STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(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 1/14/2020 through 1/16/2020. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. One complaint was investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid certification survey was conducted 1/14/2020 through 1/16/2020. Complaints were investigated during the survey. Corrections are required for compliance with the following Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 94 at the time of the survey. The survey sample consisted of 19 current Resident reviews and 3 closed record reviews.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 657	**F657- Care Plan Timing and Revision** 1. Resident #28 Comprehensive Care Plan was reviewed by the care plan coordinator and updated on January 16, 2020. 2. The Director of Nursing /designee will complete Quality Monitor Audit of current residents receiving Speech Therapy to ensure the care plan is reflective of Speech Therapy services, by February 21, 2020 3. The Director of Nursing / designee will provide re-education to Interdisciplinary team (Care manager Coordinators /Dietician) regarding reviewing and revising care plans timely by February 21, 2020. 4. Director of Nursing/designee to conduct two random quality monitoring audits of residents receiving Speech Therapy to	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Electronically Signed Mason Layne — Executive Director — 2-7-20

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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 657	Continued From page 1 the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, facility staff failed to ensure that the comprehensive care plan (CCP) was reviewed and revised by an interdisciplinary team for 1 of 22 residents in the survey sample as evidenced by failing to include Speech Therapy that the resident was receiving (Resident #28). The findings included: Resident #28 was a resident in the facility during the survey with dates of 1/14 through 1/16/2020. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 11/1/19 coded the resident as having short term and long term memory loss. Resident #28 was moderately impaired and required cues/supervision. This MDS also coded this resident requiring extensive assistance from 1 staff member for dressing and personal hygiene. Resident #28 had the following diagnoses of, but not limited to heart failure, high blood pressure, dementia and depression. The surveyor reviewed the clinical record of	F 657	ensure the care plan is reflective of Speech Therapy services, 3 x weekly x 2 weeks, 2 x weekly x 2 weeks then weekly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Allegation of Compliance February 21, 2020.	

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F 657	Continued From page 2 Resident #28 on 1/15 and 1/16/2020. During this review, the CCP was also reviewed. The surveyor noted that Resident #28 had received speech therapy services from 8/28/19 through 10/21/19. It was noted when the surveyor was reviewing the clinical record that this resident had obtained speech therapy services. During this time, the resident received speech therapy 5 times a week to " ...assess/evaluate for the safest level of oral intake, teach/instruct in environmental modifications and minimize risk of aspiration in order to enhance the patient's quality of life by improving ability to consume intake in least restrictive malnutrition/weight loss and eliminate aspiration ..." On the CCP, the surveyor noted that the resident was care planned for risk of aspiration with interventions in place but the speech therapy services were not included on this care plan. On 1/16/2020 at 11 am, the surveyor notified the DON (director of nursing) of the above findings documented above. The DON stated, "Let me go and investigate this." At 11:30 am, the DON came back to the surveyor and stated, "We had provided the services that the resident would need to prevent weight loss or aspiration. We failed to include speech therapy services on the care plan." The surveyor notified the administrator, DON and regional nurse of the above documented findings at approximately 2:30 pm. No further information was provided to the surveyor prior to the exit conference on 1/16/2020.	F 657		

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F 692 SS=D	Continued From page 3 Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on family interview, staff interview and clinical record review, facility staff failed to maintain acceptable parameters of nutritional status, such as usual body weight as evidenced by significant weight loss over 10% of body weight in 1 month without referral to physician or dietician for assessment for 1 of 22 residents in the survey sample (Resident #88). Resident #88 was admitted to the facility with diagnoses including saddle embolus of pulmonary artery, muscle weakness, dysphagia, primary hypertension, dementia, and depression.	F 692 F 692	**F692- Nutrition/Hydration Status Maintenance** 1. Resident #88 attending physician was contacted on January 27, 2020 with no new orders. The facility Dietician completed a nutritional assessment on January 16, 2020 with new orders for Med Pass 90cc by mouth twice daily. The resident care plan was reviewed and updated on January 17, 2020 by care manager coordinator. 2. The Director of Nursing / designee will complete Quality Monitor Audit of current residents with a significant weight loss for the last thirty days to ensure they have been referred to the Physician and Dietician for assessment by February 21, 2020. Follow up based on findings. 3. Director of Nursing/Designee will provide re- education to facility Licensed Nurses and Interdisciplinary Team (Unit Managers/Dietician) regarding referring residents with significant weight loss to the Physician and Dietician for an assessment by February 21, 2020. Any Licensed Nurses that did not receive the education will receive prior to working next shift. 4. Director of Nursing/designee to conduct two sample random quality monitoring audits of residents with a significant weight loss to ensure they have been referred to the Physician and Dietician for assessment, 3 x weekly x 2 weeks, 2 x weekly x 2 weeks then weekly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Allegation of Compliance February 21, 2020.	

