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 _____	C 01/06/2022

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) COMPLETION DATE
E 000	Initial Comments A Recertification Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the Virginia Department of Health - Office of Licensure and Certification on 01/03/22 through 01/06/22. The facility was found not to be in compliance with 42 CFR 483.73.	E 000		
E 018 SS=F	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b),	E 018		

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

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E 018	Continued From page 1 ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical	E 018		

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E 018	Continued From page 2 documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility Emergency Preparedness Plan (EPP), the facility failed to ensure the evacuation plan included a process for tracking patients and staff in an emergent situation. This failure had the potential to affect the 92 residents receiving care and services in the facility, any staff on duty; and hindered the facility's ability to prepare for potential emergency situations and keep patients safe during an emergency. Findings include: Review of the facility's EPP, reviewed 06/03/21, revealed the following information about tracking residents and staff in an emergency situation: "E. Resident Tracking The facility receiving residents will have a resident tracker assigned to track the residents entering and leaving the resident care areas .... The nursing staff will use the Hospital Incident Command System (HICS) form HICS 254 - Disaster Victim Resident Tracking Form (provided by District Planner) located in Attachment D, using the triage tracking number to log in residents at the point of triage. The location of these residents in the continuum of care will be	E 018	1) The Facility Emergency Preparedness Plan has been updated to include a process for tracking patients and staff. 2) Any resident has the potential to be affected if staff fail to prepare for potential emergency situations and keep patients safe during an emergency. A 100% audit was conducted of the Facility Emergency Preparedness Plan to identify any other tags that are not met. All negative findings will be corrected at the time of discovery. 3) The Maintenance Director or designee will in-service facility staff and new hires on the process for tracking patients and staff during an emergency. 4) A comprehensive life safety review of the facility by the Regional Vice President of Operations will be conducted annually. The comprehensive review of the Facility Emergency Preparedness Plan will be reviewed to include the process for tracking patients and staff. The administrator or designee will review the audit findings and report to the QAPI committee for any further recommendations monthly x3.	2/15/22

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E 018	Continued From page 3 logged in using this form until disposition status is determined. In the event that the computer system is down, the registration staff will coordinate the use of the Disaster Victim Resident Tracking Form with the Daily Census Form .... If residents are evacuated, the HICS 260 - Virginia Resident Emergency Evacuation Form (provided by VHHA) located in Attachment D will be used. Form should include, but is not limited to: resident name, date of birth, Medicare/Medicaid number, evacuation site location, date of evacuation, arrival time at evacuation site, date of return to facility (if known), and comments/notes." A review of the EPP on 01/06/22 at 6:12 PM with the Facility Administrator and Maintenance Supervisor (MS) revealed the evacuation plan defined a process and included regarding how patients and staff would be tracked in the event of an emergency evacuation. Although the facility EPP noted a number of different plans, none of the plan documentation (e.g. tracking form) was actually included or present in the facility book. During the review and interview on 01/06/22 at 7:10 PM, the Administrator stated there were facts about an evacuation but was not able to find the tracking system in the facility EPP book.	E 018		
E 024 SS=F	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5),	E 024		

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E 024	Continued From page 4 §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's Emergency Preparedness Plan (EPP), the facility	E 024		

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E 024	Continued From page 5 failed to ensure the EPP included a policy regarding the integration of State and Federally designated healthcare professional volunteers in the case of emergency to care for the facility's residents. This has the potential to affect the continuity of care for all 92 current facility residents. Findings include: A review of the facility's 06/03/21 reviewed EPP on 01/06/22 at 6:12 PM with the Facility Administrator and Maintenance Supervisor (MS) revealed no policy inclusion regarding the use of State and/or Federal healthcare professional volunteers in an emergency, or other emergency staffing strategies. Volunteers were addressed as follows: "C. Volunteer Needs The facility's policy and procedure for the use of volunteers is as follows: 1. Volunteers who are called upon in the case of an actual emergency must have attended facility orientation and have been screened for barrier crimes. They must also not be on the active sex abuse registry for the protection of the resident population. Orientation for volunteers will be conducted bi-annually. 2. Volunteers will be assigned tasks that meet their professional qualifications and physical ability. 3. Volunteers can feed residents if they are a currently licensed CNA, LPN, RN, or Speech Therapist. All other volunteers must have completed the state approved feeding curriculum and have approval from the facility DON. 4. As practicable the facility will provide food and external housing in return for their services. While	E 024	1) The Facility Emergency Preparedness Plan has been updated to include the integration of volunteers in the case of emergency. 2) Any resident has the potential to e affected. A 100% audit was conducted of the Facility Emergency Preparedness Plan to identify any other E tags that are not met. All negative findings will be corrected at the time of discovery. 3) The Maintenance Director or designee will in-service facility staff and new hires on the process for volunteer integration during an emergency. 4) A comprehensive life safety review of the facility by the Regional Vice President of Operations will be conducted annually. The comprehensive review of the Facility Emergency Preparedness Plan will be reviewed to include the process volunteer integration. The Administrator or designee will review the audit findings and report to the QAPI committee for any further recommendations monthly x3 months.	2/15/22

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E 024	Continued From page 6 sheltering in place volunteers must come to the facility prepared to stay for an extended period of time. The facility will allocate various office spaces and common space for sleeping arrangements. 5. The facility's three day emergency food supply will be at a level to support staff and volunteers for the 3 day timeframe. 6. The facility activity director will be responsible for communicating to the volunteers and supervising them while onsite. If the need should arise the activity director will initiate the CALL TREE for volunteers. 7. Volunteers are expected and will be required to submit to the governing authority onsite during the emergency. Volunteer contact list can be found in Annex A: Communications" In an interview on 01/06/22 at 7:23 PM, the Administrator confirmed that the emergency plan did not address the use of volunteer federal and state healthcare professionals for emergency staffing strategies. The Administrator stated, "It [the EPP] talks about volunteers able to do what they are licensed for," but confirmed it did not identify how federal or state volunteers would be integrated.	E 024		
E 026 SS=F	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7). [(b) Policies and procedures. The [facilities] must	E 026		

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E 026	Continued From page 7 develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on interview and a review of the facility Emergency Preparedness Plan (EPP), the facility failed to include the role of the facility if a waiver was declared in accordance with section 1135 of the Social Security Act. This failure had the potential to affect the 92 residents living and receiving care in the facility and hindered the facility's ability to provide care and services during an emergency. Findings Include: A review of the facility's 06/03/21 reviewed EPP	E 026	1. The Facility Emergency Preparedness Plan has been updated to include the role of the facility if an 1135 waiver was declared. 2. Any resident has the potential to be affected. A 100% audit was conducted of the Facility Emergency Preparedness Plan to identify any other E tags that are not met. All negative findings will be corrected at the time of discovery. 3. The Maintenance Director or designee will in-service facility staff and new hires on the role of the facility if an 1135 waiver is declared in accordance with the Social Security Act. 4. A comprehensive life safety review of the facility by the Regional Vice President of Operations will be conducted annually. The comprehensive review of the Facility Emergency Preparedness Plan will be reviewed to include the role of the facility if an 1135 waiver is declared. Administrator or designee will report findings to the QAPI committee for any further recommendations monthly x 3 months.	2/15/22

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E 026	Continued From page 8 on 01/06/22 at 6:12 PM with the Facility Administrator and Maintenance Supervisor (MS) did not show a policy or procedure regarding the role of the facility if the United States Department of Health and Human Services Secretary should declare a section 1135 waiver in an emergency. In an interview on 01/06/22 at 7:27 PM, the Administrator confirmed no policy regarding the facility role in a declared 1135 waiver stating, "I don't see it and searching through the entire book I didn't see it."	E 026		
E 030 SS=F	Names and Contact Information CFR(s): 483.73(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers.	E 030	1. The Communication Plan located in the Facilities Emergency Preparedness Plan has been updated to include a current list of names and contact information of staff. 2. Any resident has the potential to e affected. A 100% audit was conducted of the Facility Emergency Preparedness Plan to identify any other E tags that are not met. All negative findings will be corrected at the time of discovery.	2/15/22

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E 030	Continued From page 9 *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement.	E 030	3. The Administrator is responsible for maintaining and updating the list of names and contact information of staff in the Facilities Emergency Preparedness Plan. The Administrator has been in-serviced by the Regional Vice President of Operations on maintaining accurate names and contact information of staff in the Facility emergency Preparedness Plan. 4. A comprehensive life safety review of the facility by the Regional Vice President of Operations will be conducted annually. The comprehensive review of the Facility Emergency Preparedness Plan will be reviewed to include the role of the facility if an 1135 waiver is declared. Administrator or designee will report findings to the QAPI committee for any further recommendations monthly x 3 months.	

