| | | AND HUMAN SERVICES | | | FORM, |
|--------------------------|--|---|---------------------|---|---|
| | | & MEDICAID SERVICES | | | OMB NO. |
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA !DENTIFICATION NUMBER: | CS 704 | LE CONSTRUCTION | (X3) DAT COMPLETED |
| NAME OF F | MOVIDED OF OURDINGS | 495249 | B. WING | | C 01/25/2019 |
| INAME OF F | PROVIDER OF SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 200 10 10 10 10 10 10 10 10 10 10 10 10 1 |
| FARMVIL | LE HEALTH & REHAI | | 1 | 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY) | D BE COMPLETION |
| F 000 | INITIAL COMMENT | S | F 000 | | ſ |
| | | edicare/Medicaid abbreviated | | | |
| ļ | | s conducted 1/24/19 through | | | ls E |
| | survey. corrections | nt was investigated during the were required for compliance | | E F | l) |
| | | 3 Federal Long Term Care | | | į į |
| | and F609. The defic | level II Deficency at F 607 ient practice was deemed | | | ſ |
| ſ | Past Non Compliant 1/21/19. | ce with an AOC date of | | | |
| | 105 at the time of th | 20 certified bed facility was e survey. The survey sample | | ľ | |
| | consisted of six curr (Residents #1 through one closed record re | gh #5 and Resident #7) and | | | |
| F 607 | Develop/Implement | Abuse/Neglect Policies | F 607 | a a | |
| SS=D | CFR(s): 483.12(b)(1 |)-(3) | | I | Ŭ |
| | | ity must develop and plicies and procedures that: | | Ī | |
| | | oit and prevent abuse, | | | |
| | misappropriation of | | | | f. |
| ľ | | lish policies and procedures | | [| |
| | to investigate any su | ich allegations, and | | ł | |
| | | le training as required at | | F | |
| | | T is not met as evidenced | | | e E |
| 30 | by: Based on staff inter | view, facility document review | | Past noncompliance: no plan of | |
| | and clinical record re | eview, it was determined that | | correction required. | l) |
| l. | | d to implement the facility of seven residents in the | | I. | a V |
| | survey sample, Res | | | | L _i |
| | | ER/SUPPLIER REPRESENTATIVE'S SIGN | ATUDE | TITLE | (X6) DATE |

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.

Facility ID: VA0080

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION NG | (X3) DATE SURVEY COMPLETED |
|---|--|--|---------------------|---|-------------------------------|
| | | 495249 | B. WING | | C 01/25/2019 |
| | PROVIDER OR SUPPLIER | B CENTER | | STREET ADDRESS. CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901 | 011202010 |
| (X4) ID PREFIX TAG | FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE COMPLETION |
| F 607 | Continued From pa | ge 1 | F 6 | 07 | |
| j ž | policy immediately reporting and inves | ed to implement the abuse or within two hours, for tigating an allegation that a dent #1) sucked Resident #2's | | | |
| 00.02007 | The findings include | e: | | | 8 |
| | 9/17/14. Resident were not limited to depression and chr disease. (2) Reside (minimum data set) an ARD (assessme coded the resident decision-making as coded Resident #2 assistance of two sextensive assistance ating and personal Resident #1 was ac 7/17/2014. Reside | dmitted to the facility on nt #1's diagnoses included but | | | |
| | were not limited to depression, diabete chronic obstructive #1's most recent M annual assessment reference date) of cognitively intact. Sonot exhibiting behalf Resident #7 was as 4/23/2009. Reside were not limited to | metabolic encephalopathy (3), es, high blood pressure and pulmonary disease. Resident DS (minimum data set), an t with an ARD (assessment I/10/19, coded the resident as ection E coded Resident #1 as | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION IG | (X3) DATE SURVEY COMPLETED |
|---|---|--|--------------------------|--|-------------------------------|
| | | 495249 | B. WING | | C 01/25/2019 |
| | PROVIDER OR SUPPLIER | B CENTER | | STREET ADDRESS, CITY, STATE, ZIP CO 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE COMPLETION |
| F 607 | (minimum data set) an ARD (assessme | ge 2 , an annual assessment with int reference date) of 11/3/18, as cognitively intact. | F 60 | 7 | j |
| | submitted to the sta revealed document | cility reported incident) ate agency on 1/14/19 ation that Resident #7 alleged priate contact between (name Resident #2)". | | | |
| | Department of Hea and Certification (V "(name of Resident Resident #1) suckin Resident #2) in the of Resident #7) rep members in the fac members went to s that they did not se time the four facility | up submitted to Virginia Ith Department of Licensure DH OLC), documented in part, #7) witnessed (name of ng the breast of (name of hallway of the facility. (Name orted this to four staff illity. One of those facility ee about this (Sic) and reports e the above reported. At this e staff failed to report to the | | | |
