State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0080	A. BUILDING: _____ B. WING _____	02/02/2022

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) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 2/1/22 through 2/2/22. Corrections are required for compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 112 bed facility was 91 at the time of the survey. The survey sample consisted of eight 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: 12VAC5-371-140. Policies and procedures. Based on staff interview and facility document review, it was determined that the facility staff failed to obtain license verifications and/or reference checks upon hire for six of 25 employee record reviews. The facility staff failed to obtain license verifications upon hire for ASM (administrative staff member) #2 (registered nurse/director of nursing) and CNA (certified nursing assistant) #2, and failed to obtain reference checks upon hire for ASM #2, CNA #1, OSM (other staff member) #3 (receptionist), LPN (licensed practical nurse) #1, CNA #2 and CNA #3. The findings include: ASM #2 was hired on 1/18/21. Review of ASM #2's employee record failed to reveal a license verification upon hire. The license verification in the record was dated 5/24/21. Also, ASM #2's record failed to contain evidence that reference	F 001	12VAC5-371-140 1. Reference checks have been completed on C.N.A #1, C.N.A. #2, C.N.A. #3, OSM #3, LPN #1, and ASM # 2. License verification was completed on ASM #2 and C.N.A. #2. 2. All other residents may have been potentially affected. A 100% audit of current and past employees will be conducted looking back 2 years. Any discrepancies will be corrected where applicable at time of discovery. 3. The HR director will have a one on one in service on the "Employee Background Screening Policy". 4. The Administrator will review all new hire paperwork weekly for 12 weeks. Variances will be investigated, and appropriate actions taken. Analysis of the audits will be submitted to QAPI monthly for review/recommendations.	3/1/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator (X6) DATE 2/16/22

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F 001	Continued From page 1 checks were attempted upon hire. CNA #1 was hired on 11/25/20. Review of CNA #1's employee record failed to reveal evidence that reference checks were attempted upon hire. OSM #3 was hired on 11/11/20. Review of OSM #3's employee record failed to reveal evidence that reference checks were attempted upon hire. LPN #1 was hired on 12/9/20. Review of LPN #1's employee record failed to reveal evidence that reference checks were attempted upon hire. CNA #2 was hired on 12/9/20. Review of CNA #2's employee record failed to reveal a license verification upon hire. The record contained a phone screenshot of a license verification but there was no license verification date. Also, CNA #2's record failed to contain evidence that reference checks were attempted upon hire. CNA #3 was hired on 3/12/21. Review of CNA #3's employee record failed to reveal evidence that reference checks were attempted upon hire. On 2/1/22 at 2:37 p.m., an interview was conducted with OSM #1 (the payroll coordinator). OSM #1 stated license verifications and reference checks are completed prior to hire. OSM #1 stated that usually the nurse who conducts the interview will complete license verifications but if not, she does them. OSM #1 stated the staffing coordinator previously completed reference checks but she has been completing them for the last month. OSM #1 was made aware of the above concerns. On 2/1/22 at 3:48 p.m., OSM #1 stated she could not locate a license verification upon hire for ASM	F 001		

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F 001	Continued From page 2 #2 and CNA #3. OSM #1 further stated she could not locate reference checks for the above employees. On 2/2/22 at 11:50 a.m., ASM #1 (the administrator) and ASM #2 were made aware of the above findings. The facility policy titled "Employee Background Screening Policy" documented, "A. Prior to hiring, the facility will perform exclusion, background and licensure checks on all new employees...Document attempt to obtain two references from prior employers..." No further information was presented prior to exit. 12VAC5-371-220. Nursing services. Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide treatments per physician's order for two of eight residents in the survey sample, Residents #2 and #4. The findings include: 1. The facility staff failed to administer oxygen to Resident #2 per the physician prescribed rate of two liters per minute. Resident #2 was admitted to the facility on 6/30/21. Resident #2's diagnoses included but were not limited to chronic kidney disease, major depressive disorder and diabetes. Resident #2's quarterly minimum data set assessment with an assessment reference date of 12/9/21, coded the resident's cognition as severely impaired.	F 001	12VAC5-371-220 1. Resident #2 and Resident #4's oxygen flow rates were adjusted at the time of discovery. 2. All residents on oxygen could be affected. A 100% audit of current residents who are receiving oxygen was conducted to ensure the flow rate matched the physicians order. Variances will be investigated, and corrective actions will be taken as appropriate including staff reeducation/counseling.	