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E 030	Continued From page 10 (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's Emergency Preparedness Plan (EPP), the facility failed to maintain a current list of names and contact information in the Emergency Preparedness communication plan that included all facility staff members. This failure had the potential to affect the 92 residents receiving care and services in the facility and would delay the facility's ability to respond to an emergency. Findings include: A review of the facility's 06/03/21 reviewed EPP on 01/06/22 at 6:12 PM with the Facility Administrator and Maintenance Supervisor (MS)	E 030		

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E 030	Continued From page 11 revealed there was no identification of and/or contact information for facility staff such as nurses and nurse aides, dietary staff, and/or housekeeping staff. The only list of staff identified in the EPP were the facility's key personnel. In an interview on 01/06/22 at 7:31 PM, the Facility Administrator confirmed that only the list of key personnel names and their contact information was included in the EPP.	E 030		
F 000	INITIAL COMMENTS A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the Virginia Department of Health - Office of Licensure and Certification. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 01/03/22 - 01/06/22 Survey Census: 92 Sample Size: 31 Supplemental Residents: 14 A deficiency was issued related to Intake ID VA00050942 at F804 and F812. No deficiencies were issued related to Intakes VA0053886 and VA00053413.	F 000		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive	F 578	1) The Director of Social Services (DSS) or designee will review R73, R83, R93, R77, R3, R68, R79, R64, R35, R94, R195 and R81 wishes for advance directives to verify their wishes are being met and provide them with written information regarding the right to formulate an advanced directive.	

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F 578	Continued From page 12 the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to provide written information to the resident and/or resident's representative regarding the right to formulate an advanced directive for 12 of 31 residents	F 578	2) Any resident has the potential to be affected if staff fail to provide them with written information to assist them to make an informed decision to accept or refuse medical treatment. The Director of Social Services or designee will complete all current residents to verify they have received written information to assist them to make an informed decision to accept or refuse medical treatment regarding advance directives and if not they will provide them or their responsible party with written information and verify their current wishes for advance directives are being met. 3) The Admissions and Social Services department personal, RN's and LPN's will be educated by the Administrator or designee on the community's protocol for providing residents and/or their responsible party with written information regarding their right to formulate an advanced directive.	

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F 578	Continued From page 13 sampled (Resident (R) 73, R83, R93, R77, R3, R68, R79, R64, R35, R94, R195, and R81). Findings include: 1. Review of R73's "Admission Record" located in the Electronic Medical Record (EMR) under the "Profile" tab, revealed an admission date of 10/18/19 and full code status. There was no evidence in the medical record that written information regarding the right to formulate an advanced directive was provided to the resident and/or resident's representative. 2. Review of R83's "Admission Record" located in the EMR under the "Profile" tab, revealed an admission date of 02/19/20 and Do Not Resuscitate (DNR) status. There was no evidence in the medical record that written information regarding the right to formulate an advanced directive was provided to the resident and/or resident's representative. 3. Review of R93's "Admission Record" located in the EMR under the "Profile" tab, revealed an admission date of 08/07/19 and DNR status. There was no evidence in the medical record that written information regarding the right to formulate an advanced directive was provided to the resident and/or resident's representative. 4. Review of R77's "Admission Record" located in the EMR under the "Profile" tab, revealed an admission date of 03/18/15 and full code status. There was no evidence in the medical record that written information regarding the right to formulate an advanced directive was provided to the resident and/or resident's representative.	F 578	4) An audit of all new admits will be completed weekly x 12 weeks to verify they have received written information regarding the right to formulate an advanced directive. The Administrator or designee will review the audit findings and report to the QAPI committee for any further recommendations monthly x 3 months.	2/15/22

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F 578	Continued From page 14	F 578		

5. Review of R3's "Admission Record" located in the EMR under the "Profile" tab, revealed an admission date of 07/14/14 and DNR status. There was no evidence in the medical record that written information regarding the right to formulate an advanced directive was provided to the resident and/or resident's representative.

6. Review of the EMR for R68 revealed an admission date of 12/08/15. Review of the EMR, including the orders tab, the care plan tab and the face sheet revealed that all matched the resident's code status; however, there was no evidence of written information/education given to the resident or resident representative

7. Review of the EMR for R79 revealed an admission date of 02/24/17. Review of the EMR, including the orders tab, the care plan tab and the face sheet revealed that all matched the resident's code status; however, there was no evidence of written information/education given to the resident or the resident representative.

8. Review of the EMR for R64 revealed an admission date of 12/04/20. Review of the EMR, including the orders tab, the care plan tab and the face sheet revealed that all matched the resident's code status; however, there was no evidence of written information/education given to the resident or the resident representative.

9. Review of the EMR for R35 revealed an admission date of 06/11/19. Review of the EMR, including the orders tab, the care plan tab and the face sheet revealed that all matched the resident's code status; however, there was no evidence of written information/education given to the resident or the resident representative.

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F 578	Continued From page 15	F 578		

10. Review of R94's "Admission Record" from the "Profile" tab in the EMR showed an original admission date of 10/21/21, with a readmission date of 11/28/21. Review of R94's entire EMR on 01/04/22 at 5:36 PM did not reveal any documentation in the record that the resident and/or resident representative had received written information regarding advance directives.

11. Review of the EMR for R195 revealed an admission date of 12/20/21. Review of the EMR, including the orders tab, the care plan tab and the face sheet revealed that all matched the resident's code status; however, there was no evidence of written information/education given to the resident or the resident representative.

12. Review of R81's "Admission Record" from the "Profile" tab in the EMR showed an admission date of 05/05/21. Review of R81's EMR on 01/05/22 at 5:43 PM did not reveal any documentation in the record that the resident and/or resident representative had received written information regarding advance directives.

During an interview on 01/05/22 at 1:30 PM with Social Services Worker (SSW) 2, she stated the social services department only updates the advanced care tracking form during the care plan conference.

During an interview on 01/05/22 at 3:25 PM with the Admissions Coordinator (AC), she stated the social services department gives the resident an advance directive handout, which provides education regarding advanced directives. The AC further stated there was no information in the resident's admission packet that educates the

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F 578	Continued From page 16	F 578		

resident on advanced directives.

During an interview on 01/05/22 at 3:30 PM with SSW3, she stated the social services department does not give the resident education on advanced directives. SSW3 further stated the social services department does not give the resident an advanced directive handout.

During an interview on 01/05/22 at 3:41 PM with Registered Nurse (RN) 7, she stated the nursing staff does not give the residents written information on advanced directives.

During an interview on 01/05/22 at 3:46 PM with Supervising Licensed Practical Nurse (SLPN) 8, she stated the nursing staff is instructed to give the resident a form acknowledging the resident has received written communication regarding advanced directive; however, the nursing staff does not give the written communication. SPLN8 further stated the only information given to the residents are located in the "red admission packet" and the advanced directives handout is not included the packet.

During an interview on 01/05/22 at 3:51 PM with the Administrator, she stated residents should receive verbal or written communication regarding advanced directives. The Administrator stated she was going to meet with the department heads for the process to be streamlined across departments.

Review of the facility's policy titled, "Your Path Advance Care Planning Meeting Protocol" revised 09/01/15 indicated, "Information regarding Advance Directives and Living will is provided to the resident and family by the facility during the

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F 578	Continued From page 17 Your Path meeting when necessary."	F 578		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, review of facility incident files, and review of facility policy, the facility failed to ensure that reports related to allegations of abuse and/or neglect were immediately reported	F 609	1) The Administrator working at the time of FRI's 51726, 51644, 51403, 52521 and the incident of injury of unknown origin (fracture) involving Resident #245 dated 07/19/21 is no longer employed by Farmville Health & Rehab Center. The current Administrator and Director of Nursing will be re-educated on the community's "Resident Abuse Policy" addressing timeliness of reporting to appropriate agencies with submission of final summary of investigation within 5 working days. 2) Any resident has the potential to be involved in an allegation of abuse and/or neglect that may not have been reported to the appropriate agency timely or submission of final investigation. A review of the past 30 days of 24 hr report to ensure all potential allegations have been reported per community policy.	

