STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	A. BUILDING _____ B. WING _____	02/21/2019

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FARMVILLE HEALTH & REHAB CENTER	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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted on 2/21/19. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000	Preparation and submission of this Plan of Correction does not constitute an admission of or agreement with, it is required by State and Federal law. It is executed and implemented as a means to continuously improve the quality of care to comply with state and federal requirements.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 02/19/19 through 02/21/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 120 certified bed facility was 103 at the time of the survey. The survey sample consisted of 36 resident reviews.	F 000	F550 a. Resident #94 and all other residents in the dining room are served per the policy. b. All current residents have the potential to be affected by the deficient practice. 1:1 education given to staff member regarding dining process on 3-1-19.	
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal	F 550	c. ADON and or designee will educate the nursing staff on proper dining room services by 3-8-19. d. Nursing manager will conduct audits of the dining room area to ensure that all residents in dining room are receiving appropriate dining services. Audit will be conducted 5 times per week for 4 weeks then 3 times per week for 4 weeks then weekly thereafter for a total of 3 months. All findings will be reviewed and brought to QAPI monthly for any follow up that is needed. e. DOC 3-15-19	

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LHHA | 3-9-19

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

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F 550	Continued From page 1 access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and 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 subpart. This REQUIREMENT is not met as evidenced by: 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 minutes later. The findings include:	F 550		

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F 550	Continued From page 2 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 1/31/19, 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 r/t (related to) impaired mobility...EATING: 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 2/21/19 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, "My biggest thing would be to make sure everybody at 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 #1 was made aware of this	F 550		

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F 550	Continued From page 3 surveyor's observation on 2/19/19 when Resident #94 was not served and assisted with eating until nine minutes after she (CNA #1) began feeding another resident at the same table. CNA #1 stated, "I was wondering why. We was told we have to serve everyone at the same table. I feel if I was feeding (name of the other resident) then someone should have been feeding (name of Resident #94) as well." On 2/21/19 at 11:31 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "DINING ROOM ENVIRONMENT" documented, "9. Tables shall be served in a manner so that all residents seated at a table receive meals at the same time." No further information was presented prior to exit.	F 550	F580 a. Notified MD and RP of the missed medications of Aldactone, Potassium, and Klonopin for resident #73 on various dates in October 2018(10/14, 10/15, 10/23, and 10/24/18), January 2019 (1/7/19, 1/11/19), and February 2019 (2/13, 2/17, 2/18/19). There were no negative outcome to the resident. b. All current residents have the potential to be affected by the deficient practice. A 100% audit was conducted of all residents for missed meds or unavailable meds documentation. An audit of all 4 med carts and orders to ensure all medication availability was completed on 2/22/19 by ADON, Unit Managers and Staff Development Coordinator.	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);	F 580	c. SDC to educate nurses on stat box contents, notification of the MD for an alternate treatment if the med is not available, RP notification, and documentation will be completed by 3-8-19.	

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F 580	Continued From page 4 (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to notify the physician of a	F 580	d. ADON/UM will perform a med cart to MAR audit weekly on 10 residents per unit for a total of 20 residents per week for 4 weeks, then Q month for 8 weeks for total of 3 months. UM/ADON will check cart 5 days/week for new MD orders to ensure delivery of medications for total of 3 months. All findings will be reviewed and brought to QAPI monthly for any follow up that is needed. e. DOC 3-15-19	

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F 580	Continued From page 5 possible need to alter treatment for one of 36 residents in the survey sample, Resident #73. The facility staff failed to notify Resident #73's physician when the medications aldactone (1), potassium (2) and klonopin (3) were not administered to the resident on various dates in October 2018, January 2019 and February 2019. The findings include: 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 reference date) of 1/17/19, coded the resident's cognitive skills for daily decision making as moderately impaired. Section G coded Resident #73 as requiring extensive assistance of one staff with dressing, toileting and personal hygiene. Resident #73's comprehensive care plan dated 1/18/18 and 1/25/19 documented, "I HAVE AN ALTERATION IN MY BEHAVIOR AEB (as evidenced by): PACING THE HALLWAY AND FOLLOWING A NURSE AND STAFF THROUGHOUT THE BUILDING...ADMINISTER MY MEDICATIONS AS ORDERED...The resident has dehydration or potential fluid deficit r/t (related to) Diuretic use...Administer medications as ordered..." Review of Resident #73's clinical record revealed a physician's order with a start date of 2/2/17 for aldactone 25 mg (milligrams) by mouth one time a day. Review of Resident #73's October 2018 MAR (medication administration record) revealed the resident was not administered aldactone on	F 580		

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F 580	Continued From page 6	F 580		

10/14/18, 10/15/18, 10/23/18 and 10/24/18. A nurse's note dated 10/14/18 documented the medication was not available. A nurse's note dated 10/15/18 documented the pharmacy was notified. A nurse's note dated 10/23/18 documented the medication was on order. A nurse's note dated 10/24/18 documented the medication was on order. There was no further documentation that aldactone 25 mg was eventually administered on the above dates or that Resident #73's physician was notified.

Review of Resident #73's clinical record revealed a physician's order with a start date of 11/8/16 for potassium 40 mEQ (milliequivalents) by mouth one time a day. Review of Resident #73's October 2018 MAR (medication administration record) revealed the resident was not administered potassium 40 mEQ on 10/14/18 and 10/15/18. A nurse's note dated 10/14/18 documented the medication was not available. A nurse's note dated 10/15/18 documented the pharmacy was notified. Review of Resident #73's January 2019 MAR revealed the resident was not administered potassium 40 mEQ on 1/11/19. A nurse's note dated 1/11/19 documented the potassium was on order from the pharmacy. There was no further documentation that potassium 40 mEQ was eventually administered on the above dates or that Resident #73's physician was notified.

Further review of Resident #73's clinical record revealed a physician's order with a start date of 11/1/16 for klonopin 0.5 mg (milligrams) two times a day. Review of Resident #73's January 2019 MAR revealed the resident was not administered the 9:00 a.m. dose of klonopin 0.5 mg on 1/7/19. A nurse's note dated 1/7/19 documented the

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F 580	Continued From page 7 pharmacy was to deliver the medication. Review of Resident #73's February 2019 MAR revealed klonopin 0.5 mg was not administered to the resident on 2/13/19 at 5:00 p.m., 2/17/19 at 9:00 a.m., 2/17/19 at 5:00 p.m. and 2/18/19 at 9:00 a.m. A nurse's note dated 2/13/19 documented, "Rx (Prescription) called pharmacy..." A nurse's note dated 2/17/19 documented, "Waiting for medication from pharmacy..." Another nurse's note dated 2/17/19 documented, "Waiting for medication from pharmacy..." A nurse's note dated 2/18/19 documented, "Awaiting on pharmacy..." There was no further documentation that klonopin 0.5 mg was eventually administered on the above dates or that Resident #73's physician was notified. On 2/21/19 at 7:45 a.m., an interview was conducted with LPN (licensed practical nurse) #5. 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 they have enough until they can get a hard prescription from the doctor. When asked about the process staff follows for routine medications that are not controlled substances, LPN #5 stated the medication packets document the next refill due date but sometimes pills hit the floor and have to be refilled before the next refill due date. When asked at what point medications should be refilled, LPN #5 stated, "If you know you are getting down, maybe six left, being nursing, you have to know and refill but if it's too early, the pharmacy will not refill and you have to communicate with the pharmacy." LPN #5 was	F 580		

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F 580	Continued From page 8	F 580		

asked what should be done if medications are due to be administered and are not in the medication cart. LPN #5 stated nurses should look for the medications, inform the nurse manager and contact the pharmacy. When asked if the physician should be notified if an ordered medication is not administered to a resident, LPN #5 stated, "Of course you notify the doctor. You don't want your resident to go without medicine at all. You have to have an order to hold the medication." When asked if the physician notification should be documented, LPN #5 stated it should.

Review of the facility emergency medication supply lists revealed aldactone was not in the facility emergency medication supply. The list revealed five doses of potassium 10 mEQ and three doses of klonopin 0.5 mg were available in the supply for administration.

On 2/21/19 at 11:31 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility pharmacy policy titled, "7.0 Medication Shortages/Unavailable Medications" documented, "1. Upon discovery that facility has an inadequate supply of a medication to administer to a resident, facility staff should immediately initiate action to obtain the medication from the pharmacy...2. If a medication shortage is discovered during normal 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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F 580	Continued From page 9 dose in the resident's medication schedule, facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose. 2.3 If the medication is not available in the Emergency Medication Supply, facility staff should notify pharmacy and arrange for an emergency delivery...4. If an emergency delivery is unavailable, facility nurse should contact the attending physician to obtain orders or directions..." No further information was presented prior to exit. (1) Aldactone is used to treat low potassium levels, heart failure and fluid retention. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682627.html (2) "Potassium is a mineral that your body needs to work properly. It is a type of electrolyte. It helps your nerves to function and muscles to contract. It helps your heartbeat stay regular. It also helps move nutrients into cells and waste products out of cells." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=potassium&_ga=2.93431001.578943081.1551101203-1667741437.1550160688 (3) Klonopin is used to treat seizures and panic attacks. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682279.html	F 580		
F 640	Encoding/Transmitting Resident Assessments	F 640	F640 a. Resident #1 Death in Facility MDS was transmitted on 2-26-19. Resident #2 discharge assessment from the facility was scheduled and completed on 2-25-19 and transmitted on 2-25-19. b. All current residents have the potential to be affected by the deficient practice. Completed 100% audit on transmissions and completions of MDS for all residents looking back one quarter. c. Regional MDS educated the MDSC and the PRN MDS on transmissions and completion of all MDS on 3-1-19 d. Compare Submissions report to the MDS calendar to ensure all completed MDS are	

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F 640 SS=D	Continued From page 10 CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review.	F 640	submitted weekly times 3 months. All findings will be reviewed and brought to QAPI monthly for any follow up that is needed. e. DOC 3-15-19	

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F 640	Continued From page 11 (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure the timely transmission of resident assessments for two of 36 residents in the survey sample, Residents #1 and #2. 1. The facility staff completed, but failed to submit, a Death in Facility Assessment for Resident #1. 2. The facility staff failed to complete a Discharge assessment following the Resident's discharge from the facility for Resident #2. The Findings Included: 1. The facility staff completed, but failed to submit, a Death in Facility Assessment for Resident #1. Resident #1 was admitted to the facility on 06/27/2018. Their diagnoses that included, but are not limited to Hypertension (high blood pressure), Hyperlipidemia (high levels of fat in the blood), Heart Disease, and Chronic Kidney Disease Stage 4(1). Resident #1's most recent	F 640		

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	495249	A. BUILDING _____ B. WING _____	02/21/2019