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F 001	Continued From page 3 Review of Resident #2's clinical record revealed a physician's order dated 10/1/21 for oxygen at two liters per minute via nasal cannula (tubing into the nostrils) as needed for shortness of breath or an oxygen saturation level less than 88%. Resident #2's comprehensive care plan reviewed by the facility staff on 12/16/21, documented, "At risk for altered cardiac/resp (respiratory) status. 02 (oxygen) prn (as needed)." On 2/1/22 at 10:32 a.m., 2/1/22 at 2:59 p.m. and 2/2/22 at 8:13 a.m., Resident #2 was observed lying in bed and receiving oxygen via nasal cannula. The oxygen concentrator was set at a rate of one and a half liters as evidenced by the center of the ball in the concentrator flowmeter positioned on the one and a half liter line. On 2/2/22 at 8:33 a.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked to describe where the ball in an oxygen concentrator flowmeter should be if a resident has a physician's order for two liters of oxygen. LPN #2 stated the ball should be centered with the line indicating two liters. On 2/2/22 at 11:50 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. The oxygen concentrator manufacturer's instructions documented, "5. Adjust the flow to the prescribed setting by turning the knob on the top of the flow meter until the ball is centered on the line marking the specific flow rate." The facility policy titled, "Oxygen Administration (all routes) Policy" documented, "Licensed clinicians with demonstrated competence will	F 001	3. Licensed nursing staff will be reeducated by the DON/designee on the Oxygen Administration Policy. 4. DON/designee will complete 5 audits weekly x 2 months to ensure that the oxygen flow rate matches the physician order. Variances will be investigated, and appropriate actions taken. Analysis of the audits will be submitted to QAPI monthly for review/recommendations.	3/1/22

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F 001	Continued From page 4 administer oxygen via the specified route as ordered by a provider..." No further information was presented prior to exit. 2. The facility staff failed to administer oxygen to Resident #4 per the physician prescribed rate of five liters per minute. Resident #4 was admitted to the facility on 7/29/08. Resident #4's diagnoses included but were not limited to chronic respiratory failure, diabetes and high blood pressure. Resident #4's annual minimum data set assessment with an assessment reference date of 12/8/21, coded the resident was in a persistent vegetative state. Review of Resident #4's clinical record revealed a physician's order dated 1/8/22 for oxygen at five liters per minute via tracheostomy (1) collar. Resident #4's comprehensive care plan reviewed by the facility staff on 1/23/22 documented, "At risk for altered cardiac/resp (respiratory) status. 02 (oxygen) as ordered..." On 2/1/22 at 10:32 a.m., 2/1/22 at 3:00 p.m. and 2/2/22 at 8:14 a.m., Resident #4 was observed lying in bed and receiving oxygen via tracheostomy. The oxygen concentrator was set at a rate of four and a half liters as evidenced by the center of the ball in the concentrator flowmeter positioned on the four and a half liter line. On 2/2/22 at 8:33 a.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked to describe where the ball in an oxygen concentrator flowmeter should be if a resident has a physician's order for five liters of oxygen. LPN #2 stated the ball should be	F 001		