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F 609	Continued From page 18 to the State Survey Agency (SSA). The facility failed to assure that allegations of abuse and/or serious injury were reported in no more than two hours, while allegations of neglect were reported in no more than 24 hours for four of 11 facility-reported allegations, which involved Resident (R) 65, R90, R145, R50, R32, R41, and R146. In addition, the facility failed to assure that results of an investigation into an injury of unknown origin sustained by R245 were reported to the SSA within five working days. Findings include: 1. a. Review of Facility Incident Report (FRI) 51726, dated 04/14/21 at 11:43 AM, revealed an allegation of unknown injury-resident to resident abuse. The allegation was identified on 04/11/21 at 11:59 PM, when staff observed that R65 had a bruise and the resident alleged being hit by R90. Review of the report revealed the allegation of abuse was not reported to the SSA until 04/14/21. The facility lacked documentation that a report was made to the state survey agency within two hours of when the allegation of abuse was reported to facility staff. b. Review of Facility Incident Report 51644, dated 04/22/21 at 10:56 AM, revealed an allegation of resident to resident abuse was reported to have occurred on 04/20/21 when R145 threw a shampoo bottle at R50, hitting him on the arm. R50 returned the shampoo bottle to R145, striking him on the arm as well. Review of the report revealed that although the allegation of resident-to-resident abuse was reported to staff on 04/20/21 at 4:30 PM, the facility failed to report	F 609	3) Current staff will be re-educated on the community's abuse policy on reporting and investigating all allegations of abuse/neglect and will be included in new employee and agency/temporary staff orientation. 4) The Administrator, Director and/or designee will audit all allegations of abuse and/or neglect weekly x 12 weeks to verify the allegation has been reported to the State Survey Agency timely. The Administrator and/or Director of Nursing will report findings of the audit to the QAPI committee monthly x 3 months for any further recommendations.	2/15/22

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it to the SSA until two days later, on 04/22/21.

The facility lacked documentation that a report was made to the state survey agency within two hours of when the allegation of abuse was reported to facility staff.

c. Review of Facility Incident Report 51403, dated 03/31/21 at 1:03 PM, revealed an allegation of resident to resident abuse reported by Certified Nurse Aide (CNA) 7 on 03/30/21 at 6:35 AM which involved R32 kicking R41. Review of the report revealed it was not reported to the SSA until the following day on 03/31/21.

d. Review of Facility Incident Report 52521 dated 07/19/21 revealed an allegation of "Abuse/patient client neglect" which occurred on 06/22/21. At which time, per the report, R146 spilled hot coffee into his lap, leaving red and edematous areas on his legs. Review of the intake form revealed the allegation was not reported the SSA until 07/19/21, almost a month after the facility was aware of the allegation.

Interview with the Administrator on 01/04/22 at 2:30 PM revealed she was the facility's Abuse Coordinator. The Administrator stated the reports referenced above were complete with no further information to explain the delays in reporting. The Administrator stated she was not the administrator when each of the events are alleged to have occurred and was unable to answer questions about delays in their reporting. Further interview with the Administrator revealed she would contact the corporate office to find out if there was any additional information available.

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No additional information was provided, other than the above-referenced reports, as of the date of the exit conference conducted on 01/06/22.

Review of the facility abuse policy titled "Virginia Resident Abuse Policy," last revised 05/26/21, revealed "Facility staff must immediately report all such allegations to the Administrator/Abuse Coordinator." Per the policy, the Administrator/Abuse Coordinator was to immediately begin an investigation and notify local and state agencies in accordance with this policy. Review of Section 6 "Initial Reports" revealed that for timing of reporting, "All allegations of abuse, neglect, involuntary seclusion, injuries of unknown source and misappropriation of resident property must be reported immediately to the Administrator, Director of Nursing and to the applicable state agency. If the event that caused the allegation involves abuse or serious bodily injury, it should be reported to DOH [Department of Health] immediately, but not later than two hours after the allegation is made."

2. Review of R245's "Facility Reported Incident" (FRI), reported to the SSA on 09/11/21, revealed reporting that R245 sustained an injury of unknown origin (fracture) that occurred on 09/10/21. The FRI indicated the five-day report would be submitted by 09/17/21; however, further review of the facility's investigation records revealed no evidence the five-day follow-up was submitted to the SSA.

During an interview on 01/06/22 at 1:15 PM with the Director of Nursing (DON), she stated the interim Administrator completed the five-day

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F 609	Continued From page 21 follow-up report and submitted the report to the Virginia DOH but failed to keep a copy of the information. The DON stated she would contact the Virginia DOH in order to get a copy of the 5-day report that was submitted. During an interview on 01/06/22 at 1:25 PM with the Administrator, she stated that she spoke with a representative at the Virginia DOH and the representative reported only the initial report, not the five-day report, was submitted. The Administrator stated the Virginia DOH representative further stated the initial report indicated a follow-up report would be given but they did not receive a follow-up. The Administrator confirmed that a five-day follow-up report should have been submitted to the Virginia DOH. Review of the facility's policy titled, "Virginia Resident Abuse Policy" revised 05/26/21 indicated, " Final report will be submitted to applicable State agency, after the investigation is completed, but no later than five (5) working days from the alleged occurrence."	F 609		
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 610	1) The administrator and director of nursing will be educated on the facility abuse policy regarding components of a through investigation.	

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F 610	Continued From page 22 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility abuse policy, the facility failed to ensure that a thorough investigation was completed for four allegations (involving Resident (R) 245, 65. R90, R145, R50, R32 and R41) of eleven reportable incidents and/or complaints. The facility failed to assure that allegations of resident-to-resident abuse and/or injuries of unknown origin were thoroughly investigated, with all potential witnesses interviewed, to assure that investigations had sufficient information to form an accurate conclusion in response to the allegation. Findings include: 1. Review of R245's "Facility Reported Incident" (FRI), reported to the Virginia Department of Health (State Survey Agency - SSA) on 09/11/21, revealed R245 had an injury of unknown origin that occurred on 09/10/21. The FRI indicated an investigation into the injury of unknown origin was underway; however, the facility could not provide evidence that a thorough investigation into this allegation was conducted. Review of R245's "Quick Response" incident note, dated 09/10/21, located in the EMR under the "Documents" tabs, revealed that the wound	F 610	2) Any resident has the potential to be involved in an allegation or suspicion of abuse or neglect. An audit of allegations of abuse /or injuries of unknown origin have been thoroughly investigated with all potential witnesses interviewed. 3) Current staff will be re-educated on the community's abuse policy on reporting and investigating all allegations of abuse /neglect and upon orientation. 4) The administrator or director, and/or designee will audit all allegations of abuse and/or injures of unknown origin weekly x12 weeks to verify that the investigation protocol is adhered to . The administrator and/or director of nursing will report findings of the audit to the QAPI committee monthly x3 months for further review and analysis.	2/15/22

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doctor was in to debride a wound on the left shin. At the completion of the procedure, the doctor expressed concern over the appearance of the bone. An order was given for X-rays, which showed a transverse tibial shaft fracture. Per the note, the resident's Hospice, family, and facility nurse practitioner were made aware of results.

Review of R245's letter from Centra Hospice, dated 09/14/21, located in the EMR under the "Documents" tabs, revealed the following from the hospice physician: "The left tibial transverse shaft fracture identified by xray on 9/10/21 appears to be consistent with osteoporotic pathologic fracture."

During an interview on 01/06/22 at 1:20 PM with Supervising Licensed Practical Nurse (SLPN) 8, she stated the facility completed X-ray and labs for R245 but could not remember obtaining statements from staff. SLPN8 further stated that R245 resided on the unit that SLPN8 supervised at the time of the injury.

During an interview on 01/06/22 at 1:25 PM with the Administrator, she stated the facility did not have documentation that a thorough investigation into the injury of unknown origin was completed. The Administrator stated the investigation should have included, but not been limited to, the following: interviewing of staff members that cared for R245 within the last 3 days of the incident, nursing assessments, in-services, skin assessments, and follow-up to the FRI.

2. Review of a facility incident report dated 04/12/21 at 12:15 AM revealed R65 reported that her roommate, R90, grabbed her arm and hit her

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with her cane in the right forearm. According to the incident report which alleged resident-to-resident abuse, R65 was noted to have a red-brown bruise to her right outer-upper forearm and right outer mild deltoid bruise. The resident was examined however, no further documentation was provided as to the status of the injury to the right forearm.