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F 692	Continued From page 4 On the admission Minimum Data Set assessment, the resident scored 6/15 on the Brief Interview for Mental Status and was assessed as having inability to focus attention and rejecting care (1-3 days in the prior week). The surveyor interviewed the resident's power of attorney(POA) on 1/14/20. The POA reported being generally satisfied with care. When asked about the resident's food intake (the lunch tray appeared to have approximately 75% remaining), the POA reported the resident did not care for the pureed foods or thickened liquids necessary to avoid aspiration. The POA reported bringing the resident's preferred flavors of Ensure brand supplement to the facility. Clinical record review of weights and vital signs on 1/14/20 revealed that on 12/26/2019, the resident weighed 145 lbs. On 01/07/2020, the resident weighed 131.4 pounds which is a -9.38 % loss. On 01/14/2020, the resident weighed 129.4 pounds which is a -10.76 % loss. The clinical record software generated automatic weigh loss warnings on 1/7/20 for 5% and 7.5% loss and on 1/14/20 for 5%, 7.5%, and 10% weight loss. On 1/16/20 08:24 AM there were no references to weight in the progress notes. The dietary notes on 1/3 and annual CDM (dietary manager) assessment on 1/8 used the admission weight of 145 lbs. on 1/16/20 08:38 AM, the surveyor asked a nurse how staff addressed weight loss. The nurse stated that the interdisciplinary team (IDT) addressed weight loss. The surveyor was unable to locate an IDT note referring to weight loss. One	F 692		

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F 692	Continued From page 5 IDT note indicated staff had discussed the resident's pressure ulcers, but there was no mention of weight loss. The nurse practitioner (NP) was at the nurse's station when the surveyor asked staff about the resident's weights. The NP said he had the weight list right there. Resident #88 was not on the weight list. The nurse stated the director of nursing (DON) also maintained a weight loss list. The resident was not on the weight list for the DON. The care plan indicated potential for weight loss with a goal to maintain weight. Interventions included reporting lab/diagnostic results to the MD. The resident's weight changes were not reported to the MD or NP. The administrator and director of nursing were notified of the concern on 1/16/20.	F 692		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist	F 756	**F756- Drug Regimen Review, Report Irregular, Act On** 1. Resident #49 Pharmacy Recommendation reviewed by attending physician on January 16, 2020 with no new orders. 2. The Director of Nursing /designee will completed Quality Monitor Audit of Monthly Pharmacist recommendations for previous three months to ensure Physician has reviewed and acted upon timely by February 21, 2020. Follow up based on findings. 3. The Director of Nursing /designee will provide re- education to the Unit Managers and Physicians to review and act upon Pharmacist recommendations timely by February 21, 2020 4. Director of Nursing/designee to conduct random quality monitoring audits of Pharmacist recommendations to ensure Physicians have reviewed and acted	

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F 756	Continued From page 6 during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, facility staff failed to ensure pharmacist reported irregularities were acted upon by the attending physician, the facility's medical director and director of nursing for 1 of 22 residents in the survey sample (Resident #49). The findings included: For Resident #49 the facility staff failed to review and act upon pharmacist recommendations noted during the monthly drug regimen review. Resident #49's diagnosis list located in the clinical record includes diagnoses not limited to anemia,	F 756	upon timely, 3 x weekly x 2 weeks, 2 x weekly x 2 weeks then weekly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Allegation of Compliance February 21, 2020.	

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F 756	Continued From page 7 coronary artery disease, congestive heart failure, diabetes mellitus, hyperlipidemia, anxiety, depression, and bipolar disorder. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 11/25/19 assigned Resident #49 a BIMS (brief interview for mental status) score of 15 out of 15 in section C, cognitive patterns. Resident #49's clinical record was reviewed on 01/16/2020. It contained monthly drug regimen review (DRR) forms, located under the physician's orders section of the clinical record. The DRR for the months of June and August 2019 indicated that a pharmacist consultation form was completed. The surveyor could not locate these consultation forms in the resident's clinical record. The surveyor spoke with the DON (director of nursing) on 01/16/2020 at approximately 11:00 am to inform DON that pharmacist consultation forms could not be located in Resident #49's clinical record. DON stated that --- would look for them. DON provided the surveyor with the consultation forms on 01/16/2020 at approximately 1:45 pm. Resident #49's pharmacist consultation form, dated 06/04/2019, read in part "Comment: .... (Resident #49) has not had an assessment of renal function within the past 6 months" and "Recommendation: Please order a CMP (comprehensive metabolic panel), CBC (complete blood count), TSH (thyroid stimulating hormone), fasting lipid panel on the next convenient lab day and every 6 months thereafter". Facility medical director, attending	F 756		

