	TMENT OF HEALTH	% f				APPROVED
CENTE	RS FOR MEDICARE	& MEDICATO SERVICES		o	MB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION		E SURVEY PLETED
		495249	B. WING		02/2	21/2019
NAME OF	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		***************************************
EADM///	LLE HEALTH & REHA	P CENTED	1	575 SCOTT DRIVE ROUTE 5		
raniwi v ii	LLE REALIN & RENA	D VENTER	<u> </u> F	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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	survey was conduct are required for con 483.73, Requirement Facilities.	mergency Preparedness led on 2/21/19. Corrections apliance with 42 CFR Part ant for Long-Term Care	E 000	Preparation and submission of this Correction does not constitute an a of or agreement with, it is required and Federal law. It is executed and implemented as a means to continuing improve the quality of care to comstate and federal requirements.	admission I by State d uously	n e
F 000	survey was conduct 02/21/19. Correction compliance with 42 Term Care requirem survey/report will for investigated during. The census in this 1	ledicare/Medicaid standard ed 02/19/19 through ns are required for CFR Part 483 Federal Long nents. The Life Safety Code low. No complaints were the survey. 20 certified bed facility was e survey. The survey sample	F 000	a. Resident #94 and all other reside in the dining room are served per t policy. b. All current residents have the policy be affected by the deficient practic education given to staff member redining process on 3-1-19.	the otential to e. 1:1 garding	
F 550 SS=D	self-determination, a access to persons a outside the facility, i this section. §483.10(a)(1) A faci with respect and digresident in a manner promotes maintenance her quality of life, reindividuality. The faci promote the rights of	t Rights. right to a dignified existence, and communication with and and services inside and including those specified in lity must treat each resident nity and care for each r and in an environment that nice or enhancement of his or cognizing each resident's cility must protect and f the resident.	F 550	c. ADON and or designee will educt the nursing staff on proper dining reservices by 3-8-19. d. Nursing manager will conduct at of the dining room area to ensure the residents in dining room are received appropriate dining services. Audit where the conducted 5 times per week for weeks then 3 times per week for 4 weeks then weekly thereafter for a service of 3 months. All findings will be reviewed and brought to QAPI months for any follow up that is needed. e. DOC 3-15-19	room udits hat all ing will 4 total	MAR 12 2019
	1	acility must provide equal			***************************************	
ABORATORY	DIRECTOR'S OF PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	TITLE	0	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 saleguards provide sufficient projection 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.

	TMENT OF HEALTH RS FOR MEDICARE	AND HUM SERVICES			O	FORM	: 02/28/2019 APPROVED : 0938-0391
	FOF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		PLE CONSTRUCTION G	(X3) DAT	E SURVEY IPLETED
		495249	B. WING	à		02/	21/2019
NAME OF	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
FARMVII	LLE 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 PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 550	access to quality ca severity of condition must establish and practices regarding provision of services residents regardless §483.10(b) Exercises The resident has the rights as a resident or resident of the Unity §483.10(b)(1) The fi- resident can exercise interference, coercise from the facility.	re regardless of diagnosis, a, or payment source. A facility maintain identical policies and transfer, discharge, and the s under the State plan for all s of payment source. The of Rights. The right to exercise his or her of the facility and as a citizen	F	550			

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The findings include:

minutes later.

subpart.

by:

reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this

This REQUIREMENT is not met as evidenced

Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide a dignified dining experience for one of 36 residents in the survey sample, Resident #94.

The facility staff failed to serve lunch to Resident #94 in a dignified manner. Another resident seated at the same table as Resident #94 was served a meal and Resident #94 was not served a meal and assisted with eating, until nine

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Facility ID: VA0080

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DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 02/28/2019 FORM APPROVED OMB NO. 0938-0391

A95249 NAME OF PROVIDER OR SUPPLIER FARMVILLE HEALTH & REHAB CENTER B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5			495249	B. WING			02/21/2019		
					1575 SCOTT DRIVE ROUTE 5				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
Resident #94 was admitted to the facility on 9/26/07. Resident #94's diagnoses included but were not limited to difficulty swallowing, acute kidney failure and diabetes. Resident #94's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/3/119, coded the resident's cognition as severely impaired. Section G coded Resident #94 as requiring extensive assistance of one person with eating. Resident #94's comprehensive care plan dated 6/1/17 documented, "SELF CARE DEFICIT rh (related to) impaired mobilityEATING: ASSIST AS INDICATED" On 2/19/19 at 12:30 p.m., Resident #94 was observed sitting at a table in the dining room. At this time, a resident seated at the same table was served a meal tray and assisted with eating by CNA (certified nursing assistant) #1. Resident #94 was not served a meal tray and assisted with eating by another CNA until 12:39 p.m. On 2/2/19 at 7:40 a.m., an interview was conducted with CNA #1. CNA #1 was asked about the facility process for providing meal trays and assisting residents seated at the same table in the dining room. CNA #1 stated, "Ny biggest thing would be to make sure everybody at the same table are all served at the same table in the same table are all served at the same table in the same table are all served at the same table in the same table are all served at the same table in the same table are all served at the same table in the same table are all served at the same table are all served at the same table in the same table are all served at the same table in the same table are all served at the same time." When asked why, CNA #1 stated, "That way the other resident wouldn't feel some type of way why this resident has food and they don't." When asked how she would feel if someone else at her table was served a meal and she had to wait nine minutes to receive her meal, CNA #1 stated, "I would feel kind of upset and probably lash out a little bit." CNA #4 was made aware of this	F 550	Resident #94 was 9/26/07. Resident were not limited to kidney failure and crecent MDS (minin assessment with a date) of 1/31/19, co as severely impairs #94 as requiring experson with eating comprehensive cardocumented, "SEL to) impaired mobilif INDICATED" On 2/19/19 at 12:3 observed sitting at this time, a residen served a meal tray CNA (certified nurs #94 was not served eating by another COn 2/21/19 at 7:40 conducted with CN about the facility prand assisting residin the dining room. thing would be to make a why, other resident would this resident has fo asked how she wortable was served a minutes to receive would feel kind of the control	admitted to the facility on #94's diagnoses included but difficulty swallowing, acute diabetes. Resident #94's most num data set), a quarterly in ARD (assessment reference oded the resident's cognition ed. Section G coded Resident attensive assistance of one. Resident #94's re plan dated 6/1/17 F CARE DEFICIT r/t (related byEATING: ASSIST AS O p.m., Resident #94 was a table in the dining room. At at seated at the same table was and assisted with eating by sing assistant) #1. Resident dia meal tray and assisted with CNA until 12:39 p.m. a.m., an interview was A #1. CNA #1 was asked occess for providing meal trays ents seated at the same table CNA #1 stated, "My biggest make sure everybody at the served at the same time." CNA #1 stated, "That way the dn't feel some type of way why od and they don't." When all feel if someone else at her meal and she had to wait nine her meal, CNA #1 stated, "I upset and probably lash out a		50				

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DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARE SERVICES

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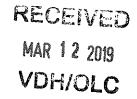
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		NG		E SURVEY PLETED
,		495249	B. WING		02/:	21/2019
NAME OF PROVIDER OR SUPPLIER FARMVILLE HEALTH & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 550	surveyor's observat #94 was not served nine minutes after sanother resident at stated, "I was wond have to serve every if I was feeding (nar someone should ha Resident #94) as wood on 2/21/19 at 11:31 staff member) #1 (the director of nursabove concern. The facility policy titt ENVIRONMENT" do be served in a mann seated at a table rectime." No further information Notify of Changes (I CFR(s): 483.10(g)(14) Notif (i) A facility must improve consistent with his corepresentative(s) where (A) An accident invoresults in injury and physician intervention (B) A significant chamental, or psychosodeterioration in health	ion on 2/19/19 when Resident and assisted with eating until he (CNA #1) began feeding the same table. CNA #1 ering why. We was told we one at the same table. I feel ne of the other resident) then we been feeding (name of ell." a.m., ASM (administrative ne administrator) and ASM #2 ing) were made aware of the ed, "DINING ROOM ocumented, "9. Tables shall ner so that all residents beive meals at the same on was presented prior to exit. Injury/Decline/Room, etc.) 4)(i)-(iv)(15) ication of Changes. Inediately inform the resident; dent's physician; and notify, or her authority, the resident which has the potential for requiring in; nge in the resident's physical, cial status (that is, a ith, mental, or psychosocial preatening conditions or	F 58	a. Notified MD and RP of the miss medications of Aldactone, Potassiu Klonopin for resident #73 on varior in October 2018(10/14, 10/15, 10/2 10/24/18), January 2019 (1/7/19, 1/2 and February 2019 (2/13, 2/17, 2/1). There were no negative outcome to resident. b. All current residents have the pot be affected by the deficient practice 100% audit was conducted of all refor missed meds or unavailable med documentation. An audit of all 4 medication availability was completed on 2/22/ADON, Unit Managers and Staff Development Coordinator.	m, and us dates (3, and (11/19), 8/19). the tential to c. A sidents ds ed carts (19 by	

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Facility ID: VA0080

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		AND HUM SERVICES				02/28/2019 APPROVED
CENTE	RS FOR MEDICARE	& MEDICATO SERVICES	·			0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG		E SURVEY PLETED
		495249	B. WING		02/:	21/2019
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI		
FARMVIL	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 CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	a need to discontinut reatment due to ad commence a new for (D) A decision to train resident from the far §483.15(c)(1)(ii). (ii) When making not (14)(i) of this section all pertinent informatic available and prosphysician. (iii) The facility must resident and the resident and composite (§483.10(g)(15)). Admission to a composite (§483.10(g)(15)). Admission to a composite (§483.5) must disclosits physical configurations that compropert, and must spectroom changes between the resident and clinical record resident and clinical reco	reatment significantly (that is, se an existing form of verse consequences, or to orm of treatment); or insfer or discharge the cility as specified in of the facility must ensure that the facility must ensure that the specified in §483.15(c)(2) wided upon request to the state also promptly notify the ident representative, if any, and or roommate assignment 1.10(e)(6); or dent rights under Federal or ons as specified in paragraph in. It record and periodically (mailing and email) and expecite distinct part (as defined in see in its admission agreement action, including the various rise the composite distinct ify the policies that apply to seen its different locations	F 5	d. ADON/UM will perform a man MAR audit weekly on 10 reside for a total of 20 residents per weeks, then Q month for 8 week of 3 months. UM/ADON will 5 days/week for new MD order delivery of medications for total months. All findings will be a brought to QAPI monthly for a that is needed. e. DOC 3-15-19	lents per unit week for 4 eks for total Il check cart rs to ensure al of 3 reviewed and	

		AND HUM SERVICES			FOR	D: 02/28/2019 M APPROVED
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	LTIPLE CONSTRUCTION DING	(X3) DA	O. 0938-0391 ATE SURVEY OMPLETED
		495249	B. WING	ì	O	2/21/2019
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		***
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 PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 580	The facility staff failed physician when the potassium (2) and ke administered to the October 2018, January The findings included Resident #73 was a 1/30/14. Resident #were not limited to lea anxiety disorder. Resident #73 was a status assessment and reference date) of 1 cognitive skills for demoderately impaired #73 as requiring ext with dressing, toileting Resident #73's com 1/18/18 and 1/25/19 ALTERATION IN Machine widenced by): PAC FOLLOWING A NUITHROUGHOUT THE MY MEDICATIONS has dehydration or particular form of the control of the cont	er treatment for one of 36 vey sample, Resident #73. ed to notify Resident #73's medications aldactone (1), clonopin (3) were not resident on various dates in ary 2019 and February 2019. e: dmitted to the facility on e73's diagnoses included but ow potassium, diabetes and esident #73's most recent a set), a significant change in with an ARD (assessment /17/19, coded the resident's aily decision making as d. Section G coded Resident ensive assistance of one staff ing and personal hygiene. prehensive care plan dated documented, "I HAVE AN Y BEHAVIOR AEB (as ING THE HALLWAY AND	F 5	580		

the resident was not administered aldactone on

DEPARTMENT OF HEALTH AND HUM SERVICE	S
CENTERS FOR MEDICARE & MEDICARD SERVICE	S

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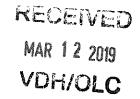
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IG	(X3) DATE SURVEY COMPLETED		
		495249	B. WING_		02	/21/2019	
FARMVILLE HEALTH & REHAB CENTER (VA) ID SUMMARY STATEMENT OF DEFICIENCIES				STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 580	10/14/18, 10/15/18 nurse's note dated medication was not dated 10/15/18 documented the minurse's note dated medication was on documentation that eventually administ that Resident #73's Review of Resident a physician's order potassium 40 mEQ one time a day. Record) revealed the administered potas 10/15/18. A nurse's documented the minurse's note dated pharmacy was notiful January 2019 MAR administered potas nurse's note dated potassium was one of the was no further was no further was no further was no further the side of Revealed a physician was notification. Review of Revealed a physician 11/1/16 for klonopina day. Review of Revealed the rethe 9:00 a.m. dose	, 10/23/18 and 10/24/18. A 10/14/18 documented the available. A nurse's note amented the pharmacy was note dated 10/23/18 edication was on order. A 10/24/18 documented the order. There was no further aldactone 25 mg was ered on the above dates or physician was notified. #73's clinical record revealed with a start date of 11/8/16 for (milliequivalents) by mouth eview of Resident #73's (medication administration the resident was not sium 40 mEQ on 10/14/18 and the resident was not available. A 10/15/18 documented the fied. Review of Resident #73's revealed the resident was not sium 40 mEQ on 1/11/19. A 1/11/19 documented the order from the pharmacy. For documentation that was eventually administered or that Resident #73's	F 58				

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Event ID: E6TN11

Facility ID: VA0080

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DEPARTMENT OF HEALTH AND HUM SERVI	CES
CENTERS FOR MEDICARE & MEDICARI SERVIC	CES.

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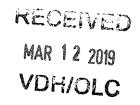
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495249	B. WING		02	/21/2019		
NAME OF PROVIDER OR SUPPLIER FARMVILLE HEALTH & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901	<u>-</u>			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE		
F 580	pharmacy was to do of Resident #73's F klonopin 0.5 mg waresident on 2/13/19 a.m., 2/17/19 at 5:0 a.m. A nurse's note "Rx (Prescription) on note dated 2/17/19 medication from phote dated 2/17/19 medication from phote dated 2/18/19 docupharmacy" Theredocumentation that eventually administration that Resident #73's On 2/21/19 at 7:45 conducted with LPN LPN #5 was asked ensuring medication substances are ava#5 stated nurses have enough medication nurses count the cohow often the medication have to be refilled by when asked at wharefilled, LPN #5 state getting down, mayb	eliver the medication. Review ebruary 2019 MAR revealed is not administered to the at 5:00 p.m., 2/17/19 at 9:00 to p.m. and 2/18/19 at 9:00 to p.m. and 2/18/19 at 9:00 to dated 2/13/19 documented, alled pharmacy" A nurse's documented, "Waiting for armacy" Another nurse's documented, "Waiting for armacy" A nurse's note mented, "Awaiting on the was no further klonopin 0.5 mg was ered on the above dates or physician was notified. a.m., an interview was all (licensed practical nurse) #5. about the facility process for the including controlled illable for administration. LPN the to make sure they have on hand. LPN #5 stated antrolled substances and see cations are ordered to ensure intil they can get a hard the doctor. When asked about allows for routine medications and efore the next refill due date. It point medications should be the doctor, who was not fill due date. It point medications should be ed, "If you know you are the six left, being nursing, you afill but if it's too early, the	F 580					

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		AND HUM SERVICES			FORM	: 02/28/2019 APPROVED
CENTERS FOR MEDICARE & MEDICARD SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION G	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
		495249	B. WING		02/	21/2019
NAME OF	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
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 SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 580	due to be administer medication cart. LF look for the medication manager and conta asked if the physicial ordered medication resident, LPN #5 stated cotor. You don't womedicine at all. You hold the medication physician notification LPN #5 stated it should be supply lists revealed facility emergency in revealed five doses three doses of klong the supply for adminitional control of the facility pharmatics. The facility pharmatics above concern. The facility pharmatics and the supply of a medicatifacility staff should in obtain the medication.	be done if medications are pred and are not in the PN #5 stated nurses should tions, inform the nurse ct the pharmacy. When an should be notified if an is not administered to a lated, "Of course you notify the leant your resident to go without a have to have an order to "." When asked if the n should be documented, bould. The yemergency medication and aldactone was not in the nedication supply. The list of potassium 10 mEQ and opin 0.5 mg were available in	F 580			

pharmacy hours: 2.1 Facility nurse should call pharmacy to determine the status of the order. If the medication has not been ordered, the licensed facility nurse should place the order or reorder for the next scheduled delivery. 2.2 If the next available delivery causes delay or a missed

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CENTERS FOR MEDICARE & MEDICARD SERVICES	

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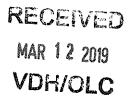
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495249	B. WING		02/	21/2019
NAME OF PROVIDER OR SUPPLIER FARMVILLE HEALTH & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 580	dose in the resident facility nurse should the Emergency Met the dose. 2.3 If the the Emergency Met should notify pharm emergency delivery is unavailable, facility attending physician directions" No further information the information was obtout the informatio	I's medication schedule, I obtain the medication from dication Supply to administer medication is not available in dication Supply, facility staff acy and arrange for an4. If an emergency delivery ty nurse should contact the to obtain orders or on was presented prior to exit. This ained from the website: gov/druginfo/meds/a682627.h mineral that your body needs is a type of electrolyte. It of function and muscles to our heartbeat stay regular. It trients into cells and waste s." This information was	F 5	F640 a. Resident #1 Death in Facility transmitted on 2-26-19. Resident #2 discharge assessment facility was scheduled and comp 25-19 and transmitted on 2-25-1 b. All current residents have the be affected by the deficient prace Completed 100% audit on transmand completions of MDS for all looking back one quarter. c. Regional MDS educated the Mather PRN MDS on transmissions completion of all MDS on 3-1-1	nt from the leted on 2-9. potential to ice. nissions residents IDSC and and	
F 640	tml	ing Resident Assessments	F 64	d. Compare Submissions report		

