

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

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Form Approved OMB  
No. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>495249                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                         | (X3) DATE SURVEY<br>COMPLETED<br><br>03/11/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Farmville Health & Rehab Center                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1575 Scott Drive Route 5<br>Farmville, VA 23901 |                                                 |
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| F 0656<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Some                        | <p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to develop and/or implement a care plan for five of 44 residents in the survey sample, Residents #25, #40, #103, #91, and #11. The findings include: 1. For Resident #25 (R25), the facility failed to develop a care plan for the use of side rails.</p> <p>On the following dates and times, R25 was observed lying in bed with bilateral side rails engaged: 3/9/26 at 1:50 p.m. and 4:24 p.m.; 3/10/26 at 8:31 a.m. and 3:52 p.m. (verified by CNA (certified nursing assistant) #1.</p> <p>A review of R25's care plan dated 12/19/25 revealed no information related to the use of side rails.</p> <p>On 3/11/26 at 8:32 a.m., RN (registered nurse) #5 was interviewed. She stated that a care plan is geared to each individual resident's needs. She stated that the MDS (minimum data set) nurses are primarily responsible for developing care plans. She added that the clinical leaders meet a couple of times a day and communicate with the MDS staff about things like the use of bed rails. She stated that the use of side rails should be included on a resident's care plan.</p> <p>On 3/11/26 at 10:01 a.m., the MDS Coordinator was interviewed. She stated that a care plan is a working plan for the interdisciplinary team so everyone can look and see what is supposed to be going on with a resident. She stated the MDS nurses develop the care plans after the nurses develop the initial care plan immediately when a resident is admitted. She stated that floor nurses typically do not develop care plans. She stated she regularly reviews physician orders and speaks with the floor staff (at least twice a day) to determine if care plans need to be developed. She stated side rails should be a part of a resident's care plan because they are something that not all residents need or have. They are unique to some residents.</p> <p>On 3/11/26 at 2:00 p.m., the Administrator and Director of Nursing were informed of these concerns.</p> <p>A review of the facility policy, Comprehensive Care Planning, revealed, in part: The facility will develop a comprehensive person-centered care plan for each resident that includes measurable goals and timetables. The services provided or arranged by the facility, as outlined by the comprehensive care plan, must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>No additional information was provided prior to exit.</p> <p>2. For Resident #40 (R40), the facility failed to develop a care plan for the use of side rails.<br/>(continued on next page)</p> |                                                                                              |                                                 |

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

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

TITLE

(X6) DATE

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| <p>F 0656</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>On the following dates and times, R40 was observed lying in bed with bilateral side rails engaged: 3/9/26 at 1:53 p.m. and 4:26 p.m.; 3/10/26 at 3:53 p.m. (verified by CNA (certified nursing assistant) #1.</p> <p>A review of R40's care plan dated 6/24/24 revealed no information related to the use of side rails.</p> <p>On 3/11/26 at 8:32 a.m., RN (registered nurse) #5 was interviewed. She stated that a care plan is geared to each individual resident's needs. She stated that the MDS (minimum data set) nurses are primarily responsible for developing care plans. She added that the clinical leaders meet a couple of times a day and communicate with the MDS staff about things like the use of bed rails. She stated that the use of side rails should be included on a resident's care plan.</p> <p>On 3/11/26 at 10:01 a.m., the MDS Coordinator was interviewed. She stated that a care plan is a working plan for the interdisciplinary team so everyone can look and see what is supposed to be going on with a resident. She stated the MDS nurses develop the care plans after the nurses develop the initial care plan immediately when a resident is admitted . She stated that floor nurses typically do not develop care plans. She stated she regularly reviews physician orders and speaks with the floor staff (at least twice a day) to determine if care plans need to be developed. She stated side rails should be a part of a resident's care plan because they are something that not all residents need or have. They are unique to some residents.</p> <p>On 3/11/26 at 2:00 p.m., the Administrator and Director of Nursing were informed of these concerns.</p> <p>No additional information was provided prior to exit.</p> <p>3. For Resident #103 (R103), the facility failed to develop a care plan for the use of side rails</p> <p>On the following dates and times, R103 was observed lying in bed with bilateral side rails engaged: 3/9/26 at 1:20 p.m. and 4:22 p.m.; 3/10/26 at 8:25 a.m. and 3:51 p.m. (verified by CNA (certified nursing assistant) #1.</p> <p>A review of R103's care plan dated 8/14/24 revealed no information related to the use of side rails.</p> <p>On 3/11/26 at 8:32 a.m., RN (registered nurse) #5 was interviewed. She stated that a care plan is geared to each individual resident's needs. She stated that the MDS (minimum data set) nurses are primarily responsible for developing care plans. She added that the clinical leaders meet a couple of times a day and communicate with the MDS staff about things like the use of bed rails. She stated that the use of side rails should be included on a resident's care plan.</p> <p>On 3/11/26 at 10:01 a.m., the MDS Coordinator was interviewed. She stated that a care plan is a working plan for the interdisciplinary team so everyone can look and see what is supposed to be going on with a resident. She stated the MDS nurses develop the care plans after the nurses develop the initial care plan immediately when a resident is admitted . She stated that floor nurses typically do not develop care plans. She stated she regularly reviews physician orders and speaks with the floor staff (at least twice a day) to determine if care plans need to be developed. She stated side rails should be a part of a resident's care plan because they are something that not all residents need or have. They are unique to some residents.</p> <p>On 3/11/26 at 2:00 p.m., the Administrator and Director of Nursing were informed of these concerns.<br/>(continued on next page)</p> |                                                                                              |                                                 |