Review of the facility's investigation documents revealed that staff assigned to the floor during the shift made statements on 04/12/21 as to their observations at or around the time of the incident. The facility interviewed both residents involved. However, further review revealed the facility failed to interview any residents to determine if there were other witnesses to the alleged incident, as well as any other incidents between the two noted residents. Moreover, the facility failed to physically check other residents on the unit where the resident to resident abuse occurred to determine if there were additional injuries so as to identify possible patterns of abuse.

3. Review of a facility reported incident dated 04/22/21 revealed an allegation of resident abuse in which R145 threw a shampoo bottle at R50 on 04/20/21 as reported at 4:30 PM. R50 stated he was hit on the left wrist by the shampoo bottle. R50 has a scabbed area on his left wrist. The incident apparently occurred earlier that same morning of 04/20/21. The two men share a bathroom in between their bedrooms. R50 indicated that R145 threw the shampoo bottle at him after accusing R50 of urinating on the bathroom floor. R50 reportedly threw the bottle back at R145 shortly after the first throw striking him the right arm.

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Review of the investigation report revealed the facility failed to thoroughly investigate the allegation, including interviews with all potential witnesses. The investigation included one written statement (no date or heading) from R145, stating he threw the shampoo bottle at R50 and, "It may have hit him in the arm, I really don't know. Then he threw the bottle back at me hitting me on the arm." The social service designee then made two statements about the incident (no date). There was no evidence of an attempt to interview R50. There was no evidence that the facility interviewed other residents on the unit to determine if they were witnesses who may have heard or seen something or interviewed staff on the unit working at the time of the incident. The facility did not thoroughly investigate to determine if the scab on R50's left arm was from the shampoo bottle or another incident. R145 also reported he was hit with the shampoo bottle; however, there was no evidence his arm was checked for injury.

4. Review of a facility-reported allegation of resident abuse, dated 03/31/21, revealed that at 6:35 AM on 03/30/21, a nurse aide alleged that R32 kicked R41 in the mid-section.

Review of the facility file on the incident revealed only one written statement as to the allegation involving R41 and R32. A statement from CNA 7 was completed on 03/30/21 at 6:35 AM stating she observed the incident. Although the facility interviewed the alleged victim (R41), the facility failed to interview the alleged perpetrator (R32). There were no interviews from other staff or residents who may have been in the area and

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seen something at the time or prior to the incident.

Interview with the facility administrator on 01/04/22 at 2:30 PM revealed she serves as the facility's Abuse Coordinator. The Administrator stated she provided all the information available to the survey team and no other information to show that thorough investigations were conducted could be found. She stated she was not the administrator at the time of the reported incidents and did not have knowledge of what occurred. The Administrator indicated she would contact the corporate office to see if more information was available. However, as of the time of the survey exit on 01/06/22, no further evidence to show that thorough investigations were conducted was provided to the survey team.

Review of the facility's policy titled, "Virginia Resident Abuse Policy" revised 05/26/21, revealed, "It is the facility's policy to investigate all allegations, suspicions and incidents of abuse, neglect, involuntary seclusion, exploitation of residents, misappropriation of resident property and injuries of unknown source. The policy further stated, "Facility staff must immediately report all such allegations to the Administrator/Abuse Coordinator. The Administrator/Abuse Coordinator will immediately begin an investigation." Under Section 7 "Investigation" the policy reads "Interview the resident, the accused and all witnesses. Witnesses generally include anyone who: witnessed or heard the incident, came in close contact with the resident the day of the incident (including other residents and family members) and employee(s) who worked closely with the accused and or alleged victim of the

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F 610	Continued From page 27 incident. If there are no direct witnesses, cover all employees on the unit. For unknown injuries will generally involve talking to both the shift on during which the injury occurred and prior shifts."	F 610		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;	F 623	1. Social Services and nurses who cared for residents #R7, #R27 and #R78 during transfer/discharging to hospital have received 1:1 education on the center's policy for resident discharge/transfer letter policy. 2. Any resident has the potential to be affected. An audit of discharges for the last 7 days will be completed to determine if transfer/discharge letter had been given to resident and/or RR. Variances identified will be investigated with follow up. 3. RN's, LPN's and Social Services will be educated by the Director of Nursing or designee on the facility's policy on transfer/discharge requirements. 4. The Director of Nursing or designee will conduct an audit of all transfers/discharges weekly x 12 weeks to ensure a written notice was sent per facility policy. Director of Nursing will report any findings to the QAPI committee x 3 months for additional oversight and recommendations.	2/15/22

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F 623	Continued From page 28 (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the	F 623		

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agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on record review, interview, and policy review, the facility failed to ensure three of five residents (Resident (R) 7, R27, and R78) reviewed for hospitalization transfer and/or discharge, as well as the resident's representative (RR), received a written notice that explained the date, reason, place of transfer/discharge, and the right to appeal the transfer or discharge.

Findings include:

1. Review of R7's "Admission Record" from the electronic medical record (EMR) "Profile" tab, showed an original admission date of 04/23/09, and a readmission date of 06/14/21.

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During an interview on 01/04/22 at 11:05 AM, R7 stated she had been sent to the hospital for chest pain in December and she came right back to the facility. When asked if she received anything in writing regarding where she was transferred to and why she was being transferred, R7 stated "They gave some paper to the emergency services and the ER [emergency room] sent paper back, but I didn't get anything in writing.

Review of R7's "Minimum Data Set" (MDS) annual assessment, with an Assessment Reference Date (ARD) of 09/20/21, revealed that R7 had a "Brief Interview for Mental Status" (BIMS) score of 15/15, indicative of being cognitively intact.

Review of R7's EMR "Progress Notes" showed no evidence of hospital transfer since 06/09/21 when a "Nursing Note" documented that the resident was sent to the emergency department and admitted to the hospital receive antibiotics for a urinary tract infection (UTI) since the resident has an allergy to the only antibiotic for which the organism was susceptible.

Further review of R7's EMR, including the scanned "Documents" tab, revealed no evidence that a written transfer notice or documentation a written notice of transfer was provided to R7 and/or the RR.

2. Observation of R27's room on 01/03/22 at 9:11 AM revealed the bed was empty, made, and in a high position. A staff member passing by the room stated R27 was currently in the hospital.

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Review of R27's EMR "Progress Notes" dated 12/26/2021 at 1:30 PM revealed which stated that the resident, "came to dining hall and was not eating, noted to have [sic] severe diaphoresis, cool and clammy with palor [sic]. At 1245 Complaining [sic] of severe scrotal pain as well as RLE [right lower extremity] pain. Over minutes he stated pain was so bad that he felt he needed to go to the hospital .... Called for ambulance and then called in report to [name] at [hospital]. Patient in route [sic] by 1330."

Further review of R27's EMR revealed no evidence that a written notice of transfer was provided to the resident and/or RR.

3. Review of R78's "Admission Record" from the EMR "Profile" tab showed an initial admission date of 04/23/09 and a readmission date of 06/14/21. Review of R78's EMR "Progress Notes" tab revealed a "Nursing Note" on 01/04/22 that the resident was "picked up by transportation for transport to the hospital for peg tube replacement." Further review of the "Progress Notes" revealed that, "resident admitted to hospital, Brother notified."

Review of R78's EMR revealed no evidence that a written notice of transfer was provided to the resident and/or RR.

In an interview on 01/05/22 at 5:13 PM, the Director of Nursing (DON) brought in hospitalization information for the residents and showed an "Interact Transfer" form. When asked who the transfer form was given to, the DON stated the form went to EMS (emergency medical services, or ambulance). When asked about what

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F 623	Continued From page 32 written documentation was provided to the resident and RR upon transfer, the DON stated she would get back to the surveyor. On 01/05/22 at 5:30 PM, the DON provided a policy regarding transfers and discussed the documentation that was being requested. On 01/06/22 at 1:46 PM, the DON confirmed there were no written notices provided to the residents or RR's regarding transfer. Review of the facility policy titled "Resident Discharge/Transfer Letter Policy," last revised 10/05/17, revealed "D) Discharge notices must have the following components: 1. The reason for discharge/transfer; 2. The effective date of transfer/discharge; 3. The location to which the resident is transferred/discharge, this must be a specific address which has accepted the resident and is an appropriate location ... E) Social Service or designee will assure the original discharge/transfer letter is given to resident or guardian/sponsor, if applicable. 1. Copies will be sent to Department of Health, Ombudsman office and filed in the business file and/or scanned into PCC [EMR name] documents tab ... 2. For emergency transfers, one list can be sent to the Ombudsman at the end of month. F) Social service or designee will document in the chart all discharge/transfer reasons, any notice given to the resident or guardian/sponsor, and discharge planning. G) The resident or responsible part will receive a bed hold notice along with the discharge/transfer letter, when applicable.	F 623		
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr	F 625		