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DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 02/28/2019 FORM APPROVED OMB NO. 0938-0391

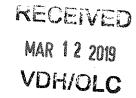
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		495249	B. WING		0	2/21/2019	
NAME OF PROVIDER OR SUPPLIER FARMVILLE HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 640 SS=D	CFR(s): 483.20(f)(1) §483.20(f) Automat requirement- §483.20(f)(1) Encode a facility completes facility must encode each resident in the (i) Admission assess (iii) Annual assessm (iv) Quarterly review (v) A subset of item reentry, discharge, (vi) Background (facility must be carried assessment, a facility must be carried in the ME standard record lay and that passes stated CMS and the State. §483.20(f)(3) Trans after a facility and that passes stated assessment, a facility encoded, accurate, the CMS System, in (i) Admission assess (ii) Annual assessm (iii) Significant chan (iv) Significant corrections.	ed data processing ding data. Within 7 days after a resident's assessment, a the following information for facility: sment. leent updates. ge in status assessments. v assessments. s upon a resident's transfer, and death. ce-sheet) information, if there ressment. mitting data. Within 7 days letes a resident's assessment, upable of transmitting to the nation for each resident OS in a format that conforms to outs and data dictionaries, ndardized edits defined by mittal requirements. Within ity completes a resident's ity must electronically transmit and complete MDS data to including the following: sment. ent. ge in status assessment. iction of prior full assessment. ction of prior quarterly	F 6-	submitted weekly times findings will be reviewed QAPI monthly for any fineeded. e. DOC 3-15-19	d and brought to		

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Event ID: E6TN11

Facility ID: VA0080

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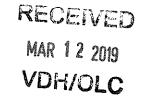
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		495249	B. WING _		02	/21/2019	
NAME OF PROVIDER OR SUPPLIER FARMVILLE HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901				
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F 640	Continued From pa	ge 11	F 64	.0			
	reentry, discharge, (viii) Background (fainitial transmission does not have an assertion as \$483.20(f)(4) Data transmit data in the for a State which haby CMS, in the form approved by CMS. This REQUIREMENT by: Based on staff intereview, the facility stransmission of resi	ns upon a resident's transfer, and death. ace-sheet) information, for an of MDS data on resident that dmission assessment. format. The facility must format specified by CMS or, as an alternate RAI approved nat specified by the State and NT is not met as evidenced rview and clinical record taff failed to ensure the timely dent assessments for two of survey sample, Residents #1					
		completed, but failed to Facility Assessment for					
		ailed to complete a Discharge ng the Resident's discharge Resident #2.	·				
CONTRACTOR DESCRIPTION OF THE CO.	The Findings Includ	ed:				And the same of th	
		completed, but failed to Facility Assessment for					
Per	06/27/2018. Their d are not limited to Hy pressure), Hyperlipi blood), Heart Diseas	mitted to the facility on iagnoses that included, but pertension (high blood demia (high levels of fat in the se, and Chronic Kidney					

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CENTERS FOR MEDICARE & MEDICARD	SERVICES

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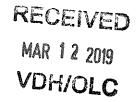
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495249	B. WING _		02	/21/2019	
NAME OF PROVIDER OR SUPPLIER FARMVILLE HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901				
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F 640	Minimum Data Set Day Reassessmer Reference Date (A Interview for Menta Resident #1 at 14, impairment. Resident moderate assistant toileting, and hygie person for bed mo assistance for eatindependent in all (ADLs). A review of Reside on the morning of triggering an alert being greater than Resident #1's MDS Electronic Health F Resident #1 died an Facility MDS Ass However, the facility record) indicated the Facility Assessmer submitted for approximate of the morning of 02/2 provide any addition submission of the Monta of the Mesident #1's Deat the morning of 02/2 provide any addition submission of the Monta of the Mesident #1's Deat the morning of 02/2 provide any addition submission of the Monta of the Mesident #1's Deat the morning of 02/2 provide any addition submission of the Monta of the Mesident #1's Deat the morning of 02/2 provide any addition submission of the Monta of the Mesident #1's Deat the morning of 02/2 provide any addition submission of the Monta of the Mesident #1's Deat the morning of 02/2 provide any addition submission of the Mesident #1's Deat the morning of 02/2 provide any addition submission of the Mesident #1's Deat the morning of 02/2 provide any addition submission of the Mesident #1's Deat the morning of 02/2 provide any addition submission of the Mesident #1's Deat the morning of 02/2 provide any addition submission of the Mesident #1's Deat the morning of 02/2 provide any addition submission of the Mesident #1's Deat the morning of 02/2 provide any addition submission of the Mesident #1's Deat the morning facility Assessment #1	(MDS) Assessment was a 30 at with an Assessment RD) of 07/27/2019. The Brief al Status (BIMS) coded indicating little to no ent #1 was coded as requiring ce of 1 person for dressing, ne, standby assistance of 1 bility and transfers, and setuping. Resident #1 was coded as other Activities of Daily Life on the last MDS Assessment 120 days old. A review of a Assessments in the Facility's accord (EHR) revealed that the facility, triggering a Death at the facility, triggering a Death at Resident #1's Death in at Resident #1's Death in the was completed, but never oval. Strator (administrative staff SM #2, the Director of Nursing the concerns regarding the 12/2019. They were asked to nal information regarding the	F 64				

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		AND HUI SERVICES				D: 02/28/2019
		& MEDICAID SERVICES	1	**************************************	OMB N	O. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		ATE SURVEY OMPLETED
	!	495249	B. WING _		0:	2/21/2019
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP C		
FARMVII	LLE HEALTH & REHA	P CENTED		1575 SCOTT DRIVE ROUTE 5		
	while I floribition a concess.	DUCINILA		FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 640	Continued From ps	10	F. C.			
F Unu		-	F 64	40		
ļ	immediately upon d	iscovering this.				
ļ	No further documer	ntation was provided.				THE STATE OF THE S
**************************************	· Landande					
diamen	2. The facility staff f	failed to complete a Discharge				
	assessment following	ng the Resident's discharge				
Military	from the facility for F					
and the state of t	06/13/2018. Their dinot limited to Hypert Pneumonia, and De recent Minimum Datwas a Quarterly Ass Reference Date (AF Interview for Mental Resident #2 as scor impairment. Resider extensive assistance transfers; extensive ambulation, dressing as requiring setup as	dmitted to the facility on diagnoses included but were rension (high blood pressure), epression. Resident #2's most ata Set (MDS) Assessment sessment with an Assessment RD) of 09/20/2018. The Brief I Status (BIMS) coded ring 12, indicating mild ent #2 was coded as requiring the ent #2 was coded as requiring the ent #2 of 2 or more people for assistance of 1 person for and, toileting, and hygiene; and assistance for eating.				
	on the morning of 02 triggering an alert fo being greater than 1 Resident #2's Progre Electronic Health Resident #2 was ser 10/05/2018, and did However, a review of triggering and the series of the	nt #2's record was conducted 12/21/2019 following the record or the last MDS Assessment 120 days old. A review of ress Notes in the Facility's ecord (EHR) revealed that ent to the hospital on 1 not return to the facility. of the MDS Assessment ost recent MDS Assessment				

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completed for Resident #2 was a Quarterly

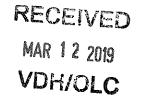
The Facility Administrator, ASM (administrative staff member) #1 and ASM #2, Director of

Assessment dated 09/20/2018.

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Facility ID: VA0080

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DEPARTMENT OF HEALTH AND HUN SERVICES

CENTERS FOR MEDICARE & MEDICARD SERVICES

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

(X4) PROVIDER OR SUPPLIER

(X4) PROVIDER OR SUPPLIER

(X5) DATE SURVEY COMPLETED

		495249	B. WING		02/21/2019
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
FARMVI	LLE 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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 640	Nursing were inform Resident #2's lack of the morning of 02/2 provide any addition submission of the N On the afternoon of Director of Nursing facility staff had bee documentation of R Assessment having No further document 1. Chronic kidney di kidney function ove kidneys is to remove from the body. Chro slowly gets worse of not notice any symp of function may be a symptoms until your working. The final s end-stage renal disc the kidneys are no l wastes and excess point, you would net transplant https://medlineplus. Accuracy of Assess CFR(s): 483.20(g) §483.20(g) Accurace The assessment more resident's status.	ned of the concerns regarding of a Discharge Assessment on 1/2019. They were asked to nal information regarding the MDS Assessment. O2/21/2019, ASM #2, the informed this surveyor that en unable to evidence resident #2's Discharge been completed. Intation was provided. Isease is the slow loss of time. The main job of the e wastes and excess water onic kidney disease (CKD) wer months or years. You may oftoms for some time. The loss is on slow that you do not have the kidneys have almost stopped tage of CKD is called ease (ESRD). At this stage, onger able to remove enough fluids from the body. At this ed dialysis or a kidney gov/ency/article/000471.htm ments	F 64	a. New Dental assessment was compon #72 by ADON. The next schedul MDS for resident #72 will have sect corrected with new dental assessment was conducted. b. All current residents have the pote be affected by the deficient practice. 100% audit of MDS's for accuracy of section L for the past quarter was completed on 3-1-19. 100% oral assessment of all residents ensure all dental assessments are acc reflected on the upcoming MDS was completed 3-8-19. c. The MDSC was educated on comp section L of the MDS based on the R manual for accuracy of the assessment the Regional MDS was completed on 19. During the Pain interviews done by M the nurses oral assessment will be cla at this time and documented in the panote. d. The L section of the MDS will be a by the MDSC weekly for the next 3 m to ensure section L of the MDS is completed accurately. All findings wereviewed and brought to QAPI month any follow up that is needed.	led tion L nt that ential to A of s to curately bleting AI nt by 13-1- MDSC, rified in audited nonths ill be
ORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: E6TN11	<u>i</u>	e. DOC 3-15-19 Facility ID: VA0080 If continuation	n sheet Page 15 of 86

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		AND HUN SERVICES & MEDICARD SERVICES			FORM	1 APPROVED
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION	(X3) DAT	. 0938-0391 TE SURVEY MPLETED
		495249	B. WING _		02	/21/2019
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
FARMVII	LLE HEALTH & REHA	B CENTER		1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		
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F 641	clinical record revier facility staff failed to (minimum data set) residents in the sum. The facility staff faile L0200 (Oral/Dental 5-Day Medicare MD reference date) of 0 The findings include Resident #72 was a 07/12/2018. Diagno but were not limited Muscle Weakness a Resident #72's Minimum Data Set (extensive assistance activities of daily living eating. Resident #72's clinic Resident #72's MDS Reference Date of 0 L0200. Oral/Dental states of the states of	interview, staff interview and w, it was determined that the maintain an accurate MDS assessment for one of 36 vey sample, Resident #72 ed to accurately code section Status) of Resident #72's vith an ARD (assessment 1/07/2019.	F 64			

interview.

On 02/20/2019 at approximately 2:22 p.m., and observation and interview was conducted with Resident #72. Resident #72 was observed with

several missing teeth, a broken tooth and noticeable decay in her mouth during the

	TMENT OF HEALTH	\$:		, P		: 02/28/2019 APPROVED
CENTE	RS FOR MEDICARE	& MEDICATO SERVICES		O		. 0938-0391
	FOF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION		E SURVEY MPLETED
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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
FARMVII	LLE 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	Continued From pa	ge 16	F 641			Addition and the second and the seco
		cal record was reviewed on realed Resident #72 did not plan.				ментин размента по предоставления по предоставления по предоставления по предоставления по предоставления по п
	approximately 4:49 staff member) #3 (r	pnducted on 02/20/2019 at p.m. with ASM (administrative egional MDS coordinator).		,		THE COLUMN TWO IS NOT
	she felt the docume per nursing docume	IDS coordinator) stated that intation was coded correctly entation and that the care plan				The control of the co
	was asked what ref an MDS Assessmen	(regional MDS coordinator) erences are used to complete nt. ASM #3 (regional MDS				
++++++++++++++++++++++++++++++++++++++	referenced when co	that the RAI manual is mpleting MDS Assessments. IDS coordinator) stated that				
TO COMMITTEE AND A CONTRACT OF THE AND A CON	dietary or nursing de Section L of the MD	epartment should complete S. If neither department has on, MDS Coordinator is to go			:	William Francisco
WHATELER COLLEGE COLLE	in and assess residence Date price					
Construction of the Constr	have been instructe	d to care plan residents for sidents do not have 100%				
Arma a marriament de Antagamana de Antagaman	(director of nursing)					
approximation that is reported and approximate the second	assessments. ASM	#2 (director of nursing) stated st be assessed by a licensed		·		

nurse and you should not just go off

The CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument)

manual used to code MDS assessments

documentation in the chart.

	TMENT OF HEALTH RS FOR MEDICARE	AND HUN SERVICES			FORM	: 02/28/2019 I APPROVED . 0938-0391
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		495249	B. WING		02/	21/2019
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F 641	chewing problems of pain/discomfort. 2. Ask the resident, whether the resident or partials. (If reside reports that the resident partials, but they do ask for a reason.) 3. If the resident has examine for loose fi and examine for chi Removal of denture for adequate assess 4. Conduct exam of	t.) ent about the presence of or mouth or facial family, or significant other at has or recently had dentures ent or family/significant other dent recently had dentures or not have them at the facility, s dentures or partials, t. Ask him or her to remove, ps, cracks, and cleanliness. s and/or partials is necessary	F 641			

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applicable. Use a light source that is adequate to visualize the back of the mouth. Visually observe and feel all oral surfaces including lips, gums, tongue, palate, mouth floor, and cheek lining. Check for abnormal mouth tissue, abnormal teeth, or inflamed or bleeding gums. The

assessor should use his or her gloved fingers to adequately feel for masses or loose teeth.

5. If the resident is unable to self-report, then observe him or her while eating with dentures or partials, if indicated, to determine if chewing problems or mouth pain are present.

6. Oral examination of residents who are uncooperative and do not allow for a thorough oral exam may result in medical conditions being

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		AND HUN SERVICES			FORM	02/28/2019 1 APPROVED
STATEMENT	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	JLTIPLE CONSTRUCTION DING	(X3) DAT	0. 0938-0391 TE SURVEY MPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE ACTION SHOU	ILD BE	(X5) COMPLETION DATE
F 641		dental evaluation should be residents and any resident	F	641	A Committee of the Comm	
	partial denture: if the cracked, uncleanab coded as loose if the loose, the denture v	roken or loosely fitting full or e denture or partial is chipped, le, or loose. A denture is e resident complains that it is isibly moves when the or her mouth, or the denture sident tries to talk.				
·	fragment(s) (edentu	o natural teeth or tooth lous): if the resident is natural teeth or parts of				
	masses, oral lesions	onormal mouth tissue (ulcers, s): select if any ulcer, mass, ed on any oral surface.				
		ovious or likely cavity or : if any cavity or broken tooth				
And any constitution of the second se	loose natural teeth: i swollen, or bleeding.	flamed or bleeding gums or if gums appear irritated, red, . Teeth are coded as loose if hen light pressure is applied				
чен и сченици чучно й дела дела дела дела дела дела дела дела	discomfort with chev	outh or facial pain or ving: if the resident reports h or face, or discomfort with				

· Check L0200G, unable to examine: if the resident's mouth cannot be examined.