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F 640	Continued From page 12 Minimum Data Set (MDS) Assessment was a 30 Day Reassessment with an Assessment Reference Date (ARD) of 07/27/2019. The Brief Interview for Mental Status (BIMS) coded Resident #1 at 14, indicating little to no impairment. Resident #1 was coded as requiring moderate assistance of 1 person for dressing, toileting, and hygiene, standby assistance of 1 person for bed mobility and transfers, and setup assistance for eating. Resident #1 was coded as independent in all other Activities of Daily Life (ADLs). A review of Resident #1's record was conducted on the morning of 02/21/2019 following the record triggering an alert for the last MDS Assessment being greater than 120 days old. A review of Resident #1's MDS Assessments in the Facility's Electronic Health Record (EHR) revealed that Resident #1 died at the facility, triggering a Death in Facility MDS Assessment to be completed. However, the facility's EHR (electronic health record) indicated that Resident #1's Death in Facility Assessment was completed, but never submitted for approval. The Facility Administrator (administrative staff member) #1 and ASM #2, the Director of Nursing were informed of the concerns regarding Resident #1's Death in Facility Assessment on the morning of 02/21/2019. They were asked to provide any additional information regarding the submission of the MDS Assessment. On the afternoon of 02/21/2019, ASM #2, the Director of Nursing informed this surveyor that the facility staff had confirmed that Resident #1's Death in Facility Assessment had not been submitted and they had proceeded to submit it	F 640		

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	495249	A. BUILDING _____ B. WING _____	02/21/2019

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F 640	Continued From page 13 immediately upon discovering this. No further documentation was provided. 2. The facility staff failed to complete a Discharge assessment following the Resident's discharge from the facility for Resident #2. Resident #2 was admitted to the facility on 06/13/2018. Their diagnoses included but were not limited to Hypertension (high blood pressure), Pneumonia, and Depression. Resident #2's most recent Minimum Data Set (MDS) Assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of 09/20/2018. The Brief Interview for Mental Status (BIMS) coded Resident #2 as scoring 12, indicating mild impairment. Resident #2 was coded as requiring extensive assistance of 2 or more people for transfers; extensive assistance of 1 person for ambulation, dressing, toileting, and hygiene; and as requiring setup assistance for eating. A review of Resident #2's record was conducted on the morning of 02/21/2019 following the record triggering an alert for the last MDS Assessment being greater than 120 days old. A review of Resident #2's Progress Notes in the Facility's Electronic Health Record (EHR) revealed that Resident #2 was sent to the hospital on 10/05/2018, and did not return to the facility. However, a review of the MDS Assessments revealed that the most recent MDS Assessment completed for Resident #2 was a Quarterly Assessment dated 09/20/2018. The Facility Administrator, ASM (administrative staff member) #1 and ASM #2, Director of	F 640		

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F 640	Continued From page 14 Nursing were informed of the concerns regarding Resident #2's lack of a Discharge Assessment on the morning of 02/21/2019. They were asked to provide any additional information regarding the submission of the MDS Assessment. On the afternoon of 02/21/2019, ASM #2, the Director of Nursing informed this surveyor that facility staff had been unable to evidence documentation of Resident #2's Discharge Assessment having been completed. No further documentation was provided. 1. Chronic kidney disease is the slow loss of kidney function over time. The main job of the kidneys is to remove wastes and excess water from the body. Chronic kidney disease (CKD) slowly gets worse over months or years. You may not notice any symptoms for some time. The loss of function may be so slow that you do not have symptoms until your kidneys have almost stopped working. The final stage of CKD is called end-stage renal disease (ESRD). At this stage, the kidneys are no longer able to remove enough wastes and excess fluids from the body. At this point, you would need dialysis or a kidney transplant. - https://medlineplus.gov/ency/article/000471.htm	F 640	F641 a. New Dental assessment was completed on #72 by ADON. The next scheduled MDS for resident #72 will have section L corrected with new dental assessment that was conducted. b. All current residents have the potential to be affected by the deficient practice. A 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 to ensure all dental assessments are accurately reflected on the upcoming MDS was completed 3-8-19. c. The MDSC was educated on completing section L of the MDS based on the RAI manual for accuracy of the assessment by the Regional MDS was completed on 3-1-19. During the Pain interviews done by MDSC, the nurses oral assessment will be clarified at this time and documented in the pain note.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced	F 641	d. The L section of the MDS will be audited by the MDSC weekly for the next 3 months to ensure section L of the MDS is completed accurately. All findings will be reviewed and brought to QAPI monthly for any follow up that is needed. e. DOC 3-15-19	

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F 641	Continued From page 15 by: Based on resident interview, staff interview and clinical record review, it was determined that the facility staff failed to maintain an accurate MDS (minimum data set) assessment for one of 36 residents in the survey sample, Resident #72 The facility staff failed to accurately code section L0200 (Oral/Dental Status) of Resident #72's 5-Day Medicare MDS with an ARD (assessment reference date) of 01/07/2019. The findings include: Resident #72 was admitted to the facility on 07/12/2018. Diagnoses for Resident #72 included but were not limited to High Blood Pressure, Muscle Weakness and Anxiety Disorder. Resident #72's Minimum Data Set (5 -day Medicare Assessment) with an Assessment Reference Date of 01/07/2019 coded Resident #72 with no cognitive impairment. In addition, the Minimum Data Set (MDS) coded Resident #72 extensive assistance of one staff member with activities of daily living and independent with eating. Resident #72's clinical record was reviewed. Resident #72's MDS with an Assessment Reference Date of 01/07/2019, in Section L, L0200. Oral/Dental Status Box Z. coded Resident #72 with no issues with oral/dental status. 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.	F 641		

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	495249	A. BUILDING _____ B. WING _____	02/21/2019

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F 641	Continued From page 16 Resident #72's clinical record 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 dietary 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 Coordinators have been instructed to care plan residents for dental services if residents do not have 100% perfect teeth. An interview was conducted with ASM #2 (director of nursing) on 02/21/2019 at approximately 11:28 a.m. regarding MDS assessments. ASM #2 (director of nursing) stated that the resident must be assessed by a licensed nurse and you should not just go off documentation in the chart. The CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) manual used to code MDS assessments documented,	F 641		

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F 641	Continued From page 17 L0200: Dental (cont.) Steps for Assessment 1. Ask the resident about the presence of chewing problems or mouth or facial pain/discomfort. 2. Ask the resident, family, or significant other whether the resident has or recently had dentures or partials. (If resident or family/significant other reports that the resident recently had dentures or partials, but they do not have them at the facility, ask for a reason.) 3. If the resident has dentures or partials, examine for loose fit. Ask him or her to remove, and examine for chips, cracks, and cleanliness. Removal of dentures and/or partials is necessary for adequate assessment. 4. Conduct exam of the resident's lips and oral cavity with dentures or partials removed, if 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	F 641		

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F 641	Continued From page 18 missed. Referral for dental evaluation should be considered for these residents and any resident who exhibits dental or oral issues. Coding Instructions · Check L0200A, broken or loosely fitting full or partial denture: if the denture or partial is chipped, cracked, uncleanable, or loose. A denture is coded as loose if the resident complains that it is loose, the denture visibly moves when the resident opens his or her mouth, or the denture moves when the resident tries to talk. · Check L0200B, no natural teeth or tooth fragment(s) (edentulous): if the resident is edentulous/lacks all natural teeth or parts of teeth. · Check L0200C, abnormal mouth tissue (ulcers, masses, oral lesions): select if any ulcer, mass, or oral lesion is noted on any oral surface. · Check L0200D, obvious or likely cavity or broken natural teeth: if any cavity or broken tooth is seen. · Check L0200E, inflamed or bleeding gums or loose natural teeth: if gums appear irritated, red, swollen, or bleeding. Teeth are coded as loose if they readily move when light pressure is applied with a fingertip. · Check L0200F, mouth or facial pain or discomfort with chewing: if the resident reports any pain in the mouth or face, or discomfort with chewing. · Check L0200G, unable to examine: if the resident's mouth cannot be examined.	F 641		

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F 641	Continued From page 19 · Check L0200Z, none of the above: if none of conditions A through F is present. On 02/21/2019 at approximately 11:35 a.m., ASM #1 (administrator) and ASM #2 (director of nursing) were made aware of findings. No further information was presented prior to exit.	F 641		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires	F 645	F645 a. Resident #32 and #38 PASARR level 1 was completed on 2/22/19. b. All current residents' charts were audited to ensure that all required PASARR level 1 was completed 2/22/19 by Social Services Director. c. Administrator educated the Admissions Director on ensuring that a PASARR 1 are completed before the resident is admitted to the 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 before potential residents are admitted to the facility are in the admission documentation weekly time 3 months. All findings will be reviewed and brought to QAPI monthly for any follow up that is needed. e. DOC 3-15-19	

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F 645	Continued From page 20 the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as	F 645		

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F 645	Continued From page 21 described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure a PASRR (Preadmission Screening and Resident Review) was complete for 2 of 36 residents in the survey sample, Residents #32 and #38. 1. The facility staff failed to ensure Resident #32's level one PASRR was completed to ensure the resident was evaluated and receiving care and services in the most integrated setting appropriate for the resident's needs. 2. The facility staff failed to ensure Resident #38's level one PASRR was completed to ensure the resident was evaluated and receiving care and services in the most integrated setting appropriate for the resident's needs. The findings include: 1. The facility staff failed to ensure Resident #32's level one PASRR was completed to ensure the resident was evaluated and receiving care and services in the most integrated setting appropriate for the resident's needs. Resident #32 was admitted on 4/25/18 with the diagnoses of but not limited to schizoaffective 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	F 645		

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F 645	Continued From page 22 life decisions. The resident was coded as receiving an antipsychotic medication and an antidepressant medication. The resident was coded as requiring total care for toileting, hygiene and dressing, extensive care for bathing and transfers, and as independent for eating. A review of the clinical record failed to reveal any evidence of a PASRR Level 1 screening. Further review revealed a note dated 12/18/18, which documented, "Resident's clinical information sent to (name of psychiatric service) requesting consult for evaluation and medication review. This is in effort to proceed with obtaining a level II PASRR." On 2/20/19 at 3:34 p.m., an interview was conducted with OSM #1 (Other Staff Member) the Social Services Director. OSM #1 was asked about the missing level 1 PASRR for Resident #32. OSM #1 stated, "We don't have the PASRR's. We identified it (PASRRs not completed), and did a QAPI (Quality Assurance and Performance Improvement) plan. In January (2019) I did an audit for (corporation) and identified that there were deficiencies with level 1 and level 2 PASRR's. There is a lengthy list of them (residents without completion of PASRR), that we don't have that I have been working on. The residents should have not have been admitted without them." When asked shown the above documented note regarding pursuing a Level 2 screening, and asked how the facility would know that a Level 2 needs to be done, when a Level 1 hasn't been completed, OSM #1 stated that a Level 1 needs to be done first but has not been.	F 645		

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F 645	Continued From page 23	F 645		

The QAPI plan was reviewed. The plan was dated 1/2/19. The AOC (Allegation of Compliance) date was not set until 4/31/19. Therefore, this concern was not PNC (past non-compliance). The deficiency for this resident as of this survey date (2/21/19) had not yet been corrected.