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F 625	Continued From page 33 CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, interview and policy review, the facility failed to ensure three of five residents (Resident (R) R7, R27, and R78) reviewed for hospitalization transfer and/or discharge, and/or the resident's representative (RR), received a written bed hold policy upon transfer to the hospital.	F 625	1. Social Services and nurses who cared for residents #R7, #R27 and #R78 during transfer/discharge to hospital have received 1:1 education on the center's policy for resident discharge/transfer letter policy which includes the bed hold policy. 2. Any resident has the potential to be affected. An audit of discharges for the last 7 days will be completed to determine if resident bed hold policy was given to resident and/or RR upon discharge from facility to hospital. Variances identified will be investigated with follow up. 3. RN's/LPN's and Social Service staff will be educated by the Director of Nursing (DON) or designee on the facility's Transfer/Discharge policy to include bed hold policy requirements. 4. The DON or designee will conduct an audit weekly x 12 weeks to verify all transfers/discharges received a written notice and bed hold policy. Any variances will be addressed accordingly. Any findings will be reported to the QAPI committee x 3 months for additional oversight and recommendations.	2/15/22

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Findings include:

1. Review of R7's "Admission Record" from the electronic medical record (EMR) "Profile" tab, showed an original admission date of 04/23/09, and a readmission date of 06/14/21.

During an interview on 01/04/22 at 11:05 AM, R7 stated she had been sent to the hospital for chest pain in December and she came right back. When asked if she received anything in writing regarding a bed hold notice, R7 responded, "Nothing in writing, they told me they would hold my bed until I return - but nothing in writing."

Review of R7's "Minimum Data Set" (MDS) annual assessment, with an Assessment Reference Date (ARD) of 09/20/21, revealed R7 had a "Brief Interview for Mental Status" (BIMS) score of 15/15, indicative of being cognitively intact.

Review of R7's EMR "Progress Notes" showed no evidence of hospital transfer since 06/09/21. Per a 12:31 PM "Nursing Note," the resident's "Urology office called back and wants resident sent to ED [emergency department] and admitted to receive IV [intravenous] for UTI [urinary tract infection] since resident has an allergy to the only antibiotic she [the organism] is susceptible."

Further review of R7's EMR, including the scanned "Documents" tab, revealed no evidence that a written bed hold notice was provided to R7 and the RR.

2. Observation of R27's room on 01/03/22 at

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9:11 AM revealed the bed was empty, made, and in a high position. A staff member passing by the room stated R27 was in the hospital.

Review of R27's "Admission Record" from the EMR "Profile" tab revealed the resident was admitted to the facility on 11/18/19.

Review of R27's EMR "Progress Notes," dated 12/26/21 at 1:30 PM, "Resident came to dining hall and was not eating, noted to be have [sic] severe diaphoresis, cool and clammy with palor [sic]. At 1245 Complaining [sic] of severe scrotal pain as well as RLE [right lower extremity] pain. Over minutes he stated pain was so bad that he felt he needed to go to the hospital .... Called for ambulance and then called in report to [name] at [hospital]. Patient in route [sic] by 1330."

Further review of R27's EMR did not show any evidence that a written bed hold notice was provided to the resident and or the RR.

3. Review of R78's "Admission Record" from the EMR "Profile" tab showed an initial admission date of 04/23/09 and a readmission date of 06/14/21.

Review of R78's EMR "Progress Notes" tab revealed "Nursing Note" entries that documented the resident was "picked up by transportation for transport to the hospital for peg tube" and was "admitted to hospital, Brother notified."

Further review of R78's EMR revealed no evidence that a written bed hold notice was provided to the resident or RR.

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In an interview on 01/05/22 at 5:13 PM, the Director of Nursing (DON) brought in hospitalization information for the residents and showed an "Interact Transfer" form. The DON stated this form went to EMS (emergency medical services, or ambulance). The DON was asked about bed hold information which was given to the resident and their RR and responded that she would get back to the surveyor. On 01/05/22 at 5:30 PM, the DON provided a policy regarding transfers and bed hold notices and a further discussion ensued about what documentation was requested.

In a follow up interview on 01/06/22 at 1:46 PM, the DON stated there was no documentation written notices were provided to the residents or RR's regarding bed hold, except for a progress note by Social Services for R78, dated 01/05/22 at 5:14 PM, that stated, "Admissions Director faxed case manager bed hold from for [sic] resident." Further interview with the DON confirmed was this was done after the documentation regarding bed hold notifications had been requested by the survey team.

Review of the facility policy titled "Resident Discharge/Transfer Letter Policy," last revised 10/05/17, revealed:

"G) The resident or responsible part will receive a bed hold notice along with the discharge/transfer letter, when applicable. Bed Hold notices can be found within PCC [EMR name], under Document Manager: ...
4. A copy of the completed bed hold notice will be scanned into PCC under Document Manager, and filed in business file with certified receipt attached if applicable, with the copy of the

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F 625	Continued From page 37 discharge/transfer letter..."	F 625		
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 by: Based on interview and record review, the facility failed to ensure medication use was accurately recorded on Minimum Data Set (MDS) assessments for three (Resident (R) 44, R68, and R81) of 32 residents reviewed during the initial resident pool of the survey process. The facility inaccurately documented that the residents received anticoagulant (blood-thinner) medications. Findings include: 1. Review of R44's "Admission Record" in the facility's electronic medical record (EMR) showed an original admission date of 09/13/17, with a readmission date of 02/21/20, with medical diagnoses that included cerebral infarction, adult failure to thrive, and metabolic encephalopathy. Review of R44's MDS quarterly assessment, with an Assessment Reference Date (ARD) of 11/09/21 revealed that the assessment documented that he received an anticoagulant medication seven of seven days of the assessment period. R44's quarterly MDS assessment with an ARD of 08/09/21 and annual assessment with an ARD of 02/06/21 were also both coded as showing that R44 received an anticoagulant medication seven of seven days of	F 641	1. The MDS for R44, R68, R81 have been modified by the MDS Director and re-submitted to CMS per the RAI manual instructions. The MDS staff have been educated on anti-platelet drugs versus anti-coagulant medication 2) Any resident has the potential to be affected. 100% audit of MDS completed in past 90 days to identify any further in accurately coded Section N0410E for anticoagulant medications. 3) The MDS staff have been educated on anti-platelet drugs versus anti-coagulant medications. 4) The director of MDS or designee will complete a weekly audit x 12 weeks of MDS' completed for that time frame to verify accuracy of coding in section N0410E. Any variances will be promptly addressed. The DON will review the findings of the audit for any trends and report summary to QAPI committee for any further recommendations.	2/15/22

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F 641	Continued From page 38 the respective assessment period. Review of R44's EMR medication administration record (MAR) revealed the resident was currently receiving aspirin and Plavix (clopidogrel, an antiplatelet medication). Further review of the MARs used for the three assessment periods (11/09/21, 08/09/21, and 02/06/21) all revealed R44 received aspirin and Plavix, which are categorized as antiplatelet, not anticoagulant, medications. Review of the MARs revealed no evidence that the resident received an anticoagulant medication during any of these look-back periods. 2. Review of R68's "Admission Record" from the EMR "Profile" tab revealed an admission date of 12/08/15 with medical diagnoses that included cerebral infarct, peripheral vascular disease, dysphagia, and vascular dementia. Review of R68's quarterly MDS with an ARD of 12/02/21 showed R68 was coded for receiving an anticoagulant medication seven of seven days of the assessment period. Review of R68's MARs for the seven days of look-back period used for this assessment revealed R68 received aspirin and Pletal (an antiplatelet medication) for the seven day assessment period. Review of the MARs revealed no evidence that the resident received an anticoagulant medication during the look-back period.	F 641		

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3. Review of R81's "Admission Record" from the "Profile" tab in the EMR revealed an admission date of 05/05/21 with medical diagnoses that included polyneuropathy, hypertension, hemiplegia, and cerebral infarction.

Review of R81's admission MDS with an ARD of 05/12/21, quarterly MDS with an ARD of 09/08/21, and a quarterly MDS with an ARD of 12/09/21 revealed that each assessment was documented to show that R81 received an anticoagulant medication for seven of seven days during each respective look back period.