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CENTERS FOR MEDICARE & MEDICARI	SERVICES

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '		E CONSTRUCTION		SURVEY PLETED
		495249	B. WING			02/2	21/2019
	PROVIDER OR SUPPLIER	B CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901				
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F 641	conditions A throug On 02/21/2019 at a	one of the above: if none of h F is present. pproximately 11:35 a.m., ASM and ASM #2 (director of	F 6	i41			
F 645 SS=D	PASARR Screening CFR(s): 483.20(k)(§483.20(k) Preadmindividuals with a mindividuals with a mindividual with intellectual disasses of the section, under the section, under the section of the section of the individual services and (B) If the individual services, whether the specialized services (ii) Intellectual disablity authority has determined the section of the individual services, whether the specialized services (ii) Intellectual disablity authority has determined the section of the individual services whether the specialized services (iii) Intellectual disability authority has determined the section of the individual services (iii) Intellectual disability authority has determined the section of the individual services (iii) Intellectual disability authority has determined the section of the individual services (iii) Intellectual disability authority has determined the individual services (iii) Intellectual disability authority has determined the individual services (iii) Intellectual disability authority has determined the individual services (iii) Intellectual disability authority has determined the individual services (iii) Intellectual disability authority has determined the individual services (iii) Intellectual disability authority has determined the individual services (iii) Intellectual disability authority has determined the individual services (iii) Intellectual disability authority has determined the individual services (iii) Intellectual disability authority has determined the individual services (iii) Intellectual disability authority has determined the individual services (iii) Intellectual disability authority has determined the individual services (iii) Intellectual disability authority has determined the individual services (iii) Intellectual disability authority has determined the individual services (iii) Intellectual disability authority has determined the individual services (iii) Intellectual disability authority has determined the individual services (iii) Intellectual disability au	ission Screening for ental disorder and individuals ability. sing facility must not admit, on 1989, any new residents with: as defined in paragraph (k)(3) aless the State mental health nined, based on an al and mental evaluation son or entity other than the authority, prior to admission, of the physical and mental vidual, the individual requires a provided by a nursing facility; requires such level of the individual requires	F6		a. Resident #32 and #38 PASARR lewas completed on 2/22/19. b. All current residents' charts were to ensure that all required PASARR was completed 2/22/19 by Social Ser Director. c. Administrator educated the Admis Director on ensuring that a PASARR completed before the resident is admithe facility on 3/1/19. d. Admission Director will conduct a weekly audit of all new admits to ensure that PASARR level 1 is completed beforential residents are admitted to the facility are in the admission document weekly time 3 months. All findings were viewed and brought to QAPI monthany follow up that is needed. e. DOC 3-15-19	audited level 1 rvices sions 1 are itted to sure efore entation will be	

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	TMENT OF HEALTH	AND HUM SERVICES & MEDICAID SERVICES			F	ITED: 02/28/2019 ORM APPROVED 3 NO. 0938-0391
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NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT		
FARMVII	LE HEALTH & REHA	B CENTER		1575 SCOTT DRIVE ROUTE FARMVILLE, VA 23901	5	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICII	ACTION SHOULD BE TO THE APPROPRIAT	
**************************************	and (B) If the individual is services, whether the specialized services §483.20(k)(2) Exception- (i) The preadmission paragraph(k)(1) of the for determinations into a nursing facility obeing admitted to the transferred for care (ii) The State may obe paragraph (k)(1) of the to a nursing facility of the total and the paragraph (k)(1) of the total and the paragraph (k)(1) of the total after received hospital after received hospital, (B) Who requires nucleated the hospital, and (C) Whose attending before admission to is likely to require less facility services. §483.20(k)(3) Definitions and the properties of the propert	requires such level of the individual requires of this of the case of the readmission of an individual who, after the nursing facility, was in a hospital. The hoose not to apply the ning program under this section to the admission of an individual who, after the nursing facility, was in a hospital. The hoose not to apply the ning program under this section to the admission of an individual—to the facility directly from a fing acute inpatient care at the the individual received care in the gphysician has certified, the facility that the individual ses than 30 days of nursing the individual ses than 30 days of nursing the individual and the individual ses than 30 days of nursing the individual ses than 30 days of nursing the individual has a serious mental dual has a serious mental	F 64			
· ·	intellectual disability intellectual disability	onsidered to have an if the individual has an as defined in §483.102(b)(3) related condition as				

	TMENT OF HEALTH	AND HUM SERVICES & MEDICAID SERVICES		O	FORM	D: 02/28/2019 MAPPROVED D: 0938-0391
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FARMVI	LLE HEALTH & REHA		1	575 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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 645	described in 435.10 This REQUIREMEN by: Based on staff inter and clinical record of the facility staff faile (Preadmission Scre was complete for 2 sample, Residents of 1. The facility staff faile level one PASRR was resident was evalual services in the most appropriate for the of 1. The facility staff faile one PASRR was resident was evalual services in the most appropriate for the of 1. The facility staff faile one PASRR was resident was evalual services in the most appropriate for the one PASRR was resident was evalual services in the most appropriate for the one PASRR was resident was evalual services in the most appropriate for the one PASRR was resident was evalual services in the most appropriate for the one PASRR was resident #32 was a facility staff faile one passed on the most appropriate for the one passed on the one pas	10 of this chapter. IT is not met as evidenced review, facility document review eview, it was determined that d to ensure a PASRR ening and Resident Review) of 36 residents in the survey #32 and #38. ailed to ensure Resident #32's as completed to ensure the ted and receiving care and integrated setting esident's needs. ailed to ensure Resident #38's as completed to ensure the ted and receiving care and integrated setting esident's needs.	F 645			

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disorder, orthopedic aftercare, frontotemporal dementia, diabetes, and high blood pressure. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 12/10/18. The resident was coded as mildly impaired in ability to make daily

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Facility ID: VA0080

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		AND HUM SERVICES & MEDICAID SERVICES			, colling,	FORM	02/28/2019 APPROVED
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F 645	life decisions. The receiving an antipsy antidepressant med coded as requiring and dressing, extentransfers, and as incompleted, and as incompleted, information sent to requesting consult freview. This is in ea a level II PASRR." On 2/20/19 at 3:34 conducted with OSI Social Services Dire about the missing left about the missing left and Performance In (2019) I did an audit identified that there and level 2 PASRR's them (residents with that we don't have to The residents should admitted without the above documented Level 2 screening, a would know that a Level 1 has	ge 22 resident was coded as ychotic medication and an dication. The resident was total care for toileting, hygiene esive care for bathing and dependent for eating. cal record failed to reveal any RR Level 1 screening. aled a note dated 12/18/18, "Resident's clinical (name of psychiatric service) or evaluation and medication fort to proceed with obtaining p.m., an interview was M #1 (Other Staff Member) the ector. OSM #1 was asked evel 1 PASRR for Resident d, "We don't have the tified it (PASRRs not 1 a QAPI (Quality Assurance in provement) plan. In January the for (corporation) and were deficiencies with level 1 s. There is a lengthy list of nout completion of PASRR), that I have been working on. In the day of the end of the	F	645			

	TMENT OF HEALTH	AND HUM SERVICES		O		FORM	02/28/2019 APPROVED 0938-0391	
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F 645	dated 1/2/19. The A Compliance) date we Therefore, this condition non-compliance). The as of this survey date corrected. On 2/21/19 at 1:36 periods with OSM #1, when the PASRR, OSM # the placement of the appropriate and to immental health needs screening." OSM # screening "makes readditional services to based on diagnoses level 1 is not done, the admitted, but that we piece a resident might a review of the facility PASRR An introduct Screening and Resident might a service of the facility PASRR An introduct Screening and Resident might a service of the facility PASRR An introduct Screening and Resident might a service of the facility PASRR An introduct Screening and Resident might a service of the facility PASRR An introduct Screening and Resident might be served as the service of the facility PASRR An introduction of	reviewed. The plan was AOC (Allegation of vas not set until 4/31/19. Sern was not PNC (past he deficiency for this resident te (2/21/19) had not yet been p.m., in a follow up interview asked about the purpose of 1 stated it was "to make sure the resident in the facility was dentify if the resident has any and requires a Level 2 that a Level 2 that the resident might need that the resident should not be the miss the mental health	F 64	45			•	

On 2/21/19 at 1:18 p.m., the ASM #1 (Administrative Staff Member) the Administrator,

receive needed services."

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admitted to a Medicaid funded NF (nursing facility) be screened to identify the presence of serious mental illness, intellectual disability, or developmental disability (related condition). If a qualifying condition is known or suspected, an individualized evaluation must be conducted to ensure that the nursing facility is the most appropriate place for the person to live and

was made aware of the findings. No further

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Facility ID: VA0080

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	TMENT OF HEALTH	AND HUN SERVICES & MEDICAND SERVICES			FORM	: 02/28/2019 1 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING	(X3) DAT	E SURVEY MPLETED
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F 645	Continued From pa information was pro	₹	F6	45		
	level one PASRR w					
	diagnoses of but no pressure, end stage asthma, psychosis, The most recent MI quarterly assessme Reference Date) wit Reference Date) of coded as severely comake daily life decise coded as receiving a The resident was cotolleting, hygiene and	dmitted on 3/22/16 with the t limited to high blood renal disease, depression, diabetes, and convulsions. OS (Minimum Data Set) was a nt with an ARD (Assessment h an ARD (Assessment 12/15/18. The resident was ognitively impaired in ability to sions. The resident was an antidepressant medication. Indeed as requiring total care for d dressing, extensive care for its, and as independent for				
		cal record failed to reveal any R Level 1 screening.				
The second secon	which documented, information sent to (requesting consult for	aled a note dated 12/19/18, "Resident's clinical name of psychiatric service) or evaluation and medication fort to proceed with obtaining				

On 2/20/19 at 3:34 p.m., an interview was conducted with OSM #1 (Other Staff Member) the

	INICINI OF DEALID	E& MEDICAD SERVICES				M APPROVED
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(VO) 141 II -	TIPLE CONSTRUCTION		D. 0938-0391
	OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '	NG		ATE SURVEY DMPLETED
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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
FARMVII	LE HEALTH & REHA	B CENTER		1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		
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F 645	Social Services Dire about the missing le #32. OSM #1 state PASRR's. We iden completed), and did and Performance In (2019) I did an audi identified that there and level 2 PASRR'them (residents with that we don't have to The residents shoul admitted without the above documented Level 2 screening, a would know that a Level 1 has not been. The QAPI plan was dated 1/2/19. The A Compliance) date with Therefore, this condition of this survey dat corrected. On 2/21/19 at 1:36 p with OSM #1, when the PASRR, OSM # the placement of the appropriate and to identify the propriate and to identify the placement of the appropriate and to identify the appropriate and to identify the placement of the appropriate and to identify the appropriate and the appropriate appropriate appropriate appropriate appropriate appropriate appropri	ector. OSM #1 was asked evel 1 PASRR for Resident d, "We don't have the tified it (PASRRs not I a QAPI (Quality Assurance inprovement) plan. In January t for (corporation) and were deficiencies with level 1 s. There is a lengthy list of nout completion of PASRR), that I have been working on. Id have not have been em." When asked shown the note regarding pursuing a land asked how the facility level 2 needs to be done, in't been completed, OSM #1 I needs to be done first but	F 64	45		
things	level 1 is not done, t	he resident should not be				

DEPARTMENT OF HEALTH AND HUM SERVICES

	TMENT OF HEALTH	AND HUM SERVICES & MEDICARD SERVICES			FORM	02/28/2019 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l .	PLE CONSTRUCTION IG	(X3) DAT	E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
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 CORRECT (EACH CORRECTIVE ACTION SHOUNDERSON SHOUNDERSON SHOUNDERSON SHOUNDERSON SHOWN SHO	JLD BE	(X5) COMPLETION DATE
F 645	admitted, but that w piece a resident mi	e miss the mental health ght need."	F 64	F656 a. Resident #44's Care plan was urespiratory treatment. Resident #	ipdated for	-
F 656 SS=D	was made aware of information was pro Develop/Implement	f Member) the Administrator, the findings. No further vided. Comprehensive Care Plan	F 65	Plan was updated for medication #72's Care Plan was updated for dental assessment	. Resident correct	
	§483.21(b) Compre §483.21(b)(1) The fi implement a compre care plan for each resident rights set fo §483.10(c)(3), that i objectives and time medical, nursing, ar	•		and medication care plans to ensicare plans are complete and update and treatments was completed on 100% oral sweep of all residents sure all dental care plans are accurreflected of the resident's actual of status.	ted meds 3- to make rately	
	assessment. The codescribe the followir (i) The services that or maintain the residual physical, mental, an required under §483 (ii) Any services that under §483.24, §485 provided due to the under §483.10, inclutreatment under §485.	omprehensive care plan must ong - are to be furnished to attain dent's highest practicable d psychosocial well-being as 3.24, §483.25 or §483.40; and t would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights ading the right to refuse		Care plans will be reviewed and uneeded during the AM clinical me weekly clinical review, and PRN. educated the IDT team on 2/25/19 c. DON or Designee will audit 5 c from each unit every week for 3 mensure accuracy and that all condichanges are adequately care plann findings will be reviewed and broad	eeting, DON Don are plans nonths to tion ed. All	

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(iii) Any specialized services or specialized

rationale in the resident's medical record. (iv)In consultation with the resident and the

provide as a result of PASARR

resident's representative(s)-

rehabilitative services the nursing facility will

recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its

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needed.

d. DOC 3-15-19

QAPI monthly for any follow up that is

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CENTE	RS FUR MEDICARE	& MEDICAID SERVICES			O	<u>MB NO</u>	. 0938-0391
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F 656	(A) The resident's of desired outcomes. (B) The resident's profuture discharge. Fawhether the resident community was assolicated contact agence entities, for this purpose, for this purpose, for this purpose, and care plans, as appropriate requirements set for section. This REQUIREMENT by: Based on observatinterview, and clinic failed to develop an care plan for three of the facility staff for the comprehensive care that in January 201 The facility staff for the facility staff for in the facility staff for in the facility staff for incomprehensive care plan to address of decay, missing, and the findings included the facility staff for incomprehensive care of the facility	reference and potential for adilities must document at's desire to return to the essed and any referrals to ites and/or other appropriate cose. In the comprehensive care and accordance with the other in paragraph (c) of this are returned in a coordance with the other in paragraph (c) of this are record review, facility staffed implement a comprehensive of 36 residents, Residents alled to implement the explan for the provision of the plan for the provision of the redication administration. The plan for the provision of the Resident #72's dental status and broken teeth. The plan for the provision of the Resident #44, on multiple the plan for the provision of the Resident #72's dental status and broken teeth.	F	556			

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DEPARTMENT OF HEALTH AND HUM

Event ID: E6TN11

Facility ID: VA0080

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PRINTED: 02/28/2019

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Continued From pa	ge 28	F 65	6	,	4414
06/20/2011, with the being 05/23/2018. Fincluded, but were re (high blood pressure) (1), and Unspecified #44's most recent N. Assessment was a Assessment Refered 12/13/2018. The Bricoded as requiring the people for bed mobal requiring total assist Activities of Daily Lift. An interview was convided in the afternoof interview, Resident she was worried the performing tracheot	eir most recent re-admission Resident #44's diagnoses not limited to, Hypertension e), Persistent Vegetative State d Intracranial Injury. Resident Minimum Data Set (MDS) Quarterly Assessment with an ence Date (ARD) of ief Interview for Mental Status formed. Resident #44 was total assistance of 2 or more ility and transfers, and tance of 1 person for all other fe (ADLs). Inducted with Resident #44's on of 02/19/2019. During that #44's wife stated she stated at facility staff were not omy care on Resident #44 as				
Upon review of Res in the Electronic Her following order was site with 1/2 hydroge saline, change disposevery shift and PRN trach (tracheostomy A review of Residen plan last revised on following: Under "Following: Under "Following: Under "Following: TRACH	ident #44's Physician orders alth Record (EHR), the documented: "Cleanse trach en peroxide and 1/2 normal osable inner cannula #8XL (as needed) every shift for care." t #44's comprehensive care 01/24/2019, documented the ocus": "AT RISK FOR GENATION R/T (related to) I FOR BREATHING" Under				
	PROVIDER OR SUPPLIER LLE HEALTH & REHA SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa Resident #44 was a 06/20/2011, with the being 05/23/2018. Fincluded, but were r (high blood pressur (1), and Unspecified #44's most recent in Assessment was a Assessment Refere 12/13/2018. The Bri (BIMS) was not per coded as requiring to people for bed mob requiring total assist Activities of Daily Lift An interview was cowife on the afternoof interview, Resident she was worried the performing tracheot often as was ordered. Upon review of Resident she was worried the performing tracheot often as was ordered. Upon review of Resident she was worried the performing tracheot often as was ordered. Upon review of Resident she was worried the performing tracheot often as was ordered. Upon review of Resident she was worried the performing tracheot often as was ordered. Upon review of Resident she was worried the performing tracheot often as was ordered. Upon review of Resident plan last revised on following: Under "Following:	PROVIDER OR SUPPLIER LLE HEALTH & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495249 B. WING	ICO PERICIENCIES OF CORRECTION (X1) PROVIDER SUPPLIER A95249 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 28 Resident #44 was admitted to the facility on 08/20/2011, with their most recent re-admission Deling 05/23/2018. Resident #44's diagnoses included, but were not limited to, Hypertension (high blood pressure), Persistent Vegetative State (1), and Unspecified Intracranial Injury. Resident #44's most recent Minimum Data Set (MDS) Assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of 12/13/2018. The Brief Interview for Mental Status (BIMS) was not performed. Resident #44 was coded as requiring total assistance of 2 or more people for bed mobility and transfers, and requiring total assistance of 1 person for all other Activities of Daily Life (ADLs). An interview was conducted with Resident #44's wife on the afternoon of 02/19/2019. During that interview, Resident #44's wife stated she stated she was worried that facility staff were not performing tracheotomy care on Resident #44's often as was ordered. Upon review of Resident #44's Physician orders in the Electronic Health Record (EHR), the following order was documented: "Cleanse trach site with 1/2 hydrogen peroxide and 1/2 normal saline, change disposable inner cannul affSXL every shift and PRN (as needed) every shift for trach (tracheostomy) care." A review of Resident #44's comprehensive care plan last revised on 01/24/2019, documented the following: Under "Focus": "AT RISK FOR INADEQUIAES TRACH FOR BREATHING" Under	RS FOR MEDICARIE & MEDICATIO SERVICES OF PERICIPATES (XI) PROVIDER (XI) PROVIDER (XI) PROVIDER UP LICATION NUMBER: 495249 PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT PRIVE ROUTE 5 FARMVILLE, VA 23901 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MIST BE PRECEDED BY PULL REGULATORY OR LISC IDENTIFYING INFORMATION) Continued From page 2B Resident #44 was admitted to the facility on 06/20/2011, with their most recent re-admission being 05/23/2018. Resident #44's diagnoses included, but were not limited to, Hypertension ((1)) and Unspecified Intracranial Injury, Resident #44's most recent Minimum Data Set (MDS) Assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of 12/1/3/2018. The Brief Interview for Mental Status (BIMS) was not performed. Resident #44 was coded as requiring total assistance of 1 person for all other Activities of Daily Life (ADLs). An interview was conducted with Resident #44's wife on the afternoon of 02/19/2019. During that interview, Resident #44's enterior was ordered. Upon review of Resident #44's Physician orders in the Electronic Health Record (EHR), the following order was documented: "Cleanare trach site with 1/2 hydrogen peroxide and 1/2 normal saline, change disposable Inner cannula #6XL every shift and PRN (as needed) every shift for trach (tracheostomy) care." A review of Resident #44's comprehensive care plan last revised on 01/24/2019, documented the following: Under "Focus." "AT RISK FOR INADEQUARES TRACH FOR BREATHINO" Under

DEPARTMENT OF HEALTH AND HUM SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES					O	<u>MB NO</u>	. 0938-0391
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F 656	Throat)/MD (Medica ORDERED." A review of Resident Administration Recovered multiple dates order for trach care completed on one of day. These dates who 1/08/19, 01/13/19, 01/26/19 and 01/28/26/19 and 01/28/26/19 and 01/28/26/26/26/26/26/26/26/26/26/26/26/26/26/	at #44's Treatment ord (TAR) revealed, there in January 2019, where the was not signed off as or more of the 3 shifts each ere: 01/01/19, 01/06/19, 01/18/19, 01/21/19, 01/23/19, 01/18/19, 01/21/19, 01/23/19, 01/18/19, 01/21/19, 01/23/19, 01/18/19, 01/21/19, 01/23/19, 01/18/19, 01/21/19, 01/23/19	F	656			
-	#73's care plan for n	nedication administration.				and the same and t	

