the bottom revealed the following: Care plan reviewed and updated by: On: F 280 For all forms presented the signature and date were blank. Fr 280 F 280 During an interview on 1/5/17 at 4:30 p.m. with ASM during an interview of 1/5/17 at 4:30 p.m. with ASM during an interview of the care plan solute the asignature of the care plan was, ASM # 2 vas asked how this review should be documented, ASM # 2 stated that the care plan should have signatures of who review should be documented, ASM # 2 stated that the care plan should have signatures of who review should be documented, ASM # 2 stated that the care plan and the date that if was done. When asked what the purpose of the care plan was, ASM # 2 stated. The purpose is that all know how to take care of residents." During the end of day interview on 1/5/17 at 6:00 p.m. with ASM # 1, the Administrator, and ASM # 2, the concern about the missing care plan review dates was revealed. Prior to exit ne further information was provided. 6. The facility staff failed to show evidence that the comprehensive care plan was (where the failed to show evidence that the comprehensive care plan was (weidence that the comprehensive care plan was reviewed	NAME OF PI		1		STREET ADDRESS, CITY, STATE, ZIP CODE		
Phericity TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PRETX TAG CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY COMPLET INFO DEFICIENCY F 280 Continued From page 63 them. F 280 F 280 Care plan reviewed and updated by: Or:	FARMVILI	E REHABILITATION & F	IEALTH CARE CENTER LLC	1			
them. Review of the "Care Plan Attendance Record" documented at the bottom revealed the following: Care plan reviewed and updated by: On:	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION DATE
documented at the bottom revealed the following: Care plan reviewed and updated by: On: On: For all forms presented the signature and date were blank. During an interview on 1/5/17 at 4:30 p.m. with ASM (Administrative Staff Member) # 2, the Director of Nurses, ASM # 2 was asked how often care plans should be reviewed. ASM # 2 stated that staff should review the care plans quarterly and as needed. When asked how this review should be documented, ASM # 2 stated that staff should review the care plans quarterly and the date that it was done. When asked what the purpose of the care plan was, ASM # 2 stated that staff = "The purpose is that all know how to take care of residents." During the end of day interview on 1/5/17 at 6:00 p.m. with ASM # 1, the Administrator, and ASM # 2, the concern about the missing care plan review dates was revealed. Prior to exit no further information was provided. 6. The facility staff failed to show evidence that the comprehensive care plan was reviewed	F 280	1.5	9 63	F 280			
On: For all forms presented the signature and date were blank. During an interview on 1/5/17 at 4:30 p.m. with ASM (Administrative Staff Member) # 2, the Director of Nurses, ASM # 2 was asked how often care plans should be reviewed. ASM # 2 stated that staff should review the care plans quarterly and as needed. When asked how this review should be documented, ASM # 2 stated that the care plan and the date that it was done. When asked what the purpose of the care plan was, ASM # 2 stated, "The purpose is that all know how to take care of residents." During the end of day interview on 1/5/17 at 6:00 p.m. with ASM # 1, the Administrator, and ASM # 2, the concern about the missing care plan review dates was revealed. Prior to exit no further information was provided. 6. The facility staff failed to show evidence that the comprehensive care plan was reviewed		documented at the bo	ottom revealed the following:				
For all forms presented the signature and date were blank. During an interview on 1/5/17 at 4:30 p.m. with ASM (Administrative Staff Member) # 2, the Director of Nurses, ASM # 2 was asked how often care plans should be reviewed. ASM # 2 stated that staff should review the care plans quarterly and as needed. When asked how this review should be documented, ASM # 2 stated that the care plan and the date that it was done. When asked what the purpose of the care plan was, ASM # 2 stated, "The purpose is that all know how to take care of residents." During the end of day interview on 1/5/17 at 6:00 p.m. with ASM # 1, the Administrator, and ASM # 2, the concern about the missing care plan review dates was revealed. Prior to exit no further information was provided.			nd updated by: 				
 were blank. During an interview on 1/5/17 at 4:30 p.m. with ASM (Administrative Staff Member) # 2, the Director of Nurses, ASM # 2 was asked how often care plans should be reviewed. ASM # 2 stated that staff should review the care plans quarterly and as needed. When asked how this review should be documented, ASM # 2 stated that the care plan should have signatures of who reviewed the care plan and the date that it was done. When asked what the purpose of the care plan was, ASM # 2 stated, "The purpose is that all know how to take care of residents." During the end of day interview on 1/5/17 at 6:00 p.m. with ASM # 1, the Administrator, and ASM # 2, the concern about the missing care plan review dates was revealed. Prior to exit no further information was provided. 6. The facility staff failed to show evidence that the comprehensive care plan was reviewed 		On:					
ASM (Administrative Staff Member) # 2, the Director of Nurses, ASM # 2 was asked how often care plans should be reviewed. ASM # 2 stated that staff should review the care plans quarterly and as needed. When asked how this review should be documented, ASM # 2 stated that the care plan should have signatures of who reviewed the care plan and the date that it was done. When asked what the purpose of the care plan was, ASM # 2 stated, "The purpose is that all know how to take care of residents." During the end of day interview on 1/5/17 at 6:00 p.m. with ASM # 1, the Administrator, and ASM # 2, the concern about the missing care plan review dates was revealed. Prior to exit no further information was provided. 6. The facility staff failed to show evidence that the comprehensive care plan was reviewed			ed the signature and date				
 p.m. with ASM # 1, the Administrator, and ASM # 2, the concern about the missing care plan review dates was revealed. Prior to exit no further information was provided. 6. The facility staff failed to show evidence that the comprehensive care plan was reviewed 		ASM (Administrative Director of Nurses, A often care plans shou stated that staff shoul quarterly and as need review should be doo that the care plan sho reviewed the care plan done. When asked w plan was, ASM # 2 st	Staff Member) # 2, the SM # 2 was asked how Id be reviewed. ASM # 2 Id review the care plans ded. When asked how this umented, ASM # 2 stated build have signatures of who in and the date that it was what the purpose of the care ated, "The purpose is that all				
6. The facility staff failed to show evidence that the comprehensive care plan was reviewed		p.m. with ASM # 1, th 2, the concern about	e Administrator, and ASM #				
the comprehensive care plan was reviewed		Prior to exit no furthe	r information was provided.				
		the comprehensive ca	are plan was reviewed				
Resident # 12 was admitted to the facility on		Resident # 12 was ac	lmitted to the facility on				

Event ID: 095F11

Facility ID: VA0080

If continuation sheet Page 64 o

PRINTED: 01/17/2017

aa 30 207 VOH/OLC

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TATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DA	NO. 0938-03 TE SURVEY MPLETED	
GD F LAIN UI	- CONNECTION	495249	A. BUILDING B. WING	3		С	
		495249				1/06/2017	
	NO NDER OR SUFFLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
FARMVIL	LE REHABILITATION & I	HEALTH CARE CENTER LLC		1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901			
(X4) ID	4) ID SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		005	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
F 280	Continued From pag	e 64	F 28	0			
	4/30/13 with diagnos	es including, but not limited					
	to: hypertension, dial	betes, hyperlipidemia,					
		and fibromyalgia (1). On the					
		inimum data set), a quarterly D (assessment reference					
		sident # 12 was coded as					
	1	possible 15 on the BIMS					
		ntal status) indicating that					
	she was cognitively i	ntact.					
	The following list of e	ompleted MDS assessments					
	was provided by RN						
	1/7/16 - Quarterly As	sessment					
	2/13/16 - Annual Ass						
	5/5/16 - Quarterly As						
	7/11/16 - Quarterly As						
	10/3/16 - Quarterly A	ssessment					
	Review of Resident #	12's active comprehensive					
	care plan documente						
		t: 08/21/2015 I am at risk					
	diabetes mellitus. Fo	nia related to diagnosis of r this problem it was					
		oal & Target Date: I will not					
	exhibit any s/s (signs						
		hru next 90 days. There					
	were no dates docum	ented under goals.					
	Under Problem Onse	t: 05/05/2014 Social					
		absence of contact with					
1	•	d prefers to stay in room.					
	-	s documented under Goal &					
	-	nt will be out of the room to ity per week thru next 30					
		will establish friendship with					
	-	ividual by day 92. There					
	were no dates docum						

Facility ID: VA0080

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TATEMENT ((X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				
		495249	B. WING	、 	C 01/06/2017			
	ROVIDER OR SUPPLIER	HEALTH CARE CENTER LLC	157	STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLE			
F 280	Continued From page	e 65	F 280					
	problem it was docum Date: I will allow staf resist assistance x (ti no dates documented Under Problem Onse impaired skin integrity documented under G maintain intact skin o issues through next 9 dates documented und Under Problem Onse down depressed or h was documented und express desire to incr activity by coming OC There were no dates Under Problem Onse FULL CODE STATUS documented under G decision for FULL CO	e: refuses careFor this nented under Goal & Target f to assist with my care and mes) 3 a week There were d under goals. t: 05/05/2014 Risk for yFor this problem it was oal & Target Date: Will r not develop any new skin 22 days. There were no						
	Comfort, r/t (related to of fibromyalgia. For the documented under Ge demonstrate (sic) a de least one point on the within one hour of inter non-pharmaceutical a	oal & Target Date: Will have ecrease in pain level of at cognitively impaired scale erventions used including						

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	F DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	(X3) DAT	O. 0938-03 E SURVEY IPLETED	
		495249	B. WING	С		
		495249				1/06/2017
CONCE OF TH	CONDER ON SOFTELER			EET ADDRESS, CITY, STATE, ZIP CODE		
FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC				SCOTT DRIVE ROUTE 5		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETIC
F 280	Continued From page	9 66	F 280			
	Linder Problem Onset	t: 04/30/2013, I am at risk				
	for falls/injuryFor thi	,				**
		oal & Target Date: I will be				
		njury resulting from falls aeb				
		such thru next 90 days. documented under goals.				
		doodinented under godio.				
		: 04/30/2013 I require staff				
		nce to maintain personal				
0		onal limitationsFor this ented under Goal & Target				
		wash my hands and face				
		t 92 days. There were no				
and the second second	dates documented un	der goals.				
	Under Problem Onset	: 04/30/2013 I am at				
1	moderate nutritional ri	2				
4	-	iy dietFor this problem it er Goal & Target Date: I will				
		measured at least every				
1	other month thru next	-				
1	-	eight +/- (plus or minus) <				
		y or through next 92 days. d on 5/17/16 at the care				
1	plan meeting but there					
	documented under go					
	During an interview on	1/5/17 at 11:40 a.m. with				
VIII VIII VIII VIII VIII VIII VIII VII	RN (Registered Nurse) # 1, the assistant director				
		vere discussed. RN # 1				
		ant to date when the care # 1 further stated, "If not				
1	documented then not a					
	During an interview on	1/5/17 at 2:46 p.m. with				
	RN # 2, an MDS coord	linator, this care plan was				
	discussed. RN # 2 sta	ted that each care plan is				1

²ORM CMS-2567(02-99) Previous Versions Obsolete

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		ND HUMAN SERVICES				FO	ED: 01/17/2017 RM APPROVED
STATEMENT		MEDICAID SERVICES	(X2) MUL	TIPLE CO	DNSTRUCTION	(X3) DA	<u>10. 0938-0391</u> te survey
AND FEAN OF	CONCECTION	IDENTIFICATION NUMBER:	A. BUILD	NG		CON	MPLETED
		495249	B. WING				C 1/06/2017
NAME OF P	ROVIDER OR SUPPLIER	**************************************		STRE	EET ADDRESS, CITY, STATE, ZIP CODE		1100/2011
FARMVILI	E REHABILITATION & H	IEALTH CARE CENTER LLC			SCOTT DRIVE ROUTE 5		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	DI		PROVIDER'S PLAN OF CORRECTIO	N1	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI	×	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	Continued From page	e 67	E	280			
	stated that there are s			_00			
		w. RN # 2 stated that she					
	would look for the sign them.	nature sheets and present					
· / /////		Plan Attendance Record"					
	documented at the bo	ttom revealed the following:					
	Care plan reviewed an	nd updated by:					
	On:						
	For all forms presente were blank.	d the signature and date					
	ASM (Administrative S Director of Nurses, AS often care plans shoul stated that staff should quarterly and as needer review should be docu that the care plan shour reviewed the care plan done. When asked wh	SM # 2 was asked how d be reviewed. ASM # 2 d review the care plans ed. When asked how this umented, ASM # 2 stated uld have signatures of who h and the date that it was hat the purpose of the care ited, "The purpose is that all					
	p.m. with ASM # 1, the	interview on 1/5/17 at 6:00 Administrator, and ASM # ne missing care plan review					
	Prior to exit no further i	information was provided.					
	NOTES:						
	(1) Fibromyalgia: Fibro	omyalgia is a disorder that					

Event ID: 095F11

Facility ID: VA0080

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*ECEIVED JAN 38 2817 /OH/OLC

ATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DA	10. 0938-039 TE SURVEY MPLETED
		495249	A. BUILDING		С	
				EET ADDRESS, CITY, STATE, ZIP CODE		1/06/2017
		HEALTH CARE CENTER LLC	1575	SCOTT DRIVE ROUTE 5 MVILLE, 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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 280	Continued From pag	e 68	F 280			
	fibromyalgia have "te https://search.nih.go	and fatigue. People with ender points" on the body. v/search?utf8= .te=nih&query=fibromy				
		ailed to revise Resident 11's of an AV fistula (1) port for				
	3/22/16 with diagnos limited to: hypertensi reflux disease (2), dia	dmitted to the facility on es that included but were not on (1), gastroesophageal abetes mellitus (3), stage renal disease (5) and				
	set) a significant char ARD (assessment re coded the resident as interview for mental s - 15, 13 being cogniti					
	management Applica documented, "Access "Surgical Information"	is Center) Dialysis Access tion" for Resident # 11 s type: AV Fistula." Under ' it documented, "Date Location: Left. Site: Above				
	dialysis shunt to left a bruit/thrill every shift.	order sheet) dated # 11 documented, "Monitor rm every shift. Assess for Notify MD (medical doctor) eeding should occur apply				

Facility ID: VA0080

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		ND HUMAN SERVICES MEDICAID SERVICES				FO	ED: 01/17/2013 RM APPROVED NO: 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION	(X3) DATE SUP COMPLET	
		495249	B. WING				C 11/06/2017
		EALTH CARE CENTER LLC		1575	EET ADDRESS, CITY, STATE, ZIP CODE 5 SCOTT DRIVE ROUTE 5 RMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 280	direct pressure & (and 11/18/16." The comprehensive of dated 3/22/2016 docu require renal dialysis renal disease)." Unde it documented, "Resid MON-WED-FRI (Mon (Name of Dialysis) wit Coordinate my transp center as scheduled; Monitor my RT (right) perma-cath (8)." Furt failed to document the Resident # 11's left up On 1/5/17 at 9:30 a.m conducted with ASM (member) # 2, director the comprehensive cat dated 3/22/2016, ASM and monitoring of Res should be part of the i comprehensive care p should be part of the i plan." According to Fundame Williams and Wilkins 2 documented, "A writte communication tool ar members that helps e careThe nursing car information about the and goals. It contains achieving the goals es and is used to direct c	d) notify MD. Start Date; care plan for Resident # 11 umented, "Problem/Need: I related to ESRD (end stage er the heading "Approaches" dent to attend dialysis on day-Wednesday-Friday) at th (Name of Physician); ortation to the dialysis Monitor my fluid intake and upper CX (chest) wall her review of the care plan e use of the AV Fistula in oper arm. A. an interview was (administrative staff of nursing. After reviewing are plan for Resident # 11 A # 2 was asked if the use sident # 11's AV fistula nterventions on the olan. ASM # 2 stated, "It nterventions on the care entals of Nursing Lippincott 2007 pages 65-77 on care plan serves as a mong health care team	F	280			

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM	: 01/17/2017 APPROVED : 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495249	B. WING		C 01/0	6/2017
	ROVIDER OR SUPPLIER	IEALTH CARE CENTER LLC	15	REET ADDRESS, CITY, STATE, ZIP CODE 75 SCOTT DRIVE ROUTE 5 ARMVILLE, VA 23901		012011
(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
F 280	there are changes in with new orders" (1 (1) Fundamentals of & Wilkins 2007 Lippir pages 65-77. On 1/5/17 at approxir (administrative staff m administrator, and AS were made aware of No further information References: (1) An AV fistula is a of vascular surgeon, of carry blood from the b carry blood from the	condition, treatments, and) f Nursing Lippincott Williams noott Company Philadelphia mately 6:00 p.m. ASM nember) # 1 the SM # 2, director of nursing, the findings. n was provided prior to exit. connection, made by a an artery to a vein. Arteries neart to the body, while veins body back to the heart. /living/kidney-failure/dialysis. ment to filter wastes and d, allowing people with better and continue doing the /living/kidney-failure/dialysis. re. This information was te: by/lowbloodpressure.html. is to leak back, or reflux, into ritate it. This information	F 280			

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	MENT OF HEALTH AN					FOR	D: 01/17/2017 MAPPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495249	B. WING			01	C I /06/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
FARMVILI	LE REHABILITATION & H	EALTH CARE CENTER LLC		15	575 SCOTT DRIVE ROUTE 5		
			FA	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
	 (5) A chronic disease regulate the amount of information was obtain https://www.nlm.nih.gr 001214.htm. (6) The term "seizure" interchangeably with " the physical findings of occur after an episode activity in the brain. T obtained from the web https://medlineplus.go (7) The last stage of cl is when your kidneys of body's needs. This inffrom the website: https://medlineplus.go (8) A permacath is a lo inserted into a vein modiant of the interced into a vein mo	in which the body cannot if sugar in the blood. This ned from the website: by/medlineplus/ency/article/ is often used convulsion." A seizure is of abnormal electrical his information was esite: v/ency/article/003200.htm. hronic kidney disease. This can no longer support your formation was obtained v/ency/article/000500.htm. is to commonly in the neck and less commonly in the nis type of ventral venous	F	280			
	centimeters usually on the neck vein. Permac	the chest before it enters ath, better known as the					
	in a variety of cases. H Regular hemodialysis t						
	permacath avoids mult serves as a permanent Route for plasmaphere sampling; Administratio	iple catheter insertions and catheter for dialysis; sis; frequent blood on of drugs and fluids					
		nemotherapy) that may a route for TPN and blood es. This information was					

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Facility ID: VA0080

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ANT 3 P 2017

DEPART	MENT OF HEALTH AN	ND HUMAN SERVICES				FORM APPROVED
		MEDICAID SERVICES			(OMB NO. 0938-0391
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED
		495249	B. WING		_	C 01/06/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE	M
FARMVILI	E REHABILITATION & H	IEALTH CARE CENTER LLC		1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA IEFICIENCY)	the second se
F 280	Continued From page http://lavascular.com/		F 2	30		
	and update the care p	acility staff failed to revise blan to include multiple falls lemented after each fall.				
	limited to protein-calo hypothyroidism, blind and Dementia with Le most recent MDS (min quarterly assessment reference date) of 11/ coded as being sever the ability to make da of 15 on the BIMS (Br status) exam. Reside requiring extensive as	es that included but were not rie malnutrition, dysphagia, ness, muscle weakness, ewy Body [1]. Resident #1's nimum data set) was a with an ARD (assessment 10/16. Resident #1 was ely cognitively impaired in ily decisions, scoring 03 out rief Interview for mental				
	revealed the first fall of The following was door p.mResident was for bedside, no injuries or timeDescribe anythi contributed to the incid unfamiliar with facility.	r wounds at this ng unusual that may have dent? New resident				
	that it was not initiated no evidence of a fall c interim care plan. The	1's fall care plan revealed I until 5/17/16. There was are plan on Resident #1's ere was no evidence that fall are plan after it was initiated				

Event ID: 095F11

Facility ID: VA0080

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0938-03 URVEY ETED 6/2017 (X5) COMPLETIC DATE
(X5) COMPLETIC
(X5) COMPLETIC
COMPLETIC
COMPLETIC

If continuation sheet Page 74 of 171

		MEDICAID SERVICES	T			1	<u>10. 0938-03</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTI			TE SURVEY MPLETED
		495249	B. WING				C
NAME OF P				STREET A	DDRESS, CITY, STATE, ZIP CODE		1/06/2017
					TT DRIVE ROUTE 5		
FARMVIL	LE REHABILITATION &	HEALTH CARE CENTER LLC	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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 280	Continued From pag	ie 74	F 2	80			
1 200			ГА	00			
	each of these falls. T	re plan was updated after					
		Increase rest breaks if					
	resident allows 8/10/						
	Bladder) trial program						
		cumented on 8/21/16. The					
		ented: "Resident noted on					
		station in front of w/c					
		tationType of injury:					
		al comments:Sent to ER					
		or evaluation." The care plan or the 8/21/16 fall. The					
		nent provided was not					
	updated on the care			NY POOR Language of the			
	The last fall was doc	umented on 10/29/16. The					
		ented: "Resident was found					
	~	nat on knees, Res (resident)					
		ero) injury notedAdditional					
	-	aken to prevent recurrence:					
	"high traffic area." Th	is intervention did not make					
	it to the care plan dat	ted 5/17/16.					
	On 1/5/17 at approxim	mately 4:00 p.m., an					
		cted with LPN (licensed					****
	•	When asked when the care					
	•	PN #3 stated that first an					
		Ild be created on admission					
		s such as code status and					
		that a fall care plan would the interim care plan; it					
		he comprehensive care plan.					
		completed within 14 days of					
		ated that all care plans					
		ed to fit each resident's					
		d that care plans must be					
		nange in care or condition	le contra c				
		ics etc. LPN #3 stated that					*

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If continuation sheet Page 75 of 171

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DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				RM APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				<u>O. 0938-0391</u>	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY IPLETED	
		495249	B. WING		01	C I/06/2017	
NAME OF P	ROVIDER OR SUPPLIER	.		STREET ADDRESS, CITY, STATE, ZIP C			
FARMVIL	LE REHABILITATION & H	IEALTH CARE CENTER LLC		1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 280	the nurse caring for the fall, the unit manager be responsible for upp fall. LPN #3 agreed the where the care plan we after each of the above interventions were put was not updated. On 1/5/17 at 4:36 p.m conducted with ASM (member) #2, the DON When asked when the revised, ASM #2 state reviewed and revised needed) for any new of purpose of the care pl purpose of the care pl to take care of each re the care plan should if and interventions nee ASM #2 stated that the updated or at least revion On 1/5/17 at 5:59 p.m and ASM #2 the DON above findings. Facility policy titled, "C part, the following: " residents are ongoing as information about to resident's condition of No further information	he resident at the time of a or the charge nurse would dating the care plan after a hat she could not locate vas updated or reviewed ve falls. LPN #3 stated that t in place but the care plan h., an interview was (administrative staff N (Director of Nursing). e care plan was reviewed or ed that care plan was quarterly and prn (as changes. When asked the lan, ASM #2 stated that the lan was to make sure how esident. ASM #2 stated that dentify each problem, goal, ded to meet each goal. e care plan should be viewed after each fall. h., ASM #1, the administrator were made aware of the Care Plans," documents in 5. Assessments of and care plans are revised he resident and the hange." was presented prior to exit.	F 28	80			

Event ID:095F11

Facility ID: VA0080

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	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495249	B. WING			C 01/06/2017	
	ROVIDER OR SUPPLIER	IEALTH CARE CENTER LLC	157	REET ADDRESS, CITY, STATE, ZIP CODE 5 SCOTT DRIVE ROUTE 5 RMVILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 280 F 282 SS=E	called Lewy bodies, a whose changes, in tu with thinking, movem LBD is one of the mo dementia, after Alzhe disease." This inform The National Institute https://www.nia.nih.gu wy-body-dementia/ba 483.21(b)(3)(ii) SERV PERSONS/PER CAR (b)(3) Comprehensive The services provided as outlined by the com must- (ii) Be provided by qu accordance with each care. This REQUIREMENT by: Based on staff interv and facility document that facility staff failed accordance with the v of 26 residents in the 10, # 17, # 6 and #7 a qualified personnel fo survey sample, Resid 1. The facility staff fai	e brain. These deposits, affect chemicals in the brain rn, can lead to problems ent, behavior, and mood. st common causes of imer's disease and vascular nation was obtained from s of Health. ov/alzheimers/publication/le asics-lewy-body-dementia. /ICES BY QUALIFIED RE PLAN e Care Plans d or arranged by the facility, mprehensive care plan, alified persons in a resident's written plan of is not met as evidenced iew, clinical record review review it was determined to provide services in written plan of care for four survey sample, Residents # and failed to provide care by r one of 26 residents in the lent # 7.	F 280	F282 1. Resident #10's behavior monitoring record will be revie and updated by the Assistant D of Nursing or the Director of N by 2/1/17 to ensure behaviors h been documented according to resident's plan of care. Resident #17 behavior monitorr record will be reviewed and up by the Assistant Director of Nu or the Director of Nursing by 2/2 to ensure behaviors have been documented according to the resident's plan of care. The licensed nurses will be reeducated on resident #6 comprehensive care plan for pa	irector ursing ave the ing dated rsing (1/17		
	the resident's plan of 2. The facility staff fa document Resident #			2/1/17 by the Director of Nursin ensure the pain care plan is foll- as required.	ng to		

Facility ID: VA0080

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
				IG	С
		495249	B. WING		01/06/2017
	ROVIDER OR SUPPLIER	IEALTH CARE CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CO 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901	DE
(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 C	IN SHOULD BE COMPLETIO DE APPROPRIATE DATE
F 282	Continued From page the resident's plan of		F 2	82	
c # c t t c	3. The facility staff failed to follow the comprehensive care plan for pain for Resident #6.				
	4. a. The facility staff failed to follow Resident #7's care plan to medicate the resident for pain one half hour prior to treatments or care.				
		led to have a licensed nurse he oxygen for Resident #7.			
	The findings include:				
	 The facility staff fa document Resident # the resident's plan of 	10's behaviors according to		Resident #7 was disch 1/19/17.	harged on
	12/6/07 with a readmi diagnoses that include dysphagia (1), anxiety disorder (3), aphasia				
	data set), an annual a (assessment reference the resident as scorin interview for mental s - 15, one being sever Resident # 10 was co	tatus (BIMS) of a score of 0 ely impaired of cognition.			