| | nurse's note dated note documented " performed on resid within normal limits | t #2's clinical record revealed a 1/14/19 at 10:21 a.m., nurse's Head to toe assessment ent. Vital signs stable and . No bruising or redness noted tremities. No complaints of noted." | | | |
| | social services note which documented department) intervipsychological well-resident was the re | t #2's clinical record revealed a e dated 1/14/19 at 11:21 a.m., "SSD (social services ewed resident for being after it was reported that cipient if inappropriate physical eported not remembering any | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDII | TIPLE CONSTRUCTION | (X | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|-------------------------|--|-------------------|-------------------------------|--|
| | | 495249 | B. WING | | (8) (1) (2) | C 01/25/2019 | |
| NAME OF | PROVIDER OR SUPPLIER | STATE OF THE PROPERTY OF THE P | | STREET ADDRESS, CITY, STATE, ZIP CO | <u>L_</u> DE | 01/23/2019 | |
| FARMVII | LLE HEALTH & REHA | R CENTER | | 1575 SCOTT DRIVE ROUTE 5 | | | |
| | ece neach a nena | B OLITICAL CONTRACTOR OF THE C | | FARMVILLE, VA 23901 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | | |
| F 607 | Continued From pa | ge 3 | F 60 | 07 | | | |
| | incident of physical resident (Resident | contact with fellow male #1)." | : | | | | |
| | interview attempted the interview could Resident #2's cogn On 1/24/18 at approinterview was condinged abuse replied "I witnessed sucking the breast When asked did shift replied "I told that I saw (name of Resident #2) and the I didn't tell her how embarrassed. I also cafeteria what happed on 1/24/19 at approinterview was condinged to 1/24/19 at approinterview was conditionally at approximately at a 1/24/19 at approximately at approximately at a 1/24/19 at a 1/24/19 at a 1/24/19 at | eximately 1:25 p.m., an sucted with Resident #7. Sked if she has witnessed or in the facility, Resident #7 (name of Resident #1) of (name of Resident #2)." he report this incident, Resident front desk lady (receptionist). Resident #1) touch (name of lat I wanted her to check it out he touched her because I was not told some ladies in the bened." Eximately 1:40 p.m., an sucted with other staff member DSM #2 was asked the facility a resident-to-resident sexual 2 replied, "It has to be reported tell the nurses so they can | | | | | |
| | administrator imme a resident had ever abuse. OSM #2 rep in the dining room of Resident #7) told m were sitting there, to sucking the breast of the hallway. We as she report that to as | idents and also I am to tell the diately." OSM #2 was asked if told her of an allegation of died "Yes, I remember sitting on 1/13/19 and (name of e and some other staff that that (name of Resident #1) was of (name of Resident #2) in ked (name of Resident #7) did nyone, she said yes the front 2 was asked did you or | | 8 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 45 69 | FIPLE CONSTRUCTION NG | | TE SURVEY MPLETED |
|---|---|---|---------------------|--|--------|----------------------------|
| | | 495249 | B. WING | | 01 | C /25/2019 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | 123/2019 |
| | | | | 1575 SCOTT DRIVE ROUTE 5 | | |
| FARMVII | LE HEALTH & REHA | B CENTER | | FARMVILLE, VA 23901 | | 4877 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| F 607 | Continued From pa | ge 4 | , F 6 | 07 | | |
| | abuse. OSM #2 re allegation of abuse | e report the allegation of plied, "No." When asked if the should have been reported, es, we should have reported it | | | | |
| | interview was cond receptionist. OSM # process regarding a altercation. OSM # resident make sure report it immediatel administrator." OSM resident had ever to OSM #4 replied, "Thappened where a resident touch anot out the resident, an as normal with noth the other resident withink it was an abust reported it right away that the resident sa On 1/25/19 at appreinterview was cond staff member) #1, the asked about the fact regarding a resident altercation. ASM # sure the resident is report the incident of stated administration and reports the incident was asked when at ASM #1 stated the | eximately 2:45 p.m., an ucted with OSM #4, the #4 was asked about the facility a resident-to-resident sexual 4 replied, "First check on the that they are okay then, y to the nurses and M #4 was asked if asked if a old her an allegation of abuse, here was an incident that resident told me she saw a her resident. I went to check if a she was sitting on the benching abnormal about her and was not on that hallway. I didn't se situation or I would have ay. I found out the next day w something sexual." I coximately 11:00 a.m., an ucted with ASM (administrative he Administrator. ASM #1 was cility process followed at-to-resident sexual 1 stated staff should make safe, assess the resident and to administration. ASM #1 on investigates the incident ident to the state. ASM #1 in incident should be reported. Incident should be reported SM #1 was asked to describe | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 21-11-24-4-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1 | TIPLE CONSTRUCTION | | X3) DATE SURVEY COMPLETED C 01/25/2019 |
