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

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 1/24/19 through 1/25/19. A complaint was investigated during the survey. corrections were required for compliance with 42 CFR Part 483 Federal Long Term Care requirements for the level II Deficency at F 607 and F609. The deficient practice was deemed Past Non Compliance with an AOC date of 1/21/19. The census in this 120 certified bed facility was 105 at the time of the survey. The survey sample consisted of six current resident reviews (Residents #1 through #5 and Resident #7) and one closed record review (Resident #6).	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement the facility abuse policy for one of seven residents in the survey sample, Residents #2.	F 607	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | 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.

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The facility staff failed to implement the abuse policy immediately or within two hours, for reporting and investigating an allegation that a male resident (Resident #1) sucked Resident #2's breast.

The findings include:

Resident #2 was admitted to the facility on 9/17/14. Resident #2's diagnoses included but were not limited to Alzheimer's disease (1), depression and chronic obstructive pulmonary disease. (2) Resident #2's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/2/18, coded the resident's cognitive skills for daily decision-making as severely impaired. Section G coded Resident #2 as requiring extensive assistance of two staff with bed mobility and extensive assistance of one staff with dressing, eating and personal hygiene.

Resident #1 was admitted to the facility on 7/17/2014. Resident #1's diagnoses included but were not limited to metabolic encephalopathy (3), depression, diabetes, high blood pressure and chronic obstructive pulmonary disease. Resident #1's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 1/10/19, coded the resident as cognitively intact. Section E coded Resident #1 as not exhibiting behavioral symptoms.

Resident #7 was admitted to the facility on 4/23/2009. Resident #7's diagnoses included but were not limited to depression, anxiety and high blood pressure. Resident #7's most recent MDS

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(minimum data set), an annual assessment with an ARD (assessment reference date) of 11/3/18, coded the resident as cognitively intact.

Review of a FRI (facility reported incident) submitted to the state agency on 1/14/19 revealed documentation that Resident #7 alleged "witnessed inappropriate contact between (name of Resident #1 and Resident #2)".

Investigation follow up submitted to Virginia Department of Health Department of Licensure and Certification (VDH OLC), documented in part, "(name of Resident #7) witnessed (name of Resident #1) sucking the breast of (name of Resident #2) in the hallway of the facility. (Name of Resident #7) reported this to four staff members in the facility. One of those facility members went to see about this (Sic) and reports that they did not see the above reported. At this time the four facility staff failed to report to the supervisors."

Review of Resident #2's clinical record revealed a nurse's note dated 1/14/19 at 10:21 a.m., nurse's note documented "Head to toe assessment performed on resident. Vital signs stable and within normal limits. No bruising or redness noted to upper body or extremities. No complaints of pain or discomfort noted."

Review of Resident #2's clinical record revealed a social services note dated 1/14/19 at 11:21 a.m., which documented, "SSD (social services department) interviewed resident for psychological well-being after it was reported that resident was the recipient if inappropriate physical contact. Resident reported not remembering any

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incident of physical contact with fellow male resident (Resident #1)."

On 1/24/18 at approximately 12:30 p.m., an interview attempted with Resident #2, however the interview could not be completed due to Resident #2's cognitive status.

On 1/24/18 at approximately 1:25 p.m., an interview was conducted with Resident #7. Resident #7 was asked if she has witnessed or experienced abuse in the facility, Resident #7 replied "I witnessed (name of Resident #1) sucking the breast of (name of Resident #2)." When asked did she report this incident, Resident #7 replied "I told the front desk lady (receptionist) that I saw (name of Resident #1) touch (name of Resident #2) and that I wanted her to check it out. I didn't tell her how he touched her because I was embarrassed. I also told some ladies in the cafeteria what happened."

