PRINTED: 09/17/2021 **FORM APPROVED** State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C VA0021 08/17/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD **BATTLEFIELD PARK HEALTHCARE CENTER** PETERSBURG, VA 23805 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 000 Initial Comments F 000 An unannounced biennial State Licensure Inspection was conducted 8/15/21 through 8/17/21. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 120 licensed bed facility was 109 at the time of the survey. The survey sample consisted of 40 Resident reviews. F 001 Non Compliance F 001 The facility was out of compliance with the following state licensure requirements: Cross Reference to F641 This RULE: is not met as evidenced by: Cross Reference to F677 12 VAC 5-371-250 (A) and (D) and (E). Cross Reference to F 641. Cross Reference to F686 12 VAC5-371-220 (C)(1). Cross reference to F686 Cross Reference to F745 12 VAC 5-371-220 (D). Cross reference to F677 12 VAC5-371-270 (A). Cross reference to F745 Cross Reference to F814 12 VAC 5-371-340 (A). Cross Reference to F COV 32.1-126.01 (A) Based on staff interview and facility COV 32.1-126.01 (A) documentation review, the facility staff failed to have evidence of a signed sworn statement, on or 1. Sworn statements for Employee E, prior to hire, for 8 employees, Employee E, Employee F, Employee G, Employee H, Employee F, Employee G, Employee H, RN A. LPN A, LPN C, and CNA C, in a sample of 25 RN A, LPN A, LPN C, and CNA C will employee records. be found and/or obtained. No residents were affected by the deficient practice.

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

Employee G, Employee H, RN A, LPN A, LPN C,

The facility staff failed to obtain a sworn statement for Employee E. Employee F.

**Electronically Signed** 

and CNA C.

STATE FORM

2. All residents and staff have a potential

to be affected by the deficient practice.

9CSE11

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		VA0021	B. WING		C 08/17/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST.	ATE, ZIP CODE		
BATTLEE	IELD PARK HEALTHCAR	E CENTER 250 FLANK	ROAD			
BATTLET	IEED FARR HEALTHOAR	PETERSBU	IRG, VA 2380	05		
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
F 001	Continued From page 1		F 001			
F 001	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 001	3. The Regional Human Ker Director will in-service the Resource Manager (HRM) Scheduler on policies and procedo obtaining sworn statements and conducted audit of all current emprecords.  4. HRM/Designee will audit employee(s) files for sworn state will be conducted weekly for 4 and findings will be reported monthly QAPI committee for 3-rand then quarterly for 1-month QAPI Committee will be responsion on going monitoring.  5. 9/29/2021	Human and/ ures for omplete oployee of 10 tements to the months th. The	
	of Nursing (DON) who for the 8 referenced far DON was asked about	confirmed the hire dates cility staff members. The				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED				
AND FLAN OF GOARECTION		, Jan 10 Mile Mile Mile Mile Mile Mile Mile Mile	A. BUILDING:		COMPLETED				
		VA0021	B. WING		C 08/17/2021				
NAME OF F	PROVIDED OR SUPPLIED		DESS CITY ST	TATE ZID CODE	00/1//2021				
I WANTE OF F	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  260 EL ANK POAD								
BATTLEFIELD PARK HEALTHCARE CENTER 250 FLANK ROAD PETERSBURG, VA 23805									
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE				
F 001	and she stated, "The pemployment is vouching they are providing is fainformation was provided as the professional employees, Employee F, RN B, LPN A, LPN of 25 employee record. The facility staff failed licenses were active a Employee B, Employee LPN A, LPN B, and LF. The findings included:  On 8/16/21, a review of conducted by Surveyof following:  1. Employee B began of 4/12/21. There was not verified Employee B's ensure it was active are employment and was peare to Residents.	person being considered for ng to the information that actual". No further ded.  (3)(A)  Ew and facility , the facility staff failed to license, prior to hire, for 7 EB, Employee E, Employee B, and LPN C, in a sample is.  to verify that professional nd in good standing for e E, Employee F, RN B, EN C.  of 25 employee files was r C and revealed the  working at the facility on a evidence that facility staff professional license to a in good standing prior to be committed to provide direct  working at the facility on evidence that facility staff professional license to a committed to provide direct	F 001	12 VAC 5-371 140(E)(3)(A)  1. Verification of Professional I for Employee B, Employee E, Em F, RN B, LPN A, LPN B, and LPN be found and/or obtained. No rewere affected by the deficient practice and staff have a pet to be affected by the deficient practice.  3. The Regional Human Red Director will in-service the Resource Manager (HRM) Scheduler on policies and proceduverification of licensure prior to ha 100% audit of employee files.  4. The HRM/ Designee will audiemployee(s) files for licensure conducted weekly for 4-week findings will be reported to the mQAPI committee for 1-months QAPI Committee will be responsiongoing monitoring.	aployee N C will esidents ectice.  otential ectice.  esource Human and/ ures for aire and  t of 10 will be as and nonthly s. The				
	ensure it was active an	nd in good standing prior to permitted to provide direct		5. 9/29/2021					

PRINTED: 09/17/2021 FORM APPROVED State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING VA0021 08/17/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD **BATTLEFIELD PARK HEALTHCARE CENTER** PETERSBURG, VA 23805 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) F 001 Continued From page 3 F 001 3. Employee F began working at the facility on 4/1/19. Employee F's license verification was dated 1/26/21. Therefore, from 4/1/19-1/26/21, facility staff was unaware if Employee F's professional license was active and in good standing and was permitted to provide direct care to Residents. 4. RN B began working at the facility on 3/22/21. RN B's license verification was dated 3/26/21. Therefore, from 3/22/21-3/26/21, facility staff was unaware if RN B's professional license was active

and in good standing and was permitted to

5. LPN A began working at the facility on 2/7/21. LPN A's license verification was dated 2/16/21. Therefore, from 2/7/21-2/16/21, facility staff was unaware if LPN A's professional license was active and in good standing and was permitted to