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		ND HUMAN SERVICES			FOF	ED: 01/17/20 RM APPROVE O. 0938-03	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED C	
		495249	B. WING		0	1/06/2017	
NAME OF PI				STREET ADDRESS, CITY, STATE, ZIP CODE		1100/2011	
				1575 SCOTT DRIVE ROUTE 5			
FARMVILL	E REHABILITATION & F	HEALTH CARE CENTER LLC	1	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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
E 202	0	- 70	E 000				
F 282	Continued From page		F 282				
		d. Under "Problem/Need" it					
		for adverse effects r/t					
		ychotropic medications."		2. The Assistant Director of Nu	ircina		
		it documented, "Monitor and					
	-	ors and inform MD (medical		and the Director of Nursing wi			
		frequency for possible		the behavior monitoring record			
	medication adjustme	ms.		current residents by 2/1/17 to e			
	The "Dhysician's Ord	er Sheet" (POS) dated		behaviors have been document	ed		
		# 10 and signed by the		according to the resident's plan	ı of		
		6 documented, "Seroquel		care.			
		m). Give one (1) tablet via		The Assistant Director and the	Unit		
	PEG (percutaneous e				Um		
) at bedtime related to		Manager will audit the current			
	schizophrenia. Start			residents' pain management pr			
				by 2/1/17 to ensure the nursing	staff		
	The MARs (medication	on administration records)		are following the resident's pai	n plan		
		ed November 1, 2016		of care as required.			
	through January 4, 2	017 documented, "Seroquel		The Assistant Director of Nurs	ing and		
	100 MG. Give 1 table	et via PEG-tube at bedtime					
	related to schizophre	nia." Further review of the		the Unit Manager will review t			
	MARs revealed Resid	dent # 10 received one		current residents that are current	•		
	Seroquel tablet each	evening for 65 of 65		receiving oxygen by 2/1/17 to	ensure		
	opportunities.		THE REAL PROPERTY AND A RE	licensed nurses are connecting	and		
		ly Flow Sheets" for Resident		turning on oxygen as required.			
		r 1, 2016 through January 4,	}				
		ent behavior monitoring for		3. The Staff Development			
	the use of Seroquel f	or 195 of 195 opportunities.	1	Coordinator will reeducated the	a		
	0- 11-117 -+ 0.00	an intonviouv was					
	On 1/5/17 at 3:20 p.m		All Andrew Market	licensed nurses by 2/1/17 relate			
		(licensed practical nurse) # t the purpose of the care		ensuring behavior monitoring r	records		
operative states and		"To know how to take care		are completed and behaviors			
		hat we need to do to help		documented and resident pain			
		N # 1 was then asked to		management programs are follo	owed.		
	review the current cal						
		ted November 1, 2016					
		017 for Resident # 10.					
		e blanks on the behavior					

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Facility ID: VA0080

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TATEMENT	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY COMPLETED C	
		495249			01/06/2017	7
	ROVIDER OR SUPPLIER	IEALTH CARE CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		ETIO
F 282	monitoring sheets, LF documented I can't si asked about following stated that it wasn't b On 1/5/17 at 4:30 p.m conducted with ASM member) # 2, the dire asked about the purp 2 stated, "It tells how ASM # 2 was then as 10's current care plan sheets dated Novem 4, 2017 for Resident si the blanks on the beh ASM # 2 stated, Novem 4, 2017 for Resident si the blanks on the beh ASM # 2 stated, "If it done." When asked a ASM # 2 stated that it On 1/5/17 at approxin (administrative staff n administrator, and AS were made aware of No further information References: (1) A swallowing diso obtained from the we <https: www.nlm.nih.<br="">disorders.html>. (2) Fear. This information website:</https:>	PN # 1 stated, "If it wasn't ay it was done." When g the care plan LPN # 1 eing followed. In an interview was (administrative staff ector of nursing. When ose of the care plan, ASM # to take care of the resident." iked to review Resident # in and behavior monitoring ber 1, 2016 through January # 10. When asked about navior monitoring sheets, wasn't documented it wasn't about following the care plan t wasn't being followed. mately 6:00 p.m. ASM nember) # 1 the SM # 2, director of nursing, the findings. in was provided prior to exit.	F 28	 The Staff Development Coordinate will reeducate the nursing staff by 2/1/17 related to ensuring oxygen connected and turned on by a licer nurse. 4. The Director of Nursing or Assistant Director of Nursing will complete audits weekly for 4 weel and monthly for 2 months to ensure the behavior monitoring records, the behavior documentation, the pain management documentation and the resident's receiving oxygen to ensure plan of care continues to be follow required The Director of Nursing submit a report to the Quality Assurance Committee monthly for months. The Director of Nursing will be responsible for monitoring follow up. Completion Date: 	is ised cs re he ure v as will r 3	/17

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	MENT OF HEALTH AN S FOR MEDICARE & I				PRINTED: 01/17/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495249	B. WING		C 01/06/2017
NAME OF PR			STI	REET ADDRESS, CITY, STATE, ZIP CODE	1 01100/2011
FARMVILL	E REHABILITATION & H	EALTH CARE CENTER LLC	1	75 SCOTT DRIVE ROUTE 5 RMVILLE, 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 COMPLETION
F 282	thoughts (obsessions) (compulsions) that he repeat over and over. obtained from the web http://www.nimh.nih.g ompulsive-disorder-ood (4) A disorder caused the brain that control I hard for you to read, v mean to say). This infi- the website: <https: www.nlm.nih.g<br="">ml>. (5) A mental disorder to difference between wh information was obtain https://medlineplus.go (6) A swelling caused tissues. This informative website: https://www.nlm.nih.go (7) A chronic disease in regulate the amount oo information was obtain https://www.nlm.nih.go 001214.htm.</https:>	uncontrollable, reoccurring or and behaviors or she feels the urge to This information was osite: ov/health/topics/obsessive-c cd/index.shtml. by damage to the parts of anguage. It can make it write, and say what you ormation was obtained from gov/medlineplus/aphasia.ht that makes it hard to tell the hat is real and not real. This hed from the website: v/ency/article/000928.htm. by fluid in your body's ion was obtained from the ov/medlineplus/edema.html. n which the body cannot f sugar in the blood. This hed from the website: ov/medlineplus/ency/article/	F 282		
	the physical findings o occur after an episode activity in the brain. To obtained from the web	convulsion." A seizure is r changes in behavior that of abnormal electrical his information was			

Facility ID: VA0080

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STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DA	10. 0938-039 TE SURVEY MPLETED
	CORRECTION	BENTHONION NOMBER.	A. BUILDING		C	
		495249	B. WING		01/06/2017	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			
FARMVIL	E REHABILITATION & H	HEALTH CARE CENTER LLC		5 SCOTT DRIVE ROUTE 5 RMVILLE, 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 CORF (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 282	Continued From page	e 81	F 282			
	 (9) Feeding tubes are needed when you are unable to eat or drink. This may be due to stroke or other brain injury, problems with the esophagus, surgery of the head and neck, or other conditions. This information was obtained from the website: <https: 000900.htm="" ency="" medlineplus.gov="" patientinstructions="">.</https:> (10) Used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions). This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a698019.h tml. 					
	the resident's plan of Resident # 17 was ac 5/2/12 with a readmis diagnoses that includ hypertension (1), peri	t 17's behaviors according to care. dmitted to the facility on ssion on 5/5/16 with				
	data set), a quarterly (assessment reference the resident as scorin for mental status (BIM being moderately imp decision making. Res	prehensive MDS (minimum assessment with an ARD ce date) of 11/15/16 coded og a 10 on the brief interview AS) of a score of 0 - 15, 10 paired of cognition for daily sident # 17 was coded as ssistance of one staff				

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Event ID: 095F11

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CENTER	RS FOR MEDICARE &	ND HUMAN SERVICES				FOF	ED: 01/17/20 RM APPROVE IO: 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495249	B. WING			C 01/06/2017	
NAME OF F			I	STR	EET ADDRESS, CITY, STATE, ZIP CODE		1100/2011
FARMVIL	LE REHABILITATION & F	HEALTH CARE CENTER LLC			5 SCOTT DRIVE ROUTE 5 RMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	Continued From page	e 82	F	282			
	member for activities	of daily living.					
	11/22/16 was reviewed documented, "At risk (related to) use of psy Under "Approaches" record target behavio doctor) of increase in medication adjustmer The "Physician's Orde 11/1/16 for Resident # physician on 11/2/16 Give 25 MG (milligran day. Start Date 11/1/ The MARs (medicatio for Resident # 17 date through January 4, 20 Give 25 MG (milligran day. Start Date 11/1/ MARs revealed Resid	ychotropic medications." it documented, "Monitor and irs and inform MD (medical frequency for possible nts." er Sheet" (POS) dated # 17 and signed by the documented, "Seroquel. n) by mouth two times a 16." on administration records) ed November 1, 2016 017 documented, "Seroquel. n) by mouth two times a 16." Further review of the lent # 17 received two					
	# 17 dated November 2017 failed to docume the use of Seroquel or On 1/6/17 at 11:05 a.r conducted with LPN (I 7. When asked about plan LPN # 1 stated, " of the resident." LPN review Resident # 17's behavior monitoring sh	y Flow Sheets" for Resident 1, 2016 through January 4, ent behavior monitoring for n 317 of 573 opportunities. m. an interview was licensed practical nurse) # the purpose of the care To know how to take care					

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Facility ID: VA0080

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RECEIVED JAN 30 2017 VOH/OLC

		ND HUMAN SERVICES MEDICAID SERVICES				FOI	ED: 01/17/20 RM APPROVE VO: 0938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495249	B. WNG			C 01/06/2017		
NAME OF P				STR	EET ADDRESS, CITY, STATE, ZIP CODE		1100/2011	
FARMVILI	E REHABILITATION & H	HEALTH CARE CENTER LLC	1575 SCOTT DRIVE ROUTE 5					
				FAF	RMVILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 282	Continued From page	e 83	F 2	282				
	about the blanks on t	he behavior monitoring						
		d, "If it wasn't documented it						
		ked about following the care hat it wasn't being followed.						
	On 1/6/17 at 1:10 p.m. an interview was							
	conducted with ASM	(administrative staff ector of nursing. When						
		ose of the care plan ASM #						
		to take care of the resident."						
		ked to review Resident #						
		n and behavior monitoring ber 1, 2016 through January						
		d about the blanks on the		-				
		sheets ASM # 2 stated, "If it						
		wasn't done." When asked are plan ASM # 2 stated that		4 PROVIDENCE OF A				
	it wasn't being followe	-						
		nately 12:35 p.m. ASM						
	(administrative staff n	nember) # 1 the SM # 2, director of nursing,						
	were made aware of							
	No further information	n was provided prior to exit.						
	References:	This information						
	(1) High blood pressu obtained from the wel	re. This information was bsite:						
		ov/medlineplus/highbloodpr						
		em is the body's network of						
and the second se		des the arteries, veins and						
		blood to and from the heart. thick and stiff, a problem						
	called atherosclerosis							
	vessels and block blo	od flow to the heart or brain.						
	Weakened blood vess	sels can burst, causing						

Facility ID: VA0080

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		ND HUMAN SERVICES MEDICAID SERVICES				FO	ED: 01/17/201
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		ONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY MPLETED
		495249	B. WING	www.co.co.co.co.co.co.co.co.co.co.co.co.co.			C
NAME OF P	ROVIDER OR SUPPLIER		J	STR	EET ADDRESS, CITY, STATE, ZIP CODE		01/06/2017
FARMVIL	LE REHABILITATION & H	EALTH CARE CENTER LLC		ł	5 SCOTT DRIVE ROUTE 5 RMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ix	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	bleeding inside the bo obtained from the wel https://www.nlm.nih.g ases.html. (3) A chronic disease regulate the amount of information was obtain https://www.nlm.nih.g 001214.htm. (4) A group of sympton affect the brain. This from the website: https://www.nlm.nih.go ml. (5) Symptoms of a bra because of sudden, at the brain. This information website: https://www.nlm.nih.go ml. (6) A disease that caus to swell and narrow. It shortness of breath, ch coughing. Information website: https://medlineplus.gov 3. The facility staff faile comprehensive care pl and assessment for Re Resident #6 was admit 10/13/09 with a recent	bdy.) This information was bsite: ov/medlineplus/vasculardise in which the body cannot of sugar in the blood. This ned from the website: ov/medlineplus/ency/article/ ms caused by disorders that information was obtained ov/medlineplus/dementia.ht in problem. They happen ponormal electrical activity in thion was obtained from the ov/medlineplus/seizures.ht sets the airways of the lungs leads to wheezing, nest tightness, and was obtained from the //ency/article/000141.htm.	F	282			

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DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE &				PRINTED: 01/17/201 FORM APPROVE OMB NO. 0938-039
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	B. WING		C 01/06/2017
NAME OF PROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP CODE	
FARMVILLE REHABILITATION &	HEALTH CARE CENTER LLC		'5 SCOTT DRIVE ROUTE 5 RMVILLE, VA 23901	
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY 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
in which nerve fibers lose their myelin covi- vascular disease, hig neurogenic bladder. The most recent MDS assessment, a quarte assessment reference the resident as scorir interview for mental s she was cognitively in decisions. The reside extensive to being tot staff for most of her a was coded as indepe assistance was provid Health Conditions, the having received sche needed pain medication non-medication intervi #6 was coded as hav of five out of zero - te ever in. The Care Plan dated, 11/2/15, documented, impaired comfort r/t (r the disease process." documented, "Reside than 2 on a scale of 1	(MS) (a progressive disease of the brain and spinal cord er (1)), dysphagia, peripheral h blood pressure, and S (minimum data set) erly assessment, with an e date of 11/14/16, coded ng a 13 on the BIMS (brief status) score, indicating that ntact to make daily ent was coded as requiring cally dependent upon the ctivities of daily living. She ndent after set up ded for eating. In Section J - e resident was coded as duled pain medication, as ion and received rentions for pain. Resident ing frequent pain on a scale n, ten being the worse pain 10/28/10 and reprinted on "Problem/Need: Risk for elated to) pain secondary to The "Goals & Target date" nt will state pain level less -10 after intervention for nutes) to 1 hour. Thru next paches" documented, terly. Administer pain	F 282		

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		ID HUMAN SERVICES MEDICAID SERVICES					FOR	D: 01/17/2017 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		(X3) DATE COMI	SURVEY PLETED
		495249	B. WING					C /06/2017
NAME OF PI	ROVIDER OR SUPPLIER	k aran karan menengan karan			STREET ADDRESS, CITY, STATE, ZIP C 1575 SCOTT DRIVE ROUTE 5	ODE	1	
FARMVILL	E REHABILITATION & H	EALTH CARE CENTER LLC			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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD B		(X5) COMPLETION DATE
F 282	she requests pain me her to rate her pain or stated, "Yes." Resider come back and ask h a scale, after they giv Resident #6 stated, "I 1:41 p.m. Resident #6 reposition her, give he relieve the pain without asks for pain medicat "No, no one does that The physician orders "Percocet (used to tree (2) 5/325 one po (by r (hours) PRN (as need) Review of the Novem administration record) documentation of the Percocet 34 times. The did not document a paid documented nothing of under the column, "Ref The December 2016 If documentation of the Percocet 15 times. The did not document a paid documented, "Eff (effe "results voiced." A review of the nurse' anything related to paid dated, 12/16/16 at 9:0 "Res (resident) rec'd (6:10 p.m. for c/o (com	esident #6 was asked when dication does the staff asks in a scale. Resident #6 int #6 was asked if staff er to rate her pain again on e her the pain medication. No they don't." On 1/5/17 at 6 was asked if staff offers to er a snack or anything to out medication, when she ion. Resident #6 stated, " dated 1/1/17, documented, eat moderate to severe pain) mouth) Q (every) 6 hrs led)." ber 2016 MAR (medication revealed the administration of the he reverse side of the MAR ain level and only or "helpful or a plus sign" esults or Response."	F	28:	2			

If continuation sheet Page 87 of 171

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/17/2017 MAPPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì,			СОМІ	E SURVEY PLETED
		495249	B. WING				C /06/2017
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 575 SCOTT DRIVE ROUTE 5		
FARMVILL	E REHABILITATION & H	EALTH CARE CENTER LLC			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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	noted." An interview was cond nurse) #5, the unit ma a.m. RN #5 was asked nurse, if the care plan will state pain level less after interventions for hour. RN #5 stated, "V pain scale again and of An interview was cond practical nurse) #1, the #6; on 1/5/17 at 1:25 p about the process staf complains of pain. LP where the pain is, asso the pain scale or watch repositioning or offer a then ! will give the pain if she went back to rea LPN #1 stated, "I go by was effective, sometim me if it's better or gone effective." Resident #6 with LPN #1. When as doing, LPN #1 stated,	ducted with RN (registered inager, on 1/5/17 at 11:30 d what is expected of the goal documents a resident as than 2 on a scale of 1 -10 pain within 30 minutes or 1 We should be asking the document it." ducted with LPN (licensed e nurse caring for Resident o.m. LPN #1 was asked if follows when a resident N #1 stated, "First I assess ess the pain level by using h facial grimacing. I offer a snack, if that doesn't work n medication." When asked assess the residents pain, ack and reassess. Ask if it nes I just ask if they can tell e. I write helpful or Vs care plan was reviewed ked what staff should be "I should be asking the her pain medication. That's	F2	282	DEFICIENCY)		
	know how to care for a to do to care for them.' An interview was cond staff member (ASM) #2 on 1/5/17 at approxima asked the purpose of th	ucted with administrative 2, the director of nursing, ately 2:30 p.m. When he care plan, ASM #2 tells us how to take care of					

If continuation sheet Page 88 of 171

	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED
	oor and official			IG		С
		495249	B. WING			01/06/2017
AME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CI		
ARMVILL	E REHABILITATION	& HEALTH CARE CENTER LLC		FARMVILLE, VA 2		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
F 282	Continued From p	age 88	F 2	82		
	interventions on h plan for Resident ASM #2. When a	ow to reach that goal." The care #6's pain was reviewed with sked if the care plan should be stated, "Yes, it should be."				
	documented in pa the resident's pair	"Pain Assessment" rt, "7. Reassess and document a scale each time pain d, when the dose changes or anges."				
	part, "1. Our facilit Planning/Interdisc with the resident, (sponsor), develo comprehensive ca	iplinary Team, in coordination his/her family or representative os and maintains a are plan for each resident that est level of functioning the				
	Williams and Wilk documented, "A w communication to members that hel careThe nursing information about and goals. It cont achieving the goa and is used to dire revise and update	damentals of Nursing Lippincott ins 2007 pages 65-77 written care plan serves as a ol among health care team ps ensure continuity of g care plan is a vital source of the patient's problems, needs, ains detailed instructions for ls established for the patient ect careexpect to review, the care plan regularly, when s in condition, treatments, and				
		and ASM #2 were made aware ngs on 1/5/17 at 6:00 p.m.				

CENTERS FOR MEDICARE & MEDICAD SERVICES Other NO. DIMENOUS PROVIDENT OF A SUBJECT ON A BUILDING Other NO. DIMENOUS PROVIDENT OF A SUBJECT ON A BUILDING Other NO. DIMENOUS PROVIDENT OF A SUBJECT ON A BUILDING Other NO. DIMENOUS PROVIDENT OF A SUBJECT ON A BUILDING Other NO. DIMENOUS PROVIDENT OF A SUBJECT ON A BUILDING Other NO. DIMENOUS PROVIDENT OF A SUBJECT ON A BUILDING Other NO. DIMENOUS PROVIDENT OF A SUBJECT ON A BUILDING Other NO. DIMENOUS PROVIDENT OF A SUBJECT ON A BUILDING Other NO. DIMENOUS PROVIDENT OF A SUBJECT ON A BUILDING PROVIDENT OF A SUBJECT OF A BUILDING PROVIDENT OF A SUBJECT OF A SUB			ND HUMAN SERVICES				FORM	APPROVED . 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET-DOPESS ON STREET CODE FARMULLE REHABILITATION & HEALTH CARE CENTER LLC International Street Control Street Control Street Control Street Control Street Control Control Street Control Control Control Street Control Control Control Street Control Contrel Contecont Control Control Control Control Contrel Control Cont	STATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				COMP	ETED
EARLY TULE REHABILITATION & HEALTH CARE CENTER LLC 1575 SCOTT DRIVE FOUTE 5 FARMVILLE, VA 23801 Mather intermed and the second			495249	B. WNG			01/	06/2017
(M) D SUMMARY STATEMENT OF DEPICIENCES ID				2				
Image: Description of the processing of the processing of the processing of the physical systems of the physical system of th	FARMVILL	E REHABILITATION & H	HEALTH CARE CENTER LLC		F	FARMVILLE, VA 23901		
 (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 380. (2) This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH TO011543/?report-details#uses. 4. a. The facility staff failed to follow Resident #7's care plan to medicate the resident for pain one half hour prior to treatments or care. Resident #7 was admitted to the facility on 12/20/16 with disease, high blood pressure, arthritis and chronic pain. The most recent MDS was in progress and not available for review. The admission nurse's note date at 42/30/16 at 4200 pm. documented, "Resident is alert/orient (sic) x (times) 3 (knows name, date and where she is) 1 assist needed for ADL (activities of dat) Wing) care." Review of the medication administration record (MAR) documented, "Percocet (1) 5/325 mg (nilligrams) 1 tab (tablet) po (by mouth) q (every) 4 hr (hours) pm (as needed) pain." Review of the medication administration record (MAR) documented that Resident #7 received pain medication on 11/1/7 at 445 pm; ;12/17 at 3:15 a.m., 11/4/17 at 5:5 a.m. Review of the care plan initiated on 11/4/17 	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	COMPLETION
Review of the care plan initiated on 1/4/17	F 282	 (1) Barron's Dictiona Non-Medical Reader Chapman, page 380 (2) This information website: https://www.ncbi.nlm T0011543/?report=d 4. a. The facility staff care plan to medicat half hour prior to treat Resident #7 was adr 12/26/16 and readm diagnoses that inclue respiratory failure, cf blood pressure, arthe The most recent MD available for review. dated 12/30/16 at 4: "Resident is alert/c name, date and whe for ADL (activities of Review of the physic "Percocet (1) 5/325 po (by mouth) q (even needed) pain." Review of the medic (MAR) documented, Q4Hrs prn pain. It w #7 received pain me p.m.; 1/2/17 at 3:15 	ry of Medical Terms for the r, 5th edition, Rothenberg and was obtained from the a.nih.gov/pubmedhealth/PMH etails#uses. If failed to follow Resident #7's e the resident for pain one atments or care. mitted to the facility on itted on 12/30/16 with ded but were not limited to: hronic lung disease, high ritis and chronic pain. S was in progress and not The admission nurse's note 00 p.m. documented, orient (sic) x (times) 3 (knows ere she is) 1 assist needed daily living) care." cian's orders documented, mg (milligrams) 1 tab (tablet) ery) 4 hr (hours) prn (as exation administration record ,"Percocet 5/325 mg 1 tab po as documented that Resident edication on 1/1/17 at 4:45 a.m.; 1/4/17 at 7:10 a.m.,	F	282			
		Review of the care p	blan initiated on 1/4/17					