On 2/21/19 at 1:36 p.m., in a follow up interview with OSM #1, when asked about the purpose of the PASRR, OSM #1 stated it was "to make sure the placement of the resident in the facility was appropriate and to identify if the resident has any mental health needs and requires a Level 2 screening." OSM #1 stated that a Level 2 screening "makes recommendations for any additional services that the resident might need based on diagnoses." OSM #1 stated that "If a level 1 is not done, the resident should not be admitted, but that we miss the mental health piece a resident might need."

A review of the facility document, "Virginia PASRR An introduction to Virginia's Preadmission Screening and Resident Review Process" documented, "PASRR requires that anyone 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 receive needed services."

On 2/21/19 at 1:18 p.m., the ASM #1 (Administrative Staff Member) the Administrator, was made aware of the findings. No further

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F 645	Continued From page 24 information was provided. 2. The facility staff failed to ensure Resident #38's level one PASRR was completed to ensure the resident was evaluated and receiving care and services in the most integrated setting appropriate for the resident's needs. Resident #38 was admitted on 3/22/16 with the diagnoses of but not limited to high blood pressure, end stage renal disease, depression, asthma, psychosis, diabetes, and convulsions. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) with an ARD (Assessment Reference Date) of 12/15/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident was coded as receiving an antidepressant medication. The resident was coded as requiring total care for toileting, hygiene and dressing, extensive care for bathing and transfers, and as independent for eating. A review of the clinical record failed to reveal any evidence of a PASRR Level 1 screening. Further review revealed a note dated 12/19/18, which documented, "Resident's clinical information sent to (name of psychiatric service) requesting consult for evaluation and medication review. This is in effort to proceed with obtaining a level II PASRR." On 2/20/19 at 3:34 p.m., an interview was conducted with OSM #1 (Other Staff Member) the	F 645		

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	495249	A. BUILDING _____ B. WING _____	02/21/2019

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F 645	Continued From page 25	F 645		

Social Services Director. OSM #1 was asked about the missing level 1 PASRR for Resident #32. OSM #1 stated, "We don't have the PASRR's. We identified it (PASRRs not completed), and did a QAPI (Quality Assurance and Performance Improvement) plan. In January (2019) I did an audit for (corporation) and identified that there were deficiencies with level 1 and level 2 PASRR's. There is a lengthy list of them (residents without completion of PASRR), that we don't have that I have been working on. The residents should have not have been admitted without them." When asked shown the above documented note regarding pursuing a Level 2 screening, and asked how the facility would know that a Level 2 needs to be done, when a Level 1 hasn't been completed, OSM #1 stated that a Level 1 needs to be done first but has not been.

The QAPI plan was reviewed. The plan was dated 1/2/19. The AOC (Allegation of Compliance) date was not set until 4/31/19. Therefore, this concern was not PNC (past non-compliance). The deficiency for this resident as of this survey date (2/21/19), had not yet been corrected.

On 2/21/19 at 1:36 p.m., in a follow up interview with OSM #1, when asked about the purpose of the PASRR, OSM #1 stated it was "to make sure the placement of the resident in the facility was appropriate and to identify if the resident has any mental health needs and requires a Level 2 screening." OSM #1 stated that a Level 2 screening "makes recommendations for any additional services that the resident might need based on diagnoses." OSM #1 stated that "If a level 1 is not done, the resident should not be

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	495249	A. BUILDING _____ B. WING _____	02/21/2019

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F 645	Continued From page 26 admitted, but that we miss the mental health piece a resident might need." On 2/21/19 at 1:18 p.m., the ASM #1 (Administrative Staff Member) the Administrator, was made aware of the findings. No further information was provided.	F 645	F656 a. Resident #44's Care plan was updated for respiratory treatment. Resident #73's Care Plan was updated for medication. Resident #72's Care Plan was updated for correct dental assessment. b. A 100% audit was completed of dental and medication care plans to ensure dental care plans are complete and updated meds and treatments was completed on 3- 100% oral sweep of all residents to make sure all dental care plans are accurately reflected of the resident's actual dental status. Care plans will be reviewed and updated as needed during the AM clinical meeting, weekly clinical review, and PRN. DON educated the IDT team on 2/25/19. c. DON or Designee will audit 5 care plans from each unit every week for 3 months to ensure accuracy and that all condition changes are adequately care planned. All findings will be reviewed and brought to QAPI monthly for any follow up that is needed. d. DOC 3-15-19	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-	F 656		

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	495249	A. BUILDING _____ B. WING _____	02/21/2019

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F 656	Continued From page 27 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, family interview, staff interview, and clinical record review, facility staff failed to develop and implement a comprehensive care plan for three of 36 residents, Residents #44, #73, and #72. 1. The facility staff failed to implement the comprehensive care plan for the provision of tracheostomy care to Resident #44, on multiple date in January 2019. 2. The facility staff failed to implement Resident #73's care plan for medication administration. 3. The facility staff failed to develop and implement a comprehensive person-centered care plan to address Resident #72's dental status of decay, missing, and broken teeth. The findings include: 1. The facility staff failed to implement the comprehensive care plan for the provision of tracheostomy care to Resident #44, on multiple date in January 2019.	F 656		

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F 656	Continued From page 28	F 656		

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 (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 as 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 cannula #8XL 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 INADEQUATE OXYGENATION R/T (related to) REQUIRES TRACH FOR BREATHING" Under "Interventions": "TRACH CARE AS ORDERED/FOLLOW-UP WITH ENT (Ear Nose

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	495249	A. BUILDING _____ B. WING _____	02/21/2019

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F 656	Continued From page 29 Throat)/MD (Medical Doctor) AS INDICATED/AS ORDERED." A review of Resident #44's Treatment Administration Record (TAR) revealed, there were multiple dates in January 2019, where the order for trach care was not signed off as completed on one or more of the 3 shifts each day. These dates were: 01/01/19, 01/06/19, 01/08/19, 01/13/19, 01/18/19, 01/21/19, 01/23/19, 01/26/19 and 01/28/19. The Administrator, ASM (administrative staff member) #1 and Director of Nursing, ASM #2, were informed of concerns regarding Resident #44's tracheotomy care during the end of day meeting on 02/20/2019. They were asked to provide the survey team with any documentation regarding Resident #44's care on the dates in question that might explain the gaps in the TAR. On 02/21/2019 at approximately 2:00p.m., a brief interview was conducted with Licensed Practical Nurse (LPN) #4. LPN #4 was asked what a blank spot in a resident's TAR might mean. LPN #4 replied, "If there's a blank on the record that usually means it wasn't done." At the end of day meeting on 02/21/2019, ASM #2, the Director of Nursing informed this surveyor that no additional documentation regarding the blank spots in Resident #44's TAR could be found. No further documentation was provided. 2. The facility staff failed to implement Resident #73's care plan for medication administration.	F 656		

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	495249	A. BUILDING _____ B. WING _____	02/21/2019

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F 656	Continued From page 30 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 reference date) of 1/17/19, coded the resident's cognitive skills for daily decision making as moderately impaired. Section G coded Resident #73 as requiring extensive assistance of one staff with dressing, toileting and personal hygiene. Resident #73's comprehensive care plan dated 1/18/18 documented, "I HAVE AN ALTERATION IN MY BEHAVIOR AEB (as evidenced by): PACING THE HALLWAY AND FOLLOWING A NURSE AND STAFF THROUGHOUT THE BUILDING...ADMINISTER MY MEDICATIONS AS ORDERED..." Further review of Resident #73's clinical record revealed a physician's order with a start date of 11/1/16 for klonopin (1) 0.5 mg (milligrams) two times a day. Review of Resident #73's January 2019 MAR revealed the resident was not administered the 9:00 a.m. dose of klonopin 0.5 mg on 1/7/19. A nurse's note dated 1/7/19 documented the pharmacy was to deliver the medication. Review of Resident #73's February 2019 MAR revealed klonopin 0.5 mg was not administered to the resident on 2/13/19 at 5:00 p.m., 2/17/19 at 9:00 a.m., 2/17/19 at 5:00 p.m. and 2/18/19 at 9:00 a.m. A nurse's note dated 2/13/19 documented, "Rx (Prescription) called pharmacy..." A nurse's note dated 2/17/19 documented, "Waiting for medication from pharmacy..." Another nurse's note dated 2/17/19 documented, "Waiting for medication from pharmacy..." A nurse's note dated 2/18/19 documented, "Awaiting on pharmacy..." There	F 656		

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F 656	Continued From page 31 was no further documentation that klonopin 0.5 mg was eventually administered on the above dates. Review of the facility emergency medication supply lists revealed three doses of klonopin 0.5 mg were available in the supply for administration. On 2/21/19 at 7:45 a.m., an interview was conducted with LPN (licensed practical nurse) #5. 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 they have enough until they can get a hard prescription from the doctor. When asked at what point medications should be refilled, LPN #5 stated, "If you know you are getting down, maybe six left, being nursing, you have to know and refill but if it's too early, the pharmacy will not refill and you have to communicate with the pharmacy." LPN #5 was asked what should be done if medications are due to be administered and are not in the medication cart. LPN #5 stated nurses should look for the medications, inform the nurse manager and contact the pharmacy. On 2/21/19 at 9:15 a.m., another interview was conducted with LPN #5. LPN #5 confirmed the facility did have an emergency medication supply that could be accessed to obtain various medications if they were not available in the medication cart. Review of the facility emergency medication	F 656		

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F 656	Continued From page 32	F 656		

supply lists revealed aldactone was not in the facility emergency medication supply. The list revealed five doses of potassium 10 mEQ and three doses of klonopin 0.5 mg were available in the supply for administration.

On 2/21/19 at 10:35 a.m., an interview was conducted with LPN #4. LPN #4 was asked the purpose of the care plan. LPN #4 stated, "The purpose of the care plan is to set goals; realistic goals and getting them (residents) back to their normal function or retain whatever function they (residents') have." LPN #4 was asked how nurses ensure they implement residents' care plans in regards to medication administration. LPN #4 stated, "Administer the medications as ordered and make sure they are able to take them as ordered."