Review of R81's MARs for the look-back periods for each of these three MDS assessments revealed that R68 received aspirin and Plavix for each of the seven day assessment period. Further review of the MARs revealed no evidence that the resident received an anticoagulant medication during the look-back periods used for these three MDS assessments.

During an interview on 01/05/22 at 2:00 PM, the Assistant Director of Nursing (ADON) confirmed all three residents were on antiplatelet medications, and not anticoagulants.

During an interview on 01/05/22 at 2:15 PM, after reviewing the information provided by the ADON, the MDS Coordinator confirmed the medications were antiplatelet medications not anticoagulants and were coded erroneously, and stated, "I'm working on correcting the MDS assessments and the care plans."

In an interview on 01/05/22 at 3:49 PM, in response to the request for a facility policy, the

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F 641	Continued From page 40 MDS Coordinator stated, "We don't have a policy - we use the RAI [Resident Assessment Instrument] Manual." Review of the October 2019 RAI Manual, page N5 - N7, revealed: "Health-related Quality of Life =Medications are an integral part of the care provided to residents of nursing homes. They are administered to try to achieve various outcomes, such as curing an illness, diagnosing a disease or condition, arresting or slowing a disease's progress, reducing or eliminating symptoms, or preventing a disease or symptom .... Planning for Care ... -Possible adverse effects of these medications should be well understood by nursing staff. Educate nursing home staff to be observant for these adverse effects. -Implement systematic monitoring of each resident taking any of these medications to identify adverse consequences early ....Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin): Record the number of days an anticoagulant medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel here."	F 641		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively	F 660	1. Social Services Director and social services personal assisted R83 with contacting local agencies for housing. 2. Any resident has the potential to be affected. The Director of Social Services or designee will assist residents with post discharge plan of care in returning to the community.	

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F 660	Continued From page 41 transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other	F 660	3. Social Services department were educated on the facility's protocol on post-discharge planning. The social services director will continue to assist R83 with plans for discharge to the community. 4. The Social Services will will audit charts of residents who have expressed an interest in returning to the community to verify documentation of referrals to local contact agencies and/or other appropriate entities have been completed weekly x 12 weeks. The Administrator or designee will review audit findings and report summary to the QAPI committee monthly x 3 months for any further recommendations	2/15/22

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appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.
(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.
This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and facility policy review, the facility failed to implement an effective discharge planning process that focused on the resident's expressed discharge goals and failed to document referrals to local housing agencies for one (Resident (R) 83) of two residents sampled for discharge.

Findings include:

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Review of R83's "Admission Record" located in the Electronic Medical Record (EMR) under the "Profile" tab, revealed an admission date of 02/19/20.

Review of R83's "Minimum Data Set" (MDS) located in the EMR under the "MDS" tab with an Assessment Reference Date (ARD) of 12/10/21 revealed a Brief Interview for Mental Status (BIMS) score of 14/15, indicating the resident was cognitively intact.

Review of R83's "Social Services Note" located in the EMR under the "Progress Notes" tab, dated 11/10/20, revealed the following: "Resident approached SS [Social Services] if we could assist in helping him find an apartment in the Roanoke area. SS reached out to transition coordinator via email."

Review of R83's "Social Services Note" located in the EMR under the "Progress Notes" tab, dated 04/19/21, documented by Social Services Worker (SSW) 2, revealed the following: "Resident asked SS when they would be shopping for cigarettes. SS educated they would go shopping on Thursday this week for cigarettes. Resident walked out of room. Resident later came back and stated he would like to work on a discharge plan. SS began to explain dc (discharge) process, needing to know when/where resident would like to dc. Resident again walked away. SS to provide education and assistance as needed/per request."

Review of R83's 06/17/21, 09/16/21, and 12/23/21 "Care Plan Conference Summary" records located in the EMR under the

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"Documents" tab, revealed the resident was there for short term care and planned to return to the community.

Review of R83's "Care Plan" dated 12/23/21 and located in the EMR under the "Care Plan" tab, noted the following interventions for R83's discharge plan: "Resident to be placed on appropriate waiting lists for low income housing options, and be updated with waiting list status ongoing; SS to collaborate with resident's family and transition coordinator to ensure appropriate community low income housing placement; Reevaluate periodically resident's capabilities to return to the community; Involve specialized home care agencies, and appropriate community support services."

During an interview on 01/04/22 at 10:39 AM with R83, the resident stated he has asked about discharge to the community and was told by the social services department, "I have to find my own apartment and to let them know when I wanted to leave. I thought it was their job to find a place for me." R83 further stated that he has asked several times about discharge and has tried calling different apartment complexes in the area.

During an interview on 01/05/22 at 5:19 PM with SSW3, she stated R83 and the social services department have reached out to R83's transition coordinator. SSW3 that R83 cannot afford apartments due to his income and long waiting lists for low income housing. SSW3 further stated it has been over a year since the facility had addressed discharge for R83.

During an interview on 01/06/22 at 9:06 AM with

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SSW2, she stated the normal process for a resident that has a discharge goal to the community and independent living is to get a list of available housing in the area, find availability and pricing, add the resident to the waiting lists, and keep the resident updated. SSW2 stated this process had not been completed for R83. SSW2 stated R83 had not been added to the waiting lists for housing and the facility had not spoken with R83's transition coordinator since 11/10/20, which was done by the previous SSW. SSW2 further stated she had not followed up with the resident regarding discharge to the community and had not completed any processes regarding discharge planning other than documenting in care plan conferences that R83 plans to discharge to the community.

During an interview on 01/06/22 at 10:06 AM with the Administrator, she stated the social services department should provide assistance by looking for housing, adding to waiting lists, working with the transition coordinator, and following up with the housing offices in the area regarding opening for residents that have a discharge plan to the community for independent living.

During a follow-up interview on 01/06/22 at 11:48 AM with SSW2, she stated there were no documented emails of contact with R83's transition coordinator.

Review of the facility's policy titled, "Discharge Planning Policy," revised 09/24/20, revealed, "Discharge to Community. Facility will document that a resident has been asked about their interest in receiving information regarding returning to the community. If the resident indicates an interest in returning to the

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F 660	Continued From page 46 community, the facility will document any referrals to local contact agencies or other appropriate entities made for this purpose."	F 660		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure one (Resident (R) 83) of two residents reviewed for pain out of 31 sampled residents received needed treatment and care in accordance with professional standards of practice. The facility failed to provide R83 pain medication as ordered. Findings include: Review of R83's "Admission Record" located in the Electronic Medical Record (EMR) under the "Profile" tab, revealed an admission date of 02/19/20 with diagnoses including, but not limited to, chronic pain, wedge compression fracture of first and fifth lumbar polyosteoarthritis, and chronic kidney disease. Review of R83's annual "Minimum Data Set" (MDS) located in the EMR under the "MDS" tab with an Assessment Reference Date (ARD) of 12/10/21 revealed a Brief Interview for Mental Status (BIMS) score of 14/15, indicating the resident was cognitively intact. Per the MDS, R83	F 697	1. Nurses who did not follow physician's orders for scheduled hydrocodone for resident #R83 on 11/24/21, 11/28/21, 12/11/21, 12/17/21, 12/26/21, 12/29/21, and 12/31/21 received 1:1 education by the DON on following physician' s orders and responsibility of accurate documentation of pain medication. 2. Any resident has the potential to be affected. An audit of current residents with orders for scheduled pain medication will be reviewed for the past 7 days to ensure that pain medication was administered per physician order. Variances identified will be investigated and the physician will be notified for consideration of any clarification orders. 3. RN's and LPN's will be educated on pain management and responsibility of documentation of medications on the Mar by the DON or designee.	