|---|-----------------------|--|--|-------------------------------------|-----------|---|
| | | | A. BOILD | | | C |
| | | 495249 | B. WING | | 0 | 35.5 |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO | | 0,20.10 |
| FARMVI | LLE HEALTH & REH | AR CENTER | | 1575 SCOTT DRIVE ROUTE 5 | | |
| | | | | FARMVILLE, VA 23901 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | SHOULD BE | (X5) COMPLETION DATE |
| F 607 | Continued From p | age 5 | F | 607 | | * * * |
| | 3.0 | tion should include. ASM #1 | 1 (| | | ÷. |
| | | terview the resident named in | | | | |
| | | e resident is able to be | | | | |
| | | iew the resident who reported | | | | |
| | | interview other residents to | | | | |
| | | happened to them. ASM #1 | | | | |
| | | le aware of the allegation of | | | | |
| | | t #2 on the morning of 1/14/19 | | | | J3 |
| | | ent #7). She came up to me | | | | |
| | | he witnessed, (name of ing the breast of (name of | | | | |
| | | hallway. I immediately opened | | | | |
| | | to this allegation and contacted | | i 1 | | |
| | | agencies including the local | | | | į |
| | | ne staff knew about the | | İ | | i |
| | | ne, we suspended those staff | | 1, | | |
| | | ned on the mandatory | | | | |
| | | ere trained to separate the | | | | |
| | | ontact administration we are not in the building, they | | | | |
| | | ers for after hours. We started | | | | ž |
| | | ent and performance | | | | |
| | improvement action | n plan (QAPI) so this does not | | × | | 8 |
| | happen in the futu | | | | | OK . |
| | | | | | | |
| | | ity QAPI plan dated 1/16/19 | | | | |
| | | cern: 1. Abuse Allegation- | | | | |
| | | : #2) was inappropriately | | N | | |
| | | of Resident #1) on 1/13/19, 2. the allegation of abuse | | | | 1 |
| | | nagement. Root Cause | | Ŧ | | |
| | | igation is pending by the facility | | 5 | | l |
| | | e. The resident has no criminal | | | | © 15 |
| | | ent denies this event happening. | | 1 | | |
| | (Sic), 2. Staff did r | ot follow policy. Goals & | | | | |
| | Objectives: 1. Tha | t Resident #2 will be kept in a | | | | |
| | | 2. That staff will abide by policy | | | | : : |
| | | t immediately to the | | | | į. |
| | supervisors." Furti | ner review of the QAPI plan | | | | .8 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 30 AN | TIPLE CONSTRUCTION NG | | 3) DATE SURVEY COMPLETED | |
|---|---|--|---------------------|---|---------|-----------------------------|--|
| | | 495249 | B. WING | | 01 | C /25/2019 | |
| | PROVIDER OR SUPPLIER | B CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODI 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901 | | 72072013 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES 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) COMPLETION DATE | |
| F 607 | facility staff on abuse abuse." Education of being completed 1/ The facility policy tit Policy" documented Staff should report their direct supervise a resident unattend summon assistance All allegations of Abseclusion, Injuries of Misappropriation of reported immediate Director of Nursing State Agency. If the allegation involves a serious bodily injury DOH (Department of later than 2 hours a During the days of the stated the process concerns were identification of the control of | mented, "Education of all se and timely reporting of off staff was signed off as 17/19. Iled, "Virginia Resident Abuse IIII, "4. Protect the Resident a. IIII incidents immediately to fors. b. Staff should not leave ed, unless it is necessary to e. 6. Initial Reports a. Timing. It is necessary to e. 6. Initial Reports a. Timing. | F 64 | 07 | | | |
| | This deficiency was Compliance. | | | | | | |
| | ivo iurinei inionilai | on was presented prior to exit. | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--|---|--|---|--|-----------|-------------------------------|--|
| | | 495249 | B. WING | | | С | |
| NAME OF I | PROVIDER OR SUPPLIER | 193249 | D. WING | | 01/ | 25/2019 | |