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| <p>F 0656</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>No additional information was provided prior to exit.</p> <p>4. For Resident #91 (R91), the facility staff failed to develop a care plan for the use of side rails.</p> <p>On the 3/10/26 at 8:30 a.m., R91 was observed sitting up in bed. The right hand side rail was engaged.</p> <p>A review of R91's care plan dated 4/25/25 revealed no information related to the use of side rails.</p> <p>On 3/11/26 at 8:32 a.m., RN (registered nurse) #5 was interviewed. She stated that a care plan is geared to each individual resident's needs. She stated that the MDS (minimum data set) nurses are primarily responsible for developing care plans. She added that the clinical leaders meet a couple of times a day and communicate with the MDS staff about things like the use of bed rails. She stated that the use of side rails should be included on a resident's care plan.</p> <p>On 3/11/26 at 10:01 a.m., the MDS Coordinator was interviewed. She stated that a care plan is a working plan for the interdisciplinary team so everyone can look and see what is supposed to be going on with a resident. She stated the MDS nurses develop the care plans after the nurses develop the initial care plan immediately when a resident is admitted . She stated that floor nurses typically do not develop care plans. She stated she regularly reviews physician orders and speaks with the floor staff (at least twice a day) to determine if care plans need to be developed. She stated side rails should be a part of a resident's care plan because they are something that not all residents need or have. They are unique to some residents.</p> <p>On 3/11/26 at 2:00 p.m., the Administrator and Director of Nursing were informed of these concerns.</p> <p>No additional information was provided prior to exit.</p> <p>5.The facility staff failed to implement the comprehensive care plan for splint application for Resident #11 (R11).</p> <p>R11 was admitted to the facility on [DATE]. R11 diagnoses included but were not limited to: CKD (chronic kidney disease), DM (diabetes mellitus), osteoarthritis and convulsions.</p> <p>R11's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 2/28/26, coded the resident as scoring 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. MDS Section G- Functional Status: coded the resident as maximum assistant with bed mobility, transfers, dressing, personal hygiene and bathing; range of motion: upper limb-impaired one side.</p> <p>A review of R11's comprehensive care plan dated 9/27/24 revealed, PROBLEM: ADL (activities of daily living) FUNCTION / REHABILITATION POTENTIAL / PERSONAL HYGIENE: resident needs assistance from staff to maintain an appearance at satisfactory level and to complete ADLs. APPROACH: Right resting hand splint to improve Right hand function.</p> <p>A review of the physician orders dated 11/5/24 revealed, Patient was fitted with a right resting hand splint to reduce contracture and improve finger extension for use independent transfers. wearing instructions and precautions provided. Patient can remove splint but need staff to assist with applying it.</p> <p>(continued on next page)</p> |                                                                                              |                                                 |