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DEPARTMENT OF HEALTH AND HUM

PRINTED: 02/28/2019

FORM APPROVED

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NAME OF F	PROVIDER OR SUPPLIER		,	STREET ADDRESS, CITY, STATE, ZIP CODE		
FARMVIL	LE HEALTH & REHA	B CENTER	1	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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 656	1/30/14. Resident # were not limited to I anxiety disorder. Re MDS (minimum data status assessment reference date) of 1 cognitive skills for d moderately impaired #73 as requiring ext with dressing, toileti Resident #73's com 1/18/18 documented IN MY BEHAVIOR A PACING THE HALL NURSE AND STAFI BUILDINGADMIN AS ORDERED" Further review of Re revealed a physician 11/1/16 for klonopin	ge 30 Idmitted to the facility on 1/473's diagnoses included but ow potassium, diabetes and esident #73's most recent a set), a significant change in with an ARD (assessment 1/17/19, coded the resident's aily decision making as d. Section G coded Resident rensive assistance of one staffing and personal hygiene. prehensive care plan dated d, "I HAVE AN ALTERATION AEB (as evidenced by): WAY AND FOLLOWING A F THROUGHOUT THE ISTER MY MEDICATIONS resident #73's clinical record on's order with a start date of (1) 0.5 mg (milligrams) two of Resident #73's January	F 656			
	administered the 9:0 mg on 1/7/19. A nul documented the pha medication. Review	the resident was not 00 a.m. dose of klonopin 0.5 rse's note dated 1/7/19 armacy was to deliver the of Resident #73's February				
	administered to the p.m., 2/17/19 at 9:00 and 2/18/19 at 9:00 2/13/19 documented pharmacy" A nurs documented, "Waitin pharmacy" Another	klonopin 0.5 mg was not resident on 2/13/19 at 5:00 D a.m., 2/17/19 at 5:00 p.m. a.m. A nurse's note dated d, "Rx (Prescription) called se's note dated 2/17/19 ang for medication from per nurse's note dated 2/17/19				
	pharmacy" A nurs	ng for medication from e's note dated 2/18/19 ing on pharmacy" There				

DEPARTMENT OF HEALTH AND HUM SERVICES

	TMENT OF HEALTH	AND HUM SERVICES & MEDICAID SERVICES			FORM	: 02/28/2019 1 APPROVED : 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LTIPLE CONSTRUCTION DING	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		495249	B. WING		02/	/21/2019
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
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 PREF TAG		D BE	(X5) COMPLETION DATE
F 656	was no further documy was eventually a dates. Review of the facility supply lists revealed my were available in administration. On 2/21/19 at 7:45 a conducted with LPN LPN #5 was asked a ensuring medication.	mentation that klonopin 0.5 administered on the above y emergency medication I three doses of klonopin 0.5	Fé	656		
	#5 stated nurses had enough medication in nurses count the conhow often the medication they have enough upprescription from the what point medication stated, "If you know six left, being nursin but if it's too early, they ou have to community ou have to community out have to community with the medications are due not in the medications and look for the manager and contact of the conducted with LPN facility did have an extended the could be accessed to the conducted with LPN facility did have an extended the could be accessed to the conducted with LPN facility did have an extended the could be accessed to the conducted with LPN facility did have an extended the could be accessed to the conducted with LPN facility did have an extended the could be accessed to the conducted with LPN facility did have an extended the could be accessed to the conducted with LPN facility did have an extended the could be accessed to the conducted with LPN facility did have an extended the could be accessed to the conducted with LPN facility did have an extended the could be accessed to the conducted with LPN facility did have an extended the could be accessed to the conducted with LPN facility did have an extended the could be accessed to the conducted with LPN facility did have an extended the could be accessed to the conducted with LPN facility did have an extended the conducted with LPN facility did have an extended the conducted with LPN facility did have an extended the conducted with LPN facility did have an extended the conducted with LPN facility did have an extended the conducted with LPN facility did have an extended the conducted with LPN facility did have an extended the conducted the conducted with LPN facility did have an extended the conducted	ve to make sure they have on hand. LPN #5 stated ntrolled substances and see rations are ordered to ensure ntil they can get a hard e doctor. When asked at ons should be refilled, LPN #5 you are getting down, maybe g, you have to know and refill ne pharmacy will not refill and nicate with the pharmacy." what should be done if to be administered and are n cart. LPN #5 stated nurses nedications, inform the nurse of the pharmacy. a.m., another interview was #5. LPN #5 confirmed the emergency medication supply				

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medication cart.

Review of the facility emergency medication

Event ID: E6TN11

Facility ID: VA0080

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	TMENT OF HEALTH RS FOR MEDICARE	AND HUM SERVICES & MEDICAID SERVICES					APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		495249	B. WING	ì		02/	21/2019
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FARMVII	LLE HEALTH & REHA	B CENTER		1	575 SCOTT DRIVE ROUTE 5 ARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES '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
F 656	supply lists revealed facility emergency in revealed five doses three doses of klond the supply for admit On 2/21/19 at 10:35 conducted with LPN purpose of the care purpose of the care goals and getting the normal function or in (residents') have." In urses ensure they plans in regards to in LPN #4 stated, "Admordered and make as them as ordered." On 2/21/19 at 11:31 staff member) #1 (the director of nurse above concern. The facility pharmatic shortages/Unavaila "1. Upon discovery is supply of a medication shortage pharmacy hours: 2. pharmacy to determ the medication has licensed facility nurse reorder for the next next available delivered.	d aldactone was not in the nedication supply. The list of potassium 10 mEQ and opin 0.5 mg were available in	F	356			

facility nurse should obtain the medication from

DEPARTMENT OF HEALTH AND HUM

DEPARTMENT OF HEALTH AND HUMA SERVICES	
CENTERS FOR MEDICABE & MEDICALLY SERVICES	

PRINTED: 02/28/2019 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
		495249	B. WING		02	2/21/2019	
NAME OF PROVIDER OR SUPPLIER FARMVILLE HEALTH & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP COE 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 PREFI TAG		HOULD BE	(X5) COMPLETION DATE	
F 656	the dose" No further informati (1) Klonopin is used attacks. This inform website: https://medlineplus.tml 1. A minimally conscomplete impairmed from widespread dapart of the brain that behavior) https://www.merckmal-cord,-and-nerve-consciousness/mini	ge 33 dication Supply to administer on was presented prior to exit. I to treat seizures and panic nation was obtained from the gov/druginfo/meds/a682279.h cious state is severe but not nt of awareness that results amage to the cerebrum (the t controls thought and nanuals.com/home/brain,-spin disorders/coma-and-impaired- mally-conscious-state?query= e%20and%20Minimally%20Co	F6	556			
	implement a compre care plan to address of decay, missing, a Resident #72 was a 07/12/2018. Diagno but were not limited Muscle Weakness a Resident #72's Mini Medicare Assessme Reference Date of 0 #72 with no cognitiv	ailed to develop and ehensive person-centered is Resident #72's dental status and broken teeth. Idmitted to the facility on ses for Resident #72 included to High Blood Pressure, and Anxiety Disorder. Immum Data Set (5 -day ent) with an Assessment of 1/07/2019 coded Resident e impairment. In addition, the IMDS) coded Resident #72					

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Event ID: E6TN11

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DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2019 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER FARMVILLE HEALTH & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFOICINCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 656 Continued From page 34 extensive assistance of one staff member with activities of daily living and independent with eating. On 02/20/2019 at approximately 2:22 p.m., and observation and interview was conducted with Resident #72 selicient #72 was observed with several missing teeth, a broken tooth and noticeable decay in her mouth during the interview. An interview was conducted on 02/20/2019 at approximately 4:49 p.m. with ASM (administrative staff member) #3 (regional MDS coordinator). ASM #3 (regional MDS coordinator) stated that she fell the documentation was coded correctly per nursing documentation and that the care plan is correct. ASM #3 (regional MDS coordinator) stated that the RAI manual is referenced when completing MDS Assessment. ASM #3 (regional MDS coordinator) stated that dietary or nursing department should complete Section to the MDS. If neither department has completed the section, MDS Coordinator is to go in and assess resident per Assessment Reference Date prior to coding. ASM #3 (regional MDS Coordinators) have been instructed to care plan residents for dental services if residents do not have 100% perfect teeth.			IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
FARMVILLE HEALTH & REHAB CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901			495249	B. WING			02/	21/2019
FREERY TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 656 Continued From page 34 extensive assistance of one staff member with activities of daily living and independent with eating. On 02/20/2019 at approximately 2:22 p.m., and observation and interview was conducted with Resident #72. Resident #72 was observed with several missing teeth, a broken tooth and noticeable decay in her mouth during the interview. Resident #72's clinical was reviewed on 02/21/2019, and revealed Resident #72 did not have a dental care plan. An interview was conducted on 02/20/2019 at approximately 4:49 p.m. with ASM (administrative staff member) #3 (regional MDS coordinator). ASM #3 (regional MDS coordinator) was saked what references are used to complete an MDS Assessment. ASM #3 (regional MDS coordinator) was asked what references are used to complete an MDS Assessment. ASM #3 (regional MDS coordinator) as completed the section, MDS in either department has completed the section, MDS Coordinator is to go in and assess resident per Assessment Reference Deficiency) PREFEX TAG CARCAS-REFERENCE TO THE APPROPRIATE PREFEX TAG CARCAS-REFERENCES TO HE APPROPRIATE PREFEX TAG CARCAS-PROPRIATE PREFEX TAG CARCAS-PROPRIATE PREFEX TAG CARCAS-PROPRIATE PREFEX TAG CARCAS-PROPRITE PREFEX TAG CARCAS-					1!	575 SCOTT DRIVE ROUTE 5		
extensive assistance of one staff member with activities of daily living and independent with eating. On 02/20/2019 at approximately 2:22 p.m., and observation and interview was conducted with Resident #72. Resident #72 was observed with several missing teeth, a broken tooth and noticeable decay in her mouth during the interview. Resident #72's clinical was reviewed on 02/21/2019, and revealed Resident #72 did not have a dental care plan. An interview was conducted on 02/20/2019 at approximately 4:49 p.m. with ASM (administrative staff member) #3 (regional MDS coordinator). ASM #3 (regional MDS coordinator) stated that she felt the documentation was coded correctly per nursing documentation and that the care plan is correct. ASM #3 (regional MDS coordinator) was asked what references are used to complete an MDS Assessment. ASM #3 (regional MDS coordinator) stated that the RAI manual is referenced when completing MDS Assessments. ASM #3 (regional MDS coordinator) stated that diletary or nursing department should complete Section L of the MDS. If neither department has completed the section, MDS Coordinator is to go in and assess resident per Assessment Reference Date prior to coding. ASM #3 (regional MDS Coordinator) stated that MDS Coordinator is attended the section, MDS Coordinator is to go in and assess resident per Assessment Reference Date prior to coding. ASM #3 (regional MDS Coordinator) stated that MDS Coordinators have been instructed to care plan residents for dental services if residents do not have 100%	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
An interview was conducted with ASM #2 (director of nursing) on 02/21/2019 at	F 656	extensive assistance activities of daily liviceating. On 02/20/2019 at a observation and interesident #72. Resident #72. Resident #72's clinicologically decay in interview. Resident #72's clinicologically and revenue a dental care part of the docume per nursing docume is correct. ASM #3 (regional Mashe felt the docume per nursing docume is correct. ASM #3 (was asked what referenced when condinator) stated referenced when condinator or nursing docume is correct. ASM #3 (regional Mashe felt the docume per nursing docume is correct. ASM #3 (regional Mashe felt the section L of the MD completed the section L of the MD completed the section and assess reside Reference Date price MDS Coordinator) shave been instructed dental services if resperfect teeth. An interview was conditional activities and assess residental services if resperfect teeth.	pproximately 2:22 p.m., and erview was conducted with dent #72 was observed with the dent #72 was observed with the above tooth and her mouth during the cal was reviewed on realed Resident #72 did not clan. Inducted on 02/20/2019 at p.m. with ASM (administrative egional MDS coordinator). IDS coordinator) stated that entation was coded correctly entation and that the care plan regional MDS coordinator) erences are used to complete of the ASM #3 (regional MDS that the RAI manual is empleting MDS Assessments. IDS coordinator) stated that epartment should complete S. If neither department has on, MDS Coordinator is to go ent per Assessment or to coding. ASM #3 (regional stated that MDS Coordinators d to care plan residents for sidents do not have 100%	F 6	656			

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Event ID: E6TN11

Facility ID: VA0080

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DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

PRINTED: 02/28/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
495249		495249	B. WING		02	/21/2019	
NAME OF PROVIDER OR SUPPLIER FARMVILLE HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901				
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 658 SS=D	approximately 11:20 and assessments. Is stated that the residicensed nurse and documentation in the nursing) stated, "If it assessed and the Nowuld've triggered to care plan." On 02/21/2019 at a #1 (administrator) and nursing) were made No further informati Services Provided No Fervices Provided No Fe	ASM #2 (director of nursing) dent must be assessed by a you should not just go off he chart. ASM #3 (director of he resident had been MDS was coded correctly, that he resident to have a dental pproximately 11:35 a.m., ASM and ASM #2 (director of e aware of findings. on was presented prior to exit. Meet Professional Standards (i) orehensive Care Plans ed or arranged by the facility, comprehensive care plan, all standards of quality. IT is not met as evidenced ion, staff interview, facility and clinical record review, it to the facility staff failed to standards of practice for one he survey sample, Resident ed to clarify a physician's so's medication of folic acid	F6	a. Resident #30's MD and RP v notified of the inappropriate do Folic Acid that was given. New obtained from the MD for diffe of Folic Acid to be dispensed. notified of the new order on 2-2 b. All current residents have the to be affected by the deficient p Med Observation was conducte nurse that made the error with d 100% med cart to MAR audit w completed 2-22-19 to ensure the medications were available. c. DON completed 1-1 education nurse on medication administrate following MD orders and profess standards on 2/21/19. SDC will nurses on medication administrate professional standards that was completed on 3/8/19. d. SDC or Designee will audit 2 unit on medication administration of 4 nurses per week for 3 month findings will be reviewed and be QAPI monthly for any follow up needed. e. DOC 3-15-19	age of order ent dose RP was 0-19. potential ractice. I with ispensing. as correct with ion and sional educate tion and murses per n for total as. All ought to		

CENTE	19 LOW MEDICARE	& MEDICAID SERVICES			U	<u>MR NO</u>	<u>. 0938-03</u> 91
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495249	B. WING			02/	21/2019
	PROVIDER OR SUPPLIER LE HEALTH & REHA	B CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 575 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOLICIENCY)	BE	(X5) COMPLETION DATE
F 658	Resident # 30 was 08/27/09 and a read diagnoses that includemiplegia (2), ane pulmonary disease. Resident # 30's moderated (minimum dada set an ARD (assessme coded the resident interview for mental - 15, 14 being cognimaking. Resident # extensive assistance activities of daily liviteating. On 02/20 19 at 8:12 administration obseing conducted with LPN 1. LPN # 1 was obsacid tablets from the Resident # 30, into cup. The bubble padocumented, "Folic LPN # 1 entered Resident # anded the small placentaining the folic acid, placed swallowed them with water.	admitted to the facility on dmission on 12/21/10 with aded but were not limited to: mia (3), chronic obstructive (4), and hypertension (5). Ist recent comprehensive MDS (1), an annual assessment, with an treference date) of 12/09/18, as scoring a 14 on the brief status (BIMS) of a score of 0 dively intact for daily decision and as independent with the folial as independent with the folial as a score of 0 dively intact for daily decision and as independent with the folial as independent with the folial as independent with the folial as a small plastic medication as a small plastic medication (1) as a small plastic medication, astic medication cup acid to Resident # 30. The medication cup containing the tablets in her mouth and the a small sip from a cup of	F	÷558			
The second secon	February 2019 for F "Folic Acid Tablet 1	's order sheet) dated lesident # 30 documented, (one) MG (milligram). Give 1 ne a day for supplement. 010."		***************************************		The state of the s	

DEPARTMENT OF HEALTH AND HUN

PRINTED: 02/28/2019

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	MENT OF HEALTH	AND HUN SERVICES			FORM	: 02/28/2019 I APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	(X3) DAT	. 0938-0391 E SURVEY IPLETED
		495249	B. WING		02/	21/2019
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
FARMVIL	LE HEALTH & REHA	B CENTER	1	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 SHOUL CROSS-REFERENCED TO THE APPROVIDERICIENCY)	D BE	(X5) COMPLETION DATE
F 658	Continued From pa	ge 37	F 658	3		
and the state of t	dated 01/11/2017 fa	care plan for Resident # 30 illed to evidence interventions istration of folic acid.				
	conducted with LPN administration folic a 1 stated, "I realized milligrams which is the administration of doctor by phone, I n asked if it was ok to stated it was ok. It sclarified, the order, I When asked to desire to eliminate a medic follow the five rights the patient, the corre	acid to Resident # 30. LPN # the error that I gave .80 less than one milligram. After if the medication, I notified the nentioned what I gave and modify the order and he should have modified or pefore I gave the medication." cribe the process she follows eation error, LPN # 1 stated, "I i, check the order, the route, ect dosage and the correct				
	(medication administ the MAR with the mireads the same thin bed side right before asked why it was imcorrect medication a stated, "Medication idiagnoses and weig administered according there could adverse describe the procedian error in medicatio stated, "I call the physical stated," I call the physical stated in the same transfer of the manufacture of	e three checks, check MAR stration record), and compare edication label to make sure it g and recheck the label at eadministration." When portant to administer the and medication dose, LPN # 1 is based on the resident's ht and other factors. If it is not ling to the physician's orders effects." When asked to ure staff follows when there is an administration, LPN # 1 vsician and responsible party the for adverse reactions."				