On 2/21/19 at 11:31 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility pharmacy policy titled, "7.0 Medication Shortages/Unavailable Medications" documented, "1. Upon discovery that facility has an inadequate supply of a medication to administer to a resident, facility staff should immediately initiate action to obtain the medication from the pharmacy...2. If a medication shortage is discovered during normal 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 dose in the resident's medication schedule, facility nurse should obtain the medication from

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	495249	A. BUILDING _____ B. WING _____	02/21/2019

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F 656	Continued From page 33 the Emergency Medication Supply to administer the dose..." No further information was presented prior to exit. (1) Klonopin is used to treat seizures and panic attacks. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682279.html 1. A minimally conscious state is severe but not complete impairment of awareness that results from widespread damage to the cerebrum (the part of the brain that controls thought and behavior). - https://www.merckmanuals.com/home/brain,-spinal-cord,-and-nerve-disorders/coma-and-impaired-consciousness/minimally-conscious-state?query=Vegetative%20State%20and%20Minimally%20Conscious%20State 3. The facility staff failed to develop and implement a comprehensive person-centered care plan to address Resident #72's dental status of decay, missing, and broken teeth. Resident #72 was admitted to the facility on 07/12/2018. Diagnoses for Resident #72 included but were not limited to High Blood Pressure, Muscle Weakness and Anxiety Disorder. Resident #72's Minimum Data Set (5 -day Medicare Assessment) with an Assessment Reference Date of 01/07/2019 coded Resident #72 with no cognitive impairment. In addition, the Minimum Data Set (MDS) coded Resident #72	F 656		

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	495249	A. BUILDING _____ B. WING _____	02/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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) 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 dietary 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 Coordinators have been instructed to care plan residents for dental services if residents do not have 100% perfect teeth. An interview was conducted with ASM #2 (director of nursing) on 02/21/2019 at	F 656		

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	495249	A. BUILDING _____ B. WING _____	02/21/2019

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F 656	Continued From page 35 approximately 11:28 a.m. regarding care plans and assessments. ASM #2 (director of nursing) stated that the resident must be assessed by a licensed nurse and you should not just go off documentation in the chart. ASM #3 (director of nursing) stated, "If the resident had been assessed and the MDS was coded correctly, that would've triggered the resident to have a dental care plan." On 02/21/2019 at approximately 11:35 a.m., ASM #1 (administrator) and ASM #2 (director of nursing) were made aware of findings. No further information was presented prior to exit.	F 656	F658 a. Resident #30's MD and RP were notified of the inappropriate dosage of Folic Acid that was given. New Order obtained from the MD for different dose of Folic Acid to be dispensed. RP was notified of the new order on 2-20-19. b. All current residents have the potential to be affected by the deficient practice. Med Observation was conducted with nurse that made the error with dispensing. 100% med cart to MAR audit was completed 2-22-19 to ensure the correct medications were available. c. DON completed 1-1 education with nurse on medication administration and following MD orders and professional standards on 2/21/19. SDC will educate nurses on medication administration and professional standards that was completed on 3/8/19. d. SDC or Designee will audit 2 nurses per unit on medication administration for total of 4 nurses per week for 3 months. All findings will be reviewed and brought to QAPI monthly for any follow up that is needed. e. DOC 3-15-19	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to follow professional standards of practice for one of 36 residents in the survey sample, Resident #30. The facility staff failed to clarify a physician's order for Resident #30's medication of folic acid (1). The findings include:			

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	495249	A. BUILDING _____ B. WING _____	02/21/2019

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

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F 658	Continued From page 36 Resident # 30 was admitted to the facility on 08/27/09 and a readmission on 12/21/10 with diagnoses that included but were not limited to: hemiplegia (2), anemia (3), chronic obstructive pulmonary disease (4), and hypertension (5). Resident # 30's most recent comprehensive MDS (minimum dada set), an annual assessment, with an ARD (assessment reference date) of 12/09/18, coded the resident as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 being cognitively intact for daily decision making. Resident # 30 was coded as requiring extensive assistance of one staff member for activities of daily living and as independent with eating. On 02/20 19 at 8:12 a.m., the medication administration observation conducted was conducted with LPN (licensed practical nurse) # 1. LPN # 1 was observed dispensing two folic acid tablets from the medication bubble pack for Resident # 30, into a small plastic medication cup. The bubble pack containing the folic acid documented, "Folic Acid 400 mcg (micrograms)." LPN # 1 entered Resident # 30's bedroom, informed Resident # 30 of her medication, handed the small plastic medication cup containing the folic acid to Resident # 30. Resident # 30 took the medication cup containing the folic acid, placed the tablets in her mouth and swallowed them with a small sip from a cup of water. The POS (physician's order sheet) dated February 2019 for Resident # 30 documented, "Folic Acid Tablet 1 (one) MG (milligram). Give 1 mg by mouth one time a day for supplement. Order Date: 12/21/2010."	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	A. BUILDING _____ B. WING _____	02/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 658	Continued From page 37 The comprehensive care plan for Resident # 30 dated 01/11/2017 failed to evidence interventions related to the administration of folic acid. 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 milligrams which is less than one milligram. After the administration of the medication, I notified the doctor by phone, I mentioned what I gave and asked if it was ok to modify the order and he stated it was ok. It should have modified or clarified, the order, before I gave the medication." When asked to describe the process she follows to eliminate a medication error, LPN # 1 stated, "I follow the five rights, check the order, the route, the patient, the correct dosage and the correct time. I also follow the three checks, check MAR (medication administration record), and compare the MAR with the medication label to make sure it reads the same thing and recheck the label at bed side right before administration." When asked why it was important to administer the correct medication and medication dose, LPN # 1 stated, "Medication is based on the resident's diagnoses and weight and other factors. If it is not administered according to the physician's orders there could adverse effects." When asked to describe the procedure staff follows when there is an error in medication administration, LPN # 1 stated, "I call the physician and responsible party and monitor resident for adverse reactions." 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	F 658		

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	495249	A. BUILDING _____ B. WING _____	02/21/2019

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

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F 658	Continued From page 38 Resident # 30. The order documented, "Folic Acid Tablet 400 MCG Give 2 (two) [sic] tablet by mouth one time a day for [sic] vitamine supplement OTC (over the counter) medication provided by facility." On 02/21/19 at approximately 2:30 p.m., ASM (administrative staff member) # 2, director of nursing provided this surveyor with following drug information: "(Name of Pharmacy the facility uses) Drug Information. Folic Acid. Folic acid is the man-made for of folate. Folate is a B-vitamin naturally found in some foods. It is needed to form health cells, especially red blood cells. They are used to treat low folate levels. Low folate level can lead to certain types of anemia" (low iron). On 02/21/19 at approximately 2:40 p.m., ASM (administrative staff member) # 2, director of nursing was asked what standard of practice the facility follows. ASM # 2 sated Lippincott. According to "Lippincott Manual of Nursing Practice", Eighth Edition: by Lippincott Williams & Wilkins, pg. 87 read: "Nursing Alert: Unusual dosages or unfamiliar drugs should always be confirmed with the health care provider and pharmacist before administration." On pg. 15, the following is documented in part, "Inappropriate Orders: 2. Although you cannot automatically follow an order you think is unsafe, you cannot just ignore a medical order, either. b. .. Call the attending physician, discuss your concerns with him, obtain appropriate ...orders. c. Notify all involved medical and nursing personnel.... d. Document clearly." On 02/20/19 at 6:00 p.m., ASM # 1	F 658		

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	495249	A. BUILDING _____ B. WING _____	02/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 658	Continued From page 39 (administrative staff member), administrator, and ASM # 2, director of nursing, were made aware of the findings. No further information was provided prior to exit. References: (1) Folic acid is man-made (synthetic) folate. It is found in supplements and added to fortified foods. The terms folic acid and folate are often used interchangeably. Folic acid is water-soluble. Leftover amounts of the vitamin leave the body through the urine. That means your body does not store folic acid. You need to get a regular supply of the vitamin through the foods you eat or through supplements. Helps tissues grow and cells work, works with vitamin B12 and vitamin C to help the body break down, use, and create new proteins, helps form red blood cells (helps prevent anemia), helps produce DNA, the building block of the human body, which carries genetic information. This information was 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 the website: https://www.nlm.nih.gov/medlineplus/anemia.html	F 658		

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	495249	A. BUILDING _____ B. WING _____	02/21/2019

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F 658	Continued From page 40 (4) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. (5) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.	F 658	F684 a. Resident #73 MD and RP notified of the missing doses of Potassium on 10/14, 10/15, 1/11 and Klonopin on 1/7, 2/13, 2/17, and 2/18. There were no negative outcomes for the resident. b. All residents could have been affected. All nurses were checked for competency with med pass observations. The nurse making error was in-serviced on Following MD orders and had a med pass competency done with her. c. SDC provided education on following MD orders and competency with meds passes with all licensed nursing staff that was completed on 3/1/19. d. SDC or Designee perform med pass competencies on 2 nurses per unit for a total of 4 per week for 3 months. All findings will be reviewed and brought to QAPI monthly for any follow up that is needed. e. DOC 3-15-19	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure that treatment and care was provided in accordance with professional standards of practice, and the comprehensive person-centered care plan for one of 36 residents in the survey sample, Resident #73. The facility staff failed to administer potassium (1) and klonopin (2) to Resident #73 per physician's order on various dates in October 2018, January 2019 and February 2019.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	A. BUILDING _____ B. WING _____	02/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 41 The findings include: 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 reference date) of 1/17/19, coded the resident's cognitive skills for daily decision making as moderately impaired. Section G coded Resident #73 as requiring extensive assistance of one staff with dressing, toileting and personal hygiene. Resident #73's comprehensive care plan dated 1/18/18 documented, "I HAVE AN ALTERATION IN MY BEHAVIOR AEB (as evidenced by): PACING THE HALLWAY AND FOLLOWING A NURSE AND STAFF THROUGHOUT THE BUILDING...ADMINISTER MY MEDICATIONS AS ORDERED..." Review of Resident #73's clinical record revealed a physician's order with a start date of 11/8/16 for potassium 40 mEQ (milliequivalents) by mouth one time a day. Review of Resident #73's October 2018 MAR (medication administration record) revealed the resident was not administered potassium 40 mEQ on 10/14/18 and 10/15/18. A nurse's note dated 10/14/18 documented the medication was not available. A nurse's note dated 10/15/18 documented the pharmacy was notified. Review of Resident #73's January 2019 MAR revealed the resident was not administered potassium 40 mEQ on 1/11/19. A nurse's note dated 1/11/19 documented the potassium was on order from the pharmacy. There was no further documentation that potassium 40 mEQ was eventually administered	F 684		

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	495249	A. BUILDING _____ B. WING _____	02/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 42 on the above dates. Further review of Resident #73's clinical record revealed a physician's order with a start date of 11/1/16 for klonopin 0.5 mg (milligrams) two times a day. Review of Resident #73's January 2019 MAR revealed the resident was not administered the 9:00 a.m. dose of klonopin 0.5 mg on 1/7/19. A nurse's note dated 1/7/19 documented the pharmacy was to deliver the medication. Review of Resident #73's February 2019 MAR revealed klonopin 0.5 mg was not administered to the resident on 2/13/19 at 5:00 p.m., 2/17/19 at 9:00 a.m., 2/17/19 at 5:00 p.m. and 2/18/19 at 9:00 a.m. A nurse's note dated 2/13/19 documented, "Rx (Prescription) called pharmacy..." A nurse's note dated 2/17/19 documented, "Waiting for medication from pharmacy..." Another nurse's note dated 2/17/19 documented, "Waiting for medication from pharmacy..." A nurse's note dated 2/18/19 documented, "Awaiting on pharmacy..." There was no further documentation that klonopin 0.5 mg was eventually administered on the above dates. Review of the facility emergency medication supply lists revealed five doses of potassium 10 mEQ and three doses of klonopin 0.5 mg were available in the supply for administration. On 2/21/19 at 7:45 a.m., an interview was conducted with LPN (licensed practical nurse) #5. 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	F 684		