On 1/24/19 at approximately 1:40 p.m., an interview was conducted with other staff member (OSM) #2, dietary. OSM #2 was asked the facility process regarding a resident-to-resident sexual altercation. OSM #2 replied, "It has to be reported immediately. I would tell the nurses so they can help protect the residents and also I am to tell the administrator immediately." OSM #2 was asked if a resident had ever told her of an allegation of abuse. OSM #2 replied "Yes, I remember sitting in the dining room on 1/13/19 and (name of Resident #7) told me and some other staff that were sitting there, that (name of Resident #1) was sucking the breast of (name of Resident #2) in the hallway. We asked (name of Resident #7) did she report that to anyone, she said yes the front desk lady." OSM #2 was asked did you or

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F 607	Continued From page 4 anybody at the table report the allegation of abuse. OSM #2 replied, "No." When asked if the allegation of abuse should have been reported, OSM #2 replied, "Yes, we should have reported it immediately." On 1/24/19 at approximately 2:45 p.m., an interview was conducted with OSM #4, the receptionist. OSM #4 was asked about the facility process regarding a resident-to-resident sexual altercation. OSM #4 replied, "First check on the resident make sure that they are okay then, report it immediately to the nurses and administrator." OSM #4 was asked if asked if a resident had ever told her an allegation of abuse. OSM #4 replied, "There was an incident that happened where a resident told me she saw a resident touch another resident. I went to check out the resident, and she was sitting on the bench as normal with nothing abnormal about her and the other resident was not on that hallway. I didn't think it was an abuse situation or I would have reported it right away. I found out the next day that the resident saw something sexual." On 1/25/19 at approximately 11:00 a.m., an interview was conducted with ASM (administrative staff member) #1, the Administrator. ASM #1 was asked about the facility process followed regarding a resident-to-resident sexual altercation. ASM #1 stated staff should make sure the resident is safe, assess the resident and report the incident to administration. ASM #1 stated administration investigates the incident and reports the incident to the state. ASM #1 was asked when an incident should be reported. ASM #1 stated the incident should be reported within two hours. ASM #1 was asked to describe	F 607		

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what the investigation should include. ASM #1 stated he would interview the resident named in the allegation if the resident is able to be interviewed, interview the resident who reported the allegation, and interview other residents to see if anything has happened to them. ASM #1 stated, "I was made aware of the allegation of abuse for Resident #2 on the morning of 1/14/19 by (name of Resident #7). She came up to me and told me that she witnessed, (name of Resident #1) sucking the breast of (name of Resident #2) in the hallway. I immediately opened an investigation into this allegation and contacted all necessary state agencies including the local police. I found some staff knew about the allegation at the time, we suspended those staff and they were trained on the mandatory reporting. They were trained to separate the residents and to contact administration immediately and if we are not in the building, they have phone numbers for after hours. We started a quality assessment and performance improvement action plan (QAPI) so this does not happen in the future."

Review of the facility QAPI plan dated 1/16/19 documented, "Concern: 1. Abuse Allegation- (name of Resident #2) was inappropriately touched by (name of Resident #1) on 1/13/19, 2. Staff did not report the allegation of abuse immediately to management. Root Cause Analysis: 1. Investigation is pending by the facility and the local police. The resident has no criminal history. The resident denies this event happening. (Sic), 2. Staff did not follow policy. Goals & Objectives: 1. That Resident #2 will be kept in a safe environment. 2. That staff will abide by policy and report incident immediately to the supervisors." Further review of the QAPI plan

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F 607	Continued From page 6 dated 1/16/19 documented, "Education of all facility staff on abuse and timely reporting of abuse." Education off staff was signed off as being completed 1/17/19. The facility policy titled, "Virginia Resident Abuse Policy" documented, "4. Protect the Resident a. Staff should report all incidents immediately to their direct supervisors. b. Staff should not leave a resident unattended, unless it is necessary to summon assistance. 6. Initial Reports a. Timing. All allegations of Abuse, Neglect, Involuntary Seclusion, Injuries of Unknown Source, and Misappropriation of resident property must be reported immediately* to the Administrator, Director of Nursing (DON) and to the applicable State Agency. If the event that caused the allegation involves an allegation of Abuse or serious bodily injury, it should be reported to the DOH (Department of Health) immediately, but not later than 2 hours after the allegation is made." During the days of the survey staff interviewed stated the process for reporting. No other concerns were identified regarding the implementation of the facility abuse policy. On 1/25/19 at approximately 11:40 a.m., ASM (administrative staff member) #1, the Administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. This deficiency was cited as Past Non-Compliance. No further information was presented prior to exit.	F 607		

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F 607	Continued From page 7 1. A brain disorder that seriously affects a person's ability to carry out daily activities. This information was obtained from the website:	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that	F 609	Past noncompliance: no plan of correction required.	