Facility ID: VA0080

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1575 SCOTT DRIVE ROUTE 5		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ARMULLE REHABILITATION & HEALTH CARE CENTER LLC 1575 SCOTT DRVE: ROUTE 5 ARMULLE REHABILITATION & HEALTH CARE CENTER LLC 1575 SCOTT DRVE: ROUTE 5 ARMULLE REHABILITATION & HEALTH CARE CENTER LLC 1575 SCOTT DRVE: ROUTE 5 ARMULLE REHABILITATION & HEALTH CARE CENTER LLC 1575 SCOTT DRVE: ROUTE 5 ARMULLE REHABILITATION & HEALTH CARE CENTER LLC 1575 SCOTT DRVE: ROUTE 5 ARMULLE REHABILITATION & HEALTH CARE CENTER LLC 1575 SCOTT DRVE: ROUTE 5 ARMULLE REHABILITATION & HEALTH CARE CENTER LLC 1575 SCOTT DRVE: ROUTE 5 ARMULE REHABILITATION & HEALTH CARE CENTER LLC 1575 SCOTT DRVE: ROUTE 5 ARMULE REHABILITATION & HEALTH CARE CENTER LLC 1575 SCOTT DRVE: ROUTE 5 ARMULE REHABILITATION & HEALTH CARE CENTER LLC 1575 SCOTT DRVE: ROUTE 5 ARMULE REHABILITATION & HEALTH CARE CENTER LLC 1575 SCOTT DRVE: ROUTE 5 ARMULE REHABILITATION & HEALTH CARE CENTER LLC 1575 SCOTT DRVE: ROUTE 5 ARMULE REHABILITATION & HEALTH CARE CENTER LLC 1575 SCOTT DRVE: ROUTE 5 ARMULE REHABILITATION & HEALTH CARE CENTER LLC 1575 SCOTT DRVE: ROUTE 5 F282 Continued Trining HERMUNCH SCOTT DRVE: ROUTE 5 1575 SCOTT DRVE: ROUTE 5 F282 Continued With Resident the resident			495249	B. WING _		01/06/2017
CMUD Factor Control and contic control and control and control and control and contr			HEALTH CARE CENTER LLC		1575 SCOTT DRIVE ROUTE 5	DDE
 documented, "Focus. The resident is at risk for alteration in comfort: pain r/l (related to) disease process. Interventions. Administer analgesia as per orders. Give 1/2 hour before treatments or care." Review of the clinical record documented that the resident received physical therapy twice a day. There was no documentation that the resident received pain medication one half hour prior to therapy. An interview was conducted on 1/8/17 at 9:50 a.m. with LPN (licensed practical nurse) #8. When asked what she would do if there was a care plan intervention to medicate the resident prior to treatments or care she was conducted on she she asks for it." When asked what she would do if there was a care plan intervention to medicate the resident prior to treatments of uside the dimensional she may. LENN #8 stated, "I would coordinate it with therapy because they have a schedule." When asked if she had coordinated giving Resident #7 pain medication with physical therapy. LPN #8 stated she had not. On 1/6/17 at 11:30 a.m. ASM (administrative staff member) #1, the administration and ASM #2, the director of nursing were made aware of the findings. An interview was conducted on 1/6/17 at 1:30 p.m. with OSM (other staff member) #8, the physical therapy. CSM #8 stated, "If's at different times. She's already had therapy today." No further information was provided prior to exit. 	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	ON SHOULD BE COMPLE HE APPROPRIATE DATE
	F 282	documented, "Focus alteration in comfort process. Intervention per orders. Give 1/2 care." Review of the clinical resident received ph There was no docur received pain medic therapy. An interview was co a.m. with LPN (licen When asked when F medication, LPN #8 it." When asked what care plan intervention prior to treatments of #8 stated, "I would of because they have she had coordinated medication with phy she had not. On 1/6/17 at 11:30 at member) #1, the ad director of nursing w findings. An interview was co p.m. with OSM (other physical therapist. W Resident #7 had the different times. She No further information	s. The resident is at risk for : pain r/t (related to) disease ns. Administer analgesia as hour before treatments or al record documented that the hysical therapy twice a day. mentation that the resident cation one half hour prior to anducted on 1/6/17 at 9:50 used practical nurse) #8. Resident #7 was given pain stated, "When she asks for at she would do if there was a on to medicate the resident or care such as therapy, LPN coordinate it with therapy a schedule." When asked if d giving Resident #7 pain rsical therapy, LPN #8 stated a.m. ASM (administrative staff liministrator and ASM #2, the vere made aware of the onducted on 1/6/17 at 1:30 er staff member) #8, the When asked what times erapy, OSM #8 stated, "It's at 's already had therapy today." on was provided prior to exit.	F2		

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		ID HUMAN SERVICES				ORM APPROVED B NO. 0938-0391
STATEMENT (S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		DATE SURVEY COMPLETED C
		495249	B. WING _			01/06/2017
	ROVIDER OR SUPPLIER	I IEALTH CARE CENTER LLC		STREET ADDRESS, CITY, 1575 SCOTT DRIVE RO FARMVILLE, VA 2390	UTE 5	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	obtained from The Ni https://www.ncbi.nlm T0011543/. b. The facility staff fa connect and turn on An observation was of Resident #7. The wheelchair. She had (soft prongs that fit in The resident request from the portable tar oxygen machine in h (certified nursing ass the time. The nurse unhooked the oxyge turned on the oxyge at the machine. CNA connect the oxygen asked the resident h resident showed CN tubing to the machin 1/2 liters. Resident # Review of the physic documented, "O2 (of flow ordered. Review of the MAR record) documented continuous. An interview was co p.m. with CNA #2. V	e 91 bain. This information was ational Institutes of Health. .nih.gov/pubmedhealth/PMH iled to have a licensed nurse the oxygen for Resident #7. made on 1/4/16 at 3:05 p.m. resident was sitting up in the oxygen on via nasal cannula the nose to deliver oxygen). ted her oxygen be changed at on the wheelchair to the the room. A nurse and a CNA sistant) were in the room at left the room and CNA #2 n from the portable tank, n machine and stood looking A #2 did not know how to tubing to the machine and ow it was attached. The A #2 where to connect the te. The oxygen was set at 3 47 stated, "I'm on 4 liters." cian's orders dated 12/30/16 xygen)." There was no liter (medication administration I, "O2 at 2L/m (liters/minute) anducted on 1/4/16 at 3:55 Vhen asked if CNAs normally he residents, CNA #2 stated,	F	282		

Facility ID: VA0080

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		ID HUMAN SERVICES MEDICAID SERVICES			FOI	ED: 01/17/2017 RM APPROVED IO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		TE SURVEY MPLETED
		495249	B. WING		0	C 1/06/2017
		I IEALTH CARE CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 282	they're busy I do it. I went to 4 (liters)." CN oxygen had been obs When asked if she kr medication, CNA #2 CNAs were allowed t CNA #2 stated, "No." An interview was com p.m. with LPN #4. Wi oxygen on the reside nurses here." When a put on oxygen, LPN a answer is because it An interview was com p.m. with CNA #3. Wi oxygen on the reside doctor prescribes it a When asked if CNAs residents, CNA #3 st residents, CNA #3 st resident) to the oxyg When asked if she kr medication, CNA #3 CNAs were allowed to stated, "No." On 1/4/16 at 4:45 p.r and ASM #2, the dire aware of the findings Review of the facility THERAPY" documer oxygen when indicat exchanges. A physic shall include liter flow divide (i.e. nasal can	didn't put it on anything, it IA #2 was told that the served set at 3 1/2 liters. new that oxygen was a stated, "No." When asked if o administer medications, aducted on 1/4/16 at 4:00 hen asked who could put nts, LPN #4 stated, "Just the asked why only nurses could #4 stated, "The correct s considered a medication." aducted on 1/4/16 at 4:05 hen asked who could put onts, CNA #3 stated, "The ated, "Yes, I hook up (the en and ask what liter it's on." put oxygen on the ated, "Yes, I hook up (the en and ask what liter it's on." new oxygen was a stated, "Yes." When asked if to administer medications m. ASM #1, the administrator ector of nursing were made 's policy titled, "OXYGEN need, Policy: To administer ed to provide adequate gas ian's order is required and v rate and administration nula, mask etc.)." The policy policies and procedures	F 28:			et Page 93 of 171

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ATEMENT (DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			MB NO. 0938-03 (3) DATE SURVEY COMPLETED
		495249	B. WING		C 01/06/2017
			S [_]	TREET ADDRESS, CITY, STATE, ZIP CODE	0110012011
FARMVILI	E REHABILITATION & H	HEALTH CARE CENTER LLC		575 SCOTT DRIVE ROUTE 5 ARMVILLE, VA 23901	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page	e 93	F 282		
	No further information	n was provided prior to exit.			
F 284 SS=D		NTICIPATE DISCHARGE:	F 284	F284	
	effective discharge pl on the resident's disc of residents to be act	elop and implement an anning process that focuses harge goals, the preparation ive partners and effectively st-discharge care, and the		 Resident #25 was discharged from the facility on 3/21/16 Social Services will audit the current residents' clinical record by 2/1/17 to ensure discharge plans hav 	
	process must be con rights set forth at 483	cility's discharge planning sistent with the discharge .15(b) as applicable and-		been developed as required.3. The Administrator will reeducated	
	(i) Ensure that the dis resident are identified development of a disc resident.			Social Service staff by 1/27/17 to ensure discharge plans are developed for residents as required.	d
	identify changes that discharge plan. The c	evaluation of residents to require modification of the discharge plan must be to reflect these changes.		4. The Social Service Coordinator of the Social Service Assistant will aud 5 current residents' clinical record weekly for 4 weeks and monthly for	lit
	by §483.21(b)(2)(ii), in developing the discha			months to ensure discharge plans continue to be developed as required The Social Service Coordinator will submit a report to the Quality	
	and the resident's or operson(s) capacity an	er/support person availability caregiver's/support id capability to perform : of the identification of		Assurance Committee monthly for 3 months. The Administrator will to responsible for monitoring and follo up.	
	(v) Involve the resider representative in the content of the conte			Completion Date:	02/03/17

Facility ID: VA0080

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				10.0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		TE SURVEY MPLETED
		495249	B. WING		0	C 1/06/2017
NAME OF PI			- ST	REET ADDRESS, CITY, STATE, ZIP CODE		
FARMVILL	E REHABILITATION & H	IEALTH CARE CENTER LLC		75 SCOTT DRIVE ROUTE 5 ARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 284	Continued From page	- 94	F 284			
1 204		form the resident and	1 204			
	(vi) Address the resid	lent's goals of care and s.				
		resident has been asked receiving information the community.				
	to the community, the referrals to local cont	icates an interest in returning e facility must document any act agencies or other nade for this purpose.				
	appropriate, in respo	date a resident's plan and discharge plan, as nse to information received contact agencies or other				
		e community is determined e facility must document who ion and why.				
	SNF or who are disch LTCH, assist residen representatives in se provider by using dat	no are transferred to another narged to a HHA, IRF, or ts and their resident lecting a post-acute care a that includes, but is not IRF, or LTCH standardized				
	the data is available. the post-acute care s assessment data, da	on resource use to the extent The facility must ensure that				

Facility ID: VA0080

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	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
DIENNOI	oon teen on		A. BUILDING			С
		495249	B. WING		01	/06/2017
AME OF PF	ROVIDER OR SUPPLIER	L	STR	REET ADDRESS, CITY, STATE, ZIP CODE		
			157	5 SCOTT DRIVE ROUTE 5		
ARMVILL	E REHABILITATION & H	IEALTH CARE CENTER LLC	FA	RMVILLE, VA 23901		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S		(X5) COMPLETIC
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE A		DATE
170				DEFICIENCY)		
E 004		- 05	F 284			
F 284	Continued From page	95	1 204			
	preferences.	tete an a timely basis based				
	(ix) Document, comp	lete on a timely basis based				
		ds, and include in the clinical				
	record, the evaluation	n of the resident's discharge				
	needs and discharge	plan. The results of the iscussed with the resident or				
		tive. All relevant resident				
	information must be i	ncorporated into the				
		ilitate its implementation and				
	to avoid unnecessan	delays in the resident's				
	discharge or transfer					
	discharge of transier					
	(c)(2) Discharge Sun	nmary				
	When the facility anti	cipates discharge, a resident				
	must have a discharg	ge summary that includes,				
	but is not limited to, t	he following:				
	(iv) A post-discharge	plan of care that is				
	developed with the p	articipation of the resident				
	and, with the residen	t's consent, the resident				
	representative(s), wh	nich will assist the resident to				
	adjust to his or her n	ew living environment. The				
	post-discharge plan	of care must indicate where				
	the individual plans t	o reside, any arrangements				
	that have been made	e for the resident's follow up				
	care and any post-di	scharge medical and				
	non-medical services	S. This net mot as ovidanced				
		T is not met as evidenced				
	by:	view, facility document				
	based on stall interv	d review, and in the course of				
	a complaint investig	ation, it was determined that				
	the facility staff failer	to develop a discharge plan				
	for one of 26 residen	its in the survey sample,				
	Resident #25.	· ·				
		d to develop a discharge				

PRINTED: 01/17/2017



OH/OLC

	MENT OF HEALTH AN S FOR MEDICARE & I						MAPPROVED 0.0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495249	B. WING			0	1/06/2017
	ROVIDER OR SUPPLIER	EALTH CARE CENTER LLC		15	REET ADDRESS, CITY, STATE, ZIP CODE 575 SCOTT DRIVE ROUTE 5 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	Continued From page	96	F	284			
	The findings include:						
	1/21/16 and discharg diagnoses included b chronic obstructive pu- high blood pressure, metabolic acidosis, h dementia, chronic an The most recent MDS assessment, a chang with an assessment r coded the resident as (brief interview for me he was capable of ma decisions. He was co for bed mobility, trans The "Social Service F 1/21/16, documented American male admit DX (diagnosis) of CC blood pressure). Res (oriented to person, p pleasant but adamar home. Resident is a disposition to home.	ut were not limited to: ulmonary disease (COPD), cerebral infarction, ypothermia, vascular email and atrial fibrillation. S (minimum data set) te of therapy assessment, reference date of 2/29/16, a scoring a 13 on the BIMS ental status) score, indicating aking daily cognitive ded as being independent afers, eating and toilet use. Progress Notes'' dated, I, "82 year old African ted to (Initials of facility) with PD and hypertension (high sident is alert, oriented X 3 olace and time). He is very t about leaving soon to get Full Code status. He has a The phone number listed on not work therefore 72 hour					
	2/2/16, documented, director) spoke with r schedule a meeting a (Resident #25) reque the facility with a visi	Progress Notes" dated, "SSD (social service resident's daughter to about her father's disposition. esting to go home. He left for on Saturday (1/30/16). ed to facility by his daughter.					

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		ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		LETED
		495249	B. WING _				C 06/2017
NAME OF PI	ROVIDER OR SUPPLIER	.		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				15	575 SCOTT DRIVE ROUTE 5		
FARMVILL	E REHABILITATION & H	IEALTH CARE CENTER LLC		F	ARMVILLE, VA 23901		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E	3E	(X5) COMPLETION DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
F 284	5:30 p.m." The "Social Service F	set for Thursday 2/4/16 at Progress Notes" dated,	F2	284			
	(responsible party) th admission care plant 2:00 p.m. SSD left m attendance via teleph asked R/P (responsit	"SSD called to advise R/P at resident will have an tomorrow 2/10/16 @ (at) hessage encouraging hone or in person. SSD ble party) to please return tent #25) was also invited to					
	2/29/16, documented R/P to tell her that re- resident)'s last cover 3/9/16. She has the home or private pay. supervision due to m requesting the name	ed day for therapy will be option to take the resident Resident requires emory deficits. R/P of the business office provided with (OSM #4)'s					
	3/4/16, documented, message for R/P of resident) to please resident) to please resetting of a d/c (disch #25). Resident have Resident will become	eturn my call in reference to harge) meeting for (Resident (sic) a d/c date of 3/10/16. e private pay. SSD advised call to myself of (OSM #4) to					
	3/8/16, documented, RP) to discuss her fa R/P (Resident #25) w	Progress Notes" dated, "SSD called R/P (name of ther (Resident #25). Per vill be staying @ (initials of rm. One of her other siblings					

Facility ID: VA0080

If continuation sheet Page 98 of 171

		ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	<u>). 0938-0391</u>
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY LETED
		495249	B. WING				06/2017
NAME OF P				ST	REET ADDRESS, CITY, STATE, ZIP CODE		
FARMVIL	LE REHABILITATION & H	EALTH CARE CENTER LLC		1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 284	will be calling today of finances with BOM (b There were no furthe Review of the nurse's documentation of dis note of 3/21/16 at 12 "Resident D/C (disch (Name of facility). Le in stable condition. L explained all medicat diagnosis and times of understanding. All pe and accounted for wi The Care Plan, printe There was nothing at related to discharge of An interview was cor member (OSM) #3 o asked the process for OSM #3 stated, "The the social worker, the discuss the plan to g the date of discharge there is any medical discharge date discharge date discharge date discharge meeting w ones." When asked to the resident and fam OSM #3 stated, "Usu services (Medicare) unless they are not p	r tomorrow to set up pusiness office manager." r social services notes. a note did not reveal any charge planning until the .00 p.m. that documented, arged) out of facility to .ft facility with his daughters .eft at 11:00 a.m. This writer ion to RP along with given. RP voiced ersonal property was present th RP signing paperwork." ed on 2/5/16, was reviewed. ddressed on the care plan olanning. aducted with other staff in 1/5/17 at 8:35 a.m. When r discharging a resident, clinical team which includes erapy and nursing. They o home. The therapist gives a. Nursing them has input if reasons not to be rsing and social services	F	284			

Facility ID: VA0080

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	MENT OF HEALTH AN S FOR MEDICARE & I					FORM	APPROVED 0938-0391
STATEMENT O		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` '		CONSTRUCTION		SURVEY LETED
		495249	B. WING				_ 06/2017
NAME OF PR				S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				1	575 SCOTT DRIVE ROUTE 5		
	E REHABILITATION & H	EALTH CARE CENTER LLC		F	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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 284	An interview was con director of therapy, or asked to discuss Res she couldn't recall an to locate any paperwor returned at 9:11 a.m. on his discharge. I w schedule. Sadly, I do it. I slightly recall my daughter. I recall spe function ability. Base doubt that she would alone. All of our door couldn't read a clock therapy goals except been met. He could it supervision." OSM # documentation indica term in the facility. Th planned long term go taken home but need asked if she was invo planning, OSM #7 sta week so yes." When planning or care plan #7 stated, "I can't rec hour meeting to discu If not held in 72 hours family is available." An interview was con admission director, of asked when the disch OSM #5 stated, "It sta evaluate the resident involved from the get involved in the plannin discharge, OSM #5 s	ducted with OSM #7, the in 1/5/17 at 8:50 a.m. When ident #25, OSM #7 stated ything and went to her office ork on him. OSM #7 stating she had no records ould have written it on my on't recall if I had a record of conversation with the eaking to her regarding his d on our documentation, I have said he could go home umentation shows confusion or calendar. All of his one long term goal had function at home with 7 stated that all therapy ted that he would stay long he speech therapist had als in the event he was ed 'full time care.' When lived with his discharge meetings were held, OSM all but normally we do a 72 uss the plan for the resident. s, it's held as soon as the ducted with OSM #5, the n 1/5/17 at 9:30 a.m. When harge process is starting, arts with admission. We in 72 hours and the family is go." When asked who's	F	284			

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Facility ID: VA0080

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING С 495249 B. WING 01/06/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1575 SCOTT DRIVE ROUTE 5 FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC FARMVILLE, VA 23901 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 284 Continued From page 100 F 284 how much notice is given to the family of a discharge, OSM #5 stated, "We have a 10 -14 day window where the discharge plan is set with the interdisciplinary team and the family." When asked if she had any recollection of conversations with Resident #25's daughter, OSM #5 stated, "Any conversation I have is on the front end prior to admission." When asked how the information she obtains prior to admission regarding discharge is passed on to the social worker or therapy staff, OSM #5 stated, "Unless someone gets back to me, it doesn't get passed down until was determined what the plan is. The social worker is not involved. The business office manager takes care of the Medicaid application and financial process with the families." When asked again if the social worker is involved in discharge planning, OSM #5 stated, "Not usually." When asked about the resident being transfers to a veteran's facility, OSM #5 stated, "We didn't know he had VA (veteran's affairs) benefits." An interview was conducted with OSM #4, the business office manager, on 1/5/17 at 9:42 a.m. When asked her involvement in the discharge of a resident, OSM #4 stated, "I'm usually in the 72 hour meeting where discharge planning starts. I don't have any notes for that meeting so I must not have been in it." OSM #4 was asked to provide any documentation she has related to Resident #25's discharge or plan to stay at the facility. A second interview was conducted with OSM #3. the social services director, on 1/5/17 at 9:50 a.m. When asked if she could find any documentation of the discharge plan to send the resident to a VA facility, OSM #3 stated, "The only documentation regarding his transfer was the nurse's note of

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Facility ID: VA0080

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ATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY	
D PLAN OF	CORRECTION	DENTIFICATION NOMBER.	A. BUILDING		-	С	
		495249	B. WING		0	1/06/2017	
			<u> </u>	STREET ADDRESS, CITY, S			
				1575 SCOTT DRIVE RO	UTE 5		
ARMVILL	E REHABILITATION & H	HEALTH CARE CENTER LLC		FARMVILLE, VA 2390	1		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID		R'S PLAN OF CORRECTION	(X5) COMPLETIO	
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY)	DATE	
F 284	Continued From pag	e 101	F 28	4			
1 204			. 20	•			
		er to (Name of facility)." ne discharge planning starts,					
		arts during the admission					
	process. My assistar	nt or I call to set up a 72 hour					
		speaker phone." When					
		sible for discharge planning,					
	OSM #3 stated, "Prir	marily it should be the social					
		d if she was told of Resident					
	#25's desire to stay I	ong term care, OSM #3 e been told, many times it's					
	stated, T should hav	o me the information from					
	admissions " When a	asked if the 72 hour meeting					
	took place. OSM #3	stated, "I can't find any					
	documentation that i	t did." When asked why it					
	took two weeks, afte	r the resident eloped, for the					
	facility to reach out a	and contact the family					
		planning, OSM #3 stated,					
		copy of the letter was					
	requested at this tim	e. OSM #3 was then asked					
	why there was no to	llow up for a meeting 72 n, if the facility is stating that					
	a 72 hour meeting is						
	residents being adm	itted. OSM #3 stated, "I don't					
	know. I take response	sibility of no documentation in					
	the clinical record re	garding the discharge but the					
	daughter initiated the	e transfer to (Name of					
	facility)." When aske	d if the social worker should					
	be informed of any i	mpending discharge, OSM #3					
		e been but wasn't. The					
	RP." A copy of any c	ad communication with the					
		ked why there was no					
		e resident's impending	MAC MICH IN CONTRACT				
	transfer to another fa	acility in the clinical record,					
	OSM #3 stated, "I w	asn't involved with it."					
	An interview was co	nducted with RN (registered					
	nurse) #3, the MDS	coordinator, on 1/5/17 at					

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/17/201 FORM APPROVED OMB NO. 0938-039		
STATEMENT ((X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495249	B. WING		C 01/06/2017		
	ROVIDER OR SUPPLIER	HEALTH CARE CENTER LLC	157	REET ADDRESS, CITY, STATE, ZIP CODE 75 SCOTT DRIVE ROUTE 5 RMVILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION		
F 284	they plan to stay long plan discharge." Whe discharge planning, f worker starts the disc hours of admission. therapy, social servic asked if Resident #22 #3 stated, "I don't rec her on the phone afte investigated during a investigated during a investigation) but we were talking about ke asked where the doc was, RN #3 stated sh RN #3 stated, "I reme didn't want him to go private pay." On 1/5/17 at 10:46 a office manager return she keeps on file. Th documented, "Skilled secondary payer. Pl and return to home." The social worker ret approximately 1:30 p documentation of a c at 5:46 p.m. Also pre from the RP and the #5). The email dated received a call from (that they has been tr medications list for m And he is having diffi What is being faxed to	re plan, RN #3 stated, "No, if g term care then I don't care en asked the process for RN #3 stated, "The social charge process within 72 We have a meeting with ces and nursing." When 5 had a 72 hour meeting, RN call. We had a meeting with er he eloped (previously nother complaint didn't discuss discharge, we eeping him safe." When cumentation of that meeting he would have to look for it." ember this family, the family home but didn't want to c.m. OSM #4, the business hed and presented notes that he note of 3/8/16 d resident admitted and no an is STC (short term care) curned on 1/5/17 at c.m. and presented care plan meeting on 2/4/16 sented email communication admissions director (OSM 3/18/16 documented, "I (name and contact number) ying to get a CURRENT by father (Resident #25). culty getting that information. to him is the ADMISSION he CURRENT med list. I	F 284				