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	495249	A. BUILDING _____ B. WING _____	02/21/2019

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

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F 684	Continued From page 43 they have enough until they can get a hard prescription from the doctor. When asked about the process for routine medications that are not controlled substances, LPN #5 stated the medication packets document the next refill due date but sometimes pills hit the floor and have to be refilled before the next refill due date. When asked at what point medications should be refilled, LPN #5 stated, "If you know you are getting down, maybe six left, being nursing, you have to know and refill but if it's too early, the pharmacy will not refill and you have to communicate with the pharmacy." LPN #5 was asked what should be done if medications are due to be administered and are not in the medication cart. LPN #5 stated nurses should look for the medications, inform the nurse manager and contact the pharmacy. On 2/21/19 at 9:15 a.m., another interview was conducted with LPN #5. LPN #5 confirmed the facility did have an emergency medication supply that could be accessed to obtain various medications if they were not available in the medication cart. On 2/21/19 at 11:31 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility pharmacy policy titled, "7.0 Medication Shortages/Unavailable Medications" documented, "1. Upon discovery that facility has an inadequate supply of a medication to administer to a resident, facility staff should immediately initiate action to obtain the medication from the pharmacy...2. If a medication shortage is discovered during normal pharmacy hours: 2.1 Facility nurse should call	F 684		

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	495249	A. BUILDING _____ B. WING _____	02/21/2019

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F 684	Continued From page 44 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 dose in the resident's medication schedule, facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose..." No further information was presented prior to exit. (1) "Potassium is a mineral that your body needs to work properly. It is a type of electrolyte. It helps your nerves to function and muscles to contract. It helps your heartbeat stay regular. It also helps move nutrients into cells and waste products out of cells." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=potassium&_ga=2.93431001.578943081.1551101203-1667741437.1550160688 (2) Klonopin is used to treat seizures and panic attacks. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682279.html	F 684	F695 a. Residents #85 and #86's respiratory equipment is currently being stored appropriately. Resident #44 MD and RP were notified of the omitted holes in the January 2019 TAR. b. All residents with O2/Trach/Nebulizers equipment rooms were checked for proper storage of the respiratory equipment not in use on 2/22/19. 100% of all residents with respiratory trach treatments were printed and audited for any omissions in documentation by ADON, UM and SDC on 2/22/19. c. SDC educated nursing staff regarding proper storage of respiratory equipment completed on 3-1-19. SDC to educate licensed nursing staff on appropriate documentation of treatments, completed on 3/1/19. d. ADON/Designee to audit all respiratory equipment to ensure all respiratory equipment is stored appropriately 5 times per week for 4 weeks then 3 times a week for 4 weeks then weekly times 4 weeks. Findings brought to monthly QAPI for review. DON/Designee will audit all respiratory treatment TARS for omissions 5 times per week during clinical morning meeting for 3 months and bring all findings to monthly QAPI for review. e. DOC 3-15-19	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	A. BUILDING _____ B. WING _____	02/21/2019

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

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F 695	Continued From page 45 care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure respiratory treatment was provided consistent with professional standards of practice, and the comprehensive person-centered care plan, for three of 36 residents in the survey sample, Resident # 85, # 86 and # 44. 1. The facility staff failed to store Resident # 85's nebulizer mask in a sanitary manner. 2. The facility staff failed to store Resident # 86's nebulizer mask in a sanitary manner. 3. The facility staff failed to perform ordered tracheotomy care for Resident #44 on multiple dates during the month of January 2019. The findings include: 1. The facility staff failed to store Resident # 85's nebulizer mask in a sanitary manner. Resident # 85 was admitted to the facility on 12/28/18 with diagnoses that included but were not limited to cerebral vascular disease (1), diabetes mellitus, (2), gastroesophageal reflux disease (3), hypertension (4). Resident # 85's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 01/25/19,	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	A. BUILDING _____ B. WING _____	02/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 695	Continued From page 46 coded Resident # 85 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 85 was coded as requiring extensive assistance to being totally dependent of one staff member for activities of daily living. On 02/19/19 at 2:55 p.m., during an observation, Resident # 85 was sitting on the edge of her bed. Observation of Resident # 85' room reveal a nebulizer mask lying on the bedside table, in front of the television, uncovered. On 02/19/19 at 3:28 p.m., during an observation, Resident # 85 was sitting on the edge of her bed. Observation of Resident # 85's room reveal a nebulizer mask lying on the bedside table, in front of the television, uncovered. On 02/20/19 at 8:06 a.m., during an observation, Resident # 85 was sitting on the edge of her bed. Observation of Resident # 85's room reveal a nebulizer mask lying on the bedside table, in front of the television, uncovered. The POS (physician's order sheet) dated February 2019, for Resident # 85 documented, "Ipratropium-albuterol (5) 3(three) ml (milliliter). Two times daily. Order date: 01/02/2019." On 02/21/19 at 12:55 p.m., an interview was conducted with LPN (licensed practical nurse) # 1. When informed of the observations of Resident # 85's nebulizer mask lying on the bedside table, LPN # 1 stated, "It has to be placed in a plastic bag and the bag should be dated when it was originally put in use." When asked why it was important to keep the mask in a bag, LPN # 1 stated, "To keep it clean and free	F 695		

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	495249	A. BUILDING _____ B. WING _____	02/21/2019

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F 695	Continued From page 47 from bacteria." On 02/21/19 at 2:40 p.m., ASM # 1 (administrative staff member), administrator, and ASM # 2, director of nursing, were made aware of the findings. No further information was provided prior to exit. References: (1) A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm . (2) A chronic disease in which the body cannot regulate the amount of sugar in the blood. The goal of treatment at first is to lower your high blood glucose level. Long-term goals are to prevent complications. The most important way to treat and manage type 2 diabetes is by being active and eating healthy foods. This information was obtained from the website: https://medlineplus.gov/ency/article/000313.htm. (3) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	A. BUILDING _____ B. WING _____	02/21/2019

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

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F 695	Continued From page 48 (5) The combination of albuterol and ipratropium is used to prevent wheezing, difficulty breathing, chest tightness, and coughing in people with chronic obstructive pulmonary disease (COPD; a group of diseases that affect the lungs and airways) such as chronic bronchitis (swelling of the air passages that lead to the lungs) and emphysema (damage to the air sacs in the lungs). Albuterol and ipratropium combination is used by people whose symptoms have not been controlled by a single inhaled medication. Albuterol and ipratropium are in a class of medications called bronchodilators. Albuterol and ipratropium combination works by relaxing and opening the air passages to the lungs to make breathing easier. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601063.html. 2. The facility staff failed to store Resident # 86's nebulizer mask in a sanitary manner. Resident # 86 was admitted to the facility on 11/06/17 with diagnoses that included but were not limited to diabetes mellitus (1), chronic kidney disease (2), and atrial fibrillation (3). Resident # 86's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 01/26/19, coded Resident # 86 as scoring a 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 - being cognitively for making daily decisions. Resident # 86 was coded as being independent requiring only set up of one staff member for activities of daily living.	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	A. BUILDING _____ B. WING _____	02/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 695	Continued From page 49 On 02/19/19 at 2:05 p.m., during an observation, Resident # 86 sitting in his wheelchair in his room and appeared dressed neat and clean. Observation of Resident # 86's room reveal a nebulizer mask lying on the dresser uncovered. On 02/19/19 02:54 p.m., during an observation, Resident # 86 sitting in his wheelchair in his room and appeared dressed neat and clean. Observation of Resident # 86's room reveal a nebulizer mask lying on the dresser uncovered. The POS (physician's order sheet) dated February 2019, for Resident # 86 documented, "Ipratropium-albuterol (4) 3(three) ml (milliliter) inhale every 4 (four) hours as needed. Order date: 01/24/2019." On 02/21/19 at 12:55 p.m., an interview was conducted with LPN (licensed practical nurse) # 1. When informed of the observations of Resident # 86's nebulizer mask lying on the dresser uncovered, LPN # 1 stated, "It has to be placed in a plastic bag and the bag should be dated when it was originally put in use." When asked why it was important to keep the mask in a bag LPN # 1 stated, "To keep it clean and free from bacteria." On 02/21/19 at 2:40 p.m., ASM # 1 (administrative staff member), administrator, and ASM # 2, director of nursing, were made aware of the findings. No further information was provided prior to exit. References: (1) A chronic disease in which the body cannot regulate the amount of sugar in the blood. The	F 695		

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	495249	A. BUILDING _____ B. WING _____	02/21/2019

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F 695	Continued From page 50 goal of treatment at first is to lower your high blood glucose level. Long-term goals are to prevent complications. The most important way to treat and manage type 2 diabetes is by being active and eating healthy foods. This information was obtained from the website: https://medlineplus.gov/ency/article/000313.htm. (2) Kidneys are damaged and can't filter blood as they should. This information was obtained from the website: https://medlineplus.gov/chronickidneydisease.html. (3) A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html. (4) The combination of albuterol and ipratropium is used to prevent wheezing, difficulty breathing, chest tightness, and coughing in people with chronic obstructive pulmonary disease (COPD; a group of diseases that affect the lungs and airways) such as chronic bronchitis (swelling of the air passages that lead to the lungs) and emphysema (damage to the air sacs in the lungs). Albuterol and ipratropium combination is used by people whose symptoms have not been controlled by a single inhaled medication. Albuterol and ipratropium are in a class of medications called bronchodilators. Albuterol and ipratropium combination works by relaxing and opening the air passages to the lungs to make breathing easier. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601063.html.	F 695		

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	495249	A. BUILDING _____ B. WING _____	02/21/2019

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F 695	Continued From page 51 3. The facility staff failed to perform ordered tracheotomy care for Resident #44 on multiple dates during the month of January 2019. 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 (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 as 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 cannula #8XL 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 INADEQUATE OXYGENATION R/T (related to)	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	A. BUILDING _____ B. WING _____	02/21/2019

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

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F 695	Continued From page 52 REQUIRES TRACH FOR BREATHING" Under "Interventions": "TRACH CARE AS ORDERED/FOLLOW-UP WITH ENT (Ear Nose Throat)/MD (Medical Doctor) AS INDICATED/AS ORDERED." A review of Resident #44's Treatment Administration Record (TAR) revealed, there were multiple dates in January 2019, where the order for trach care was not signed off as completed on one or more of the 3 shifts each day. These dates were: 01/01/19, 01/06/19, 01/08/19, 01/13/19, 01/18/19, 01/21/19, 01/23/19, 01/26/19 and 01/28/19. The Administrator, ASM (administrative staff member) #1 and Director of Nursing, ASM #2, were informed of concerns regarding Resident #44's tracheotomy care during the end of day meeting on 02/20/2019. They were asked to provide the survey team with any documentation regarding Resident #44's care on the dates in question that might explain the gaps in the TAR. On 02/21/2019 at approximately 2:00p.m., a brief interview was conducted with Licensed Practical Nurse (LPN) #4. LPN #4 was asked what a blank spot in a resident's TAR might mean. LPN #4 replied, "If there's a blank on the record that usually means it wasn't done." At the end of day meeting on 02/21/2019, the Director of Nursing, ASM #2, informed this surveyor that no additional documentation regarding the blank spots in Resident #44's TAR could be found. No further documentation was provided.	F 695		