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the facility staff failed to immediately report an allegation of abuse for one of seven residents in the survey sample, Residents #2.

The facility staff failed to notify the administrator immediately and failed to immediately or within two hours, notify the state agency and other officials in accordance with state law when a male resident (Resident #1) allegedly touched Resident #2's breast on 1/13/19.

The findings include:

Resident #2 was admitted to the facility on 9/17/14. Resident #2's diagnoses included but were not limited to Alzheimer's disease (1), depression and chronic obstructive pulmonary disease. (2) Resident #2's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/2/18, coded the resident's cognitive skills for daily decision-making as severely impaired. Section G coded Resident #2 as requiring extensive assistance of two staff with bed mobility and extensive assistance of one staff with dressing, eating and personal hygiene.

Resident #1 was admitted to the facility on 7/17/2014. Resident #1's diagnoses included but were not limited to metabolic encephalopathy (3), depression, diabetes, high blood pressure and chronic obstructive pulmonary disease. Resident #1's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 1/10/19, coded the resident as cognitively intact. Section E coded Resident #1 as not exhibiting behavioral symptoms.

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Resident #7 was admitted to the facility on 4/23/2009. Resident #7's diagnoses included but were not limited to depression, anxiety and high blood pressure. Resident #7's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 11/3/18, coded the resident as cognitively intact.

Review of a FRI (facility reported incident) submitted to the state agency on 1/14/19 revealed documentation that Resident #7 alleged "witnessed inappropriate contact between (name of Resident #1 and Resident #2)".

Investigation follow up submitted to Virginia Department of Health Department of Licensure and Certification (VDH OLC), documented in part, "(name of Resident #7) witnessed (name of Resident #1) sucking the breast of (name of Resident #2) in the hallway of the facility. (Name of Resident #7) reported this to four staff members in the facility. One of those facility members went to see about this (Sic) and reports that they did not see the above reported. At this time the four facility staff failed to report to the supervisors."

Review of Resident #2's clinical record revealed a nurse's note dated 1/14/19 at 10:21 a.m., nurse's note documented "Head to toe assessment performed on resident. Vital signs stable and within normal limits. No bruising or redness noted to upper body or extremities. No complaints of pain or discomfort noted."

Review of Resident #2's clinical record revealed a social services note dated 1/14/19 at 11:21 a.m., which documented, "SSD (social services

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department) interviewed resident for psychological well-being after it was reported that resident was the recipient if inappropriate physical contact. Resident reported not remembering any incident of physical contact with fellow male resident (Resident #1)."

On 1/24/18 at approximately 12:30 p.m., an interview attempted with Resident #2, however the interview could not be completed due to Resident #2's cognitive status.

On 1/24/18 at approximately 1:25 p.m., an interview was conducted with Resident #7. Resident #7 was asked if she has witnessed or experienced abuse in the facility, Resident #7 replied "I witnessed (name of Resident #1) sucking the breast of (name of Resident #2)." When asked did she report this incident, Resident #7 replied "I told the front desk lady (receptionist) that I saw (name of Resident #1) touch (name of Resident #2) and that I wanted her to check it out. I didn't tell her how he touched her because I was embarrassed. I also told some ladies in the cafeteria what happened."

On 1/24/19 at approximately 1:40 p.m., an interview was conducted with other staff member (OSM) #2, dietary. OSM #2 was asked the facility process regarding a resident-to-resident sexual altercation. OSM #2 replied, "It has to be reported immediately. I would tell the nurses so they can help protect the residents and also I am to tell the administrator immediately." OSM #2 was asked if a resident had ever told her of an allegation of abuse. OSM #2 replied "Yes, I remember sitting in the dining room on 1/13/19 and (name of Resident #7) told me and some other staff that were sitting there, that (name of Resident #1) was

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sucking the breast of (name of Resident #2) in the hallway. We asked (name of Resident #7) did she report that to anyone, she said yes the front desk lady." OSM #2 was asked did you or anybody at the table report the allegation of abuse. OSM #2 replied, "No." When asked if the allegation of abuse should have been reported, OSM #2 replied, "Yes, we should have reported it immediately."