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F 756	Continued From page 8 physician or the DON, has not signed this consultation form. The surveyor could not locate information regarding the recommended lab tests. Resident #49's pharmacist consultation form, dated 08/06/2019, read in part "Comment: REPEATED RECOMMENDATION from 6/4/2019: Please respond promptly to assure facility compliance with Federal regulations. ... (Resident #49) has not had an assessment of renal function within the past 6 months" and "Recommendation: Please order a CMP, CBC, fasting lipid panel on the next convenient lab day and every 6 months thereafter". The facility medical director, attending physician or the DON, has not signed this consultation form. The surveyor could not locate information regarding the recommended lab tests. The surveyor requested and was provided with a facility policy entitled "Monthly Drug Regimen Review", which read in part "Consultant Reports-Non-Urgent: Report provided to the attending physician for timely response: -Day 1-14 provide recommendation(s) to physician(s) for review and response. -Day 15-21 the DON/designee will contact the physician(s) with any outstanding recommendation if no response from physician notify the Medical Director for further assistance..." Surveyor spoke with the DON on 01/16/2020 at approximately 3:20 regarding the pharmacist consultations not being acted upon. DON stated that --- was on leave during the period of the first consultations and could not say why the recommendations were not acted on. DON stated that for the second consultation, it was a "medical	F 756		

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F 756	Continued From page 9 records issue". The concern of not following up on pharmacist recommendations was discussed with the administrative team (administrator, DON, regional nurse consultant) during a meeting on 01/16/2020 at approximately 3:20 pm. No further information was provided prior to exit.	F 756		
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 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	F 761	**F761- Label/Store Drugs and Biologicals** 1. LPN #1 re-educated on January 16, 2020 by Unit Manager not to leave medications unattended on medication cart not under direct observation of the nurse administering the medications, re-education completed on January 16, 2020. 2. Director of Nursing/designee will complete Quality Monitor Audit of current nurses during their medication pass to ensure medications are not left unattended by February 21, 2020. Follow up based on findings. 3. Director of Nursing/designee will provide re-education Licensed nurses by February 21, 2020 regarding on supervision/storage of medications during their medication administration passes by February 21, 2020. 4. Director of Nursing/designee to conduct random quality monitoring audits of nurses during their medication pass to ensure medications are not left unattended, 3 x weekly x 2 weeks, 2 x weekly x 2 weeks then weekly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Allegation of Compliance February 21, 2020.	

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F 761	Continued From page 10	F 761		

by:
Based on observation, staff interview, and facility document review, facility staff failed to store all drugs and biologicals in locked compartments as evidenced by medications were observed unattended on the medication cart not under the direct observation of the person administering the medications. This observation was made on the 400 hallway in the facility.

The findings included:

The surveyor was observing a medication pass and pour with LPN (licensed practical nurse) #1 on 1/16/2020 at 8:30 am. LPN #1 was preparing medications for an unsampled resident. LPN #1 turned around with the medications that were to be given and walked into the resident's room. While doing so, LPN#1 left the card of medications lying on the table that was being used by the surveyor. LPN #1 did not have direct observation of the medication cart. The following cards of medications that were left on the table were:

- Buspar 10 mg (milligram)
- Eliquis 5 mg
- Lexapro 5 mg
- Namendia 5 mg

At 8:40 am, LPN #1 walked back to her medication cart. The surveyor asked LPN #1 if she saw anything wrong concerning medications. LPN #1 stated, "I left these cards of meds (medications) on the table that you were using and left them unattended."

At 9 am, the surveyor notified the regional nurse and the DON (director of nursing) of the above observations made by the surveyor during the

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F 761	Continued From page 11 medication pass and pour observation. The surveyor requested a copy of the facility's policy on storage of medications. At 9:30 am, the regional nurse provided the surveyor with a copy of the facility's titled "6.0 General Dose Preparation and Medications Administration" which read in part " ...Facility staff should not leave medications or chemicals unattended ..." The administrator, DON and the regional nurse were notified of the above documented observations made by the surveyor on 1/16/2020 at 8:30 am. The administrative team was notified concerning this on 1/16/2020 at approximately 1 pm. No further information was provided to the surveyor prior to the exit conference on 1/16/2020.	F 761		
F 775 SS=D	Lab Reports in Record - Lab Name/Address CFR(s): 483.50(a)(2)(iv) §483.50(a)(2) The facility must- (iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, the facility staff failed to file laboratory reports in the resident's clinical record for 1 of 22 residents in the clinical record (Resident #79). The finding included:	F 775	**F775- Lab Reports in Record- Lab Name/Address** 1. Resident #79's laboratory reports have been scanned into the resident's clinical record on January 16, 2020. 2. The Director of Nursing/designee will complete Quality Monitor Audit of current residents who have had laboratory tests obtained in the last thirty days to ensure the reports have been scanned into the resident's clinical record by February 21, 2020 Follow up based on findings. 3. The Director of Nursing will provide re- education the facility Licensed Nurses and Medical Records related to scanning laboratory reports into the resident's clinical record timely by February 21, 2020. Any Licensed Nurses who did not receive the education will receive prior to working next shift.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