Facility ID: VA0080

If continuation sheet Page 103 of 171

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/17/201 M APPROVEI D. 0938-039
STATEMENT ((X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE	E SURVEY PLETED
		495249	B. WING			C 01/06/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
				1575	SCOTT DRIVE ROUTE 5		
FARMVILL	E REHABILITATION &	HEALTH CARE CENTER LLC			MVILLE, VA 23901		
	CLIMMADY C	TATEMENT OF DEFICIENCIES		I	PROVIDER'S PLAN OF CORREC		(75)
(X4) ID PREFIX TAG	(EACH DEFICIENC	LATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	1	(EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 284	Continued From pag	e 103	F	284			
		dmission to (name of facility).					
		ssist? The fax number for					
	An interview was cor	aducted with the					
		istrative staff member (ASM)					
		f nursing, ASM #2, on 1/5/17					
		and ASM #2 were asked					
	•	ning for residents starts.					
	ASM #2 stated, "Upo	on admission." When asked if					
	the resident should h	-					
		ASM #2 stated, "Yes." When					
		care plan would be done if					
		ing to stay long term care.					
		." When asked for any ding the planning of the					
		nt #25 to another facility,					
	-	asn't in the building at that					
		they could not locate the					
		sent for the 72 hour meeting.					
		nat only one care plan					
		2/4/16 over the phone with					
		dent had eloped from the					
		rge planning was done at					
	Ŭ	1 was shown the email the admissions director to					
		on 3/18/16, and was asked,					
		on of the social workers					
	-	scharge planning, and					
		the other facility. ASM #1					
		r initiated the transfer."					
	When asked if that n						
	responsibility to ensu stated, "No."	ıre a safe discharge, ASM #1					
	The administrator an	d ASM #2 were made aware					
		n on 1/5/17 at 6:00 p.m.					
	No further informatio	n was provided prior to exit.					
RM CMS-256	7(02-99) Previous Versions Ob	solete Event ID: 095F1	11	Facility	ID: VA0080 If col	ntinuation sheet	Page 104 of 17

*ECEIVED BAN 3.9 2017 *DH/OLC

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		OMB NO. 0938-0 (X3) DATE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:				TE SURVEY MPLETED		
		495249	B. WING		_	С		
		1		STREET ADDRESS, CITY, STATE, ZIP CO		1/06/2017		
IN MIL OF T	CONDERCOR SOLVEIER			1575 SCOTT DRIVE ROUTE 5	DE			
FARMVILL	E REHABILITATION &	HEALTH CARE CENTER LLC		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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE		
F 284	Continued From pag	e 104	F 28	4				
	Complaint Deficiency	1						
	483.24, 483.25(k)(l) FOR HIGHEST WEL	PROVIDE CARE/SERVICES L BEING	F 30	9 F309				
				1. Resident #7 was disch	arged from	Dem ATE COMPLETI DATE DATE DATE DATE		
	-	damental principle that d services provided to facility		the facility on 1/9/17.	anged from			
		dent must receive and the		Resident #3's physician	was notified			
		he necessary care and		by the Director of Nursir				
	services to attain or r			facial treatments, 8 abdo	···			
		mental, and psychosocial		treatments, and 2 right th				
	well-being, consisten	ssment and plan of care.		wound care were not doc				
	comprehensive asse	sament and plan of care.		the December 2016 med				
	483.25							
	(k) Pain Managemen			Resident #3's facial area	s, abdominal			
		ure that pain management is		skin areas, and right third				
		who require such services, ssional standards of practice,		were reassessed by the li				
		erson-centered care plan,		on 1/6/17 and no decline				
	and the residents' go					***		
				Resident #6 was reassess	ed for pain			
	(I) Dialysis. The facili	•		on 1/6/17 by the Unit Ma	•			
		e dialysis receive such vith professional standards		The Licensed nurses will				
		rehensive person-centered		reeducated by the Staff D				
	care plan, and the res			Coordinator by 2/1/17 re	•			
	preferences.			ensuring non pharmacolo				
		is not met as evidenced		interventions are attempt				
	by: Based on resident in	terview, staff interview,		administration of as need	•			
	facility document revie			medication and the effect	•			
		ined that that facility staff		the administered pain me				
	•	and services to maintain the		assessed using a pain sca				
	highest practicable we	-		Resident #1 was discharg				
	residents in the surve Resident #3, Residen	y sample, Resident #7,		facility on 1/7/17.	/			

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

Facility ID: VA0080

TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			OMB NO. 0938-00 (X3) DATE SURVEY COMPLETED C	
		495249					
	ROVIDER OR SUPPLIER	HEALTH CARE CENTER LLC	B: Winds 01/06/2017 STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901 FARMVILLE, VA 23901				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	 Resident #11. The facility staff fail pain prior to administ medication. The facility staff fail ordered facial treatmed of 62 opportunities in ordered abdominal skoccasions out of 62 of 2016; and physician of care on two occasion December 2016 for R The facility staff fail pharmacological inter administration of as n failed to assess the emedication administer Resident #6. For Resident #1, fail non-pharmacological administration of prinedication. The facility medication. The facility medication. The facility staff fail monitor pain prior to t medication. The facility staff fail 	iled to assess Resident #7's ering as needed pain hiled to provide the physician ents on seven occasions out December 2016; physician kin treatments on eight opportunities in December ordered right third toe wound s out of 31 occasions in Resident #3. led to attempt non rventions prior to the needed pain medication and ffectiveness of the red using a pain scale for acility staff failed to attempt interventions prior to the	F	309	Resident #11's AV fistula was assessed on 1/6/17 by the Regist Nurse with no concerns noted. 2. The Assistant Director of Nur and the Director of Nursing will the current resident's treatment records by 2/1/17 to ensure treat have been documented as requir The Assistant Director of Nursir the Director of Nursing will aud current residents' medical record 2/1/17 to ensure non pharmacold interventions are attempted prior the administration of as needed p medications and the effectivenes the administered pain medication assessed using a pain scale. The Assistant Director of Nursir will audit the current dialysis residents' by 2/1/17 to ensure Af fistula and shunt are assessed an monitored as required.	sing audit ments ed. ng and it the d by ogical r to opain ss of n is	
	The findings include:						
		o assess Resident #7's pain as needed pain medication.					

Facility ID: VA0080

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		ID HUMAN SERVICES MEDICAID SERVICES			FO	ED: 01/17/2017 RM APPROVED NO. 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION	(X3) DA	TE SURVEY
		495249	B. WING _			C 01/06/2017
NAME OF P			Ĩ	STREET ADDRESS, CITY, STATE, ZIP CODE		
FARMVILI	E REHABILITATION & H	EALTH CARE CENTER LLC		1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 309	Resident #7 was adm 12/26/16 and readmitt diagnoses that include respiratory failure, chr blood pressure, arthrit The most recent MDS available to review. Th dated 12/30/16 at 4:00 "Resident is alert/orin name, date and where for ADL (activities of d Review of the care plat documented, "Focus. alteration in comfort: p process. Interventions of pain interventions. If alleviating of symptom resident satisfaction w functional ability and in Review of the physicia "Percocet (1) 5/325 m po (by mouth) q (every needed) pain." Review of the medicatt (MAR) documented, "F Q4Hrs prn pain. It was #7 received pain medic p.m.; 1/2/17 at 3:15 a.1 1/5/17 at 2:30 a.m. and was no documentation rating prior to administ	itted to the facility on ted on 12/30/16 with ed but were not limited to: ionic lung disease, high tis and chronic pain. was in progress and not he admission nurse's note 0 p.m. documented, ient (sic) x (times) 3 (knows e she is) 1 assist needed aily living) care." an initiated on 1/4/17 The resident is at risk for bain r/t (related to) disease . Evaluate the effectiveness Review for compliance, is, dosing schedules and ith results, impact on mpact on cognition." an's orders documented, g (milligrams) 1 tab (tablet) /) 4 hr (hours) prn (as ion administration record Percocet 5/325 mg 1 tab po io documented that Resident cation on 1/1/17 at 4:45 m.; 1/4/17 at 9:55 a.m. There of the resident's pain ration of the pain a documentation that the	F3	 3. The Licensed nurses will reeducated by the Staff De Coordinator by 2/1/17 relatensuring treatments are dot as required, dialysis AV fissishunts are assessed and morequired, and non pharmace interventions are attempted the administration of as new medications and the effect in the administered pain medications and the effect is the administered pain medications and the effect is assessed using a pain scale 4. The Director of Nursing Assistant Director of Nursing Assistant Director of Nursing audit 5 current resident's mirecord on each unit weekly weeks and monthly for 2 ministration as required, diffistula and shunts continue assessed and monitored and pharmacological interventions and the effect if the administration of as needed medications and the effect if the administered pain medications and the effect if the adm	velopment ted to cumented stula and onitored as ological l prior to eded pain veness of ication is or ng will nedical for 4 nonths to to be alysis AV to be d non- ons rior to the d pain veness of cation is ing a pain sing will ity	

Event ID: 095F11

Facility ID: VA0080

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STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			OMB NO. 093 (X3) DATE SURVI COMPLETED	
		495249	B. WING			06/2017
	SUMMARY ST. (EACH DEFICIENC	IEALTH CARE CENTER LLC ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	1	TREET ADDRESS, CITY, STATE, ZIP CODE 575 SCOTT DRIVE ROUTE 5 CARMVILLE, VA 23901 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 309	1/5/17 did not evidend assessment prior to the medication. There was completed on 1/14/17 An interview was com- a.m. with RN (register process staff follows the RN #5 stated, "Ask the cognitively intact we us look at the MAR and a and offer interventions medication and follow medication was effect pain scale was docum documented on the M An interview was com- a.m. with ASM (admin the director of nursing assessed a resident's get a baseline on thei this was documented the back of the MAR.' An interview was com- a.m. with LPN (license When asked how staff pain, LPN #3 stated, " long (have they had it of zero pain to ten bei When asked if this was stated, "Yes, on the M review Resident #7's When asked if there w documented, LPN 3 s my nurse's note." LPN	a notes on 1/1/17, 1/2/17 and ce documentation of a pain he administration of the pain is a pain assessment 7. ducted on 1/5/16 at 11:30 red nurse) #5 regarding the to assess a resident's pain. ie pain scale or if not use facial expressions. We see if there are parameters is before giving the pain 7 up after (to see if the tive)." When asked if the nented, RN #5 stated it was IAR. ducted on 1/5/16 at 11:35 nistrative staff member) #2, g. When asked how staff is pain, ASM #2 stated, "We r pain level." When asked if , ASM #2 stated, "We r pain level." When asked if , ASM #2 stated, "Yes, on ' ducted on 1/5/16 at 11:45 ed practical nurse) #3. f assesses a resident's 'Where (is the pain), how)ask them the pain scale ing the worst pain ever." as documented, LPN #3 IAR." LPN #3 was asked to MAR for the Percocet.	F 309	The Director of Nursing will be responsible for monitoring and fol up. Completion Date:	llow	02/03/17

Facility ID: VA0080

If continuation sheet Page 108 of 171

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CON	ISTRUCTION	(X3) DAT	O. 0938-03 E SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		СОМ	IPLETED
		495249	B. WING			C 01/06	
NAME OF P	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		/06/2017
FARMVILI	E REHABILITATION & I	HEALTH CARE CENTER LLC		1575 \$	SCOTT DRIVE ROUTE 5		
				FARM	IVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETH DATE
F 309	Continued From pag	e 108	F	309			
		sment, LPN #3 stated, "It's					
		SM #2, the director of					
nursing were made aware of the findings. Review of the facility's policy titled, "PAIN ASSESSMENT" documented, "Policy: An in-depth pain assessment will be completed for each resident who presents with acute or chronic; unrelieved pain symptoms. The comprehensive pain assessment includes: origin, location, severity, exacerbating and alleviating factors, and current treatment and response to treatment. Procedure: 7. Reassess and document the resident's pain using the pain scale each time pain medication is used, when the dose changes		umented, "Policy: An ment will be completed for esents with acute or chronic; otoms. The comprehensive udes: origin, location, g and alleviating factors, and d response to treatment. ess and document the the pain scale each time					
	_	n was provided prior to exit.					
	severe pain. This med reliever. This informat	moderate to moderately dicine is a narcotic pain tion was obtained from: nih.gov/pubmedhealth/?ter					
	ordered facial treatme of 62 opportunities in ordered abdominal sk occasions out of 62 o 2016; and physician o	iled to provide the physician ents on seven occasions out December 2016; physician in treatments on eight pportunities in December ordered right third toe wound s out of 31 occasions in esident #3.					
RM CMS-2567	Resident #3 was adm			Enallity ID	: VA0080 If contin	uation sheet P	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

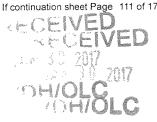
RECEIVED

PRINTED: 01/17/2017

FORM APPROVED

	MENT OF HEALTH AN S FOR MEDICARE & I					FORM	<i>APPROVED</i> 0.0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		495249	B. WING				C 106/2017
	ROVIDER OR SUPPLIER	EALTH CARE CENTER LLC		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 309	fracture left thigh bom pressure and bladder The most recent MDS day assessment, with reference date) of 12/ having scored seven interview for mental si was severely impaired was coded as requirin for all activities of dail coded as being at risk ulcers. The resident w more unhealed press Review of the physicia documented: - "Cleanse face with w hydrocortisone (1) 0.1 two times a day. Start - Cleanse skin to abde saline, pat dry apply r units/gram topical pow treatment. Start date. - Cleanse right 3rd too xeroform (3) gauze, c with kling and secure date. 10/20/16." Review of the Decemi administration record - "Cleanse face with w hydrocortisone 0.1% two times a day." Rev	red on 10/19/16 with itted to the facility on red on 10/19/16 with ed but were not limited to: e, pain, anxiety, high blood cancer. 6 (minimum data set, a thirty an ARD (assessment 3/16 coded the resident as but of 15 on the BIMS (brief tatus) indicating the resident d cognitively. The resident d cognitively. The resident g the assistance from staff y living. The resident was t for developing pressure vas coded as having one or ure ulcers. an orders dated 12/30/16 vater only and apply % to red areas on face BID date. 10/19/16." ominal fold with normal hystatin (2) 1000,000 vder bid two times a day for 10/19/16." e with normal saline, apply over with 4x4 gauze, wrap daily every day shift. Start ber 2016 treatment (TAR) documented:	F	309			

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/17/2017 MAPPROVED D: 0938-0391
STATEMENT ((X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		495249	B. WNG				C 06/2017
		I		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				15	575 SCOTT DRIVE ROUTE 5		
FARMVILI	_E REHABILITATION & H	EALTH CARE CENTER LLC		F/	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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	a.m. or 6:00 p.m.; 12/ at 9:00 a.m.; 12/16/16 6:00 p.m. and 12/26/* treatment was not pro out of 62 opportunitie - "Cleanse skin to abore saline, pat dry apply r topical powder bid two Start date. 10/19/16." evidence documentat been provided as ord a.m. or 6:00 p.m.; 12/ at 9:00 a.m.; 12/16/16 9:00 a.m. or 6:00 p.m. treatment was not pro out of 62 opportunitie - "Cleanse right 3rd to xeroform gauze, cov kling and secure daily 10/20/16." Review of the TAR di documentation that th provided on 12/7/16 a was not provided a to opportunities. Review of Resident # 5/26/15 and revised o "Problem. Arterial (ar for further damage r/t disease process." Review of the weekly report dated 11/15/16 "SITE/LOCATION: ab IS: MASD (moisture a	ered on: 12/2/16 at 9:00 (7/16 at 9:00 a.m.; 12/13/16 5 at 6:00 p.m.; 12/21/16 at 16 at 6:00 p.m. The ovided a total of seven times s. dominal fold with normal hystatin 1000,000 units/gram o times a day for treatment. Review of the TAR did not tion that the treatment had ered on: 12/2/16 at 9:00 (3/16 at 6:00 p.m.; 12/13/16 5 at 6:00 p.m.; 12/21/16 at a.; 12/26/16 at 6:00 p.m. The ovided a total of eight times s. be with normal saline, apply er with 4x4 gauze, wrap with y every day shift. Start date. d not evidence he therapy had been and 12/13/16. The treatment otal of two times out of 31 et al of two times (sic)	F	309	DEFICIENCY)		
FORM CMS-25	67(02-99) Previous Versions Obs	solete Event ID: 095F	11	Fac	cility ID: VA0080 If continua		Page 111 of 171



		ID HUMAN SERVICES					APPROVED
		MEDICAID SERVICES	r			(. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		LETED
		495249	B. WING				C 06/2017
NAME OF PR	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					1575 SCOTT DRIVE ROUTE 5		
FARIVIVILL		IEALTH CARE CENTER LLC			FARMVILLE, VA 23901		
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI	DULD BE	 (X5) COMPLETION DATE
TAG					DEFICIENCY)		
F 309	Continued From page	e 111	F	309	9		
	(redness and (no) bro	oken skin."					
	On 1/4/17 a request v						
	N	nember) #2, the director of e wound care for Resident					
	0	o made for all wound care					
	sheets for the resider present date.	nt from October 2016 to the					
		n. ASM #2 stated that the n already been completed					
	1	she would facilitate an					
	observation of wound made available for ob	l care. Wound care was not oservation on 1/5/17.					
		ducted on 1/5/17 at 11:45 ed practical nurse) #3 was					
	asked what blank spa	aces on the TAR meant. LPN					
	#3 stated, "If it isn't de	ocumented it didn't happen."					
		ducted on 1/5/17 at 12:15					
		nen asked what it meant ik spaces on the TAR, LPN					
	#1 stated, "It means i						
		n. ASM (administrative staff					
		ninistrator and ASM #2, the					
		ere made aware of the as made for the weekly body					
		as not provided during the					
	survey. A request wa	s made to speak to the					
	nurses who worked th						
	-	provided. The nurses were					
		r interview during the lest to observe wound care					
	for Resident #3 was a						
		m. a request to observe					
	Resident #3's wound	care again to ASM #2. ASM			<u></u>		 2000 112 of 171

If continuation sheet Page 112 of 171

		D HUMAN SERVICES					MAPPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	<u>0. 0938-0391</u>
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION		E SURVEY IPLETED
		495249	B. WING			0-	C 1/06/2017
NAME OF PF			- 1		ET ADDRESS, CITY, STATE, ZIP CODE		
FARMVILL	E REHABILITATION & H	EALTH CARE CENTER LLC			SCOTT DRIVE ROUTE 5 MVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	Resident #3's wounder ASM #2 again stated that occurred. On 1/6/17 at 12:50 a. to ASM #2 to observe Wound care was not Review of the facility! Medication Orders" d administering medica No further information (1) Hydrocortisone cr corticosteroids share anti-pruritic and vaso mechanism of anti-infit topical corticosteroids was obtained from: <https: dailymed.nlm<br="">ugXsl.cfm?id=602655 (2) Nystatin - Treats i This information was <https: www.ncbi.nln<br="">HT0011455/?report=60 (3) XeroformComm occlusive dressings (wound dressing) have</https:></https:>	make sure it occurred. m. a request to observe is was made to ASM #2. that she would make sure m. a final request was made Resident #3's wounds. made available prior to exit. is policy titled, "Physician id not specifically address tions as ordered. in was provided prior to exit. eam Topical anti-inflammatory, constrictive actions. The l'ammatory activity of the is unclear. This information nih.gov/dailymed/fda/fdaDr nih.gov/pubmedhealth/PM details> mercial silver-impregnated such as Aquacel Ag Surgical	F 3	09			
	<https: www.ncbi.nln<br="">></https:>	n.nih.gov/pubmed/27776905					

Facility ID: VA0080

If continuation sheet Page 113 of 171

		ND HUMAN SERVICES					APPROVED . 0938-0391
	FDEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION		(X3) DATE COMPI	LETED
		495249	B. WING _				06/2017
NAME OF PR	OVIDER OR SUPPLIER	1		STREET ADDRESS,	CITY, STATE, ZIP CODE		
i		HEALTH CARE CENTER LLC		1575 SCOTT DRIVE			
			<u> </u>	FARMVILLE, VA	DVIDER'S PLAN OF CORREC	CTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	CORRECTIVE ACTION SHO REFERENCED TO THE APPI DEFICIENCY)	OULD BE	COMPLETION DATE
F 309	Continued From pag	e 113	F3	09			
	administration of as failed to assess the medication administ Resident #6. Resident #6 was add 10/13/09 with a rece with diagnoses that to: multiple sclerosis in which nerve fibers lose their myelin cov vascular disease, hi neurogenic bladder. The most recent ME assessment, a quar assessment referen the resident as scor interview for mental she was cognitively decisions. The resi extensive to being t staff for most of her was coded as indep assistance was prov Health Conditions, th having received sch needed pain medica non-medication inte #6 was coded as ha of five out of zero - ever in.	erventions prior to the needed pain medication and effectiveness of the ered using a pain scale for mitted to the facility on ent readmission on 9/16/16, included but were not limited is (MS) (a progressive disease is of the brain and spinal cord ver (1)), dysphagia, peripheral gh blood pressure, and OS (minimum data set) terly assessment, with an ce date of 11/14/16, coded ing a 13 on the BIMS (brief status) score, indicating that intact to make daily dent was coded as requiring otally dependent upon the activities of daily living. She bendent after set up vided for eating. In Section J - the resident was coded as neduled pain medication, as ation and received erventions for pain. Resident aving frequent pain on a scale ten, ten being the worse pain					
	"Percocet (used to	rs dated 1/1/17, documented, treat moderate to severe pain by mouth) Q (every) 6 hrs		Facility ID: VA0080	If ~	ontinuation sheet	Page 114 of 171

Facility ID: VA0080

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495249	B. WING		0	1/06/2017
NAME OF PR				STREET ADDRESS, CITY, STATE, ZIP C	CODE	
FARMVILL	E REHABILITATION 8	HEALTH CARE CENTER LLC		1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 309	(hours) PRN (as ne Review of the Nove administration reco	eeded)." ember 2016 MAR (medication rd) revealed the	F 3(99		
	Percocet 34 times. did not document a	he administration of the The reverse side of the MAR a pain level and documented or a plus sign" under the r Response."				
	documentation of t Percocet 15 times. did not document a	I6 MAR revealed the he administration of the The reverse side of the MAR a pain level and only effective)" or a plus sign with				
	anything related to dated, 12/16/16 at "Res (resident) rec 6:10 p.m. for c/o (c	se's notes did not document pain except one nurse's note 9:00 p.m. that documented, 'd (received) PRN Percocet at complaint of) wound pain after neffective. (A plus sign) results				
	11/2/15, document impaired comfort r/ the disease proces documented, "Res than 2 on a scale of pain within 30 min	ed, 10/28/10 and reprinted on ed, "Problem/Need: Risk for /t (related to) pain secondary to ss." The "Goals & Target date" ident will state pain level less of 1 -10 after intervention for (minutes) to 1 hour. Thru next proaches" documented,				
	"Assess for pain que medications PRN (uarterly. Administer pain (as needed). Monitor for erventions for pain. Assess for				

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	MENT OF HEALTH AN						D: 01/17/2017 MAPPROVED
CENTER	S FOR MEDICARE & I		T			OMB NO	<u> </u>
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED	
		495249	B. WING			C 01/06/2017	
NAME OF PI	ROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, ZIP CODE		
EA DMALUL				1	1575 SCOTT DRIVE ROUTE 5		
FARMIVILL		EALTH CARE CENTER LLC		F	FARMVILLE, VA 23901		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	×	(EACH CORRECTIVE ACTION SHOULD B		COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE .	DATE
E 200	o 11 15						
F 309	Continued From page		E F S	309			
	record was dated, 9/1						
	documented, "11/15/1						
	through it indication 'n	· ·					
	-	e (A zero with a line through ased c/o (complaints of)					
	pain."	ased to (complaints of)					
	pair.						
	An interview was cond	ducted with RN (registered					
		nt director of nursing, on					
		regarding the process staff					
		ng pain medications. RN					
	#1 stated, "First you a	ssess where the pain is. If					
	the resident is capable	e, you ask the pain scale					
		cological interventions, and					
	-	you go to the medications					
		ations. After you give the					
	medications, you go b						
		nedication was effective."					
		aff ask residents' the pain					
	scale rating again on r	When asked where the					
	assessment using the						
	-	interventions implemented					
		t using the pain scale is					
		tated, "In the nurses notes."					
		lucted with Resident #6 on					
	-	sident #6 was asked when					
		dication does the staff asks					
	her to rate her pain on		****				
	stated, "Yes." Residen		V-V-V-V-V-V-V-V-V-V-V-V-V-V-V-V-V-V-V-				
		er to rate her pain again on her the pain medication.					
	, , , ,	lo they don't." On 1/5/17 at					
		was asked if staff offers to					
		r a snack or anything to					
		it medication, when she					
	•	on. Resident #6 stated,					
	"No, no one does that.						