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	495249	A. BUILDING _____ B. WING _____	02/21/2019

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F 695	Continued From page 53 1. A minimally conscious state is severe but not complete impairment of awareness that results from widespread damage to the cerebrum (the part of the brain that controls thought and behavior). - https://www.merckmanuals.com/home/brain,-spinal-cord,-and-nerve-disorders/coma-and-impaired-consciousness/minimally-conscious-state?query=Vegetative%20State%20and%20Minimally%20Conscious%20State	F 695		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to	F 732	F732 a. On 2/19/19 the daily posting was replaced by staffing at 11:30A.M b. Night shift nurses to post current days 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 times 3 months that the correct staffing sheet is posted. All findings to be brought to monthly QAPI for review. e. DOC 3-15-18	

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	495249	A. BUILDING _____ B. WING _____	02/21/2019

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F 732	Continued From page 54 residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to post daily nurse staffing information. On 2/19/19 at 11:47 a.m., the facility staff failed to post the daily nurse staffing information. The posting observed in the lobby was dated 2/18/19. The findings include: On 2/19/19 at 11:47 a.m., observation of the posted daily nurse staffing information was conducted in the lobby. The posting was dated 2/18/19. There was no posted nurse staffing information for 2/19/19. On 2/21/19 at 8:20 a.m., an interview was conducted with CNA (certified nursing assistant) #2 (the person responsible for posting the daily nurse staffing information). CNA #2 was asked about the facility process for posting the nurse staffing information. CNA #2 stated most of the time, she writes up the staffing information and	F 732		

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	495249	A. BUILDING _____ B. WING _____	02/21/2019

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F 732	Continued From page 55 posts the information after she obtains the census from the admissions nurse at the morning meeting. When asked to specify a time she usually posts the information, CNA #2 stated it is usually posted at approximately 9:30 a.m. CNA #2 was made aware of this surveyor's observation on 2/19/19. CNA #2 stated she assists residents with smoking on certain mornings and sometimes she forgets to post the information until after she assists the smokers. On 2/21/19 at 11:31 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Daily Posting of Nurse Staffing" documented, "(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (e) (1) of this section on a daily basis at the beginning of each shift..." No further information was presented prior to exit.	F 732		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving,	F 755	F755 a. Resident #73's MD and RP notified of the medication of Aldactone not being available on 10/14, 10/15, 10/23, and 10/24/19. The resident had no adverse effects of the med not being available. b.100% medication MAR/Cart audit was completed on 2-22-19 to ensure all meds available. c. SDC provided education to nursing staff on med availability policy and med administration completed by 3-8-19 d. SDC will audit 2 nurses per unit on medication administration for total of 4	

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	495249	A. BUILDING _____ B. WING _____	02/21/2019

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F 755	Continued From page 56 dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide pharmacy services for one of 36 residents in the survey sample, Resident #73. The facility staff failed to ensure aldactone (1) was available for administration to Resident #73, on multiple dates in October 2018. The findings include: 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	F 755	nurses per week for 3 months. All findings will be reviewed and brought to QAPI monthly for any follow up that is needed. e. DOC 3-15-19	

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	495249	A. BUILDING _____ B. WING _____	02/21/2019

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F 755	Continued From page 57 reference date) of 1/17/19, coded the resident's cognitive skills for daily decision making as moderately impaired. Section G coded Resident #73 as requiring extensive assistance of one staff with dressing, toileting and personal hygiene. Resident #73's comprehensive care plan dated 1/25/19 documented, "The resident has dehydration or potential fluid deficit r/t (related to) Diuretic use...Administer medications as ordered..." Review of Resident #73's clinical record revealed a physician's order with a start date of 2/2/17 for aldactone 25 mg (milligrams) by mouth one time a day. Review of Resident #73's October 2018 MAR (medication administration record) revealed the resident was not administered aldactone on 10/14/18, 10/15/18, 10/23/18 and 10/24/18. A nurse's note dated 10/14/18 documented the medication was not available. A nurse's note dated 10/15/18 documented the pharmacy was notified. A nurse's note dated 10/23/18 documented the medication was on order. A nurse's note dated 10/24/18 documented the medication was on order. There was no further documentation that aldactone 25 mg was eventually administered on the above dates. Review of the facility emergency medication supply lists revealed aldactone was not in the facility emergency medication supply. On 2/21/19 at 7:45 a.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 was asked about the facility process for ensuring medications are available for administration. LPN #5 stated nurses have to make sure they have enough medication on hand. LPN #5 stated the medication packets	F 755		

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	495249	A. BUILDING _____ B. WING _____	02/21/2019

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F 755	Continued From page 58 document the next refill due date but sometimes pills hit the floor and have to be refilled before the next refill due date. When asked at what point medications should be refilled, LPN #5 stated, "If you know you are getting down, maybe six left, being nursing, you have to know and refill but if it's too early, the pharmacy will not refill and you have to communicate with the pharmacy." LPN #5 was asked what should be done if medications are due to be administered and are not in the medication cart. LPN #5 stated nurses should look for the medications, inform the nurse manager and contact the pharmacy. On 2/21/19 at 11:31 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility pharmacy policy titled, "7.0 Medication Shortages/Unavailable Medications" documented, "1. Upon discovery that facility has an inadequate supply of a medication to administer to a resident, facility staff should immediately initiate action to obtain the medication from the pharmacy...2. If a medication shortage is discovered during normal 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 dose in the resident's medication schedule, facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose. 2.3 If the medication is not available in the Emergency Medication Supply, facility staff should notify pharmacy and arrange for an emergency delivery..."	F 755		

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F 755	Continued From page 59 No further information was presented prior to exit. (1) Aldactone is used to treat low potassium levels, heart failure and fluid retention. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682627.html	F 755		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure a medication error rate less than five percent for three of six residents in the medication administration observation, Residents #30, #28 and #75. Five errors out of 35 opportunities resulted in an error rate of 14.29 percent. 1. The facility staff failed to administer Resident #30's medication of folic acid (1) and Incruse Ellipta [powder inhaler] (2) according to the physician's order. 2. The facility staff failed to administer Resident #28's medication of Dorzolamide [eye drops] (1) according to the physician's order. 3. The facility staff failed to administer Aspirin 81	F 759	F759 a. Resident #30's mouth assessed for thrush on 2/21/19. New order for Folic Acid was obtained from the MD on 2/21/19. Resident #28 Left eye was assessed for redness form receiving drops on 2/21/19 and MD/RP was made aware of the error. Resident #75 MD/RP was made aware of the incorrect ASA being given and crushed. None of the above noted resident had any adverse effects from the errors. b. All residents have the potential to be affected by the deficient practices. Both nurses that made errors during the med pass observations were given 1-1 in services on med administration and were observed by the SDC for competency of meds administration on 2/21/19. An audit was completed of all the residents' mouths that have orders for steroidal inhalers for signs and symptoms of side effects from inappropriate administration of inhaler on 2/22/19.	

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	495249	A. BUILDING _____ B. WING _____	02/21/2019

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

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F 759	Continued From page 60 mg (milligrams) to Resident #75 per physician's order. LPN (licensed practical nurse) #2 prepared and administered Aspirin 81 mg EC (enteric coated) to Resident #75 instead of regular Aspirin 81 mg. In addition, LPN #2 crushed the enteric coated Aspirin and the medication was listed on the facility should not be crushed list. The findings include: 1. The facility staff failed to administer Resident #30's medication of folic acid (1) and Incruse Ellipta [powder inhaler] (2) according to the physician's order. Resident # 30 was admitted to the facility on 08/27/09 and a readmission on 12/21/10 with diagnoses that included but were not limited to: hemiplegia (3), anemia (4), chronic obstructive pulmonary disease (5), and hypertension (6). Resident # 30's most recent comprehensive MDS (minimum dada set) an annual assessment with an ARD (assessment reference date) of 12/09/18 coded the resident as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 being cognitively intact for daily decision making. Resident # 30 was coded as requiring extensive assistance of one staff member for activities of daily living and as independent with eating. On 02/20 19 at 8:12 a.m., the medication administration observation conducted was conducted with LPN (licensed practical nurse) # 1. PN # 1 was observed to dispensing two folic acid tablets from the medication bubble pack for Resident # 30 into a small plastic medication cup. The bubble pack containing the folic acid	F 759	c. DON completed 1-1 education with nurse on medication administration of steroidal inhalers and following MD orders on 2/28/19. SDC completed education of licensed nurses on medication administration and professional standards on 3/8/19. d. SDC will audit 2 nurses per unit on medication administration for total of 4 nurses per week for 3 months. All findings will be reviewed and brought to QAPI monthly for any follow up that is needed. e. DOC 3-15-19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	A. BUILDING _____ B. WING _____	02/21/2019

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

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F 759	Continued From page 61 documented, "Folic Acid 400 mcg (micrograms)." LPN # 1 entered Resident # 30's bedroom, informed Resident # 30 of her medication, handed the small plastic medication cup containing the folic acid to Resident # 30. Resident # 30 took the medication cup containing the folic acid, placed the tablets in her mouth and swallowed them with a small sip from a cup of water. LPN # 1 then handed Resident # 20 the Incruse Ellipta [powder inhaler]. Resident # 20 took the inhaler, placed it up to her mouth, depressed the inhaler and inhaled the medication. Resident #20 then handed the inhaler back to LPN # 1. LPN # 1 asked Resident # 20 if she required anything else. Resident # 20 stated no and LPN # 1 walked out of the room and back to the medication cart and proceeded to the next resident. The POS (physician's order sheet) dated February 2019 for Resident # 30 documented, "Folic Acid Tablet 1 (one) MG (milligram). Give 1 mg by mouth one time a day for supplement. Order Date: 12/21/2010." "Incruse Ellipta Aerosol Powder Breath Activated 62.5 MCG (microgram) 1 (one) inhalation inhale orally one time a day related to chronic obstructive pulmonary disease. Rinse mouth after each use and DO NOT SWALLOW. Order Date: 03/16/2018." The comprehensive care plan for Resident # 30 dated 01/11/2017 failed to evidence interventions related to the administration of folic acid or the use of an inhaler. 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	F 759		

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	495249	A. BUILDING _____ B. WING _____	02/21/2019