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F 775	Continued From page 12 For Resident #79 the facility staff failed to file a laboratory test for Tacrolimus level in the clinical record. According to LabCorp.com, Tacrolimus is an immunosuppressive drug that is used to prevent rejection in transplantation patients. Measurement of tacrolimus blood levels may be used in monitoring patients receiving this drug. Resident #79's diagnosis list includes diagnoses not limited to kidney transplant, hypertension, and hyperlipidemia. Resident #79's most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 09/30/19 assigned the resident a BIMS (brief interview for mental status) score of 15 out of 15 in section C, cognitive patterns. Resident #79's clinical record was reviewed on 01/16/2020. It a contained a pharmacist consultation report for the month of December 2019, which read in part, "Comment: REPEATED RECOMMENDATION from 11/4/2019: Please respond promptly to assure facility compliance with Federal regulations. ... (Resident #79) has orders for labs to be drawn, but at the time of this review they were not available in the resident record. The missing lab values include: 1. tacrolimus level from 9-12-19. Recommendation: Unless otherwise indicated, please follow up with the lab and have results forwarded to the facility". The surveyor reviewed to lab section of the resident's clinical record, but could not locate results for the tacrolimus level. Surveyor spoke with the DON (director of nursing) on 01/16/19 at approximately 1:15 pm regarding the missing lab reports. DON stated she did not know why they	F 775	4. Director of Nursing/designee to conduct two random quality monitoring audits of residents who have had laboratory tests obtained to ensure the reports have been scanned into the resident's clinical record, 3 x weekly x 2 weeks, 2 x weekly x 2 weeks then weekly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Allegation of Compliance February 21, 2020.	

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F 775	Continued From page 13 reports were not in the clinical record. Surveyor requested and was provided with a facility policy entitled "Laboratory, Diagnostic and X-Ray", which read in part "Laboratory work, diagnostic testing and x-rays to be filed in the medical record". The concern of not filing the tacrolimus level in the resident's clinical record was discussed with the administrative team (administrator, DON, regional nurse consultant) during a meeting on 01/16/19 at approximately 3:20 pm. No further information was provided prior to exit.	F 775		

State of Virginia

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	VA0208	A. BUILDING: _____ B. WING _____	01/16/2020

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F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 1/14/2020 through 1/16/2020. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 101 bed facility was 94 at the time of the survey. The survey sample consisted of 19 current resident reviews.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Nursing Home Rules and Regulations: 12VAC5-371-140 E 3 The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities: 12 VAC 5-371-140. Based on staff interview and facility document review, facility staff failed to obtain criminal background checks within the required time frame for 2 of 29 newly hired employees reviewed. The findings included: On 1/15/2020 through 1/16/2020, the surveyor reviewed files of 29 newly hired employees. During this review, the surveyor noted the following:	F 001		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed Meesa Layne — TITLE: Executive Director — (X6) DATE: 2-7-20

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F 001	Continued From page 1 " Employee #13 had a criminal record verification dated for 2/26/19. The employees hire date was 4/1/19. " Employee #29 was hired on 8/5/19 and had no criminal record verification. The administrator was notified of the above documented findings on 1/15 at 10:30 am by the surveyor. The administrator stated, "when you asked for those files, we realized that we did not have a background check on _____ (employee #29). We have already submitted a request for the background check to be done on ____ (employee #29). The surveyor requested the facility's policy on obtaining a criminal record check on new and rehired employees. At 10:45 am, the surveyor was provided a copy of the facility's policy titled "Re-employment and Re-hire". The policy read in part, " ...who were separated from employment longer than thirty (30) days, will be considered a "new hire" subject to Introductory Period and any required waiting period for benefits and time accrual eligibility ..." The surveyor asked the human resourse's (HR) employee if there were any other polices that could support this policy to include obtaining criminal record check within the first thirty (days) of employment. The HR employee stated this was what is in place and that she was new in this role. No further information was provided to the surveyor prior to the exit conference on 1/16/2020. 12VAC5-371-250 F cross-reference to F657 12VAC5-371-220 C 5 cross-reference to F692	F 001		

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F 001	Continued From page 2 12VAC5-371-300 H cross-reference to F756 12VAC5-371-300 L cross-reference to F761 12VAC5-371-310 B cross-reference to F775	F 001		