On 1/24/19 at approximately 2:45 p.m., an interview was conducted with OSM #4, the receptionist. OSM #4 was asked about the facility process regarding a resident-to-resident sexual altercation. OSM #4 replied, "First check on the resident make sure that they are okay then, report it immediately to the nurses and administrator." OSM #4 was asked if asked if a resident had ever told her an allegation of abuse. OSM #4 replied, "There was an incident that happened where a resident told me she saw a resident touch another resident. I went to check out the resident, and she was sitting on the bench as normal with nothing abnormal about her and the other resident was not on that hallway. I didn't think it was an abuse situation or I would have reported it right away. I found out the next day that the resident saw something sexual."

On 1/25/19 at approximately 11:00 a.m., an interview was conducted with ASM (administrative staff member) #1, the Administrator. ASM #1 was asked about the facility process followed regarding a resident-to-resident sexual altercation. ASM #1 stated staff should make sure the resident is safe, assess the resident and report the incident to administration. ASM #1 stated administration investigates the incident

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and reports the incident to the state. ASM #1 was asked when an incident should be reported. ASM #1 stated the incident should be reported within two hours. ASM #1 was asked to describe what the investigation should include. ASM #1 stated he would interview the resident named in the allegation if the resident is able to be interviewed, interview the resident who reported the allegation, and interview other residents to see if anything has happened to them. ASM #1 stated, "I was made aware of the allegation of abuse for Resident #2 on the morning of 1/14/19 by (name of Resident #7). She came up to me and told me that she witnessed, (name of Resident #1) sucking the breast of (name of Resident #2) in the hallway. I immediately opened an investigation into this allegation and contacted all necessary state agencies including the local police. I found some staff knew about the allegation at the time, we suspended those staff and they were trained on the mandatory reporting. They were trained to separate the residents and to contact administration immediately and if we are not in the building, they have phone numbers for after hours. We started a quality assessment and performance improvement action plan (QAPI) so this does not happen in the future."

Review of the facility QAPI plan dated 1/16/19 documented, "Concern: 1. Abuse Allegation- (name of Resident #2) was inappropriately touched by (name of Resident #1) on 1/13/19, 2. Staff did not report the allegation of abuse immediately to management. Root Cause Analysis: 1. Investigation is pending by the facility and the local police. The resident has no criminal history. The resident denies this event happening. (Sic), 2. Staff did not follow policy. Goals &

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	A. BUILDING _____ B. WING _____	C 01/25/2019

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

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Objectives: 1. That Resident #2 will be kept in a safe environment. 2. That staff will abide by policy and report incident immediately to the supervisors." Further review of the QAPI plan dated 1/16/19 documented, "Education of all facility staff on abuse and timely reporting of abuse." Education off staff was signed off as being completed 1/17/19.

The facility policy titled, "Virginia Resident Abuse Policy" documented, "4. Protect the Resident a. Staff should report all incidents immediately to their direct supervisors. b. Staff should not leave a resident unattended, unless it is necessary to summon assistance. 6. Initial Reports a. Timing. All allegations of Abuse, Neglect, Involuntary Seclusion, Injuries of Unknown Source, and Misappropriation of resident property must be reported immediately* to the Administrator, Director of Nursing (DON) and to the applicable State Agency. If the event that caused the allegation involves an allegation of Abuse or serious bodily injury, it should be reported to the DOH (Department of Health) immediately, but not later than 2 hours after the allegation is made."

During the days of the survey staff interviewed stated the process for reporting. No other concerns were identified regarding the implementation of the facility abuse policy.

On 1/25/19 at approximately 11:40 a.m., ASM (administrative staff member) #1, the Administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

This deficiency was cited as Past Non-Compliance.

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No further information was presented prior to exit.

1. A brain disorder that seriously affects a person's ability to carry out daily activities. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/alzheimersdisease.html.

2. Disease that makes it difficult to breath that can lead to shortness of breath). The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

3. Acute toxic-metabolic encephalopathy (TME), which encompasses delirium and the acute confusional state, is an acute condition of global cerebral dysfunction in the absence of primary structural brain disease. This information was obtained from the website: https://www.uptodate.com/contents/acute-toxic-metabolic-encephalopathy-in-adults?search=metabolic%20encephalopathy&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1