| 2 ************************************ | | D. OCULTED | | STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 | | | |
| FARMVII | LE HEALTH & REHA | AB CENTER | ŀ | FARMVILLE, VA 23901 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO | BE | (X5) COMPLETION DATE | |
| F 607 | Continued From pa | ige 7 | F6 | 07 | Cristo di | | |
| | person's ability to c | that seriously affects a arry out daily activities. This tained from the website: | | | | į | |
| F 609 SS=D | Reporting of Allege CFR(s): 483.12(c)(| | F6 | 09 | | | |
| | | onse to allegations of abuse, n, or mistreatment, the facility | | | | | |
| | involving abuse, ne mistreatment, inclu source and misapp are reported immed hours after the alleg that cause the alleg serious bodily injunthe events that cau abuse and do not rethe administrator of officials (including tadult protective ser for jurisdiction in los accordance with St procedures. | ire that all alleged violations iglect, exploitation or ding injuries of unknown repriation of resident property, diately, but not later than 2 gation is made, if the events gation involve abuse or result in y, or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to f the facility and to other the State Survey Agency and vices where state law provides ing-term care facilities) in ate law through established | | | | | |
| | designated represe accordance with St Survey Agency, wit incident, and if the appropriate correct | ort the results of all e administrator or his or her entative and to other officials in ate law, including to the State hin 5 working days of the alleged violation is verified ive action must be taken. NT is not met as evidenced | | | | | |
| | Based on staff inte | erview, facility document review review, it was determined that | | Past noncompliance: no plan of correction required. | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 55 50 | TIPLE CONSTRUCTION NG | (X3) DATE SURVEY COMPLETED |
|--------------------------|--|--|---------------------|--|-------------------------------|
| | | 495249 | B. WING | | C 01/25/2019 |
| | PROVIDER OR SUPPLIER | B CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901 | 01/20/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETION |
| F 609 | allegation of abuse the survey sample, The facility staff fail immediately and fait two hours, notify the officials in accordancesident (Resident #2's breast on 1/13/ The findings include Resident #2 was ac 9/17/14. Resident #2 was ac 9/17/14. Resident were not limited to // depression and chrodisease. (2) Reside (minimum data set) an ARD (assessme coded the resident's decision-making as coded Resident #2 assistance of two stextensive assistance ating and persona Resident #1 was ac 7/17/2014. Resider were not limited to redepression, diabete chronic obstructive #1's most recent Mi annual assessment reference date) of 1 | d to immediately report an for one of seven residents in Residents #2. ed to notify the administrator led to immediately or within e state agency and other nee with state law when a male #1) allegedly touched Resident #19. e: Imitted to the facility on #2's diagnoses included but Alzheimer's disease (1), onic obstructive pulmonary ent #2's most recent MDS, a quarterly assessment with nt reference date) of 12/2/18, is cognitive skills for daily severely impaired. Section G as requiring extensive raff with bed mobility and re of one staff with dressing, I hygiene. Imitted to the facility on the #1's diagnoses included but metabolic encephalopathy (3), is, high blood pressure and pulmonary disease. Resident DS (minimum data set), an with an ARD (assessment /10/19, coded the resident as rection E coded Resident #1 as | F6 | 09 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIF | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|--|---|---------------------|---|-------------------------------|
| | | 495249 | B. WING | | C 01/25/2019 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901 | 1 01120/2010 |
| (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 CROSS-REFERENCED TO THE APPROVIDERICIENCY) | D BE COMPLETION |
| F 609 | 4/23/2009. Residing were not limited to blood pressure. R (minimum data sean ARD (assessm | rage 9 admitted to the facility on ent #7's diagnoses included but o depression, anxiety and high esident #7's most recent MDS t), an annual assessment with ent reference date) of 11/3/18, t as cognitively intact. | F 609 | | |