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F 697	Continued From page 47 was on a scheduled pain medication regimen. Review of R83's current "Care Plan," dated 04/09/21 and located in the EMR under the "Care Plan" tab, revealed the following interventions related to pain: Administer analgesia/medications per orders and note effectiveness. Review of R83's "Order Summary Report" located in the EMR under the "Orders" tab revealed the following physician's order: "Hydrocodone 10-325 mg - Give one tablet by mouth five times a day for pain." Review of R83's "December Medication Administration Record [MAR]" located in the EMR under the "Orders" tab, revealed no evidence that R83 received the ordered noon dose of Hydrocodone on 12/11/21, 12/17/21, 12/26/21, 12/29/21, or 12/31/21. The December "MAR" further revealed R83 did not receive the ordered morning dose of Hydrocodone on 12/26/21. Review of R83's "November MAR" located in the EMR under the "Orders" tab, revealed no evidence that R83 received the ordered noon dose of Hydrocodone on 11/24/21 or 11/28/21. The November MAR further revealed R83 did not receive the ordered morning dose of Hydrocodone on 11/28/21. During an interview on 01/04/22 at 10:53 AM with R83, the resident stated pain medication is not given timely. R83 further stated the pain medication is supposed to be given five times a day and this does not always happen, especially upon return from appointments. During an interview on 01/06/22 at 10:57 AM with Registered Nurse (RN) 7, she stated R83 should	F 697	4. ADON/designee will review medication administration audit to verify medications have been administered and documented during the clinical morning meeting weekly x12 weeks. Identified opportunities will be investigated and interventions implemented. Findings from audits will be reviewed by the DON/designee for trends and a summary analysis will be reported to the QAPI committee x 3 months for additional oversight and recommendations.	2/15/22

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(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 697	Continued From page 48	F 697		

receive Hydrocodone five times a day as ordered by the physician. RN7 confirmed the lack of documentation ('holes') in the MAR for the above listed dates in November and December. RN7 stated the nurse should have documented on the MAR the reason the medication was not given.

During an interview on 01/06/22 at 11:07 AM with Licensed Practical Nurse (LPN)1, she stated there should not be any 'holes' in the MAR. LPN1 stated when a medication is not given, the nurse is to document against the MAR. LPN1 further revealed the facility cannot determine the reason the medication was not given if it was not documented in the MAR.

During an interview on 01/06/22 at 11:08 AM with Supervising Licensed Practical Nurse (SLPN) 8, she stated the MAR should be signed as soon as the medication is given or completed prior to completing the shift. SLPN8 stated if a resident in not in the room at the time of medication pass, the nurse should circle back to the resident after medication has been passed to the other residents. SLPN8 further stated the nurse should document in the MAR a specific code if the resident is out of the facility and should not leave 'holes' in the MAR. SLPN8 also stated she did not know why the nurse did not give the Hydrocodone as ordered by the physician.

During an interview on 01/06/22 at 1:10 PM with the Director of Nursing (DON), she stated the MAR should not have any 'holes.' The DON stated the nurse should give the resident the medication upon return if the resident is not in the facility during medication pass if the resident returns during a certain window of time. The DON further stated that if the resident does not return

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F 697	Continued From page 49 during that window of time, the nurse should document it in the MAR. Review of the facility's policy titled, "Pain Management Protocol" revised 08/25/21, revealed, "When it is determined the resident's pain will need pharmacological interventions: a. documentation of administration of medications will be located in the electronic medication record (eMAR)." Review of the facility's policy titled, "General Dose Preparation and Medication Administration." revised 01/01/22, revealed that staff were to, "Document necessary medication administration/treatment information (e.g. [for example], when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN [as needed] medications, application sight) on appropriate forms."	F 697		
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.	F 732	1. The staffing coordinator received 1:1 education on the center's daily nurse staffing policy by the administrator. 2. Any resident has the potential to be affected. Rounds were completed to verify the nurse staffing daily post sheet by the DON to ensure accurate staffing had been posted on a daily basis. Variances identified were corrected.	

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F 732	Continued From page 50 (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 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, interview, and facility policy review, the facility failed to ensure the nurse staffing daily post was current and updated in a timely manner. This failure had the potential to incorrectly inform any of the 92 residents and/or their family members about the number of staff available to provide care and services. Findings include: Observation of the daily nurse staff posting information located just past the main lobby on 01/03/22 at 9:11 AM revealed the posted information was for 01/01/22, two days earlier.	F 732	3. Staffing Coordinator, DON and weekend supervisor will be educated on the center's daily nurse staffing posting policy by the administrator/designee. 4. DON/designee will conduct random audit of the nurse staffing daily post sheets 3 times per week x 12 weeks and then monthly x 2 months. Findings from audit will be reviewed for trends and a summary analysis will be reported to the QAPI committee x 3 months for additional oversight.	2/15/22

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F 732	Continued From page 51 During an observation and interview on 01/03/22 at 9:12 AM, the Administrator verified the posting visible was for 01/01/22. The Administrator then opened the front of the clear folder type frame, thumbed past the 01/01/22 sheet and located staff posting sheets for 01/02/22, 01/03/22, and 01/04/22, which were pre-completed. At 9:15 AM, the Administrator stated the person who completed the forms and updated them was the Staffing Coordinator, "who should be in any time now." During an interview on 01/05/22 at 10:55 AM regarding the forms, the Staff Coordinator stated she changes the staffing information when she gets in, based on the call-offs and changes the census as needed, based on transfers out/in. The Staff Coordinator stated she does not work seven days a week, and the weekend posting information would be caught up when she gets in on Monday. Review of the facility policy "Daily Nurse Staffing Posting Policy," last revised 08/13/20, revealed, "Procedure: (1) The facility will post the following information on a daily basis, at the beginning of each shift: -Facility Name -The current date -Resident Census -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."	F 732		
F 804 SS=F	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink	F 804		

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F 804	Continued From page 52 Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, the facility failed to ensure each resident received food and drink that was palatable and served at an appropriate temperature. The failure to assure that that hot and cold foods were served at a palatable temperature had the potential to affect 91 of 92 residents residing on the facility's two wings (North and East) who consume food by mouth. Findings include: 1. Review of R83's "Minimum Data Set" (MDS) located in the electronic medical record (EMR) under the "MDS" tab with an Assessment Reference Date (ARD) of 12/10/21 revealed a Brief Interview for Mental Status (BIMS) score of 14/15, indicating the resident was cognitively intact. During an interview on 01/04/22 at 10:22 AM with R83, the resident stated the food was served cold at every meal. During this interview, R83 was observed to reside on the East Wing of the facility. 2. Review of R3's "MDS" located in the EMR under the "MDS" tab with an ARD of 12/17/21 revealed a BIMS score of 15/15, indicating the	F 804	1) The facility's registered dietician was made aware that the facility failed to maintain hot and cold serving temperatures and that a taste test has been conducted to verify temperatures are , now within acceptable range. 2) Any resident has the potential to be affected. The dietary food services supervisor or designee will conduct taste test to verify temperatures are in acceptable range. 3) The dietary food services supervisor and dietary staff will be educated by Administrator or designee on the community's policy for providing residents meals that are cooked and/or held at appropriate temperatures. 4) A random taste test will be completed weekly x 12 weeks to verify food is served at acceptable temperature at point of delivery. The Administrator or designee will review the audit findings and report to QAPI committee for any further recommendations monthly x 3 months.	2/15/22

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F 804	Continued From page 53	F 804		

resident was cognitively intact.

During an interview on 01/04/22 at 12:29 PM with R3, the resident stated the food was served cold at nearly every meal. During this interview, R3 was observed to reside on the East Wing of the facility.
During a follow-up interview on 01/06/22 at 8:00 AM with R3, the resident stated, "Lunch and dinner were cold on last night."

3. Review of R69's significant change MDS, with an ARD of 09/01/21 revealed the resident had a BIMS score or 15/15, indicating the resident was cognitively intact.

Interview with R69 on 01/04/22 at 1:43 PM revealed the food that is served is not good to eat and is always cold. During this interview, R69 was observed to reside on the North Wing of the facility.

In response to resident complaints related to palatability/temperature, a test tray was requested for the lunch meal on 01/05/22 by the survey team. Temperatures were taken of the food on the steam table in the kitchen on 01/05/22 at 11:30 AM. The pork loin slices that were to be served were 177 degrees Fahrenheit (F) at that time. Further observation revealed that the meat remained uncovered on the steam table between 11:30 AM and 12:10 when the cart with the test tray left the kitchen. Milk in eight ounce cartons that was to be served with the meal was in a bin of lightly covered ice for use on the tray line. The ice was noted at the bottom of the cartons only and not spread on top.

Meal service began on 01/05/22 at 11:45 AM.