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On 02/20/19 at approximately 3:00 p.m., ASM (administrative staff member) # 5, assistant director of nursing, provided this surveyor with a

copy of a physician's telephone order for

Event ID: E6TN11

Facility ID: VA0080

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CENTE	NO FUN MEDICANE	A MEDICAID SERVICES				MR MO	. 0938-039 1
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495249	B. WING			02/	21/2019
	PROVIDER OR SUPPLIER	B CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE
F 658	Resident # 30. The Acid Tablet 400 MC mouth one time a d supplement OTC (c provided by facility." On 02/21/19 at app (administrative staff nursing provided thinformation: "(Name uses) Drug Informathe man-made for conaturally found in soform health cells, es are used to treat low level can lead to ce iron). On 02/21/19 at app (administrative staff nursing was asked facility follows. ASM According to "Lippir Practice", Eighth Ecwilkins, pg. 87 reac dosages or unfamilic confirmed with the health pharmacist before a following is docume Orders: 2. Although follow an order you just ignore a medica attending physician, him, obtain appropri	order documented, "Folic of Give 2 (two) [sic] tablet by ay for [sic] vitamine over the counter) medication roximately 2:30 p.m., ASM member) # 2, director of is surveyor with following drug of Pharmacy the facility tion. Folic Acid. Folic acid is of folate. Folate is a B-vitamin ome foods. It is needed to specially red blood cells. They we folate levels. Low folate rtain types of anemia" (low roximately 2:40 p.m., ASM member) # 2, director of what standard of practice the M # 2 sated Lippincott. Incott Manual of Nursing lition: by Lippincott Williams & I: "Nursing Alert: Unusual ar drugs should always be nealth care provider and administration." On pg. 15, the ented in part, "Inappropriate you cannot automatically think is unsafe, you cannot al order, either. b Call the discuss your concerns with iateorders. c. Notify all id nursing personnel d.	F	658			

DEPARTMENT OF HEALTH AND HU

PRINTED: 02/28/2019

FORM APPROVED

	TMENT OF HEALTH	AND HU N SERVICES				FORM	: 02/28/2019 APPROVED : 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	''		E CONSTRUCTION		E SURVEY IPLETED
		495249	B. WING			02/	21/2019
	PROVIDER OR SUPPLIER	B CENTER		14	TREET ADDRESS, CITY, STATE, ZIP CODE 575 SCOTT DRIVE ROUTE 5 ARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTIES OF T	D BE	(X5) COMPLETION DATE
F 658	ASM # 2, director of the findings. No further information of the findings. No further information of the findings. References: (1) Folic acid is marked in the supplementation of the terms for the folic acid. The terms for the folic acid. The supplementation of the finding supplementation of the first work, works with the first work.	ge 39 if member), administrator, and f nursing, were made aware of on was provided prior to exit. In-made (synthetic) folate. It is ats and added to fortified olic acid and folate are often oly. Folic acid is water-soluble. If the vitamin leave the body that means your body does You need to get a regular in through the foods you eat or its. Helps tissues grow and ith vitamin B12 and vitamin C eak down, use, and create new in red blood cells (helps elps produce DNA, the element of the contraction was a reference of the contraction was information was	F 6	\$58			

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the website:

obtained from the website:

https://medlineplus.gov/ency/article/002408.htm.

(2) Also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just

one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html.

(3) Low iron. This information was obtained from

https://www.nlm.nih.gov/medlineplus/anemia.html

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Facility ID: VA0080

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DEPARTMENT OF HEALTH AND HUNN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495249	B. WING			02/21/2019	
	PROVIDER OR SUPPLIER	B CENTER		19	TREET ADDRESS, CITY, STATE, ZIP CODE 575 SCOTT DRIVE ROUTE 5 ARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	(4) Disease that may can lead to shortner was obtained from the https://www.nlm.nih (5) High blood pressobtained from the whittps://www.nlm.nih essure.html. Quality of Care CFR(s): 483.25 § 483.25 Quality of Quality of care is a sapplies to all treatm facility residents. Bay assessment of a resthat residents received accordance with propractice, the compressional standard clinical record in the facility staff faile and care was provided professional standard comprehensive persone of 36 residents Resident #73. The facility staff faile and klonopin (2) to lorder on various data	care fundamental principle that ent and care provided to ased on the comprehensive sident, the facility must ensure we treatment and care in ofessional standards of ehensive person-centered esidents' choices. IT is not met as evidenced rview, facility document review eview, it was determined that d to ensure that treatment ded in accordance with rds of practice, and the son-centered care plan for in the survey sample, ed to administer potassium (1) Resident #73 per physician's tes in October 2018, January	F6	A service and the service of the ser	a. Resident #73 MD and RP notified the missing doses of Potassium on 10/14, 10/15, 1/11 and Klonopin on 2/13, 2/17, and 2/18. There were in negative outcomes for the resident. b. All residents could have been affected. All nurses were checked competency with med pass observed. The nurse making error was in-served on Following MD orders and had a pass competency done with her. c. SDC provided education on follor MD orders and competency with measurement passes with all licensed nursing state that was completed on 3/1/19. d. SDC or Designee perform med prompetencies on 2 nurses per unit for total of 4 per week for 3 months. A findings will be reviewed and broug QAPI monthly for any follow up the needed. e. DOC 3-15-19	for tions. viced med owing leds ff	
THE PROPERTY OF THE PROPERTY O	and klonopin (2) to I	Resident #73 per physician's tes in October 2018, January				The state of the s	

DEPARTMENT OF HEALTH AND HUNN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	PRINTED:	02/28/2019
	FORM A	APPROVED
And the second s	OMB NO.	0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		495249	B. WING		P. C.	02/21/2019	
	PROVIDER OR SUPPLIER	B CENTER		15	REET ADDRESS, CITY, STATE, ZIP CODE 75 SCOTT DRIVE ROUTE 5 ARMVILLE, VA 23901		THE STATE OF THE S
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	Resident #73 was a 1/30/14. Resident were not limited to anxiety disorder. RMDS (minimum dat status assessment reference date) of 1 cognitive skills for a moderately impaire #73 as requiring ex with dressing, toilet Resident #73's com 1/18/18 documente IN MY BEHAVIOR / PACING THE HALL NURSE AND STAF		F	584			
	Review of Resident a physician's order potassium 40 mEQ one time a day. Re October 2018 MAR record) revealed the administered potass 10/15/18. A nurse's documented the menurse's note dated pharmacy was notif January 2019 MAR administered potassium was on of There was no further	#73's clinical record revealed with a start date of 11/8/16 for (milliequivalents) by mouth view of Resident #73's (medication administration e resident was not sium 40 mEQ on 10/14/18 and a note dated 10/14/18 edication was not available. A 10/15/18 documented the ied. Review of Resident #73's revealed the resident was not sium 40 mEQ on 1/11/19. A 1/11/19 documented the order from the pharmacy. For documentation that was eventually administered					

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Event ID: E6TN11

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE			O	FORM	: 02/28/2019 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION NG	(X3) DAT	E SURVEY APLETED
	495249	B. WING _		02/	21/2019
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
FARMVILLE HEALTH & REHA	B CENTER		1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		
PREFIX (EACH DEFICIENCY	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)	JLD BE	(X5) COMPLETION DATE
F 684 Continued From pa	-	F 68	14		A Landa de Carlos de Carlo
revealed a physicia 11/1/16 for klonopir a day. Review of RMAR revealed the results the 9:00 a.m. dose A nurse's note date pharmacy was to do of Resident #73's Fellonopin 0.5 mg was resident on 2/13/19 a.m., 2/17/19 at 5:00 a.m. A nurse's note "Rx (Prescription) of note dated 2/17/19 medication from phenote dated 2/17/19 medication from phenote dated 2/18/19 documentation that eventually administrate Review of the facilits supply lists revealed mEQ and three dose available in the supplementation of 2/21/19 at 7:45	desident #73's clinical record in's order with a start date of in 0.5 mg (milligrams) two times desident #73's January 2019 resident was not administered of klonopin 0.5 mg on 1/7/19. In 1/7/19 documented the eliver the medication. Review desired to the date of the desired to				

LPN #5 was asked about the facility process for ensuring medications including controlled

substances are available for administration. LPN #5 stated nurses have to make sure they have enough medication on hand. LPN #5 stated nurses count the controlled substances and see how often the medications are ordered to ensure

DEPARTMENT OF HEALTH AND HUNN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 02/28/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495249	B. WING			02/	21/2019
	PROVIDER OR SUPPLIER	B CENTER		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 PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	prescription from the the process for rouse controlled substant medication packets date but sometimes be refilled before the asked at what poin refilled, LPN #5 stagetting down, may have to know and repharmacy will not recommunicate with asked what should due to be administed medication cart. Lil look for the medication cart. Lil look for the medication cart. Under the total did have an that could be access medications if they medication cart. On 2/21/19 at 11:3 staff member) #1 (If the director of nurse above concern. The facility pharma Shortages/Unavailation the medication shortage facility staff should obtain the medication shortage medication shortage.	until they can get a hard ne doctor. When asked about tine medications that are not ces, LPN #5 stated the s document the next refill due s pills hit the floor and have to ne next refill due date. When t medications should be ted, "If you know you are ne six left, being nursing, you refill but if it's too early, the refill and you have to the pharmacy." LPN #5 was be done if medications are red and are not in the PN #5 stated nurses should tions, inform the nurse	Fe	84			

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Event ID: E6TN11

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DEPARTMENT OF HEALTH AND HUNN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2019 **FORM APPROVED** OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495249	B. WING _		02/21/2019	
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC 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 695	the medication has licensed facility nurs reorder for the next next available delivedose in the resident facility nurse should the Emergency Medithe dose" No further information of the work properly. It helps your nerves to contract. It helps you also helps move nu products out of cells obtained from the whitps://vsearch.nlm.meta?v%3Aprojectemedlineplus-bundle 431001.578943081 50160688 (2) Klonopin is used attacks. This inform website: https://medlineplus.tml	nine the status of the order. If not been ordered, the se should place the order or scheduled delivery. 2.2 If the ery causes delay or a missed is medication schedule, I obtain the medication from dication Supply to administer on was presented prior to exit. mineral that your body needs is a type of electrolyte. It of function and muscles to our heartbeat stay regular. It trients into cells and waste s." This information was	F 68	a. Residents #85 and #86's respirate equipment is currently being stored appropriately. Resident #44 MD at were notified of the omitted holes January 2019 TAR. b. All residents with O2/Trach/Nebulizers equipment rowere checked for proper storage of respiratory equipment not in use of 2/22/19. 100% of all residents with respiratory trach treatments were pand audited for any omissions in documentation by ADON, UM and on 2/22/19. c. SDC educated nursing staff regard proper storage of respiratory equipment completed on 3-1-19. SDC to educated nursing staff on appropriate documentation of treatments, compon 3/1/19. d. ADON/Designee to audit all respiratory equipment to ensure all respiratory equipment is stored appropriately 5 times per week for	d nd RP in the soms of the n h brinted d SDC arding sment cate ate pleted	
SS=D	CFR(s): 483.25(i) § 483.25(i) Respirat tracheostomy care a The facility must en needs respiratory care care and tracheal si	ory care, including and tracheal suctioning. sure that a resident who are, including tracheostomy uctioning, is provided such		then weekly times 4 weeks. Finding brought to monthly QAPI for review DON/Designee will audit all respit treatment TARS for omissions 5 to per week during clinical morning meeting for 3 months and bring all findings to monthly QAPI for reviewed.	ngs ew. ratory imes	
DRM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: E6TN11		Facility Hindings to monthly QAP1 for fevi	et P	age 45 of 86

DEPARTMENT OF HEALTH AND HUI SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3	OMPLETED
		495249	B. WING			02/21/2019
	ROVIDER OR SUPPLIER LE HEALTH & REHA	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 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	1	SHOULD BE	(X5) COMPLETION DATE
	practice, the compressed plan, the resident 483.65 of this series REQUIREMENT by: Based on observate document review are was determined the ensure respiratory to consistent with professed plan, for three sample, Resident #1. The facility staff nebulizer mask in aseronal and the consistent with professed plan, for three sample, Resident #1. The facility staff nebulizer mask in aseronal and the consistent with professed plan, for three sample, Resident #1. The facility staff nebulizer mask in aseronal and the findings included the findings inclu	h professional standards of ehensive person-centered ents' goals and preferences, subpart. NT is not met as evidenced ion, staff interview, facility and clinical record review, it at the facility staff failed to reatment was provided essional standards of emprehensive person-centered of 36 residents in the survey 85, # 86 and # 44. failed to store Resident # 85's sanitary manner. failed to perform ordered or Resident #44 on multiple onth of January 2019. Established to store Resident # 85's sanitary manner. admitted to the facility on oses that included but were ral vascular disease (1), 2), gastroesophageal reflux	F 6	95		

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	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		495249	B. WING			02/21/2019	
	PROVIDER OR SUPPLIER	B CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 575 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	coded Resident # 8 interview for menta - 15, 15 - being cog decisions. Resident extensive assistant one staff member for the conducted with LPN placed in a plastic b dated when it was in sesident # 85's nebulizer mask lying of the television, under the compact of the television, under the compact of the television of	is as scoring a 15 on the brief I status (BIMS) of a score of 0 initively intact for making daily at #85 was coded as requiring the to being totally dependent of or activities of daily living. 5 p.m., during an observation, sitting on the edge of her bed. ident #85' room reveal a g on the bedside table, in front covered. 8 p.m., during an observation, sitting on the edge of her bed. ident #85's room reveal a g on the bedside table, in front covered. 6 a.m., during an observation, sitting on the edge of her bed. ident #85's room reveal a g on the bedside table, in front covered.	F	695			

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Facility ID: VA0080

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		AND HUI SERVICES & MEDICAID SERVICES			\circ		FORM	: 02/28/2019 I APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495249	B. WING	ì	·		02/	21/2019
NAME OF I	PROVIDER OR SUPPLIER			ŧ	STREET ADDRESS, CITY, STATE, ZIP CODE	= -		
FARMVII	LE HEALTH & REHA	B CENTER		1	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 PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD E	3E	(X5) COMPLETION DATE
F 695	Continued From pag from bacteria."	ge 47	F	5 9 5	5			
		p.m., ASM # 1 member), administrator, and nursing, were made aware of						
	No further information	on was provided prior to exit.						
	brain stops. A stroke attack." If blood flow few seconds, the bra oxygen. Brain cells of damage. This inform website:	blood flow to a part of the is sometimes called a "brain v is cut off for longer than a ain cannot get nutrients and can die, causing lasting nation was obtained from the gov/ency/article/000726.htm.						
The second secon	regulate the amount goal of treatment at blood glucose level. prevent complication to treat and manage active and eating he was obtained from the	e in which the body cannot of sugar in the blood. The first is to lower your high Long-term goals are to as. The most important way type 2 diabetes is by being althy foods. This information he website: gov/ency/article/000313.htm.						
1000	the esophagus and i was obtained from th https://www.nlm.nih.	gov/medlineplus/gerd.html.					es en	
	obtained from the we	ure. This information was ebsite: gov/medlineplus/highbloodpr					######################################	

PRINTED: 02/28/2019

CENTE	AS FOR MEDICARE	& MEDICAID SERVICES	····		O	<u>MB NO</u>	<u>. 0938-0391</u>	
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495249	B. WING	·		02/	21/2019	
NAME OF	PROVIDER OR SUPPLIER			i	TREET ADDRESS, CITY, STATE, ZIP CODE			
FARMVII	LLE HEALTH & REHA	B CENTER			575 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 695	(5) The combination is used to prevent we chest tightness, and chronic obstructive group of diseases the airways) such as che the air passages the emphysema (damalungs). Albuterol and used by people who controlled by a sing. Albuterol and ipratromedications called be ipratropium combined opening the air passibreathing easier. The from the website:	ge 48 In of albuterol and ipratropium wheezing, difficulty breathing, discoughing in people with pulmonary disease (COPD; a hat affect the lungs and pronic bronchitis (swelling of at lead to the lungs) and ge to the air sacs in the dipratropium combination is ose symptoms have not been le inhaled medication. Opium are in a class of pronchodilators. Albuterol and ation works by relaxing and sages to the lungs to make this information was obtained gov/druginfo/meds/a601063.h	F€	695				
	nebulizer mask in a Resident # 86 was a 11/06/17 with diagnor not limited to diabete disease (2), and atri Resident # 86's mos set), an annual asse (assessment reference Resident # 86 as so interview for mental - 15, 13 - being cognition. Resident	admitted to the facility on oses that included but were es mellitus (1), chronic kidney ial fibrillation (3). It recent MDS (minimum data essment with an ARD nce date) of 01/26/19, coded oring a 13 on the brief status (BIMS) of a score of 0 nitively for making daily the 486 was coded as being no only set up of one staff						

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DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 02/28/2019 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING				(X3) DATE SURVEY COMPLETED		
		495249	B. WING	i	The state of the s	02	/21/2019	
	PROVIDER OR SUPPLIER	B CENTER		1:	TREET ADDRESS, CITY, STATE, ZIP CODE 575 SCOTT DRIVE ROUTE 5 ARMVILLE, VA 23901	*	2112010	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 695	On 02/19/19 at 2:09 Resident # 86 sittin and appeared dres Observation of Res nebulizer mask lyin On 02/19/19 02:54 Resident # 86 sittin and appeared dress Observation of Res nebulizer mask lyin The POS (physicial February 2019, for "Ipratropium-albute inhale every 4 (four date: 01/24/2019." On 02/21/19 at 12:50 conducted with LPN 1. When informed Resident # 86's nebulizer uncovered, placed in a plastic bid dated when it was in bag LPN # 1 stated from bacteria." On 02/21/19 at 2:40 (administrative staff ASM # 2, director of the findings. No further information References: (1) A chronic disease	5 p.m., during an observation, g in his wheelchair in his room sed neat and clean. ident # 86's room reveal a g on the dresser uncovered. p.m., during an observation, g in his wheelchair in his room sed neat and clean. ident # 86's room reveal a g on the dresser uncovered. n's order sheet) dated Resident # 86 documented, rol (4) 3(three) ml (milliliter)) hours as needed. Order 55 p.m., an interview was l (licensed practical nurse) # of the observations of oulizer mask lying on the LPN # 1 stated, "It has to be originally put in use." When aportant to keep the mask in a , "To keep it clean and free	F	695				