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F 001	Continued From page 5 centered with the line indicating five liters. On 2/2/22 at 11:50 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. The oxygen concentrator manufacturer's instructions documented, "To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/min (liters per minute) line prescribed." No further information was presented prior to exit. Reference: (1) "A tracheostomy is surgery to create a hole in your neck that goes into your windpipe." This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000076.htm 12VAC5-371-340. Dietary and food service program. Based on observation, staff interview and facility document review, it was determined that the facility staff failed to wear a hair restraint while in the kitchen. On 2/1/22, OSM #2 (kitchen supervisor) was observed in the kitchen without a hair restraint. The findings include: On 2/1/22 at 4:22 p.m. (during dinner preparation), OSM #2 was observed in the kitchen without a hair restraint. During this observation, OSM #2 was observed near clean	F 001	12VAC5-371-340 1. OSM #2 put on a hair net at the time of discovery. An In-service was conducted with OSM #2 on the proper use of a hairnet any time they enter the kitchen food preparation area. 2. All other residents may have been potentially affected. The Food Service Manager, and/or Registered Dietician will randomly monitor the kitchen preparation area before, during and after meals to identify any negative findings with adherence to hair net. Any negative findings will be corrected at the time of discovery and disciplinary action will be taken as needed.	

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F 001	Continued From page 6 pans and entering the walk-in refrigerator. On 2/1/22 at 4:25 p.m., an interview was conducted with OSM #2. OSM #2 stated she should apply a hair restraint as soon as she walks into the kitchen. OSM #2 stated she forgot to do this. On 2/2/22 at 11:50 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. The facility food and nutrition policy titled, "Dress and Personal Hygiene" documented, "2. Employees in the FNS (food and nutrition services) Department, will wear a clean and appropriate hairnet/hair restraint..." No further information was presented prior to exit. 12VAC5-371-360. Clinical records. Based on 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 three of eight residents in the survey sample, Residents #1, #3 and #7. The findings include: 1. The facility staff failed to document all of Resident #1's medication administration on 1/15/22, 1/20/22 and 1/21/22. Resident #1 was admitted to the facility on 12/13/17. Resident #1's diagnoses included but were not limited to Huntington's disease (1), chronic pain syndrome and anxiety disorder.	F 001	3. Dietary staff were educated by the Administrator on the "Dress and Personal Hygiene policy". 4. The Administrator will complete 5 kitchen inspections weekly x 2 months to ensure that the Dress and Personal Hygiene Policy is being followed. Variances will be investigated, and appropriate actions taken. Analysis of the audits will be submitted to QAPI monthly for review/recommendations. 12VAC5-371-360 1. Nurses who failed to maintain a complete and accurate clinical record for resident #1, resident #3 and resident #7 received 1:1 education by the DON on accurate documentation of medication administration on the MAR and accurate documentation of treatment administration on the TAR.	3/1/22

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F 001	Continued From page 7 Resident #1's quarterly minimum data set assessment with an assessment reference date of 12/25/21, coded the resident as being cognitively intact. Review of Resident #1's clinical record revealed the following physician's orders: -11/19/21 Baclofen (2) 10 mg (milligrams) by mouth three times a day related to Huntington's disease. -10/5/20 Methadone (3) 10 mg- two tablets by mouth every eight hours for pain. -Risperdal (4) 1 mg by mouth three times a day related to Huntington's disease. Review of Resident #1's January 2022 MAR (medication administration record) failed to reveal documentation that the medications Baclofen, Methadone and Risperdal were administered to the resident at 2:00 p.m. on 1/15/22, 1/20/22 and 1/21/22 (as evidenced by blank spaces on the MAR). On 2/22/22 at 10:58 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated nurses evidence medication administration by signing the MAR. LPN #3 stated nurses' signatures on the MAR is proof that they administered medications but everyone makes mistakes and may forget to sign, even if they did administer the medications. On 2/2/22 at 11:50 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. The facility pharmacy policy titled, "General dose Preparation and Medication Administration" documented, "6. Document necessary medication	F 001	2. Any resident has the potential to be affected. An audit of current residents will be reviewed for the past 7 days to identify any omissions on the MAR or TAR. The Medical Director was notified of any omissions and orders clarified per physician. Variances will be investigated, and corrective actions will be taken as appropriate including staff reeducation/counseling on medication administration and documentation. 3. RN's and LPN's will be educated by the DON/designee on accurate documentation of medication administration on the MAR and accurate documentation of treatment administration on the TAR. 4. ADON/designee will review medication administration and treatment administration audit to verify medications and treatments have been administered and documented during the clinical morning meeting 5 times a week for 12 weeks. Variances will be investigated, and appropriate actions taken. The DON/designee will analyze the weekly findings for trends trends/patterns and actions to be taken. Analysis of the audits will be submitted to QAPI monthly for review/recommendations.	3/1/22