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F 759	Continued From page 62 milligrams which is less than one milligram. After the administration of the medication, I notified the doctor by phone, I mentioned what I gave and asked if it was ok to modify the order and he stated it ok. It should have modified or clarified the order before I gave the medication." When asked about the Incruse Ellipta inhaler, LPN # 1 stated, "I didn't offer her the opportunity to rinse her mouth after administering the medication. When asked why the resident should rinse after using the inhaler, LPN # 1 stated, "To prevent the mouth from being coated." When asked to describe the process she follows to eliminate a medication error, LPN # 1 stated, "I follow the five rights, check the order, the route, the patient, the correct dosage and the correct time. I also, follow the three checks, check MAR (medication administration record), and compare the MAR with the medication label to make sure it reads the same thing and recheck the label at bed side right before administration." When asked why it was important to administer the correct medication, LPN # 1 stated, "Medication is based on the resident's diagnoses and weight and other factors. If it is not administered according to the physician's orders there could adverse effects." When asked to describe the procedure when there is an error in medication administration, LPN # 1 stated, "I call the physician and responsible party and monitor resident for adverse reactions." 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 Resident # 30. The order documented, "Folic Acid Tablet 400 MCG Give 2 (two) [sic] tablet by mouth one time a day for [sic] vitamine	F 759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	A. BUILDING _____ B. WING _____	02/21/2019

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

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F 759	Continued From page 63 supplement OTC (over the counter) medication provided by facility." On 02/21/19 at approximately 2:30 p.m., ASM (administrative staff member) # 2, director of nursing provided this surveyor with following drug information: - "(Name of Pharmacy the facility uses) Drug Information. Folic Acid. Folic acid is the man-made for of folate. Folate is a B-vitamin naturally found in some foods. It is needed to form health cells, especially red blood cells. They are used to treat low folate levels. Low folate level can lead to certain types of anemia" (low iron)." - "(Name of Pharmacy the facility uses) Drug Information. Incruse Ellipta 62.5 MCG. Umeclidinium Powder Inhaler - Oral. Umeclidinium is used to control and prevent symptoms (such as wheezing, shortness of breath) caused by ongoing lung disease (chronic obstructive pulmonary disease)." Further review of the drug information sheet failed to evidence documentation of rinsing the mouth after use. The facility's policy "6.0 General Dose Preparation and Medication Administration" documented in part, "3.7 Facility staff should verify that the medication name and dose are correct and should inspect the medication for contamination, particulate matter, discoloration or defects ..." On 02/20/19 at 6:00 p.m., ASM # 1 (administrative staff member), administrator, and ASM # 2, director of nursing, were made aware of the findings.	F 759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	A. BUILDING _____ B. WING _____	02/21/2019

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

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F 759	Continued From page 64 No further information was provided prior to exit. References: (1) Folic acid is man-made (synthetic) folate. It is found in supplements and added to fortified foods. The terms folic acid and folate are often used interchangeably. Folic acid is water-soluble. Leftover amounts of the vitamin leave the body through the urine. That means your body does not store folic acid. You need to get a regular supply of the vitamin through the foods you eat or through supplements. Helps tissues grow and cells work, works with vitamin B12 and vitamin C to help the body break down, use, and create new proteins, helps form red blood cells (helps prevent anemia), helps produce DNA, the building block of the human body, which carries genetic information. This information was obtained from the website: https://medlineplus.gov/ency/article/002408.htm. (2) Is used in adults to control wheezing, shortness of breath, coughing, and chest tightness caused by chronic obstructive pulmonary disease (COPD; a group of diseases that affect the lungs and airways, that includes chronic bronchitis and emphysema). Umeclidinium inhalation is in a class of medications called anticholinergics. It works by relaxing and opening air passages in the lungs, making it easier to breathe. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a614024.html. (3) 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	F 759		

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	495249	A. BUILDING _____ B. WING _____	02/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 759	Continued From page 65 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. (4) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html . (5) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. (6) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. 2. The facility staff failed to administer Resident #28's medication of Dorzolamide [eye drops] (1) according to the physician's order. 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 (3), anxiety (4), and hypertension (5). 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	F 759		

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	495249	A. BUILDING _____ B. WING _____	02/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 759	Continued From page 66 to being totally dependent of one staff member for activities of daily living. On 02/20 19 at 8:22 a.m., the medication administration observation conducted was conducted with LPN (licensed practical nurse) # 1. LPN # 1 entered Resident # 28's room to administer eye drops. Resident # 28 was observed lying down in her bed on her back. LPN # 1 informed Resident # 28 that it was time for her eye drops. LPN # 1 put on a clean pair of plastic gloves, removed the cap on the eye drop bottle, held the bottle in one hand and used her other gloved hand to spread Resident # 28's eyelid and the lower area of the right eye, to hold open Resident # 28's eye. LPN #1 administered one drop of medication into the right eye then repeated the same process on the opposite side and administered one drop of medication into the left eye. The POS (physician's order sheet) dated February 2019 for Resident # 28 documented, "Cosopt Solution 22.3-6.8MG/ML (milligram/milliliter) [Dorzolamide] Instill 1 (one) drop in right eye every 12 hours related to UNSPECIFIED GLAUCOMA. Order Date: 02/11/2017." The comprehensive care plan for Resident # 28 dated 04/03/2017 documented, "Focus. Alteration in visual function r/t (related to) seizures, tremors, ID (intellectual disability) as evidenced by eye exam and resident statement." Further review of the comprehensive care plan failed to evidence interventions related to the administration of eye drops. On 02/20/19 at 10:45 a.m., an interview was	F 759		

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	495249	A. BUILDING _____ B. WING _____	02/21/2019

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F 759	Continued From page 67 conducted with LPN # 1 regarding the administration of Dorzolamide to Resident # 28. After reviewing the POS (physician order sheet) for Resident # 28' Dorzolamide (eye drops), LPN # 1 was asked, which of Resident # 28's eyes was ordered to have the eye drops. LPN # 1 stated, "It should be one drop, the right eye." LPN # 1 agreed she administered a drop in both eyes. LPN # 1 stated, "It's an error. I made a mistake." When asked to describe the process she follows to eliminate a medication error, LPN # 1 stated, "I follow the five rights, check the order, the route, the patient, the correct dosage and the correct time. I also, follow the three checks, check MAR (medication administration record), and compare the MAR with the medication label to make sure it reads the same thing and recheck the label at bed side right before administration." When asked why it was important to administer the correct medication and correct dose, LPN # 1 stated, "Medication is based on the resident's diagnoses and weight and other factors. If it is not administered according to the physician's orders, there could adverse effects. If given in the wrong eye could there be an adverse effect." When asked to describe the procedure staff follows when there is an error, in the medication administration, LPN # 1 stated, "I call the physician and responsible party and monitor resident for adverse reactions." On 02/21/19 at approximately 2:30 p.m., ASM (administrative staff member) # 2, director of nursing provided this surveyor with following drug information: "(Name of Pharmacy the facility uses) Drug Information. Dorzolamide 2% eye drops. Dorzolamide is used to treat high pressure inside the eye due to glaucoma or other eye diseases."	F 759		

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	495249	A. BUILDING _____ B. WING _____	02/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 759	Continued From page 68 On 02/20/19 at 6:00 p.m., ASM # 1 (administrative staff member), administrator, and ASM # 2, director of nursing, were made aware of the findings. No further information was provided prior to exit. References: (1) Is used to treat glaucoma, a condition in which increased pressure in the eye can lead to gradual loss of vision. Dorzolamide is in a class of medications called carbonic anhydrase inhibitors. It works by decreasing the pressure in the eye. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697049.html. (2) A group of diseases that can damage the eye's optic nerve. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/glaucoma.html. (3) Inflammation of the iris and the ciliary body. This information was obtained from the website: https://www.merriam-webster.com/medical/iridocyclitis. (4) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary. (5) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. 3. The facility staff failed to administer Aspirin 81 mg (milligrams) to Resident #75 per physician's	F 759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	A. BUILDING _____ B. WING _____	02/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 759	Continued From page 69 order. LPN (licensed practical nurse) #2 prepared and administered Aspirin 81 mg EC (enteric coated) to Resident #75 instead of regular Aspirin 81 mg. In addition, LPN #2 crushed the enteric coated Aspirin and the medication was listed on the facility should not be crushed list. Resident #75 was admitted to the facility on 04/11/2013. Diagnoses for Resident #75 included but were not limited to Anxiety Disorder, High Blood Pressure and Constipation. Resident #75's Minimum Data Set with an Assessment Reference Date of 01/18/2019 coded Resident #75 with moderate cognitive impairment, as requiring extensive assistance of one staff member with activities of daily living and one staff person for eating. Resident #75's care plan dated 02/17/2019 documented..."Administer medications as ordered. Observe for tolerance and effectiveness. Report any possible adverse side effects to MD (medical doctor)/ARNP (advanced registered nurse practitioner). Resident #75's clinical record was reviewed. A physician order dated 04/11/2013 documented, "Aspirin Tablet 81 mg (milligram) Give 1 tablet by mouth one time a day related to High Blood Pressure." On 02/20/2019 at approximately 8:43 a.m., LPN (licensed practical nurse) #2 prepared and administered an Aspirin 81 mg EC (enteric coated) tablet to Resident #75 during med (medication) pass. LPN #2 crushed the Aspirin 81 mg EC tablet and administered the crushed tablet to Resident #75 in applesauce. Resident #75 was given a cup of water (approximately 236 milliliters) after administration.	F 759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	A. BUILDING _____ B. WING _____	02/21/2019

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

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F 759	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 mistake." On 02/20/2019 at approximately 5:30 p.m., ASM #1 (administrator) and ASM #2 (director of nursing) were made aware of findings. A copy of the facility policy regarding medication administration was requested from ASM (administrative staff member) #2 (director of nursing) on 02/20/2019 at approximately 5:00 p.m. The Omnicare LTC Facility Pharmacy 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	F 759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	A. BUILDING _____ B. WING _____	02/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARMVILLE HEALTH & REHAB CENTER	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 759	Continued From page 71 forth in Appendix 16: Common Oral Dosage 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.	F 759	F761 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 reviewed and brought to QAPI monthly for any follow up that is needed. e. DOC 3-15-19	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	A. BUILDING _____ B. WING _____	02/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARMVILLE HEALTH & REHAB CENTER	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 761	Continued From page 72	F 761		

storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review, it was determined that the facility staff failed to store medications in a safe and secure manner on one of four medication carts, the team four medication cart.

1. LPN (Licensed practical nurse) #2 failed to lock the team four medication cart (located in the hall) while administering medication to a resident in a resident room.

2. The facility staff failed to store medications in a safe and secure manner on the team four medication cart. LPN (licensed practical nurse) #2 left a closed bottle of Vitamin D3 tablets on top of the medication cart while the cart was out of her line of sight between rooms 125 through 127.

The findings include:

1. LPN (Licensed practical nurse) #2 failed to lock the team four medication cart (located in the hall) while administering medication to a resident in a resident room.