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		AND HUI SERVICES & MEDICAID SERVICES				FORM	02/28/2019 APPROVED
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ŧ		IPLE CONSTRUCTION	(X3) DA	0. 0938-0391 TE SURVEY MPLETED
		495249	B. WING	3_		02	/21/2019
NAME OF	PROVIDER OR SUPPLIER			Τ	STREET ADDRESS, CITY, STATE, ZIP CODE		
FARMVI	LLE 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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIUM DEFICIENCY)) BE	(X5) COMPLETION DATE
F 695	blood glucose level. prevent complication to treat and manage active and eating he was obtained from t https://medlineplus. (2) Kidneys are dam they should. This inf the website: https://medlineplus. [. (3) A problem with th heartbeat. This info the website: https://www.nlm.nih. on.html. (4) The combination is used to prevent w chest tightness, and chronic obstructive p group of diseases th airways) such as chi the air passages tha emphysema (damag lungs). Albuterol and used by people who controlled by a single Albuterol and ipratro medications called b ipratropium combina opening the air pass breathing easier. Th from the website:	first is to lower your high Long-term goals are to ns. The most important way type 2 diabetes is by being ealthy foods. This information	F	69	5		

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DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	PRINTED: 02/28/2019
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	OMB NO. 0938-0391

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILD		(X3) DATE SURVEY COMPLETED			
		495249	B. WING			02/	21/2019
	PROVIDER OR SUPPLIER	B CENTER		15	REET ADDRESS, CITY, STATE, ZIP CODE 175 SCOTT DRIVE ROUTE 5 ARMVILLE, VA 23901		2.112010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	3. The facility staff of tracheotomy care for dates during the model of the control of the contr	railed to perform ordered or Resident #44 on multiple onth of January 2019. admitted to the facility on eir most recent re-admission Resident #44's diagnoses not limited to, Hypertension e), Persistent Vegetative State d Intracranial Injury. Resident Minimum Data Set (MDS) Quarterly Assessment with an ence Date (ARD) of ief Interview for Mental Status formed. Resident #44 was total assistance of 2 or more illity and transfers, and tance of 1 person for all other fe (ADLs). Inducted with Resident #44's on of 02/19/2019. During that #44's wife stated she stated at facility staff were not comy care on Resident #44 as ed. Sident #44's Physician orders alth Record (EHR), the	F6	995			
	site with 1/2 hydrog saline, change disp	documented: "Cleanse trach en peroxide and 1/2 normal osable inner cannula #8XL I (as needed) every shift for I) care."		We that the teacher the second t			
	plan last revised on following: Under "Fo	ot #44's comprehensive care 01/24/2019, documented the ocus": "AT RISK FOR (GENATION B/T (related to)	Anna della d	***************************************			

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Event ID: E6TN11

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	INENI OF REALIR	¥ /					APPROVED
		& MEDICAID SERVICES					<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION		E SURVEY IPLETED
		495249	B. WING	ì		02/	21/2019
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FARMVII	LE HEALTH & REHA	R CENTER		1	575 SCOTT DRIVE ROUTE 5		
1 WIGHT AT		D OCKI CII		F	FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDEFICIENCY)	D BE	(X5) COMPLETION DATE
F 695	"Interventions": "TR ORDERED/FOLLO Throat)/MD (Medica ORDERED." A review of Resider Administration Recovere multiple dates order for trach care completed on one of day. These dates w 01/08/19, 01/13/19, 01/26/19 and 01/28. The Administrator, / member) #1 and Divere informed of complete the survey tregarding Resident question that might On 02/21/2019 at a interview was conductive (LPN) #4. LP spot in a resident's	If FOR BREATHING" Under ACH CARE AS W-UP WITH ENT (Ear Nose al Doctor) AS INDICATED/AS INDICATED	F	695			
	At the end of day m Director of Nursing, surveyor that no add	eeting on 02/21/2019, the ASM #2, informed this ditional documentation spots in Resident #44's TAR					

No further documentation was provided.

PRINTED: 02/28/2019

DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

PRINTED: 02/28/2019 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
		495249	B. WING			02/:	21/2019
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FARMVIL	LE HEALTH & REHA	B CENTER			575 SCOTT DRIVE ROUTE 5		
				F	ARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC 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 695	Continued From pa	ge 53	F 6	95			
F 732 SS=C	complete impairment from widespread da part of the brain that behavior) https://www.mercknal-cord,-and-nerve-consciousness/minivegetative%20State nscious%20State Posted Nurse StafficFR(s): 483.35(g)(1) S483.35(g)(1) Data must post the follow basis: (i) Facility name. (ii) The current date (iii) The total number by the following cate unlicensed nursing resident care per shand (A) Registered nurse (B) Licensed practic vocational nurses (a) (C) Certified nurses (a) (iv) Resident census \$483.35(g)(2) Postii (i) The facility must specified in paragra daily basis at the be (ii) Data must be po (A) Clear and reada	taffing Information. requirements. The facility ring information on a daily ar and the actual hours worked egories of licensed and staff directly responsible for lift: es. eal nurses or licensed as defined under State law). aides. s. ng requirements. post the nurse staffing data ph (g)(1) of this section on a ginning of each shift. sted as follows: ble format.	F 7:	32	F732 a. On 2/19/19 the daily posting was replaced by staffing at 11:30A.M b. Night shift nurses to post current posting. c. DON educated the staffing coordinator on policy of posting the daily staffing on 2-21-19 d. DON to audit 5 times per week tit 3 months that the correct staffing shis posted. All findings to be brought monthly QAPI for review. e. DOC 3-15-18	days mes	
**************************************	(B) In a prominent p	lace readily accessible to					

(X2) MULTIPLE CONSTRUCTION

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

Event ID: E6TN11

Facility ID: VA0080

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DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED:	02/28/2019
FORM	APPROVED
OMB NO.	0938-0391

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		495249	B. WING			02	/21/2019
	PROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, C 1575 SCOTT DRIVE FARMVILLE, VA 2		,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOUL RENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 732	residents and visitor §483.35(g)(3) Publistaffing data. The written request, material available to the public exceed the community of the comm	ic access to posted nurse facility must, upon oral or ake nurse staffing data olic for review at a cost not to unity standard. Ity data retention facility must maintain the staffing data for a minimum of equired by State law, whichever of the staff interview and facility the was determined that the post daily nurse staffing of a.m., the facility staff failed to estaffing information. The in the lobby was dated 2/18/19. The cost of the staffing information was below. The posting was dated is no posted nurse staffing	F 7	32			
	conducted with CN #2 (the person rest nurse staffing information about the facility pr staffing information	a.m., an interview was A (certified nursing assistant) consible for posting the daily mation). CNA #2 was asked ocess for posting the nurse c. CNA #2 stated most of the the staffing information and	٠				

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Event ID: E6TN11

Facility ID: VA0080

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DEPARTMENT OF HEALTH AND HUM SERVICES	
CENTERS FOR MEDICARE & MEDICARD SERVICES	

PRINTED: 02/28/2019 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	G	(X3) DATE SURVEY COMPLETED		
		495249	B. WING _		02/21/2019	
	PROVIDER OR SUPPLIER LLE HEALTH & REHA	B CENTER		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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 755 SS=D	posts the informatic census from the ad meeting. When as usually posts the introduced posts are usually posted at ap #2 was made award observation on 2/19 assists residents with mornings and some information until aft. On 2/21/19 at 11:31 staff member) #1 (the director of nursuabove concern. The facility policy tit Staffing" documents (i) The facility must specified in paragradaily basis at the beautiful paragradaily facility must prodrugs and biological them under an agree \$483.45 (a) (b) \$483.45 (a) The facility must prodrugs and biological them under an agree \$483.70(g). The facility must prodrugs and biological them under an agree \$483.70(g). The facility must prodrugs and biological them under an agree \$483.70(g). The facility must prodrugs and biological them under an agree \$483.70(g). The facility must prodrugs and biological them under an agree \$483.70(g). The facility must prodrugs and biological them under an agree \$483.70(g). The facility must prodrugs and biological them under an agree \$483.70(g). The facility must prodrugs and biological them under an agree \$483.70(g). The facility must prodrugs and biological them under an agree \$483.70(g). The facility must prodrugs and biological them under an agree \$483.70(g). The facility must prodrugs and biological them under an agree \$483.70(g). The facility must prodrugs and biological them under an agree \$483.70(g). The facility must prodrugs and biological them under an agree \$483.70(g). The facility must prodrugs and biological them under an agree \$483.70(g). The facility must prodrugs and biological them under an agree \$483.70(g).	on after she obtains the missions nurse at the morning ked to specify a time she formation, CNA #2 stated it is oproximately 9:30 a.m. CNA e of this surveyor's 1/19. CNA #2 stated she th smoking on certain etimes she forgets to post the er she assists the smokers. a.m., ASM (administrative he administrator) and ASM #2 ing) were made aware of the led, "Daily Posting of Nurse ed, "(2) Posting requirements. post the nurse staffing data ph (e) (1) of this section on a eginning of each shift" on was presented prior to exit. occedures/Pharmacist/Records o)(1)-(3) Services ovide routine and emergency is to its residents, or obtain	F 73	F755 a. Resident #73's MD and RP notified the medication of Aldactone not be	eing nd verse ble. it was meds ng l med on	

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Event ID: E6TN11

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		AND HUM SERVICES				FOR	D: 02/28/2019 MAPPROVED D: 0938-0391	
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495249	B. WING			02	2/21/2019	
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
FARMVI	LLE 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 APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 755	§483.45(b) Service must employ or obto pharmacist who- §483.45(b)(1) Provide aspects of the provide facility. §483.45(b)(2) Established and disposition sufficient detail to expression and services for one of 3 sample, Resident #5	ministering of all drugs and the needs of each resident. Consultation. The facility ain the services of a licensed des consultation on all sion of pharmacy services in plishes a system of records of ion of all controlled drugs in mable an accurate mines that drug records are in ecount of all controlled drugs eriodically reconciled. It is not met as evidenced eview, facility document review eview, it was determined that d to provide pharmacy as residents in the survey 73. ed to ensure aldactone (1) ministration to Resident #73, October 2018.	F 75		nurses per week for 3 months. All findings will be reviewed and brou QAPI monthly for any follow up the needed. e. DOC 3-15-19	ght to		

Resident #73 was admitted to the facility on 1/30/14. Resident #73's diagnoses included but

were not limited to low potassium, diabetes and anxiety disorder. Resident #73's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment

DEPARTMENT OF HEALTH	No. 1 /				: 02/28/2019 APPROVED
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	& MEDICATO SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	. 0938-0391 E SURVEY MPLETED
	495249	A. BUILDIN	NG		
NAME OF PROVIDER OR SUPPLIER	793273	L D: 11 (10 -	STREET ADDRESS, CITY, STATE, ZIP CODE	02/	/21/2019
			1575 SCOTT DRIVE ROUTE 5		
FARMVILLE HEALTH & REHA	B CENTER	l	FARMVILLE, VA 23901		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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
cognitive skills for d moderately impaired #73 as requiring ext with dressing, toileting Resident #73's com 1/25/19 documented dehydration or poter Diuretic useAdmir ordered" Review of Resident a physician's order addactone 25 mg (madactone 25 mg (madactone 25 mg (maday. Review of Resident was not 10/14/18, 10/15/18, nurse's note dated medication was not dated 10/15/18 documented the medication was one documented the medication was one documentation that eventually administed Review of the facility supply lists revealed facility emergency moderated was 12/21/19 at 7:45 and 12/21/21/19 at 7:45 and 12/21/21/21/21/21/21/21/21/21/21/21/21/2	/17/19, coded the resident's aily decision making as d. Section G coded Resident rensive assistance of one staffing and personal hygiene. prehensive care plan dated d, "The resident has ntial fluid deficit r/t (related to) nister medications as #73's clinical record revealed with a start date of 2/2/17 for nilligrams) by mouth one time resident #73's October 2018 dministration record) revealed administered aldactone on 10/23/18 and 10/24/18. A 10/14/18 documented the available. A nurse's note rumented the pharmacy was note dated 10/23/18 redication was on order. A 10/24/18 documented the order. There was no further aldactone 25 mg was rered on the above dates.	F 75	55		

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LPN #5 was asked about the facility process for

administration. LPN #5 stated nurses have to make sure they have enough medication on hand. LPN #5 stated the medication packets

ensuring medications are available for

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CENTE	<u>RS FOR MEDICARE</u>	E & MEDICAID SERVICES			O	MB NO	. 0938-0391	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495249	B. WING	3		02/	/21/2019	
NAME OF	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE			
SADMANI	II S USAITU & DSUA	D CENTED		•	1575 SCOTT DRIVE ROUTE 5			
PARISIVI	LLE HEALTH & REHA	B CENTER			FARMVILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO) BE	(X5) COMPLETION DATE	
F 755	document the next pills hit the floor and next refill due date. medications should you know you are g being nursing, you it's too early, the ph have to communica #5 was asked what are due to be admit medication cart. LF look for the medicar manager and conta On 2/21/19 at 11:31 staff member) #1 (timestion care)	refill due date but sometimes d have to be refilled before the . When asked at what point d be refilled, LPN #5 stated, "If getting down, maybe six left, have to know and refill but if narmacy will not refill and you ate with the pharmacy." LPN to should be done if medications nistered and are not in the PN #5 stated nurses should tions, inform the nurse	F	755				
	Shortages/Unavaila "1. Upon discovery supply of a medicat facility staff should i obtain the medication medication shortage pharmacy hours: 2. pharmacy to determ the medication has licensed facility nurs reorder for the next next available delived dose in the resident facility nurse should the Emergency Medithe dose. 2.3 If the the Emergency Medical shorts a should the Emergency Medithe	cy policy titled, "7.0 Medication able Medications" documented, that facility has an inadequate tion to administer to a resident, immediately initiate action to on from the pharmacy2. If a e is discovered during normal 1 Facility nurse should call nine the status of the order. If not been ordered, the se should place the order or scheduled delivery. 2.2 If the ery causes delay or a missed t's medication schedule, d obtain the medication from dication Supply to administer medication is not available in dication Supply, facility staff nacy and arrange for an"						

SERVICES

DEPARTMENT OF HEALTH AND HUM

PRINTED: 02/28/2019

FORM APPROVED

		AND HUM SERVICES & MEDICAID SERVICES			FORM	: 02/28/2019 APPROVED
STATEMENT	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		495249	B. WING		02/	21/2019
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
FARMVII	LE HEALTH & REHA	B CENTER	ı	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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 755	Continued From pa	ge 59	F 75	5		A CONTRACTOR OF THE CONTRACTOR
	No further informati	on was presented prior to exit.				The state of the s
F 750	levels, heart failure information was obt https://medlineplus.tml	ed to treat low potassium and fluid retention. This ained from the website: gov/druginfo/meds/a682627.h Error Rts 5 Pront or More	اران ماران ال			The state of the s
F 759 SS=E	CFR(s): 483.45(f)(1		F 759	F/39		Control of the Contro
	percent or greater; This REQUIREMEN by: Based on observat document review ar was determined tha ensure a medication percent for three of medication administ #30, #28 and #75.	ation error rates are not 5 IT is not met as evidenced ion, staff interview, facility and clinical record review, it the facility staff failed to a error rate less than five		a. Resident #30's mouth assessed thrush on 2/21/19. New order for Acid was obtained from the MD 2/21/19. Resident #28 Left eye assessed for redness form received drops on 2/21/19 and MD/RP was ware of the error. Resident #75 MD/RP was made aware of the ASA being given and crushed. The above noted resident had any adverse effects from the errors. b. All residents have the potential affected by the deficient practices	or Folic O on was ving vas made 5 incorrect None of y	
	percent. 1. The facility staff #30's medication of	failed to administer Resident folic acid (1) and Incruse ler] (2) according to the		nurses that made errors during the pass observations were given 1-1 services on med administration an observed by the SDC for compete meds administration on 2/21/19.	e med in ad were ency of	

2. The facility staff failed to administer Resident #28's medication of Dorzolamide [eye drops] (1)

3. The facility staff failed to administer Aspirin 81

according to the physician's order.

of inhaler on 2/22/19.

was completed of all the residents' mouths that have orders for steroidal

inhalers for signs and symptoms of side effects from inappropriate administration

	TMENT OF HEALTH					FORM	02/28/2019 APPROVED
STATEMEN	OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		495249	B. WING			02/	21/2019
NAME OF	PROVIDER OR SUPPLIER		·	1	TREET ADDRESS, CITY, STATE, ZIP CODE		
FARMVII	LLE HEALTH & REHA	B CENTER			575 SCOTT DRIVE ROUTE 5 ARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC 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 759	mg (milligrams) to Forder. LPN (license and administered Accoated) to Resident 81 mg. In addition, coated Aspirin and the facility should not the facility should not the facility should not the facility should not the facility staff #30's medication of Ellipta [powder inhaphysician's order. Resident # 30 was a 08/27/09 and a read diagnoses that incluhemiplegia (3), anel pulmonary disease Resident # 30's most (minimum dada set) an ARD (assessmet coded the resident a interview for mental - 15, 14 being cognimaking. Resident # extensive assistance activities of daily living eating. On 02/20 19 at 8:12 administration obseiconducted with LPN	Resident #75 per physician's d practical nurse) #2 prepared spirin 81 mg EC (enteric #75 instead of regular Aspirin LPN #2 crushed the enteric the medication was listed on by the crushed list.	F	759	c. DON completed 1-1 education of nurse on medication administration steroidal inhalers and following Morders on 2/28/19. SDC complete education of licensed nurses on medication administration and professional standards on 3/8/19. d. SDC will audit 2 nurses per unit medication administration for total nurses per week for 3 months. All findings will be reviewed and broug QAPI monthly for any follow up the needed. e. DOC 3-15-19	n of ID d t on l of 4	

acid tablets from the medication bubble pack for Resident # 30 into a small plastic medication cup.