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		ND HUMAN SERVICES			FORM	APPROVED
		MEDICAID SERVICES	(X2) MULTIPLE C	CONSTRUCTION		<u>. 0938-0391</u> SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPI	
					0)
		495249	B. WING		01/(06/2017
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
FARMVILI	E REHABILITATION & F	IEALTH CARE CENTER LLC		25 SCOTT DRIVE ROUTE 5 RMVILLE, VA 23901		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION DATE
F 309	Continued From page	e 116	F 309			
-	practical nurse) #1, th #6; on 1/5/17 at 1:25 about the process sta complains of pain. Lf where the pain is, ass the pain scale or wate repositioning or offer then I will give the pai if she went back to re LPN #1 stated, "I go th was effective, sometim me if it's better or gon effective." LPN #1 was offered prior to the ad the pain scale rating a LPN #1 stated, "We h were told to use them LPN #1 left to look at had a flow sheet. LPI she couldn't find any stated, "I guess it sho then."	as asked where interventions ministration medication and assessment is documented. ad pain flow sheets. We then told not to use them." the MAR to determine if she N #1 returned and stated old pain flow sheets and uld be in the nurse's notes				
	approximately 2:30 p. staff follows for reside #2 stated, "First you a pain and location of th interventions first, if th medications. Then yo the medication worker once again." When a	ney don't help, you go the u go back and evaluate if d, you ask the pain scale sked where the ed prior to medication and				

	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT ((X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	SURVEY
		495249	B. WNG_				C 106/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				1	575 SCOTT DRIVE ROUTE 5		
FARMVILI	LE REHABILITATION & H	EALTH CARE CENTER LLC		F	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 309	Continued From page notes." The facility policy, "Pa documented in part, " interventions are used in conjunction with me can include: positionir modalities, relaxation Reassess and docum the pain scale each tii when the dose chang changes. 8. If pain m of a pain management Management Flow Sh assess pain each time provided. This record MAR." Fundamentals of Nurs Perry, 2005, pages 12 approach pain manag understand a client's p appropriate intervention monitor pain on a con of common characteri nurse form an underst its pattern, and types bring reliefOnset ar durationLocation PatternRelief Meas SymptomsPain the individualized approat monitor interventions pain relief and indepen measures that comple physicianEffective of	a 117 ain Assessment" 4. Non pharmacological d to provide pain relieve (sic) edication use. Interventions ng, physical therapy techniques, etc7. eent the resident's pain using me pain medication is used, es or when the drug edication is provided as part at program, the Pain neet should be used to e pain medication is I should be kept with the sing, 6th Edition, Potter and 239-1287, "Nurses need to tement systematically to pain and to provide onit is necessary to sistent basisAssessment stics of pain helps the tanding of the type of pain, of interventions that may ad IntensityQualityPain uresContributing rapy requires an chNurses administer and ordered by physicians for		309			
	intervention is facilitate						

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	MENT OF HEALTH AN				FC	TED: 01/17/2017 DRM APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) D.	NO. 0938-0391 ATE SURVEY DMPLETED
		495249	B. WING			C 01/06/2017
NAME OF F			-	STREET ADDRESS, CITY, STATE, ZIP		01100/2011
FARMVIL	LE REHABILITATION & H	EALTH CARE CENTER LLC		1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 309	needs to transpire fro shift, and nurse to oth is the professional res caring for the client to effective for managing client is not responsib information is accurat tools such as a pain fl centralize the informa management. The administrator and of the above findings of (1) Barron's Dictionary Non-Medical Reader, Chapman, page 380. (2) This information we website: https://www.ncbi.nlm.r T0011543/?report=det 4. For Resident #1, far non-pharmacological i administration of prn (a medication. The facility monitor pain prior to th medication and failed prn pain medication. Resident #1 was admi 4/28/16 with diagnoses limited to protein-calor hypothyroidism, blindn and Dementia with Lew most recent MDS (min quarterly assessment of	m nurse to nurse, shift to her health care providers. It sponsibility of the nurse report what has been g the client's pain. The le for ensuring that this ely transmitted. A variety of ow sheet or diary will help tion about pain ASM #2 were made aware on 1/5/17 at 6:00 p.m. ASM #2 were made aware	F3	309		

Event ID: 095F11

Facility ID: VA0080

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495249	B. WING _		0	C 1/06/2017
	ROVIDER OR SUPPLIER	IEALTH CARE CENTER LLC		STREET ADDRESS, CITY, STATE, 2 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED		(X5) COMPLETION DATE
F 309	the ability to make da of 15 on the BIMS (Br status) exam. Reside requiring extensive as transfers, dressing, ea hygiene, and bathing. Review of Resident # (medication administr following orders initiat "Lortab Tablet [2] 5-32 tablet po (by mouth) a Lortab Tablet 5-325 m mouth) at bedtime." T on 12/23/16. Review of the NovemI PRN (as needed) Lort time on 11/12/16 as be Documentation in the regarding the administr non-pharmacological i prior to the administrat the Lortab. Review of Resident #1 that Resident #1 was a needed) Lortab on 11/ a.m., 11/5/16 at 2 p.m. 11/16/16 at 11 a.m., 11 11/25/16 at 8 a.m. No documentation cour resident's pain level at times, non-pharmacological	ely cognitively impaired in ily decisions, scoring 03 out rief Interview for mental ent #1 was coded as ssistance with bed mobility, ating, toileting, personal 1's November 2016 MAR ation record) revealed the ed on 10/28/16: 25 mg (milligrams) Give 1 as needed for PAIN. Ing Give 1 tablet po (by This order was discontinued over 2016 MAR revealed that ab was documented one eing administered. nursing notes was found	F3	****		
ORM CMS-256	7(02-99) Previous Versions Obso	ete Event ID: 095F11		Facility ID: VA0080	If continuation sheet	Page 120 of 171

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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ACCEIVED VOH/OLC

	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION	(X3) DA	TE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:		S	COMPLETED		
		495249	B. WING		0	C 01/06/2017	
NAME OF PI		· · · · · · · · · · · · · · · · · · ·		STREET ADDRESS, CITY, STATE, ZIP	CODE		
FARMVILL	E REHABILITATION & H	EALTH CARE CENTER LLC		1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
F 309	Continued From page 120 the Lortab.		F 3C	99			
	Review of Resident #1's December 2016 MAR (medication administration record) revealed the following orders initiated on 10/28/16: "Lortab Tablet 5-325 mg (milligrams) Give 1 tablet po (by mouth) as needed for PAIN."						
	Lortab Tablet 5-325 mg Give 1 tablet po (by mouth) at bedtime." This order was discontinued on 12/23/16.						
	Review of the Decem (as needed) Lortab w documented as being month.						
	revealed that nursing scheduled and PRN I narcotic pack. The fo	(acetaminophen) 5 -325 mg" was dispensing the _ortab from the same Illowing was documented: (Lortab) 5-325 mg Tablet					
		c log sheet revealed that tab was administered on 2/28/16 at 8 p.m., and					
	resident's pain level a times, non-pharmaco	uld be found regarding the it the above administered logical interventions prior to _ortab, or effectiveness of					

	MENT OF HEALTH AN S FOR MEDICARE & I		FORM APPROVED OMB NO. 0938-0391				
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495249	B. WING _				C 06/2017
	ROVIDER OR SUPPLIER	EALTH CARE CENTER LLC		1	TREET ADDRESS, CITY, STATE, ZIP CODE 575 SCOTT DRIVE ROUTE 5 ARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIJ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	was asked about the administering prn (as a resident, RN #1 sta resident the pain scal non-pharmacological pain medication, and medications if non-ph were not effective. S write the resident's pa MAR or in a nursing r would check back to was effective and doo the back of the MAR On 1/5/17 at 4:30 p.r conducted with ASM member) #2, the DOI ASM #2 was asked a follows prior to admin pain medication to a she would rate the pa interventions first, me relieved by non-pharr and then go back to e effectiveness. When documented in a nurs stated that a pain sca documented on the b administration record On 1/5/17 at 5:59 p.n administrator, and AS aware of the above fi	Registered Nurse) #1. RN #1 process staff follows prior to needed) pain medication to ted that she would ask the e, attempt interventions before giving then administer prn pain armacological interventions he stated that she would ain level on the back of the note. RN #1 stated that she see if the pain medication cument the new pain level on or in a nursing note. m., an interview was (administrative staff N (Director of Nursing). bout the process staff istering prn (as needed) resident, ASM #2 stated that in, try non-pharmacological edicate if the pain is not macological interventions, evaluation medication asked where this process is 2 stated that it should be se 's narrative. ASM #2 the should also be ack of the MAR (medication). m., ASM #1, the SM #2 the DON were made ndings.	F	309			
	documents in part, th	e following: "1. When pain is					

Event ID:095F11

Facility ID: VA0080

If continuation sheet Page 122 of 171



PRINTED: 01/17/2017

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Statistic is information (N) PROVEENSUPPLIESCUA DEDITIONATION NUMBER: (N) NULTHE CONSTRUCTION A BULDING. (N) NULTHE CONSTRUCTION A BULDING. (N) NULTHE CONSTRUCTION A BULDING. NAME OF PROVIDER OR SUPPLIES. 495249 8 WHO (T) OUTO STATUS, 20*000 1975 SOUTD RAVE, 20*000 1975 SOUTD RAVE, 20*000 1975 SOUTD RAVE, 20*0000 1975 SOUTD RAVE, 20*00000 1975 SOUTD RAVE, 20*00000000 1975 SOUTD RAVE, 20*00000000 1970 SOUTD RAVE, 20*00000000000000000000000000000000000			ID HUMAN SERVICES MEDICAID SERVICES				FOR	MAPPROVED 0. 0938-0391
495249 8.MND 01106/2017 NMME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE: 1975 SOOT BRUE, VL 32301 STREET ADDRESS, CLTY, STATE, ZIP CODE: 1975 SOOT BRUE, VL 32301 Street ADDRESS, CLTY, STATE, ZIP CODE: 1975 SOOT BRUE, VL 32301 Configuration of ADDRESS, CLTY, STATE, ZIP CODE: 1975 SOOT BRUE, VL 32301 Configuration of ADDRESS, CLTY, STATE, ZIP CODE: 1975 SOOT BRUE, VL 32301 Configuration of ADDRESS, CLTY, VL 32301 Configuration of CLTY, CLTS, CLTY, CLT	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE COMF	SURVEY
PARMVILLE REHABILITATION & HEALTH CARE CENTER LLC 1575 SCOTT DRIVE : ROUTE 5 PARMVILE, VA 23801 PREINT TAG SUMMAY STATEMENT OF DEPCENDES (EACH DEPCENT MUST BE PRECEDED BY FULL TAG D PREFIX TAG Continued From page 122 identified through the MDS process, the initial nursing assessment, or the resident has complaints of pain not relieved for proloid periods of time, initiate the pain assessment tool to further assess the type, frequency. Location, and other factors or causes related to the resident's pain. A. Non-pharmacological interventions are used are used to provide pain relieve in conjunction with medication use. Interventions are used are used to provide pain relieve in conjunction with medication use. Interventions are used are used to provide pain relieve in conjunction with medication use. Interventions are used are used to provide pain relieve in conjunction with medication use. Interventions are used are used to provide pain relieve in conjunction with medication use. Interventions are used are used to provide pain relieve in conjunction with medication use. Interventions can use failed to the resident's pain. A. Non-pharmacological interventions can use are used to provide pain relieve in conjunction with medication use. Interventions can include: positioning, physical therapy modalities, relaxation techniques, etc." F 309 No further information was presented prior to exit. If Lewy Body. "LBD is a disease associated with abnormal deposits of a protein called disease." This information was obtained from the National Institutes of Health. https://www.na.in.gov/ablemers/publication/le wy-body-dementiabasica.lewy.body-demential. [2] Lortab - Hydrocodne and Actaminophan combination used to relieve moderate to severe pain. This information was obtained from the National Institutes of Health. https://www.na.in.min.pov/pubmedhealth/P			495249	B. WING				
FARMULLE RUADING BILINAMY STATEMENT OF DEFICIENCES D PROVIDER INACTORMECTION (Mail D) PRETIX TXG BILINAMY STATEMENT OF DEFICIENCES D PROVIDER THAN OF CORRECTION (BCOCORRECTINE ACTOR SECILO BILIN RESULTATION & INFORMATION D PROVIDER THAN OF CORRECTION (BCOCORRECTINE ACTOR SECILO BILIN RESULTATION TO THE TRADET OF DEFICIENCES) D PROVIDER THAN OF CORRECTION (BCOCORRECTINE ACTOR SECILO BILIN RESULTATION TO THE TRADET OF DEFICIENCY) D PROVIDER THAN OF CORRECTION (BCOCORRECTINE ACTOR SECILO BILIN (BCOCORRECTINE ACTOR SECILO (BCOCORRECTINE ACTOR SECILO (BCOCORCT))	NAME OF P		.					
Mathematic (EACH CORE CENCY VLICE OF PRECIDENCE STYPLIL TAG PRETX TAG TEACH CORECTIVE ACTION SHOULD BE CROSS-HEEPENDED TO THE PRECIDENCE STYPLIL DEFICENCY CONTENTION (INTENTION) CONTENTION TAG F 309 Continued From page 122 Identified through the MDS process, the initial nursing assessment, or the resident has complaints of pain not relieved for prolong periods of time, initiate the pain sussessment tool to further assess the type, frequency. Location, and other factors or causes related to the resident's pain A Non-pharmacological interventions are used are used to provide pain relieve in conjunction with medication use. Interventions can include: positioning, physical therapy modalities, relaxation techniques, etc." F 309 No further information was presented prior to exit. [1] Lewy Body- "LBD is a disease associated with abnormal deposits of a protein called alpha-synuclein in the brain. These deposits, called Lewy bodies, affect chemicals in the brain whose changes, in turn, can lead to problems with thinking, movement, behavior, and mood. LBD is one of the most optimers/publication/le wy-body-dementia. [2] Lortab- Hydrocodone and Acetaminophen combination used to relayer modarate to severe pain. This information was obtained from the National Institutes of Health. https://www.ncb.nim.nim.gov/pubmedhealth/PMH T0010590. Event content and the addition of the content as the addition of the most orbitability staff failed to monitor Resident # 11's AV fistula (1) (aterial - venous) fistula port for	FARMVILI	E REHABILITATION & H	IEALTH CARE CENTER LLC					
identified through the MDS process, the initial nursing assessment, or the resident has complaints of pain not relieved for prolong periods of time, initiate the pain assessment tool to further assess the type, frequency. Location, and other factors or causes related to the resident's pain4. Non-pharmacological interventions are used are used to provide pain relieve in conjunction with medication use. Interventions can include: positioning, physical therapy modalities, relaxation techniques, etc." No further information was presented prior to exit. [1] Lewy Body- "LBD is a disease associated with abnormal deposits of a protein called alpha-synuclein in the brain. These deposits, called Lewy bodies, affect chemicals in the brain whose changes, in turn, can lead to problems with thinking, movement, behavior, and mood. LBD is one of the most common causes of dementia, after Alzheimer's disease and vascular disease." This information was obtained from The National Institutes of Health. https://www.nia.nih.gov/alzheimers/publication/le wy-body-dementiabasics-lewy-body-dementia. [2] Lortab- Hydrocodone and Acetaminophen combination used to relieve moderate to severe pain. This information was balained from the National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH TO010590/. [5. The facility staff failed to monitor Resident # 11's AV fistula (1) (arterial - venous) fistula port for	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFD	x	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLETION
11's AV fistula (1) (arterial - venous) fistula port for	F 309	identified through the nursing assessment, complaints of pain no periods of time, initiat to further assess the and other factors or cor- resident's pain4. No interventions are used relieve in conjunction Interventions can inclu- therapy modalities, re- No further information [1] Lewy Body- "LBD abnormal deposits of alpha-synuclein in the called Lewy bodies, a whose changes, in tu- with thinking, movem LBD is one of the mo dementia, after Alzhe disease." This inform The National Institute https://www.nia.nih.gu wy-body-dementia/ba [2] Lortab- Hydrocodo combination used to 1 pain. This information National Institutes of https://www.ncbi.nlm. T0010590/.	MDS process, the initial or the resident has it relieved for prolong the the pain assessment tool type, frequency. Location, causes related to the on-pharmacological d are used to provide pain with medication use. ude: positioning, physical elaxation techniques, etc." In was presented prior to exit. is a disease associated with a protein called to brain. These deposits, affect chemicals in the brain rn, can lead to problems ent, behavior, and mood. st common causes of imer's disease and vascular nation was obtained from the alth. ov/alzheimers/publication/le asics-lewy-body-dementia. one and Acetaminophen relieve moderate to severe in was obtained from the Health. nih.gov/pubmedhealth/PMH	F	309			
CORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 095F11 Facility ID: VA0080 If continuation sheet Page 123 of 171		11's AV fistula (1) (art	erial - venous) fistula port for			sility ID: VA0080 If contin	uation sheet	Page 123 of 171

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		ND HUMAN SERVICES				M APPROVED 0. 0938-0391
STATEMENT		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		495249	B. WING		01	C /06/2017
		IEALTH CARE CENTER LLC		STREET ADDRESS, CITY, STATE, Z 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901	IP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 309	dialysis (2). Resident # 11 was ad 3/22/16 with diagnos limited to: hypertensi reflux disease (4), dia convulsions (6), end depression. Resident # 11's most set) a significant cha ARD (assessment re coded the resident a interview for mental s - 15, 13 being cognit making. Resident # limited assistance of activities of daily livin The "(Name of Dialy management Applica documented, "Access" "Surgical Information Placed: 06/23/2016. Elbow." The POS (physician 1/1/2017 for Resider dialysis shunt to left bruit/thrill (9) every s doctor) of any chang apply direct pressure Date; 11/18/16." The comprehensive dated 3/22/2016 doc require renal dialysis renal disease). Und	dmitted to the facility on es that included but were not on (3), gastroesophageal abetes mellitus (5), stage renal disease (7) and t recent MDS (minimum dada nge assessment with an ofference date) of 10/5/16 s scoring a 13 on the brief status (BIMS) of a score of 0 ively intact for daily decision 11 was coded as requiring one staff member for ng. sis Center) Dialysis Access ation" for Resident # 11 as type: AV Fistula." Under " it documented, "Date Location: Left. Site: Above	F 3(99		

Facility ID: VA0080

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED C
		495249	B. WING		01/06/2017
		IEALTH CARE CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODI 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901	E
(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)	I SHOULD BE COMPLETION
F 309	Resident # 11's left u Review of the clinica which included the M administration record through December 3 "Progress Notes" dat through December 3 "Hemodialysis Comm monitoring of the AV opportunities. On 1/5/17 at 3:40 p.r conducted with LPN 1. When asked if Red dialysis center, LPN went to dialysis ever Friday. When asked dialysis access site, access site was loca upper arm. When as procedure staff follow dialysis site, LPN # 2 for bleeding and sord When asked about c a procedure was dor nurse would check th was asked to review November 2016 thro regarding the bruit a the blanks on the M/ wasn't checked it wa On 6/11/15 at 8:30 a conducted with the A member) # 2, directed about the procedure # 11's dialysis site, A	pper arm. I record for Resident # 11 IARs (medication Is) dated November 18, 2016 1, 2016, the nurse's ted November 18, 2016 0, 2016 and the nunication" sheets revealed fistula for only 54 out of 132 m. an interview Was (licensed practical nurse) # esident # 11 went to the # 1 stated Resident # 11 y Monday, Wednesday and I about Resident # 11's LPN # 1 stated that the ted on Resident # 11's left sked to describe the ws regarding Resident # 11's I stated, "Check it every day eness around the site." Hocumenting on the MAR that he, LPN # 1 stated that the he box and initial it. LPN # 1 Resident # 11's MARs dated ough December 2016 nd thrill. When asked about AR, LPN # 1 stated that if it asn't done. I.m. an interview was ASM (administrative staff or of nursing. When asked followed regarding Resident ASM # 2 stated, "Need to	F 30	9	
L	monitor the bruit and	thrill every shift every day."		Eacility (D: VA0080	If continuation sheet Page 125 of 171

Facility ID: VA0080

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED C 01/06/2017	
		495249	B. WING				
	ROVIDER OR SUPPLIER	HEALTH CARE CENTER LLC		157	EET ADDRESS, CITY, STATE, ZIP CODE 5 SCOTT DRIVE ROUTE 5 RMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	2	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 309	ASM # 2 was asked MARs dated Novem 2016 regarding the k about the blanks on can't say it was done The facility policy "P documented,"5. Ch AV shunt, fistula, or physician's order." According to Medica Incredibly Easy, Lipp copyright 2004 page Aftercare: "At least f circulation at the acc the presence of brui Unlike most other ci and thrills should be at a venous access indicate a blood clot attention." On 1/5/17 at approx (administrative staff administrator, and A were made aware o No further informatio References: (1) An AV fistula is a vascular surgeon, o carry blood from the carry blood from the	to review Resident # 11's ber 2016 through December oruit and thrill. When asked the MAR, ASM # 2 stated, "I e." rotocol for Dialysis" eck for bruit and thrill in the graft site Q (every) shift per al Surgical Nursing made pincott Williams & Wilkins e 565 Dialysis Monitoring and four times per day, assess cess site by auscultating for ts and palpating for thrills. rculatory assessments, bruits e present here. Lack of a bruit site during dialysis may requiring immediate surgical	F	309			

Event ID: 095F11

Facility ID: VA0080

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				1	NO. 0938-039
	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		495249	B. WING				C 01/06/2017
				ST	REET ADDRESS, CITY, STATE, ZIP CODE	1	
		HEALTH CARE CENTER LLC			75 SCOTT DRIVE ROUTE 5 ARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 309	 water from your blookidney failure to feel things they enjoy http://nkdep.nih.govshtml> (3) Low blood pressutaken from the webshttps://medlineplus.gov (4) Stomach content the esophagus and i was obtained from the the esophagus and i was obtained from the https://www.nlm.nih. (5) A chronic disease regulate the amount information was obtained from the thttps://www.nlm.nih. (6) The term "seizure interchangeably with the physical findings occur after an episo activity in the brain. obtained from the we https://medlineplus.gov (7) The last stage of is when your kidney body's needs. This from the website: https://medlineplus.gov (8) A permacath is a stage of is from the website and the stage of is when your kidney body's needs. This from the website and the stage of is a stage of is a stage of is a stage of is when your kidney body's needs. This from the website and the stage of is a stage of is a stage of is a stage of is a stage of is when your kidney body's needs. This from the website and the stage of is a st	ment to filter wastes and d, allowing people with better and continue doing the //living/kidney-failure/dialysis. ure. This information was ite: gov/lowbloodpressure.html. s to leak back, or reflux, into rritate it. This information he website: gov/medlineplus/gerd.html. e in which the body cannot of sugar in the blood. This ained from the website: gov/medlineplus/ency/article/ e" is often used h "convulsion." A seizure is for changes in behavior that de of abnormal electrical This information was ebsite: gov/ency/article/003200.htm. chronic kidney disease. This s can no longer support your information was obtained gov/ency/article/000500.htm.	F3	309			
	inserted into a vein	nong, flexible tube that is most commonly in the neck n) and less commonly in the					et Page 127 of