6. LPN B began working at the facility on 6/29/21. There was no evidence that facility staff verified LPN B's professional license to ensure it was active and in good standing prior to employment and was permitted to provide direct care to

7. LPN C began working at the facility on 8/8/19. There was no evidence that facility staff verified verified LPN C's professional license to ensure it

On 8/16/21, Surveyor C interviewed the Director of Nursing (DON) who confirmed the hire dates for the 7 referenced facility staff members. The DON was asked about the importance of

was active and in good standing prior to employment and was permitted to provide direct

provide direct care to Residents.

provide direct care to Residents.

Residents.

care to Residents.

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	(X3) DATE SURVEY COMPLETED
	С
YA0021	08/17/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  250 FLANK ROAD	
BATTLEFIELD PARK HEALTHCARE CENTER PETERSBURG, VA 23805	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORT PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION S TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE COMPLETE
F 001 Continued From page 4 obtaining a professional license verification prior to employment and she stated, "To be sure that we are hirring qualified staff to provide care and services to our residents, that staff are appropriately certified to perform or provide the services required according to the job that they are applying for in their job description".  A review of the facility's policy entitled, "Abuse, Neglect, and Exploitation Policy-Virginia", effective date 05/01/2017, subtitle, "Policy", read in part, "It is the intent of this facility to prevent the abuse, mistreatment, or neglect of residentsFurthermore, it is the intent of this facility to employ only properly screened persons as part of the resident care team by the applicable requirements' and subtitle, "Procedure", section, "I. Screening", item, "6. This facility will not employ individuals who have had a disciplinary action taken against their professional license by a state licensure body as a result of a finding of abuse, neglect, mistreatment of residents, or misappropriation of their property".  No further information was provided.  12 VAC 5-371.140 €(3)(B 32.1-126.01(A)  12 VAC 5-371.140 €(3)(B 32.1-126.01(A)  1. Criminal Background Employee D, Employee E, Employee B, Employee G, Employee E, Employee G, Employee E, Employee G, Employee B, Employee H, I C, and CNA C will be f obtain a criminal background check with the Central Criminal Records Exchange within 30 days of hire for 8 employees, Employee D, Employee B, LPNA, LPN C, and CNA C, in a	Check for Employee F, LPN A, LPN found and/or

9CSE11

FORM APPROVED State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING VA0021 08/17/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD **BATTLEFIELD PARK HEALTHCARE CENTER** PETERSBURG, VA 23805 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 001 Continued From page 5 F 001 sample of 25 employee records. The facility staff failed to obtain a criminal background check within 30 days of hire for Employee D, Employee E, Employee F. 2. All residents and staff have the Employee G, Employee H, LPN A, LPN C, and potential to be affected by the deficient CNA C. practice. The findings included: 3. The Regional Human Resources 1. Employee D was hired 4/5/21. Employee D's Director will in-service, the Human criminal background check was dated 7/1/21. Resource Manager and/ Scheduler on Therefore, from 4/5/21-7/1/21, facility staff was policies and procedures for verification unaware of Employee D's criminal background of licensure prior to hire and a 100% status. audit of employee files. 2. Employee E was hired 2/1/19. Employee E's criminal background check was dated 1/28/20. 4. The HRM/ Designee will audit of 10 Therefore, from 2/1/19-1/28/20, facility staff was employee(s) files for criminal unaware of Employee E's criminal background backgrounds will be conducted weekly status. for 4-weeks and findings will be reported 3. Employee F was hired 4/1/19. There was no to the monthly QAPI committee for 1evidence that facility staff obtained a criminal months. The QAPI Committee will be background check for Employee F and was responsible for ongoing monitoring. permitted to provide direct care to Residents. 5, 9/29/2021 4. Employee G was hired 5/31/20. There was no evidence that facility staff obtained a criminal background check for Employee G. 5. Employee H was hired 9/21/20. There was no evidence that facility staff obtained a criminal background check for Employee H. 6. LPN A was hired 2/7/21. There was no

evidence that facility staff obtained a criminal background check for LPN A and was permitted

to provide direct care to Residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
AND I DAN OF GONNEGHON			A. BUILDING:					
		VA0021	B. WING	<del></del>		C 17/2021		
NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
BATTLEF	BATTLEFIELD PARK HEALTHCARE CENTER  250 FLANK ROAD PETERSBURG, VA 23805							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE		
F 001	7. LPN C was hired 8/evidence that facility shackground check for to provide direct care  8. CNA C was hired 1/evidence that facility shackground check for to provide direct care.  On 8/16/21, Surveyor of Nursing (DON) who for the 8 referenced far DON was asked about obtaining a criminal be employment and she swe are hiring an employment and she swe are hiring an employment at risk."  A review of the facility Neglect, and Exploitate effective date 05/01/20 in part, "It is the intent abuse, mistreatment, or residentsFurthermofacility to employ only as part of the resident applicable requirement "Procedure", section, "	/8/19. There was no staff obtained a criminal LPN C and was permitted to Residents.  0/19/20. There was no staff obtained a criminal CNA C and was permitted to Residents.  C interviewed the Director confirmed the hire dates acility staff members. The true importance of ackground check prior to stated, "To make sure that byee that has not had any ould put our facility and specific properly screened persons care team by the ts" and subtitle, "I. Screening:", item, "2. A heck will be completed to its".	F 001					