| | submitted to the s revealed documer "witnessed inappro of Resident #1 and Investigation follow Department of He and Certification () "(name of Resider Resident #1) suck Resident #2) in the of Resident #7) re members in the fa members went to that they did not se time the four facilit supervisors." Review of Resider note documented performed on resi- within normal limit | acility reported incident) tate agency on 1/14/19 ntation that Resident #7 alleged opriate contact between (name d Resident #2)". If we up submitted to Virginia alth Department of Licensure VDH OLC), documented in part, int #7) witnessed (name of ing the breast of the facility. (Name ported this to four staff cility. One of those facility see about this (Sic) and reports is the above reported. At this ity staff failed to report to the out #2's clinical record revealed a if 1/14/19 at 10:21 a.m., nurse's "Head to toe assessment dent. Vital signs stable and is. No bruising or redness noted extremities. No complaints of | | | |
| | social services no | noted." ht #2's clinical record revealed a te dated 1/14/19 at 11:21 a.m., d, "SSD (social services | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULT | IPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|--|---|---------------------|---|-------------------------------|----------------------------|
| | | 495249 | B. WING _ | | C 01/25 | 10010 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 01/25 | /2019 |
| FARMVII | LE HEALTH & REHA | B CENTER | | 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY) | DBE C | (X5) COMPLETION DATE |
| | resident was the recontact. Resident reincident of physical resident (Resident resident (Resident resident (Resident resident (Resident resident review attempted the interview attempted the interview could resident #2's cogn. On 1/24/18 at approinterview was cond. Resident #7 was as experienced abuse replied "I witnessed sucking the breast When asked did sh. #7 replied "I told the that I saw (name of Resident #2) and th. I didn't tell her how embarrassed. I also cafeteria what happed interview was condit (OSM) #2, dietary. On 1/24/19 at approinterview was condit (OSM) #2, dietary. I would help protect the resident resident had ever abuse. OSM #2 repin the dining room of Resident #7) told m. | ewed resident for peing after it was reported that cipient if inappropriate physical eported not remembering any contact with fellow male #1)." eximately 12:30 p.m., an with Resident #2, however not be completed due to itive status. eximately 1:25 p.m., an ucted with Resident #7. sked if she has witnessed or in the facility, Resident #7 (name of Resident #1) of (name of Resident #2)." e report this incident, Resident e front desk lady (receptionist) Resident #1) touch (name of nat I wanted her to check it out, he touched her because I was a told some ladies in the | F 60 | 09 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION | (| (X3) DATE COMP | SURVEY PLETED |
|---|--|--|--------------------|--|----------|-------------------|----------------------------|
| | | 495249 | B, WING | 1 | ŀ | 01/2 | ; 5/2019 |
| | PROVIDER OR SUPPLIER | B CENTER | | STREET ADDRESS, CITY, STATE, ZIP CO 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901 | DE | 01/2 | .5/2015 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION) | ID PREFI TAG | | SHOULD E | | (X5) COMPLETION DATE |
| F 609 | the hallway. We as she report that to a desk lady." OSM #2 anybody at the table abuse. OSM #2 regallegation of abuse OSM #2 replied, "Ye immediately." On 1/24/19 at appresent the process regarding a altercation. OSM #4 resident make sure report it immediatel administrator." OSM resident had ever to OSM #4 replied, "Thappened where a resident touch anot out the resident, an as normal with noth the other resident withink it was an abuse reported it right away that the resident sar | of (name of Resident #2) in ked (name of Resident #7) did hyone, she said yes the front 2 was asked did you or 2 report the allegation of olied, "No." When asked if the should have been reported, 2 es, we should have reported it es, we should have reported it existence with OSM #4, the existence with OSM #4 was asked about the facility a resident-to-resident sexual existence with existence with existence was an incident that resident told me she saw a her resident. I went to check did she was sitting on the bench ing abnormal about her and was not on that hallway. I didn't be situation or I would have any. I found out the next day we something sexual." | F€ | 37 - | | | |
| | asked about the factoregarding a resident altercation. ASM # sure the resident is report the incident t | ne Administrator. ASM #1 was cility process followed t-to-resident sexual 1 stated staff should make safe, assess the resident and o administration. ASM #1 n investigates the incident | | | | | |