The bubble pack containing the folic acid

		AND HUM SERVICES & MEDICAID SERVICES			FORM): 02/28/2019 // APPROVED): 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495249	B. WING			/21/2019
	PROVIDER OR SUPPLIER LLE HEALTH & REHA	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECT	(X5) COMPLETION DATE	
F 759	documented, "Folic LPN # 1 entered Reinformed Resident # handed the small pl containing the folic Resident # 30 took the folic acid, places swallowed them with water. LPN # 1 the Incruse Ellipta [pow took the inhaler, pla depressed the inhaler medication. Reside inhaler back to LPN # 20 if she required stated no and LPN and back to the medication. The POS (physician February 2019 for F"Folic Acid Tablet 1 mg by mouth one time order Date: 12/21/2 Powder Breath Activ 1 (one) inhalation in related to chronic of Rinse mouth after e SWALLOW. Order	Acid 400 mcg (micrograms)." esident # 30's bedroom, # 30 of her medication, astic medication cup acid to Resident # 30. the medication cup containing d the tablets in her mouth and h a small sip from a cup of h handed Resident # 20 the der inhaler]. Resident # 20 ced it up to her mouth, er and inhaled the ht #20 then handed the # 1. LPN # 1 asked Resident anything else. Resident # 20 # 1 walked out of the room dication cart and proceeded to I's order sheet) dated desident # 30 documented, (one) MG (milligram). Give 1 me a day for supplement. 1010." "Incruse Ellipta Aerosol vated 62.5 MCG (microgram) hale orally one time a day pestructive pulmonary disease. ach use and DO NOT	F 7	59		

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On 02/20/19 at 10:45 a.m., an interview was

conducted with LPN # 1 regarding the administration folic acid to Resident # 30. LPN # 1 stated, "I realized the error that I gave .80

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Facility ID: VA0080

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		AND HUM SERVICES & MEDICAID SERVICES				FORM): 02/28/2019 1 APPROVED): 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		LE CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		495249	B. WING	ì		02	/21/2019
NAME OF	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		·
FARMVII	LE HEALTH & REHA	B CENTER		ı	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 PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 759	the administration of doctor by phone, I masked if it was ok to stated it ok. It shout the order before I grasked about the Incomplete asked why the using the inhaler, Lift mouth from being or describe the process medication error, Lift rights, check the orderect dosage and the three checks, chadministration reconsite the same thing and right before administration and medication, LPN # 1 on the resident's diafactors. If it is not acomplete asked to describe the asked to describe an error in International LPN # 1 stated, "I caresponsible party an adverse reactions." On 02/20/19 at appreciant appreciant asked to form the International Internationa	less than one milligram. After f the medication, I notified the mentioned what I gave and modify the order and he ld have modified or clarified ave the medication." When the elliptia inhaler, LPN # 1 of her the opportunity to rinse ministering the medication. The resident should rinse after PN # 1 stated, "To prevent the oated." When asked to she follows to eliminate a PN # 1 stated, "I follow the five der, the route, the patient, the the correct time. I also, follow neck MAR (medication ed), and compare the MAR label to make sure it reads recheck the label at bed side tration." When asked why it minister the correct is stated, "Medication is based agnoses and weight and other diministered according to the nere could adverse effects." cribe the procedure when medication administration, all the physician and admonitor resident for roximately 3:00 p.m., ASM member) # 5, assistant provided this surveyor with a stelephone order for order documented, "Folic G Give 2 (two) [sic] tablet by	F	759			

PRINTED: 02/28/2019

DEPARTMENT OF HE		I AND HUMA SERVICES				FORM	: 02/28/2019 APPROVED : 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		495249	B. WING			02/	21/2019
NAME OF PROVIDER OR SUP FARMVILLE HEALTH & I		AB CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		
PREFIX (EACH DEFI	CIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
provided by far On 02/21/19 at (administrative nursing provided information: - "(Name of Ple Information. In the Facility of the drug information." - "(Name of Ple Information. Informati	TC (cility. t appreciate t app	over the counter) medication		759			

DEPARTMENT OF HEALTH AND HUM/ SERVICE	ES
CENTERS FOR MEDICARE & MEDICARD SERVICE	2

PRINTED: 02/28/2019 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: A. BUILDING		COMPLETED			
		495249	B. WING			02/	21/2019
	PROVIDER OR SUPPLIER			18	TREET ADDRESS, CITY, STATE, ZIP CODE 575 SCOTT DRIVE ROUTE 5 ARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY 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 APPROPODE DEFICIENCY)	(X5) COMPLETION DATE	
F 759	No further information References: (1) Folic acid is material found in supplement foods. The terms used interchangeat Leftover amounts through the urine. In not store folic acid supply of the vitame through supplement cells work, works with the proteins, helps for prevent anemia), helps fo	an-made (synthetic) folate. It is ints and added to fortified folic acid and folate are often ably. Folic acid is water-soluble. of the vitamin leave the body That means your body does. You need to get a regular nin through the foods you eat or nts. Helps tissues grow and with vitamin B12 and vitamin C reak down, use, and create new med blood cells (helps nelps produce DNA, the ne human body, which carries now the human body, which carries now this information was website: a.gov/ency/article/002408.htm. It is to control wheezing, how the coughing, and chest or control wheezing, how con	F 7	759			

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Facility ID: VA0080

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		AND HUM/ SERVICES & MEDICAL SERVICES		O	FORM	: 02/28/2019 1APPROVED : 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495249	B. WING		02/	/21/2019	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
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 PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 759	can be complete or both sides of your bone area, or it can be information was obten https://medlineplus. (4) Low iron. This in the website: https://www.nlm.nih (5) Disease that macan lead to shortnes was obtained from the https://www.nlm.nih (6) High blood press obtained from the whitps://www.nlm.nih essure.html.	brain and muscles. Paralysis partial. It can occur on one or ody. It can also occur in just be widespread. This ained from the website: gov/paralysis.html. formation was obtained from gov/medlineplus/anemia.html kes it difficult to breath that se of breath. This information he website: gov/medlineplus/copd.html. sure. This information was rebsite: gov/medlineplus/highbloodpr failed to administer Resident Dorzolamide [eye drops] (1)	F 7	759			

Resident # 28 was admitted to the facility on 03/01/13 with diagnoses that included but were not limited to: glaucoma (2), iridocyclitis of left eye

Resident # 28's most recent comprehensive MDS (minimum dada set) an annual assessment with an ARD (assessment reference date) of 12/08/18 coded the resident as scoring a 9 (nine) on the brief interview for mental status (BIMS) of a score of 0 - 15, 9 (nine) being moderately impaired of cognition for daily decision making. Resident # 28 was coded as requiring extensive assistance

(3), anxiety (4), and hypertension (5).

	INICINI OF HEALIH	& MEDICAID SERVICES				0		APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		DNSTRUCTION		(X3) DAT	. 0938-0391 E SURVEY IPLETED
		495249	B. WING	7			02/	21/2019
NAME OF I	PROVIDER OR SUPPLIER		I	STREE	ET ADDRESS, CITY, STATE, ZIP COL)E	, OL	LI/LUIU
FARMVIL	LE HEALTH & REHA	B CENTER			SCOTT DRIVE ROUTE 5 NVILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD	BE	(X5) COMPLETION DATE
F 759	on 02/20 19 at 8:22 administration obse conducted with LPN 1. LPN # 1 entered administer eye drop observed lying down # 1 informed Reside her eye drops. LPN plastic gloves, remobottle, held the bottl other gloved hand to eyelid and the lower open Resident # 28 one drop of medical repeated the same	endent of one staff member for	F 7	'59				
	The POS (physician February 2019 for F "Cosopt Solution 22 (milligram/milliliter) drop in right eye eve UNSPECIFIED GLA 02/11/2017." The comprehensive dated 04/03/2017 de Alteration in visual freeizures, tremors, ll evidenced by eye ex Further review of the	[Dorzolamide] Instill 1 (one) ery 12 hours related to AUCOMA. Order Date: care plan for Resident # 28 ocumented, "Focus. unction r/t (related to) D (intellectual disability) as kam and resident statement." e comprehensive care plan iterventions related to the						

On 02/20/19 at 10:45 a.m., an interview was

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DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES						FC	TED: 02/28/2019 ORM APPROVED NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
	ļ	495249	B. WING	ì			02/21/2019
NAME OF PROVIDER OR SUF	PPLIER		•	Π	STREET ADDRESS, CITY, STATE, ZIP COL)E	Vin in it is a v
FARMVILLE HEALTH &	REHA	B CENTER		i	1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		
PREFIX (EACH DEFI	ICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
administration After reviewin for Resident # # 1 was asked was ordered t stated, "It sho LPN # 1 agree eyes. LPN # mistake." Wh she follows to 1 stated, "I fol the route, the correct time. I check MAR (r and compare to make sure the label at be When asked w the correct me stated, "Medic diagnoses and administered a there could ac eye could ther asked to desc when there is administration physician and resident for ac On 02/21/19 a (administrative nursing provid information: "(ith LPN n of Do ng the I # 28' D id, which to have bed she 1 state hen as be elimin I also, medicati it read ed side why it redicati of weig accord dverse re be a cribe th I respo dverse at appr e staff ded this (Name	N # 1 regarding the orzolamide to Resident # 28. POS (physician order sheet) Porzolamide (eye drops), LPN ch of Resident # 28's eyes the eye drops. LPN # 1 to one drop, the right eye." the administered a drop in both ed, "It's an error. I made a sked to describe the process that a medication error, LPN # the five rights, check the order, that the correct dosage and the follow the three checks, ation administration record), IAR with the medication labeled the same thing and recheck the right before administration." It was important to administer ion and correct dose, LPN # 1 is based on the resident's ght and other factors. If it is not ding to the physician's orders, the effects. If given in the wrong an adverse effect." When the procedure staff follows the ror, in the medication I # 1 stated, "I call the onsible party and monitor"	F7	759			

eye diseases."

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drops. Dorzolamide is used to treat high

pressure inside the eye due to glaucoma or other

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
495249			B. WING	i		02/21/2019	
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
FARMVII	LLE HEALTH & REHA	B CENTER			1575 SCOTT DRIVE ROUTE 5		
				<u> </u>	FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 759	Continued From pa	ge 68	F7	759)		
		D p.m., ASM # 1 f member), administrator, and f nursing, were made aware of					The state of the s
	No further informati	on was provided prior to exit.					-
	increased pressure loss of vision. Dorzo medications called It works by decreas This information wa	glaucoma, a condition in which in the eye can lead to gradual plamide is in a class of carbonic anhydrase inhibitors. ing the pressure in the eye. is obtained from the website: gov/druginfo/meds/a697049.h					
	eye's optic nerve. T from the website:	ses that can damage the This information was obtained .gov/medlineplus/glaucoma.ht					
	This information wa https://www.merrian clitis.	the iris and the ciliary body. s obtained from the website: n-webster.com/medical/iridocy					
Opposition of the control of the con	website:	mation was obtained from the .gov/medlineplus/anxiety.html					
orn in the second secon	obtained from the w https://www.nlm.nih. essure.html. 3. The facility staff fa	sure. This information was rebsite: .gov/medlineplus/highbloodpr ailed to administer Aspirin 81 Resident #75 per physician's					

DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES				O	FOR	D: 02/28/2019 M APPROVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1 ' '	TIPLE CONSTRUCTION	(X3) D	MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		495249	B. WING			2/21/2019	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
FARMVI	LLE 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		IOULD BE	(X5) COMPLETION DATE	
F 759	order. LPN (license and administered Accoated) to Resident 81 mg. In addition, coated Aspirin and the facility should not should not the facility should not should no	d practical nurse) #2 prepared spirin 81 mg EC (enteric #75 instead of regular Aspirin LPN #2 crushed the enteric the medication was listed on but be crushed list. Idmitted to the facility on ses for Resident #75 included to Anxiety Disorder, High I Constipation. Resident #75's with an Assessment 01/18/2019 coded Resident cognitive impairment, as assistance of one staff les of daily living and one staff resident #75's care plan dated	F 7	759			

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milliliters) after administration.

mg EC tablet and administered the crushed tablet to Resident #75 in applesauce. Resident #75 was given a cup of water (approximately 236

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	TMENT OF HEALTH RS FOR MEDICARE	AND HUM SERVICES & MEDICAL SERVICES				FORM	02/28/2019 APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495249	B. WING			02/:	21/2019
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FARMVII	LLE HEALTH & REHA	B CENTER			575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 759	An interview was coapproximately 2:42 was asked how she receiving the correct that she would look look at the medicatishow this surveyor to obtain and admin 81 mg tablet. LPN # took out a bottle of / coated) tablets. Who was aware that she 81 mg EC tablet to I "Yes, I made a mistashe was aware that mg EC tablet when medications. LPN # mistake." On 02/20/2019 at ap #1 (administrator) an ursing) were made. A copy of the facility administration was received.	Continued From page 70 An interview was conducted on 02/20/2019 at approximately 2:42 p.m. with LPN #2. LPN #2 was asked how she ensures residents are receiving the correct medications. LPN #2 stated that she would look at the physician order and look at the medication. LPN #2 was asked to show this surveyor the bottle of Aspirin, she used to obtain and administered Resident #75's Aspirin 81 mg tablet. LPN #2 went to medication cart and took out a bottle of Aspirin 81 mg EC (enteric coated) tablets. When LPN #2 was asked if she was aware that she had administered an Aspirin 81 mg EC tablet to Resident #75, LPN #2 stated, "Yes, I made a mistake." LPN #2 was asked if she was aware that she crushed the Aspirin 81 mg EC tablet when preparing Resident #75's medications. LPN #2 stated, "Yes, it was a		759			

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Services and Procedures Manual policy titled, "General Dose Preparation and Medication Administration" documented "Facility staff should verify that the medication name and dose are correct and should inspect the medication for contamination, particulate matter, discoloration or defects. If a medication's color has changed or if the medication does not have its normal color, facility staff should not administer the medication. "Facility staff should crush oral medications only in accordance with pharmacy guidelines as set

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
495249			B. WING		02/21/2019		
NAME OF PROVIDER OR SUPPLIER FARMVILLE HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	D BE COMPLETION		
F 759	forth in Appendix 16: Common Oral Dosage		F 759				
F 761 SS=D	Forms that Should Not Be Crushed and/or facility policy." A copy of the "Do Not Crush" list was requested from ASM #2 (director of nursing) on 02/20/2019 at approximately 5:00 p.m. The Omnicare Appendix 16: Common Oral Dosage Forms that Should Not Be Crushed list documented, "Aspirin EC (enteric coated)" as a medication that should not be crushed. On 02/20/2019 at approximately 5:30 p.m., ASM #1 (administrator) and ASM #2 (director of nursing) were made aware of findings. No further information was presented prior to exit. Label/Store Drugs and Biologicals		F 761	a. Med cart was secured immediately when noted unlocked and meds on top of cart were secured. DON conducted a 1-1 in-service with nurse that made med storage error on 2/21/19. b. No resident was effected with this error. All nurses were checked for competency with med pass observations for appropriate med storage practices. The nurse making error was in-serviced on med storage and had a med pass competency done with her. c. SDC provided education on medication storage and competency with meds passes with all licensed nursing staff that was completed on 3/1/19. d. SDC will audit 2 nurses per unit on medication storage with medication pass observations for total of 4 nurses per week for 3 months. All findings will be			
PORT DESIGNATION AND ADMINISTRATION ADMINISTRATION AND ADMINISTRATION ADMINISTRATION AND ADMINISTRATION ADMINISTRATION AND ADMINISTRATION AND ADMINISTRATION AND ADMINISTRATION ADMINISTRATION ADMINISTRATION AND ADMINISTRATION AND ADMINISTRATION AND ADMINISTRATION AND ADMINISTRATION ADMINISTRATION ADMINISTRATION AND ADMINISTRATION ADMINISTRATION AND ADMIN				for any follow up that is needed. e. DOC 3-15-19	Tange		

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		AND HUM SERVICES			FORM	: 02/28/2019 APPROVED
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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
FARMVII	LLE 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 761	the Comprehensive Control Act of 1976 abuse, except wher package drug distril quantity stored is m be readily detected. This REQUIREMEN by: Based on observat document review, it facility staff failed to and secure manner carts, the team four 1. LPN (Licensed properties that the team four medication cart. LPI #2 left a closed bott of the medication cart her line of sight betwoen the team four medication cart. LPN (Licensed properties of the medication cart. LPI #2 left a closed bott of the medication cart. LPN (Licensed properties of the team four medication cart. LPN (Licensed properties of the medication cart. LPN (Licensed properties of the medication cart. LPN (Licensed properties of the team four medication cart. LPN (Licensed proper	d drugs listed in Schedule II of Drug Abuse Prevention and and other drugs subject to the facility uses single unit bution systems in which the inimal and a missing dose can are in the facility uses single unit bution systems in which the inimal and a missing dose can are in the facility was determined that the store medications in a safe on one of four medication medication cart. Tractical nurse) #2 failed to lock eation cart (located in the hall) medication to a resident in a safe on the team four the team four the team four the facility in the failed to store medications in a safe on the team four the team four the team four the failed to store medications in a safe on the team four the facility in the failed to store medications in a safe on the team four the facility in the failed to store medications in a safe on the facility in the failed to store medications in a safe on the failed to store medications in a safe on the failed to store medications in a safe of the failed to store medications in a safe of the failed to store medications in a safe of the failed to store medications in a safe of the failed to store medications in a safe of the failed to store medications in a safe of the failed to store medications in a safe of the failed to store medications in a safe of the failed to store medications in a safe of the failed to store medications in a safe of the failed to store medication to a resident in the failed to store medications in a safe of the failed to store medications in a safe of the failed to store medications in a safe of the failed to store medications in a safe of the failed to store medications in a safe of the failed to store medications in a safe of the failed to store medications in a safe of the failed to store medications in a safe of the failed to store medications in a safe of the failed to store medications in a safe of the failed to store medications in a safe of the failed to store medications in a safe of the failed to store medications in a safe of the failed to store medic	F 76	61		

preparing medication at the team four medication cart, located in the hall outside a resident room. After preparing the medication, LPN #2 failed to lock the medication cart prior to entering the