On 2/20/19 at 8:57 a.m., LPN #2 was observed 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	A. BUILDING _____ B. WING _____	02/21/2019

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

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F 761	Continued From page 73 resident's room. LPN #2's back was facing the medication cart while administering medication to the resident in the room and the medication cart was not in LPN #2's line of sight. No residents were observed near the medication cart. On 2/20/19 at 2:32 p.m., an interview was conducted with LPN #2. LPN #2 was asked what should be done before leaving the medication cart and entering a resident room. LPN #2 stated, "Lock the cart, minimize the computer, secure all medications and turn the cart in the direction that I am going and keep in eye sight to prevent HIPAA (Health Insurance Portability and Accountability Act) violation." When asked why, LPN #2 stated, "This should be done for safety precautions and prevention of HIPAA violations." On 2/21/19 at 11:31 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility pharmacy policy titled, "5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles" documented, "3.3 Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors." No further information was presented prior to exit. 2. The facility staff failed to store medications in a safe and secure manner on the team four medication cart. LPN (licensed practical nurse) #2 left a closed bottle of Vitamin D3 tablets on top	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	A. BUILDING _____ B. WING _____	02/21/2019

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

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F 761	Continued From page 74 of the medication cart while the cart was out of her line of sight between rooms 125 through 127. On 02/20/2019 at approximately 8:33 a.m., LPN (licensed practical nurse) #2 was observed entering a resident's room, leaving a closed bottle of Vitamin D3 tablets (1) on top of medication cart #1 (team 4 medication cart) between rooms 125 through 127. LPN #2's back was to the medication cart while she was in the resident's room. No residents walked past the medication cart while LPN #2 was in the resident's room. An interview was conducted on 02/20/2019 at approximately 2:32 p.m. with LPN #2. LPN #2 was asked what she should do before leaving the medication cart to administer resident medication. LPN #2 stated that the medication cart should be locked, and medications should be put away. LPN #2 was asked why the medication cart should be locked and medications put away. LPN #2 stated, "To prevent HIPPA (Health Insurance Portability and Accountability Act) violations and other residents from getting to the medication." LPN #2 was informed at this time of the above observation. LPN #2 stated, "I didn't mean to, it was a mistake." 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	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	A. BUILDING _____ B. WING _____	02/21/2019

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

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F 761	Continued From page 75 should ensure that resident medication and biological storage areas are locked and do not contain non-medication/biological items." 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. References (1) Vitamin D3 is supplement that helps your body absorb calcium. This information was obtained from the website: https://medlineplus.gov/vitamind.html	F 761	F842 a.Resident #21 interviewed by the DON to indicate bathing preference on Resident #21 all about me, kardex and care plan updated to reflect his preferences with bathing was updated on 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.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842	c. SDC educated nursing staff on documentation of resident refusal of care in ADL record and the nurses notes completed on 3/8/19. d. UM/ADON to conduct an audit weekly on ADL books for appropriate documentation of showers by interviewing 4 residents per unit a week and weekly times 3 months. To ensure proper documentation. All findings will be brought and reviewed monthly at QAPI. e. DOC 3-15-19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	A. BUILDING _____ B. WING _____	02/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 76 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §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 provided; (iv) The results of any preadmission screening	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	A. BUILDING _____ B. WING _____	02/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARMVILLE HEALTH & REHAB CENTER	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 page 77 and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for one of 36 residents in the survey sample, Resident #21. The facility staff failed to document Resident #21's refusal of showers. The findings include: Resident #21 was admitted to the facility on 9/4/2018 with the diagnoses of but not limited to diabetes, dependence on renal dialysis, high blood pressure, End Stage Renal Disease, epilepsy, peripheral vascular disease, morbid obesity, and left above knee amputation. Resident #21's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/5/2018. The resident was coded as requiring total assistance for transfers and toilet use, extensive assistance for dressing, personal hygiene and bathing, and as independent for eating. On 2/19/19 at 12:23 p.m., in an interview with Resident #21 he stated he had received only one bath since admission. A review of the clinical record revealed a note	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	A. BUILDING _____ B. WING _____	02/21/2019

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

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F 842	Continued From page 78 dated 9/13/18, titled "All About Me" which documented "Resident prefers a shower...Preferred bathing time: Afternoon...Number of days of the week bathing is preferred: 3..." Further review of the clinical record revealed the ADL (Activities of Daily Living) sheets for January 2019 and February 2019. A review of these revealed Resident #21 had received a bed bath daily, and 2 to 3 times a day on some days. There was no documented evidence of a shower. A review of the nurse's notes failed to reveal any evidence of the resident receiving showers or any refusal of showers. On 02/21/19 at 11:31 a.m., in an interview with CNA (Certified nursing assistant) #3 regarding Resident #21's showers, she stated that Resident #21 refuses showers most of the time. When asked what she does when the resident refuses, she stated she reports it to the nurse. On 02/21/19 at 11:41 a.m., in an interview with LPN (Licensed Practical Nurse) #7, she stated that he (Resident #21) does receive showers but does refuse at times. LPN #7 stated that the refusals should be documented and the MD (Medical Doctor) and RP (Responsible Party) should be notified. The ADL sheets for January and February 2019 were reviewed with LPN #7. LPN #6 joined and added to the conversation, stating, "What we need is for it to be documented when he refuses showers." A review of the comprehensive care plan failed to reveal any documentation of Resident #21 refusing showers.	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	A. BUILDING _____ B. WING _____	02/21/2019

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

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F 842	Continued From page 79 On 2/21/19 at approximately 3:00 p.m., a policy for accurate clinical records was requested via a written list of policies submitted to the facility. No policy was provided. On 02/21/19 at 01:18 p.m., ASM #1 (Administrative Staff Member) the administrator, was notified of the findings. No further information was presented prior to exit. According to "Fundamentals of Nursing Made Incredibly Easy" Lippincott Williams and Wilkins, Philadelphia PA, page 23: "Nursing documentation is a highly significant issue since documentation is a fundamental feature of nursing care. Patient records are legally valid, and need to be accurate and comprehensive so that care can be communicated effectively to the health care team. Unless the content of documentation provides an accurate depiction of patient and family care, quality of care may not be possible. Many nurses do not realize that what they document or fail to record can produce an enormous effect on the care that is provided by other members of the health care team."	F 842	F880 a. The free standing fan was removed from the laundry room on 3-1-19. An assessment completed on resident #40 revealed no active signs or symptoms of infection. b. No residents affected by the fan in laundry room. 1-1 in-service completed with nurse on infection control practices with med pass on 2/21/19. Med pass observations with licensed nurses to ensure proper infection control practices with medication administration was completed on 3/1/19. c. SDC educated on infection control practices and completed competencies with meds passes with all licensed nursing staff on 3/1/19.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880	d. SDC or Designee will audit 2 nurses per unit on infection control practices with medication pass observations for total of 4 nurses per week for 3 months. All findings will be reviewed and brought to QAPI monthly for any follow up that is needed. e .DOC 3-15-19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	A. BUILDING _____ B. WING _____	02/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARMVILLE HEALTH & REHAB CENTER	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 880	Continued From page 80 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	A. BUILDING _____ B. WING _____	02/21/2019

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

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F 880	Continued From page 81 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, it was determined that the facility staff failed to follow infection control practices in the facility laundry room and for one of 36 residents in the survey sample, Resident # 40. 1. The facility staff failed to keep a fan in the clean laundry area free of dust when folding and storing clean linens. 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. The findings include: 1. On 02/120/19 at 5:50 p.m., an observation of	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	A. BUILDING _____ B. WING _____	02/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 82	F 880		

the facility's laundry room was conducted with OSM (other staff member) #2, director of housekeeping.

The facility's laundry room consisted of a dirty linen room that contained commercial clothes washer, soiled linens and soiled resident clothing. Another separate room adjacent to the soiled linen room was the clean laundry area. The area contained two commercial clothes dryers, table for folding clean linens and clothing and clean laundry racks. Further observation of the table for folding clean linen revealed two clean folded hand towels, six pairs of socks and 4 single socks, ten clean and folded clothing protectors and forty-two clean and folded cloth napkins. The shelving in the clean laundry area, was perpendicular to the table for folding clean linen, and contained three shelves that were uncovered. Observation of the shelving revealed multiple blankets clean and folded multiple clean and folded towels, tablecloths and a box of multiple clean socks.

Further observation of the clean laundry area revealed a wall mounted fan across from the table for folding clean linens, measuring approximately eighteen inches across. Observation of the fan revealed it was blowing toward the open shelving and the table for folding clean linens and the items on the table. OSM # 2 was asked to turn the fan off. When the fan 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,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	A. BUILDING _____ B. WING _____	02/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARMVILLE HEALTH & REHAB CENTER	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 880	Continued From page 83	F 880		

stated yes. When asked how often the fan was cleaned OSM # 2 stated, "I clean about once every two weeks. I should probably do it more often." OSM # 2 was then observed removing the fan parts and sending them to be cleaned.

On 02/21/19 at 2:40 p.m., ASM # 1 (administrative staff member), administrator, and ASM # 2, director of nursing, were made aware of the findings.

No further information was provided prior to exit.
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 un-sanitized hands.

Resident #40 was admitted to the facility on 04/04/2018. Diagnoses for Resident #40 included but were not limited to High Blood Pressure, Anxiety Disorder and Diabetes Mellitus. Resident #40's Minimum Data Set (quarterly assessment) with an Assessment Reference Date of 12/18/2018 coded Resident #40 with severe cognitive impairment. In addition, the Minimum Data Set (MDS) coded Resident #40 as requiring extensive assistance of one staff member with activities of daily living and independent for eating.

On 02/20/2019 at approximately 8:33 a.m., LPN (licensed practical nurse) #2 was observed during medication pass. LPN #2 administered the following medications:

1. Atenolol 50 mg tablet (1)
2. Vitamin D3 2000 Units (2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	A. BUILDING _____ B. WING _____	02/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARMVILLE HEALTH & REHAB CENTER	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 880	Continued From page 84 After preparing medication for Resident #40, LPN #2 was observed with her finger in Resident #40's medication cup while two pills were in the cup. LPN #2, was also been observed touching the medication cart handles and not sanitizing her hands, prior to her finger being observed in the resident's medication cup. On 02/20/2019 at approximately 2:32 p.m., an interview was conducted with LPN #2 regarding her medication administration to Resident #40. LPN #2 was asked how she maintains infection control when administering medications. LPN #2 stated that she washes her hands, wears gloves and uses universal precautions at all times. LPN #2 stated that she uses hand sanitizer one or two times then washes her hands, if she comes in contact with anything. LPN #2 was asked why infection control is important. LPN #2 stated that infection control is important because it is required to prevent contamination and spreading germs. LPN #2 was asked if her finger should be inside of the resident's medication cup. LPN #2 stated, "At no time finger be inside the resident's pill cup because it can cause contamination." LPN #2 was informed of the above observation at this time. A copy of the facility policy regarding medication administration was requested from ASM (administrative staff member) #2 (director of nursing) on 02/20/2019 at 5 p.m. The Omnicare LTC Facility Pharmacy Services and Procedures Manual policy titled, "General Dose Preparation and Medication Administration", documented "Prior to preparing or administering medications, authorized and competent facility staff should follow facility's infection control policy (e.g.,	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	A. BUILDING _____ B. WING _____	02/21/2019

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

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F 880	Continued From page 85 handwashing)." 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. References: (1) Atenolol is used alone or in combination with other medications to treat high blood pressure. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a684031.html (2) Vitamin D3 is supplement that helps your body absorb calcium. This information was obtained from the website: https://medlineplus.gov/vitamind.html	F 880		