Facility ID: VA0080

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		ND HUMAN SERVICES		0	FORM APPROV MB NO. 0938-03
ATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		X3) DATE SURVEY COMPLETED
		495249	B. WING		C 01/06/2017
NAME OF PR	OVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	
		HEALTH CARE CENTER LLC		5 SCOTT DRIVE ROUTE 5	
AKIVIVILL	E KENABIENANON W		FAI	RMVILLE, 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 BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E (X5) COMPLET DATE
F 309	Continued From pag groin (femoral vein).	This type of ventral venous	F 309		
	centimeters usually the neck vein. Perm dialysis catheter or h in a variety of cases Regular hemodialys permacath avoids m	under the skin for a few on the chest before it enters nacath, better known as the nemodialysis catheter is used . Here are a few indications; is to treat kidney failure- nultiple catheter insertions and ent catheter for dialysis;			
	Route for plasmaphe sampling; Administra during long-term trea caustic medications harm peripheral veir	eresis; frequent blood ation of drugs and fluids atment; Administration of (chemotherapy) that may hs; a route for TPN and blood cases. This information was ebsite:			
F 328 SS=D	usually heard with a may occasionally al <http: search.nih.go<br="">%E2%9C%93&affili 483.25(b)(2)(f)(g)(5)</http:>	ulent blood flow. Although stethoscope such sounds so be palpated as a thrill. ov/search?utf8= ate=nih&query=thrill> i(h)(i)(j) TREATMENT/CARE	F 328		
	(b)(2) Foot care. To proper treatment an and good foot healt	ensure that residents receive d care to maintain mobility h, the facility must:		F328	
	with professional sta	and treatment, in accordance andards of practice, including tions from the resident's) and		1. Resident #3's respiratory status was assessed on 1/6/17 by the Assistant Director of Nursing wit respiratory distress noted.	
		sist the resident in making a qualified person, and			

appointments with a qualified person, and

Event ID: 095F11

Facility ID: VA0080

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PRINTED: 01/17/2017 FORM APPROVED

		MEDICAID SERVICES	(X2) MUL		CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY	
	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	· · ·			COMPLETED	
			,				С
		495249	B. WING			01	/06/2017
				ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				15	75 SCOTT DRIVE ROUTE 5		
ARMVILI	E REHABILITATION & F	IEALTH CARE CENTER LLC		FA	ARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 328	Continued From page	e 128	F	328			
a a r r s r c t t (r t t i c a a (a s f c t t (r r s r c t t (r r s r c t t () t t t t t t t t t t t t t t t t	arranging for transpo appointments (f) Colostomy, ureter The facility must ensu- require colostomy, ur services, receive suc professional standard comprehensive perso the resident's goals a (g)(5) A resident who receives the appropri to prevent complic including but not limit diarrhea, vomiting, de abnormalities, and na			Resident #3 oxygen flow rate w adjusted to 2 liters per minute b #2 on 1/4/17. LPN #2 was reeducated on 1/6/ Staff Development Coordinator related to ensuring oxygen is administer as ordered. Resident #3's physician was no on 1/6/17 by Director of Nursin related to the 81 pulse oximetry omissions in December 2016 or medication record.	y LPN 17 by tified		
	administered consists standards of practice physician orders, the person-centered care goals and preference (i) Respiratory care, i and tracheal suctioni that a resident who n including tracheostor suctioning, is provide professional standard comprehensive perso residents' goals and this subpart. (j) Prostheses. The f resident who has a p	and in accordance with comprehensive e plan, and the resident's es. including tracheostomy care ng. The facility must ensure needs respiratory care, ny care and tracheal ed such care, consistent with			 Resident #7 was discharged from facility on 1/7/17. 2. The Assistant Director of Nursing will complete an audit by 2/1/17 to ensure curresidents' pulse oximetry is completed as ordered, resident completed oxygen orders that the flow rate, and oxygen is administer per physician's ord 	irsing omplete rrent have include	

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TEMENT O		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1			SURVEY PLETED
		105240	B. WING		C 01/06/2017	
		495249		STREET ADDRESS, CITY, STATE, ZIP CODE	1 01	100/2011
ME OF PF	OVIDER OR SUPPLIER			1575 SCOTT DRIVE ROUTE 5		
	E REHABILITATION & H	EALTH CARE CENTER LLC		FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 328	 and preferences, to v prosthetic device. This REQUIREMENT by: Based on observation interview, facility politic review, it was detern to administer oxygen physician. 1. a. Facility staff failed per minute to Resided b. Facility staff failed pulse oximetry every opportunities in Dec 2. The facility staff a Resident #7 without rate and failed to classified The findings includes 1. Resident #3 was 11/27/09 and readmin diagnoses that inclu 	 a, the comprehensive b) plan, the residents' goals b) wear and be able to use the T is not met as evidenced c) resident interview, staff c) review and clinical record d) review and clinical record c) review and clinical record d) review and clinical record e) review and clinical review and clinical record e) review and clinical record e) review and clinical review and clin	F 32	 3. The Licensed Nurses wireeducated by the Staff De Coordinator by 2/1/17 rela ensuring oxygen is admini ordered, resident have com oxygen orders that include rate, and pulse oximetry is as ordered. 4. The Director of Nursing Assistant Director of Nursing Assistant Director of Nursing ensure oxygen continues that administered as ordered, residents on each unit wee weeks and monthly for 2 mensure oxygen continues that include the flopulse oximetry continue to have complete orders that include the flopulse oximetry continue to t	velopment ted to ster as apleted the flow completed g or ing will rent ekly for 4 months to o be esidents ed oxygen w rate, and	
	day assessment, wi reference date) of 1 have seven out of 1 for mental status) in	er cancer. DS (minimum data set, a thirty ith an ARD (assessment 2/3/16 coded the resident as 5 on the BIMS (brief interview indicating the resident was iognitively. The resident was			f continuation shee	

Event ID: 095F11

PRINTED: 01/17/2017

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		MEDICAID SERVICES	(X2) MULTIPLE	CONSTRUCTION		E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			PLETED
		495249	B. WING			/06/2017
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
FARMVIL	E REHABILITATION & F	EALTH CARE CENTER LLC	1	75 SCOTT DRIVE ROUTE 5 ARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 328	all activities of daily li coded as requiring of An observation was in of Resident #3. The in her eyes closed; she nasal cannula. The of 1/2 (a half) liters. An observation was of Resident #3. The in She was wearing a ri was set a two and 1/ On 1/4/16 at 4:35 p.r. nurse) #2, the reside made an observation Resident #3. LPN #2 liters. It should be or asked when staff che #2 stated they check resident was assess knew if the oxygen h Resident #3, LPN #2 be right in the middle oxygen to two liters a Review of the physic documented, "Oxyge via nasal cannula (set to deliver oxygen) co checks Q (every) sh Review of the Decer administration record 2L/m (liters per minu- prongs that fit in the	he assistance from staff for iving. The resident was xygen therapy. made on 1/4/16 at 3:00 p.m. resident was lying in bed with was wearing an oxygen oxygen was set at two and made on 1/4/16 at 4:30 p.m. resident was lying in bed. masal cannula and her oxygen 2 liters. m. LPN (licensed practical ent's nurse, and this surveyor n of the oxygen flow rate for 2 stated, "It's on two and 1/2 n two liters." LPN #2 was ecked the oxygen rate. LPN ted the rate when the ed. When asked how staff had been correctly set for 2 stated, "The metal ball will e of the line." LPN #2 set the as ordered by the physician. cian's orders dated 10/19/16 en at 2L/m (liters per minute) oft prongs that fit in the nose pontinuous, pulse ox (oximetry)	F 328	The Director of Nursing wireport to the Quality Assura Committee monthly for 3 m The Director of Nursing wiresponsible for monitoring up. Completion date:	ince ionths. 11 be	02/03/17

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PRINTED: 01/17/2017

JAN 30 2017

VDH/OLC

PRINTED: 01/17/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION С 01/06/2017 B. WING 495249 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1575 SCOTT DRIVE ROUTE 5 FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC FARMVILLE, VA 23901 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) TAG F 328 Continued From page 131 F 328 shift." An interview was conducted on 1/5/16 at 11:30 a.m. with ASM (administrative staff member) #2, the director of nursing. When asked if there were any risks involved in administering oxygen, ASM #2 stated, "We don't want to over oxygenate someone with chronic lung disease." An interview was conducted on 1/5/16 at 11:45 a.m. with LPN (licensed practical nurse) #3, the resident's nurse. When asked if it was important to know the oxygen rate for the residents, LPN #3 stated, "You have to know how much. It can cause more harm than good if you give too much." On 1/5/16 at 6:10 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings. Review of the facility's policy titled, "OXYGEN THERAPY" documented, Policy: To administer oxygen when indicated to provide adequate gas exchanges. A physician's order is required and shall include liter flow rate and administration device (i.e. nasal cannula, mask etc.)." The policy was from the nursing policies and procedures manual revised 7/2007. Review of the oxygen machine's manufacturer's manual documented, "Chapter 1: Introduction....DO NOT change the flow setting unless your health care professional tell you to do so. (page 3). Operating Instructions: 5. Adjust the flow to the prescribed setting by turning the knob on the top of the flow meter until the ball is centered on the line marking the specific flow rate. (page 6)."

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: VA0080

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PRINTED: 01/17/2017 FORM APPROVED

		D HUMAN SERVICES				ORM APPROVED NO. 0938-0391
STATEMENT O	S FOR MEDICARE & I F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COMPLETED
		495249	B. WING			C 01/06/2017
	OVIDER OR SUPPLIER	EALTH CARE CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP COD 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901	E	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 328	Continued From page	e 132	F 32	8		
	No further information	n was provided prior to exit.				
	per minute) via nasal in the nose to deliver ox (oximetry) checks Review of the Decen administration record 2L/m (liters per minu prongs that fit in the continuous, pulse ox levels) Q (every) shift oximetry results doct Review of the nurse did not evidence doc oximetry results for 8 An interview was con a.m. with LPN #3. W December 2016 MA	d, "Oxygen at 2L/m (liters cannula (soft prongs that fit oxygen) continuous, pulse Q (every) shift." hber 2016 MAR (medication d) documented, "Oxygen at te) via nasal cannula (soft nose to deliver oxygen) (oximetry) checks (oxygen t." There were no pulse				
	p.m. with LPN #1. W December 2016 MA results, LPN #1 state there should be a nu why staff would not LPN #1 stated there the order. When ask done on a resident,	nducted on 1/5/17 at 12:15 /hen asked to review the R for the pulse oximetry ed, "I see what you're saying umber in there." When asked follow the physician's order, was no reason not to follow ked why a pulse oximetry was LPN #1 stated, "It's the most ee what level of oxygen they				sheet Page 133 of 17

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PRINTED: 01/17/2017 FORM APPROVED OMB NO. 0938-0391

DEPART	1ENT OF HEALTH AN	ID HUMAN SERVICES				FORM	APPROVED		
		MEDICAID SERVICES					. 0938-0391		
STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE S COMPL	ETED		
		495249	B. WING				C 01/06/2017		
		455245			STREET ADDRESS, CITY, STATE, ZIP COD	Ē			
NAME OF PR	OVIDER OR SUPPLIER				1575 SCOTT DRIVE ROUTE 5				
FARMVILL	E REHABILITATION & H	HEALTH CARE CENTER LLC		1	FARMVILLE, VA 23901				
			ID	I	PROVIDER'S PLAN OF CO	RRECTION	(X5)		
(X4) ID PREFIX TAG	(FACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	COMPLETION DATE		
F 328	Continued From pag	e 133	F	328	3				
	On 1/5/16 at 6:10 p.r and ASM #2, the dire aware of the findings	m. ASM #1, the administrator ector of nursing were made s.							
	Review of the facility's policy titled, "OXYGEN THERAPY" documented, "KEY STEPS: 5. Monitor the resident's response to oxygen therapy. If appropriate, use pulse oximetry to assess resident stability."								
	Resident #7 without rate and failed to cla Resident #7 was ad 12/26/16 and readm diagnoses that inclu respiratory failure, c	dministered oxygen to a physician prescribed flow arify the physicians order. mitted to the facility on hitted on 12/30/16 with ided but were not limited to: hronic lung disease, high mitis and chronic pain.							
	The most recent ME available to review. dated 12/30/16 at 4 " Resident is alert/	DS was in progress and not The admission nurse's note :00 p.m. documented, forient (sic) x (times) 3 (knows ere she is) 1 assist needed							
	of Resident #7. The wheelchair with oxy prongs that fit in the	s made on 1/4/16 at 7:10 a.m. e resident was sitting up in a rgen on via nasal cannula (soft e nose to deliver oxygen). The red set at 3 1/2 liters/minute.							
	of Resident #7. The	s made on 1/4/16 at 3:05 p.m. e resident was sitting up in a bom with the oxygen on via e oxygen was observed set at 3			Facility ID: VA0080	If continuation sheet	Page 134 of 1		

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

Facility ID: VA0080

TEMENT C	F DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 01/06/2017 DE		
		495249	B. WING					
	ROVIDER OR SUPPLIER	IEALTH CARE CENTER LLC		15	REET ADDRESS, CITY, STATE, ZIP CODE 575 SCOTT DRIVE ROUTE 5 ARMVILLE, VA 23901			
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 328	oxygen flow rate, Re When asked how mu	ed if she ever adjusted the sident #7 stated, "Never." uch oxygen she was to be on,	F	328				
	made on 1/4/16 at 3: resident's nurse. LP! three and 1/2 liters, s #10 was asked wher oxygen rate. LPN #	esident #7's oxygen was 40 p.m. with LPN #10, the N #10 stated, "Looks like should be four liters." LPN n staff checked the resident's 10 stated, "When we assess and I haven't assessed her				X		
	documented, "O2 (o flow rate ordered. Review of the Decer	cian's orders dated 12/30/16 xygen)." There was no liter mber 2016 MAR (medication						
	(liters/minute) contin Review of the Janua "O2 @ 4LPM (liters cannula)." There we	ary 2017 MAR documented, per minute) via nc (nasal						
	p.m. documented, "	's notes dated 1/1/17 at 10:00 O2 on @ 2L PER CANNULA." 's notes dated 1/2/17 at 7:00						
	a.m. documented, " 4L PER CANNULA.	Up in w/c (wheelchair) O2 @						
	Review of the nurse a.m. documented, "	e's notes dated 1/3/17 at 9:00						

Facility ID: VA0080

If continuation sheet Page 135 of 171

	MENT OF HEALTH AN S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-039
STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
		495249	B. WING		C 01/06/2017
		I	1575	EET ADDRESS, CITY, STATE, ZIP CODE SCOTT DRIVE ROUTE 5	
FARMVILL	ERENABILITATION &		FAR	MVILLE, 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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETIO
	a.m. at 10:35 docum	e 135 s notes date 1/4/17 at 10:35 ented, "O2 @ 4 LPM." ian's orders dated 1/4/17	F 328		
	(time unknown) docu 02 @ 4 LPM"	imented, "Clarification order			
	a.m. with ASM (adm the director of nursin Resident #7's oxyge "Actually I don't see doesn't have a liter." know how much oxy receive, ASM #2 sta can't answer that." V order should have be "Definitely. I would e in." When asked if th in administering oxy don't want to over ox chronic lung disease				
	a.m. with LPN (licen resident's nurse. Wh #7's oxygen order, L have clarified it, the admission orders I v back." When asked the oxygen rate, LPI know how much. It o good if you give too				
	and ASM #2, the dir aware of the finding				
	Review of the facilit	v's policy titled "OXYGEN			l

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		495249	B. WING		01	C 01/06/2017	
NAME OF PI				STREET ADDRESS, CITY, STATE, ZIP COI	******	100/2011	
				1575 SCOTT DRIVE ROUTE 5			
FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC				FARMVILLE, VA 23901			
(X4) ID	X4) ID SUMMARY STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CO		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE		COMPLETION DATE	
TAG	REGULATORTO			DEFICIENCY		-	
F 328	Continued From pa	ao 136	F 32	28			
1 520		-	1.52	.0			
		ented, Policy: To administer Ited to provide adequate gas					
		cian's order is required and					
		w rate and administration					
		nnula, mask etc.)." The policy					
		g policies and procedures					
	manual revised 7/20	JU7.					
	No further informati	on was provided prior to exit.					
F 329		EGIMEN IS FREE FROM	F 32	29			
SS=E							
				F329			
		ugs-General. Each resident's					
		be free from unnecessary		1. Resident #10's behav	iors for the		
	used	sary drug is any drug when		use of Seroquel are bein			
	uscu			the licensed nurse as of		*	
	(1) In excessive dos	se (including duplicate drug		the behavior monitoring			
	therapy); or			required.	, sheet us		
	(2) For excessive d	iration: or		i oquinou.			
				Resident #17's behavior	s for the use		
	(3) Without adequal	te monitoring; or		of Seroquel are being m	onitor by the		
				licensed nurse as of 01/1			
	(4) Without adequat	e indications for its use; or		behavior monitoring she	et as		
	(5) In the presence	of adverse consequences		required.			
		lose should be reduced or					
	discontinued; or			2. The Assistant Directo	r of Nursing		
				and Unit Manager will a	0		
		is of the reasons stated in		residents' behavior mon			
		rough (5) of this section. IT is not met as evidenced		by 2/1/17 to ensure beha	•		
	by:			being monitored and doc			
		view, facility documentation		required.			
	review and clinical r	ecord review facility staff		1			
		dents were free from					
	unnecessary medic	ations for two of 26 residents				1	

If continuation sheet Page 137 of 171 RECEIVED

jan 39.2**07**



		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			C	
		495249	B. WING		01/06/2017		
		HEALTH CARE CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		944 - 1 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIO DATE	
F 329	in survey sample, Re 1. The facility staff fa Resident # 10's use 2. The facility staff fa Resident # 17's use The findings include: 1. The facility staff fa Resident # 10's use Resident # 10 was a 12/6/07 with a readm diagnoses that includy dysphagia (1), anxie disorder (3), aphasia edema (6) diabetes (8). The most recent cord data set), an annual (assessment referent the resident as scord interview for mental - 15, one being sever Resident # 10 was cord dependent of one stad daily living. Resident # 10's caref 12/1/16 was reviewed documented, "At rist (related to) use of pa Under "Approaches" record target behavious contents (astage to be a statent of the second (astage to be a statent of the staten	esidents #10 and # 17. ailed to monitor behaviors for of Seroquel (10). ailed to monitor behaviors for of Seroquel. ailed to monitor behaviors for of Seroquel (10). admitted to the facility on hission on 8/15/16 with ded but not limited to: ty (2), obsessive compulsive a (4), schizophrenia (5), mellitus (7) and convulsions aprehensive MDS (minimum assessment with an ARD nee date) of 11/29/16 coded ing a one on the brief status (BIMS) of a score of 0 erely impaired of cognition. coded as being totally aff member for activities of e plan with a review date of ed. Under "Problem/Need" it k for adverse effects r/t sychotropic medications." " it documented, "Monitor and iors and inform MD (medical n frequency for possible	F 32	 3. The Licensed Nurses will be reeducated by the Staff Develop Coordinator by 2/1/17 to ensure behavior monitoring sheets are place and being completed as required. 4. The Director of Nursing or Assistant Director of Nursing we complete an audit on 5 residen each unit weekly for 4 weeks a monthly for 2 months to ensure behavior monitoring sheets conto be completed and document required. The Director of Nursing will submit a report to the Qua Assurance Committee monthly months. The Director of Nursi be responsible for monitoring a follow up. Completion date: 02/03/17 	pment e in will ts from nd e ntinue ed as sing lity y for 3 ng will		

Facility ID: VA0080

PRINTED: 01/17/2017

JAN 30 2017

VDH/OLC

	SFOR MEDICARE &	ID HUMAN SERVICES					RM APPROVE 10. 0938-039
TATEMENT ((X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		495249	B. WING			C 01/06/2017	
NAME OF PI		I	I	STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
FARMVILI	E REHABILITATION & H	IEALTH CARE CENTER LLC			SCOTT DRIVE ROUTE 5		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 329	Continued From page	e 138	F	329			
	12/1/16 for Resident i physician on 12/21/16 (10) 100 MG (milligra PEG (percutaneous e gastrostomy)-tube (9) schizophrenia. Start The MARs (medicatio for Resident # 10 date through January 4, 20 100 MG. Give 1 table related to schizophre MARs revealed Resid Seroquel tablet each opportunities. The "Behavior Month # 10 dated Novembe 2017 failed to docum the use of Seroquel for On 1/5/17 at 3:20 p.m conducted with LPN (1). LPN # 1 was then behavior monitoring s 2016 through Januar When asked about th monitoring sheets, LF documented I can't si On 1/5/17 at 4:30 p.m conducted with ASM member) # 2, the dire was then asked to re behavior monitoring s 2016 through Januar	 at bedtime related to Date 10/19/16." administration records) ed November 1, 2016 D17 documented, "Seroquel et via PEG-tube at bedtime nia." Further review of the dent # 10 received one evening for 65 of 65 ly Flow Sheets" for Resident r 1, 2016 through January 4, ent behavior monitoring for or 195 of 195 opportunities. an interview was (licensed practical nurse) # asked to review the sheets dated November 1, y 4, 2017 for Resident # 10. be blanks on the behavior PN # 1 stated, "If it wasn't ay it was done." an interview was (administrative staff ector of nursing. ASM # 2 					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	WJ92/11/11/2019/11/11/11/11/11/11/11/11/11/11/11/11/1	CON		
		495249	B. WING		C 01/06/2017		
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP C	······································		
FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC				1575 SCOTT DRIVE ROUTE 5			
FARMVILI	E REHABILITATION & F	IEALTH CARE CENTER LLC		FARMVILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
F 329	Continued From page	e 139	F 32	9			
	10	M # 2 stated, "If it wasn't					
	(administrative staff r	SM # 2, director of nursing,					
	No further information	n was provided prior to exit.					
	References:						
	obtained from the we	rder. This information was bsite: .gov/medlineplus/swallowing					
	website:	ation was obtained from the gov/medlineplus/anxiety.html					
	in which a person ha thoughts (obsessions (compulsions) that he repeat over and over obtained from the we	e or she feels the urge to . This information was bsite: gov/health/topics/obsessive-c					
	the brain that control hard for you to read, mean to say). This in the website:	d by damage to the parts of language. It can make it write, and say what you formation was obtained from .gov/medlineplus/aphasia.ht					

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

Event ID: 095F11

Facility ID: VA0080

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	MENT OF HEALTH AN					FOR	D: 01/17/2017 MAPPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		495249	B. WING				C / 06/2017
NAME OF P	ROVIDER OR SUPPLIER			Τ	STREET ADDRESS, CITY, STATE, ZIP CODE		
FARMVIL	LE REHABILITATION & H	EALTH CARE CENTER LLC			1575 SCOTT DRIVE ROUTE 5		
					FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	 (5) A mental disorder difference between winformation was obtain https://medlineplus.got (6) A swelling caused tissues. This informative website: https://www.nlm.nih.got (7) A chronic disease regulate the amount of information was obtain https://www.nlm.nih.got (7) A chronic disease regulate the amount of information was obtain https://www.nlm.nih.got (7) A chronic disease regulate the amount of information was obtain https://www.nlm.nih.got (8) The term "seizure" interchangeably with "the physical findings of occur after an episode activity in the brain. To obtained from the web https://medlineplus.got (9) Feeding tubes are unable to eat or drink. or other brain injury, p esophagus, surgery of other conditions. This from the website: <https: conditions.="" from="" li="" medlineplus.gotother="" the="" this="" website:<=""> </https:></https:></https:></https:></https:></https:></https:></https:></https:>	that makes it hard to tell the nat is real and not real. This ned from the website: w/ency/article/000928.htm. by fluid in your body's tion was obtained from the ov/medlineplus/edema.html. in which the body cannot f sugar in the blood. This ned from the website: ov/medlineplus/ency/article/ is often used convulsion." A seizure is or changes in behavior that e of abnormal electrical his information was osite: v/ency/article/003200.htm. enceded when you are This may be due to stroke roblems with the t the head and neck, or information was obtained ov/ency/patientinstructions/ symptoms of schizophrenia aauses disturbed or unusual st in life, and strong or s). This information was	F	32			

Facility ID: VA0080

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	MENT OF HEALTH AN						FORM	D: 01/17/2017 MAPPROVED D: 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		SURVEY PLETED
		495249	B. WNG	B. WING				C 106/2017
	ROVIDER OR SUPPLIER	EALTH CARE CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION (CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD B		(X5) COMPLETION DATE
F 329	Continued From page tml.	141	F	32	29			
	Resident # 17's use o	led to monitor behaviors for f Seroquel. mitted to the facility on						
	5/2/12 with a readmiss diagnoses that include hypertension (1), perip	sion on 5/5/16 with						
	data set), a quarterly a (assessment reference the resident as scoring for mental status (BIM being moderately impa							
	11/22/16 was reviewed documented, "At risk f (related to) use of psy Under "Approaches" it	chotropic medications." documented, "Monitor and s and inform MD (medical requency for possible						
		17 and signed by the locumented, "Seroquel.) by mouth two times a						