Event ID: E6TN11

Facility ID: VA0080

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		AND HUN I SERVICES				FORM	: 02/28/2019 I APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495249	B. WING	3		02/	/21/2019
	PROVIDER OR SUPPLIER LE HEALTH & REHA	B CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	BE	(X5) COMPLETION DATE
F 761	medication cart while the resident in the rewas not in LPN #2's were observed near On 2/20/19 at 2:32 periodicted with LPN should be done befor cart and entering a stated, "Lock the casecure all medication direction that I am governet HIPAA (Heat Accountability Act) volume LPN #2 stated, "This precautions and precondered of the director of nursiabove concern. The facility pharmace and Expiration of Meson Syringes and Needle should ensure that a biologicals, including securely stored in a medication room the and visitors." No further information.	PN #2's back was facing the le administering medication to come and the medication cart in line of sight. No residents of the medication cart. P.m., an interview was a sked what core leaving the medication resident room. LPN #2 art, minimize the computer, and turn the cart in the coing and keep in eye sight to alth Insurance Portability and violation." When asked why, as should be done for safety evention of HIPAA violations." a.m., ASM (administrative me administrator) and ASM #2 ing) were made aware of the exp policy titled, "5.3 Storage edications, Biologicals, es" documented, "3.3 Facility	F	761			
		V (licensed practical purse)					

#2 left a closed bottle of Vitamin D3 tablets on top

	TMENT OF HEALTH	AND HUN SERVICES				FORM	: 02/28/2019 APPROVEI : 0938-039
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NAME OF	PROVIDER OR SUPPLIER	1111		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FARMVII	LLE HEALTH & REHA	B CENTER		ļ	575 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 PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761	Continued From pa	ge 74	F7	761		-	
	of the medication cart while the cart was out of her line of sight between rooms 125 through 127.						
	(licensed practical rentering a resident's of Vitamin D3 tablet #1 (team 4 medicat through 127. LPN # medication cart whi room. No residents	pproximately 8:33 a.m., LPN nurse) #2 was observed s room, leaving a closed bottle is (1) on top of medication cart ion cart) between rooms 125 2's back was to the le she was in the resident's walked past the medication ras in the resident's room.		en e			
	approximately 2:32 was asked what she medication cart to a LPN #2 stated that locked, and medica LPN #2 was asked should be locked ar #2 stated, "To prever Portability and Accoother residents from	pnducted on 02/20/2019 at p.m. with LPN #2. LPN #2 e should do before leaving the dminister resident medication. The medication cart should be tions should be put away. Why the medication cart and medications put away. LPN ent HIPPA (Health Insurance untability Act) violations and a getting to the medication."		PREPARATION AND AND AND AND AND AND AND AND AND AN			

was a mistake."

observation. LPN #2 stated, "I didn't mean to, it

A copy of the facility policy regarding medication storage was requested from ASM (administrative

staff member) #2 (director of nursing) at approximately 5:00 p.m. The Omnicare LTC Facility Pharmacy Services and Procedures Manual policy titled, "Storage and Expiration of Medications, Biologicals, Syringes and Needles"

documented, "Facility should store all medications and biologicals requiring special containers for stability in accordance with manufacturer/supplier specifications. Facility

DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

PRINTED: 02/28/2019 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
		495249	B. WING _			02/	21/2019
	PROVIDER OR SUPPLIER	B CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901				
(X4) ID PREFIX TAG	(EACH 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	(X5) COMPLETION DATE
	should ensure that is biological storage a contain non-medical. On 02/20/2019 at al. #1 (administrator) a nursing) were made. No further information. References (1) Vitamin D3 is sure absorb calcium. This from the website: https://medlineplusResident Records - CFR(s): 483.20(f)(5) Resident Records - CFR(s): 483.20(f)(5) Resident-identifiable (ii) The facility may resident-identifiable accordance with a cagrees not to use or except to the extent to do so. §483.70(i) Medical residentification standal.	resident medication and reas are locked and do not tion/biological items." oproximately 5:30 p.m., ASM and ASM #2 (director of eaware of findings. on was presented prior to exit. pplement that helps your body information was obtained gov/vitamind.html Identifiable Information, 483.70(i)(1)-(5) ent-identifiable information. release information that is to the public. release information that is to an agent only in contract under which the agent of disclose the information the facility itself is permitted records. Ordance with accepted reds and practices, the facility cal records on each resident mented; ole; and	F 76		a.Resident #21 interviewed by the It to indicate bathing preference on Resident #21 all about me, kardex a care plan updated to reflect his preferences with bathing was updat 2-22-19. b. A 100% audit of ADL records performed to see if the shower preference that is documented is the resident's true preference and that the care plan also reflects the resident preferences. This audit was completed on 3/8/19. c. SDC educated nursing staff on documentation of resident refusal of in ADL record and the nurses notes completed on 3/8/19. d. UM/ADON to conduct an audit woon ADL books for appropriate documentation of showers by interviewing 4 residents per unit a wand weekly times 3 months. To ensproper documentation. All findings be brought and reviewed monthly at QAPI. e. DOC 3-15-19	ed on he he eted f care veekly veek sure will	

(X2) MULTIPLE CONSTRUCTION

	TMENT OF HEALTH	AND HUM SERVICES & MEDICAID SERVICES			FORM	02/28/2019 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495249	B. WING		02/	21/2019	
	PROVIDER OR SUPPLIER	B CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 842	Continued From pa	ge 76	F 842				
	all information contaregardless of the forecords, except who (i) To the individual, representative when (ii) Required by Law (iii) For treatment, poperations, as permy with 45 CFR 164.50 (iv) For public health neglect, or domestic activities, judicial and law enforcement pupurposes, research medical examiners, a serious threat to help and in compliance §483.70(i)(3) The farecord information a unauthorized use.	or their resident e permitted by applicable law; ; ayment, or health care iitted by and in compliance					

provided;

(ii) Five years from the date of discharge when

(iii) For a minor, 3 years after a resident reaches

§483.70(i)(5) The medical record must contain-(i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services

(iv) The results of any preadmission screening

there is no requirement in State law; or

legal age under State law.

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		AND HUM SERVICES			F	NTED: 02/28/2019 ORM APPROVED NO. 0938-0391
STATEMENT OF DEFICIEN AND PLAN OF CORRECTI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	TIPLE CONSTRUCTION NG		3) DATE SURVEY COMPLETED
		495249	B. WING _			02/21/2019
NAME OF PROVIDER OF		B CENTER		STREET ADDRESS, CITY, ST 1575 SCOTT DRIVE ROU' FARMVILLE, VA 23901		
PREFIX (EACH	DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIAT ICIENCY)	
determina (v) Physic profession (vi) Labor services r This REQ by: Based or facility do review, it failed to r record for sample, F The facilit #21's refu The findin Resident if 9/4/2018 v diabetes, blood presepilepsy, p obesity, and Resident if set) was a (assessmall resident w for transfet for dressir as indepe	ent review ations contian's, nursian's progratory, radieports as UIREMEN resident rewas determaintain a one of 36 desident # y staff fails sal of showith the didependent sure, Encorpheral and left about 121's most quarterly ent references and toing, person and toing, person at 12:23 desident for a sal 12:23 desident for	revaluations and ducted by the State; se's, and other licensed ress notes; and fology and other diagnostic required under §483.50. The is not met as evidenced interview, staff interview, view and clinical record mined that the facility staff complete and accurate clinical residents in the survey 21. The determinant of the facility on agnoses of but not limited to the facility on agnoses of but not limited to the on renal dialysis, high distage Renal Disease, vascular disease, morbid ove knee amputation. It recent MDS (minimum data assessment with an ARD note date) of 12/5/2018. The as requiring total assistance let use, extensive assistance let use, extensive assistance and hygiene and bathing, and the eating. The provided received only one interview with an and received only one	F 84	42		

A review of the clinical record revealed a note

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	PROVIDER OR SUPPLIER L LE HEALTH & REHA I	B CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 842	dated 9/13/18, titled documented "Resid showerPreferred I AfternoonNumber is preferred: 3" Further review of the ADL (Activities of Da 2019 and February revealed Resident # daily, and 2 to 3 time. There was no docur A review of the nurse evidence of the resirefusal of showers. On 02/21/19 at 11:3 CNA (Certified nursing Resident #21's show #21 refuses shower asked what she does she stated she report on 02/21/19 at 11:4 LPN (Licensed Practitat he (Resident #2 does refuse at times refusals should be confided and February 2019 and February	"All About Me" which ent prefers a pathing time: of days of the week bathing electroid color of days of these electroid color of days. The color of a shower of the time. When the short of the time. When the short of the time. When the short of the shower o	F8	142				

refusing showers.

A review of the comprehensive care plan failed to reveal any documentation of Resident #21

DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	ELE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495249	B. WING		02/:	21/2019
	PROVIDER OR SUPPLIER LLE HEALTH & REH/			STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842		age 79 roximately 3:00 p.m., a policy	F 842			
F 880 SS=D	for accurate clinical written list of policic written list of policic policy was provided on 02/21/19 at 01: (Administrative State was notified of the No further informated according to "Functional Incredibly Easy" Lipphiladelphia PA, particularly and need to be accumentation is a nursing care. Patien and need to be accumentation propatient and family of possible. Many nur they document or frenormous effect or other members of the Infection Prevention CFR(s): 483.80(a)(§483.80 Infection CThe facility must estinfection prevention designed to provide comfortable environ	Il records was requested via a les submitted to the facility. No de. 18 p.m., ASM #1 off Member) the administrator, findings. Ition was presented prior to exit. Itamentals of Nursing Made opincott Williams and Wilkins, age 23: "Nursing highly significant issue since of the factor of the facto	F 880	a. The free standing fan was remove from the laundry room on 3-1-19. A assessment completed on resident #revealed no active signs or symptom infection. b. No residents affected by the fan is laundry room. 1-1 in-service complewith nurse on infection control practivity med pass on 2/21/19. Med pass observations with licensed nurses to ensure proper infection control practivity medication administration was completed on 3/1/19. c. SDC educated on infection control practices and completed competency with medication administration was completed on 3/1/19. d. SDC or Designee will audit 2 nur per unit on infection control practice with medication pass observations for total of 4 nurses per week for 3 monthly findings will be reviewed and but to QAPI monthly for any follow up needed. e. DOC 3-15-19	n 40 hs of heted tices stices hursing reses es for ought	

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		AND HUM SERVICES & MEDICAL SERVICES				FORM	: 02/28/2019 I APPROVED . 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495249	B. WING			02/	21/2019	
NAME OF	PROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, ZIP CODE			
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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 880	program. The facility must est and control program a minimum, the follows \$483.80(a)(1) A system reporting, investigat and communicable staff, volunteers, visproviding services us arrangement based conducted according accepted national staff system of survey possible communications before the persons in the facilit (ii) When and to who communicable disease reported; (iii) Standard and trate to be followed to president; including be (A) The type and dudepending upon the involved, and (B) A requirement the least restrictive possicircumstances. (v) The circumstances.	tablish an infection prevention in (IPCP) that must include, at owing elements: tem for preventing, identifying, ing, and controlling infections diseases for all residents, sitors, and other individuals upon the facility assessment g to §483.70(e) and following tandards; en standards, policies, and program, which must include, or eillance designed to identify able diseases or ey can spread to other y; om possible incidents of ase or infections should be used for a	F	380				
1	disease or infected s	skin lesions from direct		j		ì		

	TMENT OF HEALTH RS FOR MEDICARE	AND HUN SERVICES & MEDICATO SERVICES			FORM): 02/28/2019 1 APPROVED): 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495249	B. WING		02	/21/2019
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
FARMVII	LLE 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 PREFI) TAG		DULD BE	(X5) COMPLETION DATE
F 880	contact with resident contact will transmit (vi)The hand hygient by staff involved in contact will transmit (vi)The hand hygient by staff involved in contact will be staff in the staff in t	ats or their food, if direct the disease; and the procedures to be followed direct resident contact. Item for recording incidents facility's IPCP and the taken by the facility. Indie, store, process, and as to prevent the spread of the eview. Indie and annual review of its eir program, as necessary. IT is not met as evidenced on, and staff interview, it was facility staff failed to follow citices in the facility laundry 36 residents in the survey	F8	880		

The findings include:

storing clean linens.

clean laundry area free of dust when folding and

2. The facility staff failed to practice appropriate infection control for Resident # 40 during medication administration. LPN (licensed practical nurse) #2 was observed with her finger in Resident #40's medication cup after touching medication cart handles with unsanitized hands.

1. On 02/120/19 at 5:50 p.m., an observation of

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	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DAT	E SURVEY		
		495249	B. WING _		02/	21/2019		
NAME OF PRO	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		<u></u>		
FARMVILL	E HEALTH & REHAI	B CENTER	1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT 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)	LD BE	(X5) COMPLETION DATE		
th Control of the Con	DSM (other staff me nousekeeping. The facility's laundry nen room that contivasher, soiled linen another separate romen room was the contained two commor folding clean line aundry racks. Further folding clean line and towels, six pail ocks, ten clean and forty-two clean and forty-two clean are rependicular to the and contained three ncovered. Observatultiple blankets clean did folded towels, tanultiple clean socks further observation evealed a wall mountable for folding clean pproximately eighted by the proximately eighted by t	y room was conducted with ember) #2, director of y room consisted of a dirty tained commercial clothes as and soiled resident clothing. From adjacent to the soiled clean laundry area. The area mercial clothes dryers, table ens and clothing and clean ther observation of the table en revealed two clean folded irs of socks and 4 single and folded clothing protectors and folded cloth napkins. The in laundry area, was a table for folding clean linen, e shelves that were ration of the shelving revealed ean and folded multiple clean ablecloths and a box of	F 88	30				

blades stopped rotating OSM # 2, was asked to describe the condition of the fan blades and the front figure guard of the fan. OSM # 2 stated that it needed to be cleaned. Observation of the fan blades and the front figure guard of the fan revealed the parts were coated with grey dust and lint. OSM # 2 when informed of the observation,

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PRINTED: 02/28/2019 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY MPLETED
,		495249	B. WING		02/21/2019	
NAME OF PROVIDER OR SUPPLIER FARMVILLE HEALTH & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 880	stated yes. When a cleaned OSM # 2 s every two weeks. I often." OSM # 2 w fan parts and sendi On 02/21/19 at 2:40 (administrative staff ASM # 2, director of the findings. No further informati 2. The facility staff infection control for medication administ practical nurse) #2 in Resident #40's m medication cart har Resident #40 was a 04/04/2018. Diagno but were not limited Anxiety Disorder an #40's Minimum Dat with an Assessmen 12/18/2018 coded I cognitive impairmed Data Set (MDS) coextensive assistance activities of daily livicating. On 02/20/2019 at a (licensed practical resident of the company o	asked how often the fan was tated, "I clean about once should probably do it more as then observed removing the ng them to be cleaned. D. p.m., ASM # 1 f member), administrator, and f nursing, were made aware of the constant of the const	F 88	30		

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		AND HUN SERVICES					APPRO	DVED
CENTERS FOR MEDICARE & MEDICATO SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-039 ⁻ (X3) DATE SURVEY COMPLETED			
495249			B. WING	i		02/21/2019		
NAME OF I	PROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE	, ,,,,,,,	_ 1, _ 0 1	
FARMVII	LE HEALTH & REHA	B CENTER			575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5 COMPLE DAT	ÉTION
F 880	Continued From pa	ge 84 lication for Resident #40, LPN	F	380			120-1111000	
	#2 was observed with medication cup while LPN #2, was also be medication cart hands, prior to her fresident's medication on 02/20/2019 at all	ith her finger in Resident #40's le two pills were in the cup. een observed touching the idles and not sanitizing her inger being observed in the on cup.						
	her medication adm LPN #2 was asked control when admin stated that she was and uses universal #2 stated that she u times then washes contact with anythin	ucted with LPN #2 regarding inistration to Resident #40. how she maintains infection istering medications. LPN #2 hes her hands, wears gloves precautions at all times. LPN ses hand sanitizer one or two her hands, if she comes in g. LPN #2 was asked why						
	infection control is in required to prevent germs. LPN #2 was inside of the resider stated, "At no time f pill cup because it c	mportant. LPN #2 stated that mportant because it is contamination and spreading asked if her finger should be at's medication cup. LPN #2 inger be inside the resident's an cause contamination."						
	administration was a (administrative staff nursing) on 02/20/20/20 LTC Facility Pharma Manual policy titled, and Medication Admiration to preparing authorized and com	policy regarding medication requested from ASM member) #2 (director of 019 at 5 p.m. The Omnicare acy Services and Procedures "General Dose Preparation ninistration", documented or administering medications, petent facility staff should tion control policy (e.g.,				VDH/OLC	NA 12 2000	RECEIVED

	MENT OF HEALTH	AND HUN SERVICES				RINTED: FORM MB NO.	APPRO	VED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
*****		495249	B. WING			02/	21/2019	
NAME OF F	PROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE			
FARMVIL	LE HEALTH & REHA	B CENTER			ARMVILLE, VA 23901			
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F 880	#1 (administrator) a nursing) were made No further information. References: (1) Atenolol is used other medications to This information was https://medlineplus.tml (2) Vitamin D3 is su	pproximately 5:30 p.m., ASM and ASM #2 (director of e aware of findings.) on was presented prior to exit. alone or in combination with the treat high blood pressure. It is obtained from the website: gov/druginfo/meds/a684031.h	F	880				
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