| O LINE | 10 I OIT WEDIOAITE | WINEDIONID SERVICES | 2 93 | NO | CIVID | NO. 0938-0391 | |
|---|--|--|--|---|-----------|-------------------------------|--|
| STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3 | (X3) DATE SURVEY COMPLETED | |
| | | 495249 | B. WING | | | C 01/25/2019 | |
| NAME OF PROVIDER OR SUPPLIER FARMVILLE HEALTH & REHAB CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP C 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901 | ODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | SHOULD BE | | |
| F 609 | and reports the inci- was asked when ar ASM #1 stated the within two hours. As what the investigation stated he would interviewed, inte | dent to the state. ASM #1 incident should be reported. Incident should include. ASM #1 Increive the resident named in resident is able to be the resident who reported interview other residents to thappened to them. ASM #1 Increive ware of the allegation of the aware of the allegation of the witnessed, (name of the increive way. I immediately opened this allegation and contacted agencies including the local the staff knew about the term of the mandatory the trained to separate the intact administration we are not in the building, they are for after hours. We started int and performance plan (QAPI) so this does not | F6 | 609 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA (X2) I IDENTIFICATION NUMBER: A. BU | | TIPLE CONSTRUCTION NG | COV | (X3) DATE SURVEY COMPLETED | |
|--|--|---|---------------------|---|--------|-------------------------------|--|
| | | 495249 | B. WING_ | | | C /25/2019 | |
| | PROVIDER OR SUPPLIER | B CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOUNDS CROSS-REFERENCED TO THE APPRIDEFICIENCY) | ILD BE | (X5) COMPLETION DATE | |
| F 609 | safe environment. and report incident supervisors." Furth dated 1/16/19 documented facility staff on abuse." Education being completed 1/2 The facility policy ti Policy" documented Staff should report their direct supervisa resident unattend summon assistance All allegations of At Seclusion, Injuries Misappropriation of reported immediated Director of Nursing State Agency. If the allegation involves serious bodily injuried than 2 hours at During the days of stated the process concerns were ider implementation of the Control o | Resident #2 will be kept in a 2. That staff will abide by policy immediately to the er review of the QAPI plan imented, "Education of all se and timely reporting of off staff was signed off as 17/19. Itled, "Virginia Resident Abuse d, "4. Protect the Resident a. all incidents immediately to sors. b. Staff should not leave led, unless it is necessary to e. 6. Initial Reports a. Timing. Duse, Neglect, Involuntary of Unknown Source, and resident property must be ely* to the Administrator, (DON) and to the applicable e event that caused the an allegation of Abuse or y, it should be reported to the of Health) immediately, but not after the allegation is made." Ithe survey staff interviewed for reporting. No other intified regarding the the facility abuse policy. | F 60 | 09 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|---|---|---|---|-----------------------|-------------------------------|--|
| | | 495249 | B. WING | <u> </u> | | C 25/2019 | |
| NAME OF PROVIDER OR SUPPLIER FARMVILLE HEALTH & REHAB CENTER | | | 157 | REET ADDRESS, CITY, STATE, ZIP CODE 75 SCOTT DRIVE ROUTE 5 RMVILLE, VA 23901 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| F 609 | Continued From pa | ge 14 | F 609 | | 70 of officeronal and | | |
| | No further informat | ion was presented prior to exit. | | | | ; | |
| | person's ability to c information was ob | that seriously affects a arry out daily activities. This tained from the website: a.gov/medlineplus/alzheimersdi | | | 1 1 2 | × | |
| 3 | can lead to shortne types are chronic b The main cause of to substances that This is usually ciga chemical fumes, or information was ob | kes it difficult to breath that ss of breath). The two main ronchitis and emphysema. COPD is long-term exposure irritate and damage the lungs. rette smoke. Air pollution, dust can also cause it. This tained from the website: n.gov/medlineplus/copd.html. | | | 4 | · | |
| | which encompasse confusional state, is cerebral dysfunctio structural brain discobtained from the whttps://www.uptodaetabolic-encephaloolic%20encephalop | abolic encephalopathy (TME), is delirium and the acute is an acute condition of global in the absence of primary ease. This information was vebsite: te.com/contents/acute-toxic-mpathy-in-adults?search=metab eathy&source=search_result&s & & usage_type=default&display | | | | | |
| 9 | | | | | | | |