Facility ID: VA0080

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/17/2017 MAPPROVED D: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTIO	(X3) DATE		
		495249	B. WING			C 01/06/2017	
NAME OF PI			- 1	STREET ADDRESS	S, CITY, STATE, ZIP CODE		
				1575 SCOTT DRI	VE ROUTE 5		
FARMVILL	E REHABILITATION & F	IEALTH CARE CENTER LLC		FARMVILLE, VA	A 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	EAC	ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD 5-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	Continued From page	e 142	F 3	29			
	for Resident # 17 dat through January 4, 2 Give 25 MG (milligran day. Start Date 11/1/ MARs revealed Resid Seroquel tablet each opportunities. The "Behavior Month # 17 dated Novembe 2017 were reviewed. Flow Sheets" failed to monitoring for the use opportunities. On 1/6/17 at 11:05 a. conducted with LPN 7 . LPN # 7 was then 17's behavior monitor 1, 2016 through Janua about the blanks on t sheets LPN # 7 state was done." On 1/6/17 at 1:10 p.n conducted with ASM member) # 2, the dire was then asked to rev behavior monitoring s 2016 through January about the blanks on t	ly Flow Sheets" for Resident r 1, 2016 through January 4, The "Behavior Monthly o document behavior e of Seroquel for 317 of 573 m. an interview was (licensed practical nurse) # asked to review Resident # ring sheets dated November lary 4, 2017. When asked he behavior monitoring d, "If it wasn't documented it n. an interview was (administrative staff ector of nursing. ASM # 2					
	(administrative staff n	nately 12:35 p.m. ASM nember) # 1 the SM # 2, director of nursing,					
ORM CMS-256	7(02-99) Previous Versions Obs	solete Event ID: 095F11		Facility ID: VA0080	If continua	tion sheet Pa	age 143 of 171

						OMB NO	D. 0938-0391
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495249	B. WING				C /06/2017
NAME OF PR				Γ	STREET ADDRESS, CITY, STATE, ZIP CODE		
					1575 SCOTT DRIVE ROUTE 5		
FARMIVILL		EALTH CARE CENTER LLC	FARMVILLE, VA 23901		FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	Continued From page	: 143	F	329	9		
	were made aware of t	he findings.					
	No further information	was provided prior to exit.					
	References:		i.				
	(1) High blood pressu	re. This information was					
	obtained from the web						
1	https://www.nlm.nih.gi essure.html.	ov/medlineplus/highbloodpr					
	blood vessels. It incluc capillaries that carry b Arteries can become t called atherosclerosis vessels and block blood Weakened blood vess bleeding inside the bo obtained from the web	od flow to the heart or brain. sels can burst, causing dy.) This information was osite:					
1	https://www.nlm.nih.go ases.html.	ov/medlineplus/vasculardise					
	regulate the amount o information was obtain	in which the body cannot f sugar in the blood. This ned from the website: ov/medlineplus/ency/article/					
	affect the brain. This i from the website:	ms caused by disorders that information was obtained ov/medlineplus/dementia.ht					
1	ml.	,					
	because of sudden, at the brain. This informa website:	in problem. They happen pnormal electrical activity in ition was obtained from the					
	https://www.nlm.nih.go	ov/medlineplus/seizures.ht					

Event ID: 095F11

Facility ID: VA0080

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JAN 30 2017



	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
D PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		495249	B, WING		C 01/06/2017
				REET ADDRESS, CITY, STATE, ZIP CODE	01/00/2017
				5 SCOTT DRIVE ROUTE 5	
ARMVILI	_E REHABILITATION & H	IEALTH CARE CENTER LLC	FAI	RMVILLE, VA 23901	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 329	Continued From page	e 144	F 329		
F 371 SS=E	to swell and narrow. shortness of breath, coughing. Informatic website: https://medlineplus.g 483.60(i)(1)-(3) FOO STORE/PREPARE/S (i)(1) - Procure food f considered satisfacto authorities. (i) This may include f	chest tightness, and in was obtained from the ov/ency/article/000141.htm. D PROCURE, ERVE - SANITARY from sources approved or ory by federal, state or local	F 371	F371 1. The meat slicer blade and pro- table was cleaned and sanitized of 1/4/17 by the dietary manager.	1
	facilities from using p gardens, subject to c safe growing and foc (iii) This provision do	es not prohibit or prevent produce grown in facility compliance with applicable od-handling practices. es not preclude residents is not procured by the facility.		2. The Dietary Manager inspected dietary equipment and food preparation areas on 1/9/17 to enthe kitchen remains clean and sanitized.	sure
	accordance with prof service safety.	e, distribute and serve food in fessional standards for food egarding use and storage of		3. The Administrator will reeduc the Dietary Manager and Dietary by 1/27/17 related to ensuring the kitchen which include the kitchen equipment and the food preparati	staff e
	foods brought to resi visitors to ensure sat handling, and consul This REQUIREMEN by:	dents by family and other e and sanitary storage,		areas remain clean and sanitized.	

STATEMENT		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COM	D. 0938-039 SURVEY PLETED	
		495249	B. WING		1	C 01/06/2017	
	ROVIDER OR SUPPLIER	HEALTH CARE CENTER LLC	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901	ATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 371	document review, i facility staff failed to sanitary manner. The meat slicer bla observed to have for The findings includ Observation of the 1/4/17 at approxima (other staff membe was observed: Observation of the revealed a meat sli slicer was cleaned stated, "Yes." Observed to have for agreed with the find During an interview manager on 1/4/17 that the meat slicer rewashed. The facility's policy documented, "To put by the spread of for important to proper slicer as any surface contaminated. It is slicer/owner/operat	t was determined that the o prepare and serve food in a ade and product table was bood debris on it. e: kitchen was conducted on ately 7:05 a.m. with OSM r) # 11, cook. The following food preparation table cer. When asked if the meat and ready for use OSM # 11 ervation of the meat slicer and product table was bod debris on it. OSM # 11 dings. with OSM # 2, the dietary at 1:45 p.m. OSM # 2 stated was taken apart and "Cleaning and Sanitizing" revent illness or death caused od-borne pathogens, it is ly clean and sanitize the entire e of the slicer can become the responsibility of the or to follow all guidelines, ws as established by your local partments and the emical sanitizers."	F 371	 4. The Dietary Manager or Administrator will complet audit weekly for 4 weeks a for 2 months to ensure the continues to be maintained and sanitary condition inclu- kitchen equipment and the preparation areas as require Dietary Manager will subm to the Quality Assurance Comonthly for 3 months. The Administrator will be a for monitoring and follow a Completion date: 02/03/17 	te a kitchen nd monthly kitchen in a clean uding the food ed. The tit a report ommittee		

TEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	B. WING		C 01/06/2017
AME OF PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
ARMVILLE REHABILITATION & H	EALTH CARE CENTER LLC		575 SCOTT DRIVE ROUTE 5 ARMVILLE, VA 23901	
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETIO
were made aware of t No further information	nember) # 1 the M # 2, director of nursing,	F 371 F 441		
SS=F PREVENT SPREAD,			F 441	
The facility must estab and control program (i a minimum, the follow (1) A system for preve investigating, and com communicable disease volunteers, visitors, an providing services und arrangement based up conducted according t accepted national star implementation is Pha (2) Written standards, for the program, which limited to: (i) A system of surveilla possible communicabl before they can spread facility; (ii) When and to whom	blish an infection prevention IPCP) that must include, at ing elements: enting, identifying, reporting, trolling infections and es for all residents, staff, nd other individuals der a contractual bon the facility assessment to §483.70(e) and following ndards (facility assessment se 2); policies, and procedures a must include, but are not ance designed to identify e diseases or infections d to other persons in the		 F 441 The infection control logs from March, April, May, June, and September through December 20 will be updated to include the causative organisms for cultures obtained by the Infection Control Nurse by 2/2/17. The current infection control I will be audited by 2/2/17 by the Infection Control Nurse to ensur logs are updated to include the causative organisms for cultures the logs are completed as required. The Director of Nursing will reeducate the Infection Control I by 2/2/17 related to ensuring causative organisms for cultures included on the log and the infection Control I by 2/2/17 related to ensuring causative organisms for cultures included on the log and the infection Control I log is completed as required. 	2016 s rol l logs e ure the es and red. l l Nurse es are ection

JAN 38 2017

VOH/OLC

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION (X:	(X3) DATE SURVEY COMPLETED		
		495249	B. WING				C)1/06/2017	
IAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
ARMVILI	LE REHABILITATION & H	IEALTH CARE CENTER LLC			75 SCOTT DRIVE ROUTE 5 ARMVILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORREC REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 441	 to be followed to prev (iv) When and how is resident; including but (A) The type and dura depending upon the involved, and (B) A requirement that least restrictive possistic circumstances. (v) The circumstance must prohibit employed disease or infected states contact with residents contact with residents contact will transmit t (vi) The hand hygiene by staff involved in di (4) A system for recondunct the facility's IP actions taken by the for (e) Linens. Personne 	vent spread of infections; olation should be used for a it not limited to: ation of the isolation, infectious agent or organism at the isolation should be the ble for the resident under the s under which the facility ees with a communicable kin lesions from direct s or their food, if direct he disease; and e procedures to be followed rect resident contact. rding incidents identified CP and the corrective facility.	F	141	 4. The Director of Nursing or Assistant Director of Nursing will review the infection control logs weekly for 4 weeks and monthly for months to ensure infection control logs continue to be updated to inclu- the causative organisms for cultures as required. The Director of Nursin will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing w be responsible for monitoring and follow up. Completion date: 	de s ng 3 vill	02/03/17	
	annual review of its II program, as necessa This REQUIREMENT by: Based on staff interv documentation, it was staff failed to maintain control program as en	ne facility will conduct an PCP and update their ry. T is not met as evidenced iew and review of facility is determined that facility in a complete infection videnced by incomplete ting logs for March, April,						

DEPARTMENT OF HEALTH AND HUMAN SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY
				G		С
		495249	B. WING		0.	1/06/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
	E REHABILITATION & H	EALTH CARE CENTER LLC		1575 SCOTT DRIVE ROUTE 5		
				FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE	(X5) COMPLETIC DATE
F 441	Continued From page	e 148	F 4	41		
		er through December 2016.				
	The infection control log did not evidence the causative organisms for cultures obtained from residents during the months of March, April, May, June, September, through December 2016.					
	The findings include:					
	control log document cultures obtained and for an infection. A res	s March 2016 infection ed that there were eight d all cultures were positive piratory culture obtained on nce documentation of the				
	documented that ther were positive for infer were obtained on 5/2 residents. The culture being positive for infer	016 infection control log re were five cultures that ction. Two urine cultures 3/16 from two different es were documented as action there was no evidence he organisms.				
	of documentation of the organ Review of the June 2016 infect documented that there were f were positive for infection. A to obtained on 6/8/16. The cultur as being positive for infection; evidence of documentation of skin culture was obtained on 6 from two different residents. T documented as being positive was no evidence of document organisms.	re were four cultures that ction. A urine culture was 'he culture was documented nfection; there was no atation of the organism. A ined on 6/22/16 and 6/30/16 idents. The cultures were g positive for infection; there				
	Review of the Septen log documented that	nber 2016 infection control there were six cultures				

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	MENT OF HEALTH AN					FORM	MAPPROVED 0. 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495249	B. WNG				C /06/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
FARMVIL	LE REHABILITATION & H	EALTH CARE CENTER LLC			1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 441	positive for infection. 7 8/24/16 (documented was documented as b There was no evidence organism. Review of the Octobe documented that there positive for infection. 7 10/19/16 and 9/28/16 were documented as There was no evidence organisms. Review of the Novem log documented that t positive for infection. 7 11/11/16 was docume There was no evidence organism. Review of the Decem log documented that t positive for infection. 7 12/9/16 was documented that t positive for infection. 7 12/9/16 was documented organism. An interview was conce p.m. with RN (register control nurse. When a were to be documented logs, RN #4 stated, "T asked why the culture stated, "Because in ou isolation. They can be and may need somethant	A urine culture obtained on on the September report) being positive for infection. ce of documentation of the r 2016 infection control log e were seven cultures A urine culture obtained on on two different residents being positive for infection. ce of documentation of the ber 2016 infection control here were three cultures A urine infection obtained on nted as being positive. ce of documentation of the ber 2016 infection control here were two cultures A urine culture obtained on ted as being positive. There	F	441			

Facility ID: VA0080

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ENTER	S FOR MEDICARE &	MEDICAID SERVICES					D. 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>í</i>			(X3) DATE SURVEY COMPLETED C 01/06/2017	
		495249	B. WING				
		400140			REET ADDRESS, CITY, STATE, ZIP CODE	1 01	100/2011
AME OF PI	ROVIDER OR SUPPLIER				75 SCOTT DRIVE ROUTE 5		
ARMVILI	E REHABILITATION & F	IEALTH CARE CENTER LLC			RMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 441	Continued From page	e 150	F 4	41			
F 503	member) #1, the adm director of nursing we findings. No further information	n. ASM (administrative staff ninistrator and ASM #2, the ere made aware of the n was obtained prior to exit. SVCS - FAC PROVIDED,	F 5	503			
SS=D	(a) Laboratory Service	EMENT			F 503		
	(i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter.				1. The identified expired blood of tubes on the two nursing units w discarded on 1/6/17 by the Assis Director of Nursing.	ere	
	requirements for labor of this chapter.	des blood bank and it must meet the applicable pratories specified in part 493 chooses to refer specimens			2. The two nursing units were checked on 1/6/17 by the Assista Director of nursing to ensure exp laboratory supplies and other me	oired	
	for testing to another laboratory must be c specialties and subs			supplies have been discarded as required.			
	this chapter.	requirements of part 493 of			3. The Licensed Nurses will be reeducated by the Staff Develop Coordinator by 2/2/17 related to		
	(iv) If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this chapter.			a anno ann an Anna ann an Anna ann ann ann ann	ensuring laboratory and other m supplies are checked for expirational and discarded as required.	edical	
	by: Based on observation	T is not met as evidenced on and staff interview, it was facility staff failed to ensure					

JAN 38 2017

PRINTED: 01/17/2017 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING С 01/06/2017 B. WING 495249 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1575 SCOTT DRIVE ROUTE 5 FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC FARMVILLE, VA 23901 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 503 Continued From page 151 F 503 laboratory supplies were not expired on two of two nursing units. 4. The Assistant Director of Nursing and Unit Manager will complete One hundred and one blood drawing tubes were audits weekly for 4 weeks and expired on two of two nursing units. monthly for 2 months to ensure expired laboratory and other medical The findings include: supplies continue to be discarded as Observation was made on 1/5/17 at 1:50 p.m. on required. The Director of Nursing the West Nursing Unit. The following laboratory will submit a report to the Quality tubes were expired: Assurance Committee for 3 months. Green top tubes: 3 ML (milliliter) - 60 expired in 10/2016 Observation was made on 1/5/17 at 3:50 p.m. on the North Nursing Unit. The following laboratory tubes were expired: Green top tubes: 3 ML (milliliter) - 24 expired in 12/2016 Blue top tubes: 2.7 ML - 17 expired in 12/2016 During an interview on 1/5/17 at 1:50 p.m. with LPN (licensed practical nurse) # 1, LPN # 1 stated that they do not use the green tubes that The Director of Nursing will be often that is probably why they are expired. LPN responsible for monitoring and follow # 1 further stated that the nurses usually use the up. gold tubes - since they are larger. Completion date: 02/03/17 During an interview on 1/5/17 at 3:59 p.m. with LPN # 9, LPN # 9 confirmed that the tubes were expired and stated that the supervisors are the ones that use the tubes to draw blood. During the end of day interview on 1/5/17 at 6:00 p.m. with ASM (Administrative Staff Member) # 1,

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the administrator, and ASM # 2 this concern was discussed. A copy of the facility policy on storing

Facility ID: VA0080

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED C	
		495249	B. WING		01/06/2017	
	OVIDER OR SUPPLIER	EALTH CARE CENTER LLC	1	TREET ADDRESS, CITY, STATE, ZIP CODE 575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTIO REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO TH		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	SHOULD BE COMPLET		
F 503 F 514 SS=E	During an interview of ASM # 2, ASM # 2 st and procedure for the When asked about w stated, "The nurses of continued by saying to uses the blue tubes. time for documentatic each color tube is use According to applicate laboratories specified § 493.1252 Standard instruments, reagents (d) Reagents, solution materials, calibration supplies must not be exceeded their expirator or are of substandard No further information 483.70(i)(1)(5) RES RECORDS-COMPLE LE (i) Medical records. (1) In accordance with standards and practic	as requested at this time. n 1/6/17 at 8:25 a.m. with ated that there was no policy a use of blood draw tubes. ho draws blood, ASM # 2 lraw blood." ASM # 2 that the facility no longer A request was made at this on as to what laboratory test ed for. ble requirements for I in Part 493 of this chapter: : Test systems, equipment, s, materials, and supplies.(4) ns, culture media, control materials, and other used when they have ation date, have deteriorated, d quality. n was provided prior to exit. ETE/ACCURATE/ACCESSIB th accepted professional	F 503 F 514	F 514 1. Resident #1 was discharge	from the	
	(i) Complete; (ii) Accurately docum	ented:		facility on 1/7/17.		

Event ID: 095F11

RECEIVE JAN 3 0 2017 VDH/OLC

		ND HUMAN SERVICES			FOR	D: 01/17/201 MAPPROVE	
		MEDICAID SERVICES		PLE CONSTRUCTION		<u>O. 0938-039</u>	
	CORRECTION	IDENTIFICATION NUMBER:		G		E SURVEY PLETED	
		495249	B. WING		C 01/06/2017		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
FARMVILL	E REHABILITATION & H	IEALTH CARE CENTER LLC		1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 514	Continued From page	e 153	F 5	14			
	(iv) Systematically organized(5) The medical record must contain-(i) Sufficient information to identify the resident;						
	(ii) A record of the res	ident's assessments;		Resident #6 Pressure ulco	ar troalcing		
	(iii) The comprehensiv provided;	ve plan of care and services		form was updated on 1/7 Assistant Director of Nur	/17 by rsing to		
	and resident review e			include the stage of the p	ressure ulcer.		
	determinations condu	cted by the State;		Resident #3 Pressure ulce			
	(v) Physician's, nurse			form was updated on 1/7/ Assistant Director of Nur			
	professional's progres			include the stage of the pr	essure ulcer.		
	services reports as red This REQUIREMENT by: Based on staff intervi- review, and clinical red	is not met as evidenced ew, facility document cord review it was		Resident #7's Percocet ad record, nursing notes and count sheets were reviewe by the Director of Nursing	narcotic ed on 1/6/17		
	complete and accurate	y staff failed to maintain a e clinical record for five of rvey sample, Resident #1,		Resident #20 was discharg facility on 12/9/16.	ged from the		
	was administered on h December 2016 MARS	needed) pain medication ner November and					
	b. For Resident #1, fac wound documentation						

PRINTED: 01/17/2017

JAN 26 2017

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		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DA1	IO. 0938-039 FE SURVEY MPLETED
			A. BUILDING				С
		495249	B. WING			0	1/06/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
C4 D10 /01/0				15	75 SCOTT DRIVE ROUTE 5		
FARMIVILI	E REHABILITATION &	HEALTH CARE CENTER LLC		FA	RMVILLE, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETIO DATE
F 514	Continued From pag	o 154	F 51				
1 014	1.0		FDI	14	2. The Assistant Director of Nursi	ing,	
		iled to document the stage of ire ulcer on the pressure			the Unit Manager and the Directo		
	ulcer tracking forms.	ire uicer on the pressure			Nursing will complete an audit on		
	ulcer tracking lottis.		A LOO A COMMON		current residents' medical records		
	3 The facility staff fa	iled to document the stage			2/2/17 to ensure medical records	-	
	Resident #3's pressu					110	
	ľ				complete including staging of	c	
	4. The facility staff fa	iled to document Resident			pressure ulcers and documentation	n of	
1		dication administration on			medication administration as		
	the medication administration record (MA the nurse's notes on two out of nine oppo	. ,			required.		
					3. The Staff Development		
		iled to include the hospice			Coordinator will have re-educated	l the	
	records on the facility	/ chart for Resident # 20.			licensed nurses by 2/2/17 related t	0	
	The findings include:				the requirements of documenting	the	
	The infangs fielde.				staging of pressure ulcers and		
	1a. For Resident #1,	facility staff failed to			documenting the administration of	f	
		s needed) pain medication			medications.	•	
	was administered on	her November and			medications.		
	December 2016 MAF	RS (Medication			4. The Director of Nursing or		
	Administration Recor	d) on several occasions.			Assistant Director of Nursing will		
		14 I. I. I. I. I. I.			6		
		nitted to the facility on			complete an audit of 5 clinical rec		
	-	es that included but were not			from each unit weekly for 4 weeks		
	-	orie malnutrition, dysphagia, Iness, muscle weakness,			and monthly for 2 months to ensur	re	
		ewy Body [1]. Resident #1's			pressure ulcer staging and		
		inimum data set) was a			documentation of medication		
		t with an ARD (assessment			administration continues to be		
	reference date) of 11	/10/16. Resident #1 was			completed as required. The Direct	tor	
		rely cognitively impaired in			of nursing will submit a report to t		
		ily decisions, scoring 03 out			Quality Assurance Committee		
	,	rief Interview for mental			monthly for 3 months. The Directo	or	
	status) exam. Reside				of nursing will be responsible for		
	, -	ssistance with bed mobility, ating, toileting, personal			monitoring and follow up.		
	hygiene, and bathing						

If continuation sheet Page 155 of 171

DEPARTMENT OF HEALTH AND HUMAN SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		TE SURVEY MPLETED
		405340	B. WING				С
	ROVIDER OR SUPPLIER	495249	B. WING	STRI	EET ADDRESS, CITY, STATE, ZIP CODE 5 SCOTT DRIVE ROUTE 5	<u> </u>	1/06/2017
				FAR	RMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 514	Review of Resident #1's November 2016 MAR (medication administration record) revealed the following orders initiated on 10/28/16: "Lortab Tablet [2] 5-325 mg (milligrams) Give 1		F	514			
	tablet po (by mouth) Lortab Tablet 5-325 r mouth) at bedtime." on 12/23/16.			Completion date:		02/03/17	
		nber 2016 MAR revealed that rtab was documented one being administered.					
	that Resident #1 was needed) Lortab on 1 a.m., 11/5/16 at 2 p.n 11/16/16 at 11 a.m., 11/25/16 at 8 a.m. T were not documented November 2016 MAR	41's Narcotic sheet revealed also administered PRN (as 1/1/16 at 3 p.m., 11/3/16 at 9 n., 11/10/16 at 8:30 a.m., 11/20/16 at 11 a.m., and hese administration times d on Resident #1's R. Nursing notes could not he administration of Lortab at	PRN (as /16 at 9 a.m., and imes Ild not				
F (f T r L r	(medication administr following orders initia	t's December 2016 MAR ration record) revealed the ted on 10/28/16: "Lortab igrams) Give 1 tablet po (by PAIN."					
		ng Give 1 tablet po (by This order was discontinued					
	PRN (as needed) Lor	ber 2016 MAR revealed that tab was not signed out or administered for that					

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

Facility ID: VA0080

		MEDICAID SERVICES	Γ			<u>10. 0938-03</u>
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		TE SURVEY MPLETED
			A. BUILDING			С
		495249	B. WING		01/06/2017	
NAME OF P				STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	1100/2011
				1575 SCOTT DRIVE ROUTE 5		
FARMVILI	LE REHABILITATION & I	HEALTH CARE CENTER LLC		FARMVILLE, VA 23901		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PREFIX TAG	-	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)		COMPLETIO DATE
F 514	Continued From pag	e 156	F 514	4		
	month.					
	Review of the Narcot					
		(acetaminophen) (Lortab)				
	-	hat nursing was dispensing RN Lortab from the same				
		ollowing was documented:				
		(Lortab) 5-325 mg Tablet				
	Take 1 TAB (tablet) b scheduled."	y mouth at bedtime				
		ic log sheet revealed that				
	• •	rtab was administered on				
	12/29/16 at 8 p.m.	2/28/16 at 8 p.m., and				
	On 1/5/17 at 11:40 a.	m., an interview was				
		Registered Nurse) #1. When				
	•	administering prn (as				
		tion to a resident, RN #1				
		l ask the resident the pain narmacological interventions				
	before giving pain me	0				
	administer prn pain m					
		interventions were not				
	effective. She stated	that she would write the				
		on the back of the MAR or in				
		1 stated that she would				
		he pain medication was				
		nt the new pain level on the a nursing note. When				
		Id document that pain				
		nistered, RN #2 stated that				
		Id always be signed out on				
		hey are given. RN #2 stated				
	-	ation is a narcotic, it would				
	also be signed out of	the narcotic log. When				
		og was part of the clinical	***			
	record, RN #2 stated,	that it was not.				