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F 804	Continued From page 54 Two meal carts were observed coming from the kitchen to the North wing. The first full cart left at 12:00 noon for the north wing. The second cart containing the test tray left the kitchen at 12:10 PM, arriving on the unit at 12:13 PM. The last tray on the second north cart was served at 12:15 PM, The test tray was then served at 12:15 PM after all trays were delivered to the resident rooms on this unit. Temperatures taken at this time with the facility's calibrated thermometer revealed the pork loin was 103.7 (F) and the milk was 49.4 (F). Interview with Supervising Nurse Licensed Practical Nurse (SLPN8), who was present at the time of the observation verified the food temperatures noted above. A taste test was then conducted on the food at the time noted above. Both the pork (entrée) and milk (beverage) were not palatable, based on temperature. The pork loin was cold, while the milk was noted to be warm to the taste. Review of the facility policy titled "Food Temperatures Policy," last revised 08/28/19, revealed that, "Hot foods shall be palatable at point of delivery." An interview with the Dietary Food Services Supervisor (DFSS) on 01/05/22 at 12:30 PM revealed no further information about expected palatability/temperature of food at the point of service. The DFSS's only response to the complaints of inappropriate food temperatures (hot foods cold, while cold foods were warm) was to say, "OK" when informed of the surveyor's findings.	F 804		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		

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F 812	Continued From page 55 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, the facility failed to store and/or serve food in accordance with professional standards for food safety. Foods were not labeled/dated when stored. Equipment such as the nozzle used for serving juice was not clean. Scoops used to serve food from the steam table were not sanitized. This failure had the potential to affect 91 of 92 residents in the facility who consume food by mouth. Findings include: 1a. Observation of the walk in refrigerator in the main kitchen on 01/03/22 at 9:10 AM revealed a metal pan used on the steam table was full of spaghetti and meat balls covered in clear	F 812	1) The dietary food services supervisor completed inspection of walk-in refrigerator and pulled and discarded all foods not dated and/or labeled; an inspection of the kitchen was completed by dietary food services supervisor to verify all equipment and utensils were cleaned per protocol. 2) Any resident has the potential to be affected. The dietary food services supervisor or designee will conduct a food and nutrition services sanitation audit to verify foods are labeled and dated per protocol. 3) The dietary food services supervisor or designee to re-educate food and nutrition services staff on community's policy for proper food production and food safety and kitchen equipment operations and cleaning instructions. 4) The dietary food services supervisor or designee will conduct a food and nutrition sanitation audit on a weekly x 12 weeks to verify foods are labeled and dated and equipment and utensils are clean per protocol. The Administrator or designee will review the audit findings and report to QAPI committee for any further recommendations monthly x 3 months.	2/15/22

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F 812	Continued From page 56	F 812		

cellophane without a date. Interview with the Dietary Food Service Supervisor (DFSS) who was present at the time of the observation verified the food item lacked a storage date and stated, "It was from last night."

b. Observation of the walk in refrigerator in the main kitchen on 01/03/22 at 9:10 AM revealed a small metal container from the steam table full of macaroni and cheese, covered in clear cellophane without a date. Interview with the DFSS at the time of the observation indicated that she did not get a chance to clean up the refrigerator this morning.

c. Observation of the walk in refrigerator in the main kitchen on 01/03/22 at 9:10 AM revealed 10 meat balls in a metal container covered with clear cellophane lacking a date. Interview with the DFSS at the time of the observation indicated that she did not know how long the meatballs had been in storage and removed and discarded the meat balls in the waste container.

d. Observation of the walk in refrigerator in the main kitchen on 01/03/22 at 9:10 AM revealed two metal containers covered in clear cellophane, lacking a date. The two items appeared to be gravy which the DFSS acknowledged at the time of the observation. The DFSS did not know how long the gravy had been in the refrigerator in storage, removed it and threw it into the waste container.

Review of the facility policy titled "Food and Nutrition Services: Food Production and Food Safety" states on page two, item 16 "leftover food must be used within seven days (day of preparation counts as day 1) or discarded.

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F 812	Continued From page 57 Monitor daily for expiration dates." 2. Observation of the juice nozzle gun located in the main kitchen area on 01/03/22 at 9:20 AM revealed that inside the gun, the nozzle was dirty with black material covering all interior surfaces. Interview with the DFSS at the time of the observation revealed she did not have a cleaning schedule for the juice nozzle. The DFSS indicated she does not keep records and did not know when the nozzle was last cleaned. 3. Observation in the kitchen prior to lunch meal service on 01/05/22 at 11:35 AM revealed the DFSS removed two #8 scoops from the rinse (middle) section of the three compartment sink and rinsed each under a running faucet. The DFSS then removed the scoops from the running faucet and placed then in the serving table sections for pureed and mechanical meat without sanitizing each item. When interviewed at the time of the observation, the DFSS indicated the scoops were clean. Review of the facility policy titled "Equipment Cleaning and Sanitation Policy" revised 08/25/20, revealed, "The food and nutrition services staff will maintain a clean and sanitary environment in food service areas through compliance with a written, comprehensive cleaning schedule" which included items processed at the three compartment sink.	F 812		
F 909 SS=F	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all	F 909		

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F 909	Continued From page 58 bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of facility policy, and review of specifications for the use of a bed frame, the facility failed to ensure that mattresses fit snugly within the bed frame and side rails and/or that side rails were maintained in a fixed (tightened) position for two residents (Resident (R) 69 and R45). In addition, the facility failed to conduct regular inspections to assure that all bed frames, mattresses, and side rails (if present) were inspected as a part of a regular maintenance program. The failure to conduct regular inspections to identify possible entrapment hazards as part of the routine maintenance program had the potential to affect all 92 residents using beds in the facility. Findings include: Review of the facility policy titled, "Bed Rail Policy," revised 08/12/21, revealed that the facility will "ensure appropriate dimensions of the bed based on the resident size and weight." The policy also noted the requirement to, "Ensure scheduled maintenance of any bed rail in use according to manufacturer's specifications." 1. Review of R69's "Face Sheet" located in the electronic medical record (EMR) revealed the resident's diagnoses included obesity due to	F 909	1) R69 and R45 mattresses have been corrected to ensure they fit snugly within the bed frame and side rail. The facility's Maintenance Director's life safety inspection have been updated to include possible entrapment hazards. 2) Any resident has the potential to be affected. The maintenance director or designee will conduct 100% audit on all facility beds to identify any other potential hazards areas, if identified it will be conducted at the time of discovery. 3) The maintenance director and maintenance department personal, RN's and LPN's will be educated by administrator or designee on the community's policy on use of bed rails and potential entrapment hazards. The maintenance director, maintenance department personal will be educated by administrator or designee on the bed system dimensional and assessment guide and bed and bed rail safety inspection log on all beds.	

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F 909	Continued From page 59 excess calories. A significant change Minimum Data Set (MDS) with an Assessment Reference Date of 09/01/21 revealed the resident was independent in bed mobility and transfers and had a Brief Interview for Mental Status (BIMS) score of 15/15, indicating the resident was cognitively intact. Review of the specifications of the bed frame taken from the facility file on "Equipment" revealed the bed used by R69 is an adjustable bed that can be retracted by the width to a normal size or expanded for bariatric residents. Observation in R69's room on 01/04/22 at 1:50 PM revealed a large gap in between the bed side rail and R69's mattress on the bed. Measurements were taken of the gap between the mattresses and the side rail by the Director of Nursing (DON) in the presence of the survey team and revealed a 4.5 inch gap between the mattress and side rail on each side of the bed. Interview with the DON at the time of the observation confirmed the measurements and gap between the side rails, verifying that a regular size mattress was being used on a bariatric-sized bed frame. The DON confirmed that the regular-sized mattress did not fit the large bed frame. The DON stated the resident had moved rooms multiple times due to hospitalizations and requests and indicated that the beds and frames must have been moved and re-installed improperly. Further interview with the DON revealed that nursing was not involved in this process, and it was all done by maintenance. 2. Observation on 01/04/22 at 2:20 PM revealed the left side rail on R45's bed was not stable and	F 909	4) A bed and bed rail safety inspection audit of all current resident beds will be completed monthly x 3 months. The administrator or designee will review the audit findings and report to the QAPI committee for any further recommendations monthly x 3 months.	2/15/22

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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 909	Continued From page 60 moved back and forth above the mattress. Interview with R45 at the time of the observation revealed, "It's broken and doesn't work right." Interview with the Maintenance Supervisor on 01/05/22 at 4:50 PM he was unaware that R69's mattress did not fit properly within the bed frame, stating such a large gap could be dangerous. The Maintenance Supervisor also acknowledged that he was unaware that R45's side rail needed to be tightened. Further interview with the Maintenance Supervisor revealed he did not have evidence of a regular maintenance program for checking bed frames, mattresses, and, if present, side rails, to identify and prevent possible areas of entrapment. The Maintenance Supervisor stated he had no documentation of any checks of the beds, bed frame, mattresses, or side rails for any reason for the entire building of 92 beds and confirmed that he was not completing these checks in accordance with the facility's policy.	F 909		