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F 001	Continued From page 8 administration/treatment information (e.g. when medications are opened, when medications are given..." No further information was presented prior to exit. References: (1) "Huntington's disease (HD) is an inherited disease that causes certain nerve cells in the brain to waste away. People are born with the defective gene, but symptoms usually don't appear until middle age. Early symptoms of HD may include uncontrolled movements, clumsiness, and balance problems. Later, HD can take away the ability to walk, talk, and swallow." 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=huntingtons+disease&_ga=2.256614924.604563532.1643813646-1146690537.1643813646 (2) "Baclofen is used to treat pain and certain types of spasticity (muscle stiffness and tightness)..." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682530.html (3) Methadone is used to relieve severe pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682134.html (4) "Risperidone is used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions) in	F 001		

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F 001	Continued From page 9 adults and teenagers 13 years of age and older. It is also used to treat episodes of mania (frenzied, abnormally excited, or irritated mood) or mixed episodes (symptoms of mania and depression that happen together) in adults and in teenagers and children 10 years of age and older with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods)." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a694015.html 2. The facility staff failed to document all of Resident #3's medication administration from 1/18/22 through 1/21/22 Resident #3 was admitted to the facility on 11/8/10. Resident #3's diagnoses included but were not limited to diabetes, chronic kidney disease and high blood pressure. Resident #3's quarterly minimum data set assessment with an assessment reference date of 12/17/21, coded the resident as being cognitively intact. Review of Resident #3's clinical record revealed the following physician's orders: -12/24/21 Aspirin 81 mg (milligrams) by mouth one time a day for supplement. -12/24/21 Metoprolol Tartrate (1) 100 mg by mouth two times a day for high blood pressure. Review of Resident #3's January 2022 MAR (medication administration record) failed to reveal documentation that Aspirin 81 mg was administered to Resident #3 from 1/18/22 through 1/21/22 and failed to reveal documentation that Metoprolol 100 mg was administered to Resident #3 on 1/18/22 at 7:30 a.m. and 1/20/22 at 7:30 a.m. (as evidenced by blank spaces on the MAR).	F 001		

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F 001	Continued From page 10 On 2/22/22 at 10:58 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated nurses evidence medication administration by signing the MAR. LPN #3 stated nurses' signatures on the MAR is proof that they administered medications but everyone makes mistakes and may forget to sign, even if they did administer the medications. On 2/2/22 at 11:50 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. No further information was presented prior to exit. Reference: (1) Metoprolol is used to treat high blood pressure. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682864.html 3. The facility staff failed to document Resident #7's physician ordered Foley catheter care every shift on 1/9/22, 1/23/22, 1/26/22 and 1/30/22. Resident #7 was admitted to the facility on 1/13/21. Resident #7's diagnoses included but were not limited to urinary retention, diabetes and high blood pressure. Resident #7's quarterly minimum data set assessment with an assessment reference date of 12/14/21, coded the resident as being cognitively intact. Review of Resident #7's clinical record revealed a physician's order dated 3/22/21 for Foley catheter (1) care every shift and as needed.	F 001		

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F 001	Continued From page 11 Review of Resident #7's January 2022 TAR (treatment administration record) failed to reveal documentation that Foley catheter care was provided on 1/9/22 during the day and evening shifts, 1/23/22 during the day shift, 1/26/22 during the evening shift and 1/30/22 during the night shift (as evidenced by blank spaces on the TAR). On 2/22/22 at 10:58 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated nurses evidence treatment administration by signing the TAR. LPN #3 stated nurses' signatures on the TAR is proof that they administered treatments but everyone makes mistakes and may forget to sign, even if they did administer the treatments. On 2/2/22 at 11:50 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. No further information was presented prior to exit. Reference: (1) A Foley catheter is a tube placed in the body to drain and collect urine from the bladder. This information was obtained from the website: https://medlineplus.gov/ency/article/003981.htm	F 001		