Facility ID: VA0080

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 495249 B WING 01/06/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC FARMVILLE, VA 23901 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 514 Continued From page 157 F 514 On 1/5/17 at 5:59 p.m., ASM (administrative staff member) #1 and ASM #2, DON (Director of Nursing), were made aware of the above concerns. Facility policy titled, "LTC Facilities Receiving Pharmacy Products and Services from Pharmacy" did not address signing out prn pain medication. No further information was presented prior to exit. The following information is provided in Basic Nursing, Essentials for Practice, 6th edition (Potter and Perry, 2007, pages 349-360) was used as a reference for medication administration. To ensure safe medication administration, be aware of the six rights of medication administration. The right medication 1. 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation [1] Lewy Body- "LBD is a disease associated with abnormal deposits of a protein called alpha-synuclein in the brain. These deposits, called Lewy bodies, affect chemicals in the brain whose changes, in turn, can lead to problems with thinking, movement, behavior, and mood. LBD is one of the most common causes of dementia, after Alzheimer's disease and vascular disease." This information was obtained from The National Institutes of Health. https://www.nia.nih.gov/alzheimers/publication/le wy-body-dementia/basics-lewy-body-dementia.

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

If continuation sheet Page 158 of 171

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVE	8-039 Y
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED	
					C	
		495249	B. WING		01/06/201	17
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
FARMVILL	E REHABILITATION &	HEALTH CARE CENTER LLC		1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO		X5) PLETION
PREFIX TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE D.	ATE
F 514	Continued From pag	ge 158	F 514	1		
	[2] Lortab- Hydroco	done and Acetaminophen				
	combination used to	relieve moderate to severe				
		on was obtained from the				
	National Institutes o	n.nih.gov/pubmedhealth/PMH				
	T0010590/.					
		feelity staff failed to file				
		facility staff failed to file on on the clinical record.				
		#1's clinical record revealed				
	the following SBAR	(situation, background,				
	appearance and rev	<i>v</i> iew) form dated 7/17/16 that , the following: "Open area to				
	CoccyxThis starte	d on 7/17/16Appearance-				
	Open area partial th	nickness pink center,				
	macerated edges, r	no drainage, 0 (zero) odor" revealed that the MD				
		s notified on 7/17/16 at 11:55				
	a.m.					
	The following nursir	ng note was documented on				
		te: Res (Resident) observed				
		n open area to coccyx. No ted. edges intact with wound				
	bed of pink granulat	tion tissue. Tx (treatment)				
	order continues for	foam dressing q 3 (every)				
	days."					
	Review Resident #1	I's skin/pressure care plan				
	dated 5/17/2016 rev	vealed that it was updated on				
	open area partial th	owing problem area: " 7/17/16 ickness coccyx/sac				
	(sacral)Goal/Targ	et date: Res (Resident) will				
	show signs of healing					

Facility ID: VA0080

If continuation sheet Page 159 of 171

		ID HUMAN SERVICES			FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED C
		495249	B. WING		01/06/2017
NAME OF PI		<u>I</u>		STREET ADDRESS, CITY, STATE, ZIP CODE	
		EALTH CARE CENTER LLC		1575 SCOTT DRIVE ROUTE 5	
FARIVIVILL		EALTH CARE CENTER LLC		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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 514	Continued From page	9 159	F 51	4	
	dated 5/17/16 revealed were put into place pr the 7/17/16 pressure Review of Resident # revealed that different place in attempts to h discovery of Resident # weekly body audit she sheet in the clinical re before the discovery of Resident #1's 6/13/16 documented the follow Body audit sheets for and 7/11/16 could not record. Review of the June 20	1's physician orders t treatments were put into eal the wound after the #1's pressure area. 1's clinical record revealed eets. The last body audit cord was dated 6/13/16 of the open area on 7/17/16. 6 body audit report wing: "No new areas noted." 6/20/16, 6/27/16, 7/4/16 to be found in the clinical			
	development of the 7/ Further review of Res revealed wound shee through January 2017 measurements, stage wound. Wound sheet wound was discovere could not be found in	ident #1's clinical record ts from October 2016 7, documenting es, and appearance of the ts from 7/17/16 (when the d) through September 2016 the clinical record.			
	meeting with ASM (ac	n., wound sheets for uested at the end of day dministrative staff member) and ASM #2, the DON			

Event ID:095F11

Facility ID: VA0080

If continuation sheet Page 160 of 171

JAN 30 2017

VDH/OLC

TATEMENT	S FOR MEDICARE & PF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DA	10.0938-039 TE SURVEY MPLETED
		495249	B. WING			C 1/06/2017
				TREET ADDRESS, CITY, STATE, ZIP COD		110012011
			1	575 SCOTT DRIVE ROUTE 5		
FARMVILI	E REHABILITATION & H	IEALTH CARE CENTER LLC	F	ARMVILLE, 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)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 514	On 1/6/17 at 8: 20 a. 7/21/16 through 9/30 DON (Director of Nur asked where the wou		F 514			
	nursing) office in a file documentation shoul Resident's clinical red ASM #2 stated that s weekly body audit sh completed. ASM #2 s					
	on a weekly body aud pressure ulcer report report after the discov was dated 7/21/16. T documented the follo (Resident) continues (two) measuring 0.4 d					
	The following quotation Perry's Fundamental (2005, p. 477): "Doc written or printed that proof for authorized p within a client medica nursing practice. Nur	n was presented prior to exit. on is found in Potter and s of Nursing 6th edition umentation is anything is relied on as record or persons. Documentation I record is a vital aspect of rsing documentation must be sive, and flexible enough to				

Event ID: 095F11

Facility ID: VA0080

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RECEIVE JAN 30 2017 VDH/OLC

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT OF DEF	ICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
		495249	B. WING				C 06/2017
NAME OF PROVIDI	ER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
FARMVILLE RE	HABILITATION & H	EALTH CARE CENTER LLC			575 SCOTT DRIVE ROUTE 5 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 F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
retri trac star clier leve 2. T Res ulce Res 10/ ⁴ with to: r in w lose vas neu The assi assi the inte she dec exte staf was ass Skir hav 0.8 and the	k client outcomes, indards of nursing j int record provides it of quality of care he facility staff fail ident #6's pressur it tracking forms. ident #6 was adm (3/09 with a recent diagnoses that in nultiple sclerosis (thich nerve fibers their myelin cove cular disease, high rogenic bladder. most recent MDS essment, a quarte essment reference resident as scorin rview for mental s was cognitively in isions. The reside ensive to being tot f for most of her a s coded as indepe- istance was provid n Conditions, Resi ing a Stage 4 preside care in depth.	maintain continuity of care, , and reflect current practice. Information in the a detailed account of the e delivered to the clients." led to document the stage of re ulcer on the pressure hitted to the facility on the readmission on 9/16/16, focluded but were not limited (MS) (a progressive disease of the brain and spinal cord er (1)), dysphagia, peripheral h blood pressure, and S (minimum data set) erly assessment, with an e date of 11/14/16, coded ig a 13 on the BIMS (brief tatus) score, indicating that intact to make daily ent was coded as requiring ally dependent upon the ctivities of daily living. She	F	514			

Event ID: 095F11

Facility ID: VA0080

If continuation sheet Page 162 of 171 RECEIVED JAN 3.0 2017 VDH/OLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 495249 B. WING C NAME OF PROVIDER OR SUPPLIER 5TREET ADDRESS, CITY, STATE, ZIP CODE C FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX ID PROVIDER'S PLAN OF CORRECTION (X5)		STOR MEDICARE &	MEDICAID SERVICES					RM APPROVE NO. 0938-039
AMAE OF PROVIDER OR SUPPLIER 495249 B. WING		F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DA	TE SURVEY
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC 1575 SCOTT DRIVE ROUTE 5 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX F 514 Continued From page 162 Stage 4 Pressure Injury: Full-thickness skin and tissue loss F 514 F 514 Continued From page 162 or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undernining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Ulcer Record" was located in the clinical record. The report documented the onset of the pressure ulcer on the right buttock as 1/12/16. The form documented on 11/3/16, 11/10/16, 11/17/16, 11/23/16 and 11/29/16, 12/26/76 and 11/2/17 did not document the stage			495249	B. WING				
TAIL PARMVILLE PARMVILLE, VA 23901 (XA) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Comment (EACH CORRECTIVE ACTION DEFICIENCY) Comment (EACH CORRECTIVE ACTION DEFICIENCY) Comment (EACH CORRECTIVE (EACH CORRECTIVE ACTION DEFICIENCY) Comment (EACH CORRECTIVE APPROVE DEFICIENCY) Comment (EACH CORRECTIVE (EACH CORRECTIVE ACTION DEFICIENCY) F 514 (XA) The "Weekly Pressure Ulcer Moutod APPROPRIATE Record" dated, 12/8/16, 12/12/16, 12/19/1	NAME OF PR	OVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u>_</u>	1100/2017
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) commention DEFICIENCY F 514 Continued From page 162 Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. (2) F The "Weekly Pressure Ulcer Record" was located in the clinical record. The report documented the onset of the pressure ulcer on the right buttock as 1/12/16. The form documented on 11/3/16, 11/10/16, 11/17/16, 11/23/16 and 11/29/16, that the pressure ulcer wound was a Stage IV (four) pressure ulcer. The "Weekly Pressure Ulcer Record" dated, 12/8/16, 12/12/16, 12/19/16, 12/26/16 and 12/217 (di not document the stage	FARMVILL	E REHABILITATION & H	EALTH CARE CENTER LLC		1			
Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. (2) The "Weekly Pressure Ulcer Record" was located in the clinical record. The report documented the onset of the pressure ulcer on the right buttock as 1/12/16. The form documented on 11/3/16, 11/17/16, 11/123/16 and 11/29/16, that the pressure ulcer wound was a Stage IV (four) pressure ulcer. The "Weekly Pressure Ulcer Record" key pressure Ulcer Record" the stage	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP	IOULD BE	COMPLETION
Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. (2) The "Weekly Pressure Ulcer Record" was located in the clinical record. The report documented the onset of the pressure ulcer on the right buttock as 1/12/16. The form documented on 11/3/16, 11/10/16, 11/17/16, 11/23/16 and 11/29/16, that the pressure ulcer wound was a Stage IV (four) pressure ulcer. The "Weekly Pressure Ulcer Record" dated, 12/8/16, 12/12/16, 12/19/16, 12/26/16 and 1/2/17 did not document the stage	F 514	Continued From page	162	F	514	1		
Of the pressure ulcer on the right buttock. The		tissue loss Full-thickness skin and or directly palpable fas ligament, cartilage or l and/or eschar may be edges), undermining a Depth varies by anatol eschar obscures the e an Unstageable Press The "Weekly Pressure n the clinical record. To onset of the pressure u [/12/16. The form docu 1/10/16, 11/17/16, 11/ he pressure ulcer wou oressure ulcer. The "W Record" dated, 12/8/16 2/26/16 and 1/2/17 dia	d tissue loss with exposed scia, muscle, tendon, bone in the ulcer. Slough visible. Epibole (rolled and/or tunneling often occur. mical location. If slough or xtent of tissue loss this is ure Injury. (2) Ulcer Record" was located The report documented the ulcer on the right buttock as umented on 11/3/16, (23/16 and 11/29/16, that and was a Stage IV (four) /eekly Pressure Ulcer 5, 12/12/16, 12/19/16, d not document the stage					
	p A cı tř	lace for the stage, sho SM #2 stated, "Yes, th omplete. If it's asking nen a stage should be	ould it be documented, ne form should be for a stage on the form there."					
wound care nurse." When asked if the form has a place for the stage, should it be documented, ASM #2 stated, "Yes, the form should be complete. If it's asking for a stage on the form then a stage should be there." An interview was conducted with RN (registered	ni 1: a. of	urse) #1, who docume 2/19/16, 12/26/16 and	nted the wound on 1/2/17, on 1/5/17 at 11:20 she documents the stages #1 stated, "I don't					

²ORM CMS-2567(02-99) Previous Versions Obsolete

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		ID HUMAN SERVICES MEDICAID SERVICES					PRINTED: 01/1 FORM APPF OMB NO: 0938	ROVED
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				1	(X3) DATE SURVEY COMPLETED	
		495249	B. WNG				C 01/06/201	17
NAME OF P				Τ	STREET ADDRESS, CITY, STATE, ZI	P CODE		
FARMVILI	E REHABILITATION & H	EALTH CARE CENTER LLC			1575 SCOTT DRIVE ROUTE 5			
					FARMVILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE	COMPL	(5) LETION ATE
F 514	Continued From page downstage. We shou highest stage until it is Pressure Ulcer Recor RN #1. RN #1 stated, stage." An interview was cond documented on the w 12/12/16, on 1/5/17 at how she documents th ulcer, RN #5 stated, "d stages the wound, I ca I don't downstage any Pressure Ulcer Recor RN #5. RN #5 stated, stage." When asked if documented the stage The administrator and of the above findings of policy on the documer completing the weekly requested on 1/5/17. prior to exit. No further information (1) Barron's Dictionary Non-Medical Reader, Chapman, page 380 (2) http://www.npuap.org/ clinical-resources/npua	e 163 Id carry the stage the shealed." The "Weekly d" form was reviewed with "I forgot to carry over the ducted with RN #5, who ound on 12/8/16 and t 11:24 a.m. When asked he stages of a pressure Once the wound care nurse arry it over until it is healed. wound." The "Weekly d" form was reviewed with , "I forgot to document the she should have e, RN #5 stated, "Yes." ASM #2 were made aware on 1/5/17 at 6:00 p.m. A ntation of wound or pressure ulcer record was No policy was received was provided prior to exit. of Medical Terms for the 5th edition, Rothenberg and resources/educational-and- ap-pressure-injury-stages/ ed to document the stage e ulcers.		514	DEFICIE			
	Resident #3's pressure Resident #3 was admi 11/27/09 and readmitte	tted to the facility on						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 495249 B. WING 01/06/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC FARMVILLE, VA 23901 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID. (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 514 Continued From page 164 F 514 diagnoses that included but were not limited to: fracture left thigh bone, pain, anxiety, high blood pressure and bladder cancer. The most recent MDS (minimum data set, a thirty day assessment, with an ARD (assessment reference date) of 12/3/16 coded the resident as have seven out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely impaired cognitively. The resident was coded as requiring the assistance from staff for all activities of daily living. The resident was coded as being at risk for developing pressure ulcers. In section M "Skin Conditions" the resident was coded as having one stage 2 pressure ulcer and six stage 3 pressure ulcers. Review of the weekly non-pressure skin condition report dated 10/26/16 documented that the resident had a burn/abrasion to the right lower lateral leg measuring 12 cm. (centimeters) by three cm. and right inner ankle measuring 6 cm by 2 cm. "Tx (treatment) ordered for Silvasorb patch to be applied." Review of the weekly non-pressure skin condition report dated 11/5/16 documented that the resident had a moisture associated skin condition on the abdomen measuring 0.5 cm by 1.0 cm. Review of the weekly non-pressure skin condition report dated 11/3/16 documented that the resident had tissue loss to 2nd toe on R (right) foot measuring 0.9 cm. x 1.3 cm., outer aspect of R great toe and scratches to other phalanges. There was no documentation regarding the location of all of the wounds and the staging of any of the wounds.

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Event ID: 095F11

Facility ID: VA0080

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/17/2017 MAPPROVED 0. 0938-0391
STATEMENT ((X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		495249	B. WING _			01	C /06/2017
	ROVIDER OR SUPPLIER	EALTH CARE CENTER LLC		157	REET ADDRESS, CITY, STATE, ZIP CODE 75 SCOTT DRIVE ROUTE 5 RMVILLE, 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 F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 514	Continued From page	9 165	F 5	514			
	revised on 12/30/16 d integrityStage III. (R	an initiated on 5/26/15 and ocumented, "Impaired skin) [right] leg. (R) ankle. Top ot. Stag (stage) II sacrum, rt					
	member) #2 on 1/4/16	o ASM (administrative staff at 4:45 p.m. for ing Resident #3's wounds					
	On 1/5/17 no docume	ntation was obtained.					
	Resident #3's weekly	a note was attached to non-pressure skin condition ocumentation issue. Used nd care nurse change					
		nade to ASM #2 on 1/6/17 mentation regarding the 's wounds.					
		weekly pressure ulcer log ed, "Site. Sacrum. Stage					
	on 11/17/16 document	weekly pressure ulcer log ed, "Sacrum. Stage II. Right lat (lateral) leg. Stage					
	a.m. with ASM #2. Whe was to be documented stated it should be. Wh weekly pressure ulcer I	ucted on 1/6/17 at 11:30 en asked if wound staging in the clinical record she en asked if the facility's log was part of the d, ASM #2 stated it was					

Facility ID: VA0080

If continuation sheet Page 166 of 171

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/17/2017 M APPROVED O. 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COM	E SURVEY PLETED
		495249	B. WNG				C /06/2017
NAME OF PI	ROVIDER OR SUPPLIER	L			STREET ADDRESS, CITY, STATE, ZIP CODE		
FARMVILL	E REHABILITATION & H	EALTH CARE CENTER LLC			1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	L X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 514	Continued From page not.	9 166	F	514	1		
		s policy on wound care did tation of wound staging.					
	No further informatior	was provided prior to exit.					
	Percocet (1) medicati medication administra	o document Resident #7's on administration on the ition record (MAR) or the out of nine opportunities.					
		ted on 12/30/16 with ed but were not limited to: onic lung disease, high					
	available to review. Th dated 12/30/16 at 4:00 "Resident is alert/or	ient (sic) x (times) 3 (knows e she is) 1 assist needed					
	, ,	an's orders documented, g (milligrams) 1 tab (tablet) y) 4 hr (hours) prn (as					
		notes dated 1/5/17 at 6:00 proocet 5/325/mg (milligram) ."					
	administration record)	/ 2017 MAR (medication documented that Resident on 1/1/17 at 4:45 p.m.;					

If continuation sheet Page 167 of 171

	MENT OF HEALTH AN					FOF	ED: 01/17/2017 RM APPROVED IO. 0938-0391
1	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		495249	B. WING			0.	C 1/06/2017
	PROVIDER OR SUPPLIER	EALTH CARE CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
	1/2/17 at 3:15 a.m.; 1/ at 2:30 a.m. ad 1/5/17 documentation that th Percocet on 1/5/17 at Review of Resident #7 documented that ther 1/1/17 at 4:45 p.m.; 1/ 1:20 p.m.; 1/3/17 12:0 1/4/17 10:00 a.m.; 1/4 a.m.; 1/5/17 9:50 a.m. total of ten doses of Pr only five doses docum An interview was cond p.m. with LPN (license asked if staff documen received pain medicati we put it on the MAR of usually put it in there." An interview was cond a.m. with ASM #2. Wh documented that a res medication, ASM #2 st When asked if the nard permanent record, ASI On 1/5/16 at 6:10 p.m. and ASM #2, the direct aware of the findings. Review of the facility's ASSESSMENT" docum pain medication is prov management program,	 (4/17 at 10:00 p.m; 1/5/17 7 at 9:55 a.m. There was no e resident had received 6:00 a.m. 7's narcotic sheets resident received Percocet (2/17 at 3:15 a.m.; 1/2/17 at 0 p.m.; 1/4/17 2:45 a.m.; /17 9:00 p.m.; 1/5/17 2:30 and 1/5/17 at 2:00 p.m. a ercocet were given with hented on the MAR. Aucted on 1/5/17 at 12:20 ed practical nurse) #1.When hed that a resident ion, LPN #1 stated, "Yes, or when I write my note I Aucted on 1/5/16 at 11:30 en asked where staff ident received a pain tated, "On the MAR." cotic record was part of the M #2 stated it was not. ASM #1, the administrator for of nursing were made policy titled, "PAIN nented, "Procedure: 8. If rided as part of a pain the Pain Management used to assess pain each provided. This record 	F	514	4		

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Event ID: 095F11

Facility ID: VA0080

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	MENT OF HEALTH AN					FOR	D: 01/17/2017 M APPROVED D. 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		495249	B. WING			1	C /06/2017
NAME OF P	ROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE		
					1575 SCOTT DRIVE ROUTE 5		
FARMVILI	E REHABILITATION & H	EALTH CARE CENTER LLC			FARMVILLE, VA 23901		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	I	L	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFI	х	(EACH CORRECTIVE ACTION SHOULD E	ΙE	COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI	ATE	DATE
					DEFICIENCY)		
F 514	Continued From page	168	F	514	4		
	No further information	was provided prior to exit.					
	(1) Doropost Tracto	madarata ta madaratalu					
		moderate to moderately licine is a narcotic pain					
		ion was obtained from:					
		nih.gov/pubmedhealth/?ter					
	m=percocet						
	5 The facility staff fail	ed to include the hospice					
rever numbers as a		chart for Resident # 20.					
	records on the facility	chart for resident # 20.					
	Resident # 20 was ad	mitted to the facility on					
	12/1/15 and readmitte						
		out not limited to: anemia,					
	coronary disease, hyp						
		ntia, and schizophrenia (1).					
		DS (minimum data set), a					
		essment with assessment					
		6, Resident # 20 was coded					
		possible 15 on the BIMS					
	-	tal status) indicating that					
	•	nitively impaired. She was					
	coded as receiving hos						
	A review of the clinical	record for Resident # 20					
	revealed a nurse's not						
	12/8/2016 1114 pm (11	I:14 p.m.) that					
	documented, "@ (at) 1						
		mbol for with) cool, clammy					
		pon assessment. Pupils					
		call placed to (name of					
		all nurse as well as RP					
		d made aware of resident's					
		is. Spoke (symbol for with)					
	on-call nurse who state						
		oute (sic) to facility. Res					
		· · · · · · · · · · · · · · · · · · ·	1		1		

Facility ID: VA0080

If continuation sheet Page 169 of 171

ATEMENT (F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CC	ONSTRUCTION	(X3) DA	10. 0938-03 TE SURVEY
ID PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COL	MPLETED
		495249	B. WING		0	C 1/06/2017
NAME OF PR		-	STRE	ET ADDRESS, CITY, STATE, ZIP COD		
			1575	SCOTT DRIVE ROUTE 5		
FARMVILL	E REHABILITATION & F	HEALTH CARE CENTER LLC	FAR	MVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIC DATE
F 514	Continued From page	e 169	F 514			
1 014			1 014			
		② this time (symbol for pirations. (Symbol for no)				
		ted (symbol for after) 1 full				
		otain a blood pressure. MD				
		spice provider) aware."				
	,	nsed practical nurse) # 3.				
	A review of the aligie	al record, including the				
		led to reveal any evidence of				
	•	tion of the hospice nurse's				
	assessment of Resid	-				
		n 1/5/17 at approximately				****
		Administrative staff member)				
		irses, a request was made				
		n from the hospice nurse in				
	regards her linal asse	essment of Resident # 20.				
	During an interview o	n 1/5/17 at 3:30 p.m. with				
	ASM # 2, ASM # 2 st					
		inical record - there is no				
	note from the hospice	e nurse in the record. I'm				
	waiting for (name of h	nospice provider) to fax a				
	copy of the note to m	e."				
	A faxed copy of the n	ote (faxed on 1/5/17 at				
	15:48:54) was provid					
	documented a copy of					
		nospice nurse on 12/09/16				
		documented the following:				
		urse (name of nurse) at				
		orting PT (patient Resident				
		Vriter received PT lying in				
		lo signs of Respirations nor				
	. ,	uscultated. No carotid pulse				
		ated. Pupils fixed and touch. No signs of life				
	noted. PT was prond					
	Signed by RN (registe					-

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: VA0080



jan 30 2**017**

VDH/OLC

		ND HUMAN SERVICES MEDICAID SERVICES				FOI	RM APPROVEL
STATEMENT	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		INSTRUCTION	(X3) DA	10.0938-039 TE SURVEY MPLETED
		495249	B. WING	NG			C 1/06/2017
NAME OF PI		1		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	1 0	1/06/2017
FARMVILL	E REHABILITATION & H	EALTH CARE CENTER LLC			SCOTT DRIVE ROUTE 5 MVILLE, VA 23901		
			I		PROVIDER'S PLAN OF CORREC		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 514	Continued From page	e 170	Ft	514			
	p.m. with ASM # 1, th 2 this concern was ag	r interview on 1/5/17 at 6:00 e administrator, and ASM # gain discussed. A copy of complete and accurate ed at this time.					
	ASM # 2, ASM # 2 sta	n 1/6/17 at 8:25 a.m. with ated that there was no policy having a complete and rd.					
	No further information	was provided prior to exit.					
	NOTES:						
	disorder that affects h and behaves.	a chronic and severe mental low a person thinks, feels, alth/topics/schizophrenia/ind					

Facility ID: VA0080

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