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| <p>F 0656</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>A review of the MARs (medication administration records) for February and March 2026 revealed, splint on/off-coded off on following dates and shifts: day shift- 2/13, 3/11; evening shift- 2/1-2/13, 2/15-2/19, 2/21-2/28, 3/1, 3/3-3/10 and night shift- 2/1-2/17, 3/3-3/10/26.</p> <p>A review of the OT' (occupational therapy)'s progress note dated 9/2/25 and 11/26/25 revealed, Patient and Caregiver Training: instructed patient and primary caregivers in compensatory strategies in positioning maneuvers. Goal: Patient will be consistent with wearing RUE (right upper extremity) orthosis to prevent further contractures.</p> <p>R11 observed on 3/10/26 at 8:30 AM, 12:15 PM and 3/11/26 8:35 AM without splint on right hand.</p> <p>On 3/11/26 at 8:35 AM, R11 was observed without splint on right hand, when asked about right hand contracture, R11 stated, I am to wear a splint on the hand. The splint helps my hand stay open more. I do not know where the splint is.</p> <p>On 3/11/26 at 10:00 AM, an interview was conducted with the MDS coordinator, asked the purpose of the care plan, the MDS coordinator stated, it is for the interdisciplinary team, so everyone knows what is going on with the resident. The nurses do the baseline, then MDS does comprehensive care plan. If changes need to be made, MDS updates the care plan. If approaches on the care plan are not followed, the care plan was not implemented.</p> <p>On 3/11/26 at 2:00 PM, the administrator and director of nursing were made aware of the concerns.</p> <p>No further information was provided on exit.</p> |                                                                                              |                                                 |

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| <p>F 0583</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Keep residents' personal and medical records private and confidential.</p> <p>Based on observation, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to provide privacy during care for one of 44 residents in the survey sample, Resident #3. The findings include: For Resident #3 (R3), the facility staff failed to provide privacy during tracheostomy (1) care on 3/10/2026. On the most recent minimum data set (MDS), an admission assessment with an assessment reference date (ARD) of 2/4/2026, R3 was assessed as having a tracheostomy and receiving tracheostomy care at the facility. On 3/10/2026 at 10:52 AM, an observation was conducted of licensed practical nurse (LPN) #2 providing tracheostomy care to R3. LPN #3 was observed donning a mask, gown and gloves prior to performing tracheostomy care at the bedside of R3 which included changing the inner cannula of the tracheostomy tube, cleaning the outer stoma of the tracheostomy and suctioning the tracheostomy. During the procedure, R3's room door remained open, the privacy curtain open and pushed back to the wall and the blinds on the window remained open. Other residents, visitors and other staff were observed passing by the room in the hallway during the procedure. Additional staff entered the room to assist LPN #3 during the procedure including the unit manager and the director of nursing while the room door, privacy curtain and blinds remained open. On 3/10/2026 at 3:40 PM, an interview was conducted with LPN #2 who stated that privacy was provided during procedures by pulling the curtain in semi-private rooms and by closing the door in private rooms. She stated that she should have closed the door to R3's room during the tracheostomy care to provide privacy and had forgotten. The facility policy Resident Rights and Facility Responsibilities revised 10/7/2025 documented in part, It is the facility's policy to comply with all Resident Rights. On 3/10/2026 at approximately 5:00 PM, the administrator, the director of nursing, the regional director of clinical services, the regional director of operations and registered nurse #2, the assistant director of nursing, were made aware of the findings. No further information was provided prior to exit. Reference: (1) A tracheostomy is surgery to create a hole in your neck that goes into your windpipe. If you need it for just a short time, it will be closed later. Some people need the hole for the rest of their life. The hole is needed when your airway is blocked, or for some conditions that make it hard for you to breathe. You may need a tracheostomy if you are on a breathing machine (ventilator) for a long time; a breathing tube from your mouth is too uncomfortable for a long-term solution. The tracheostomy provides a way for your health care providers to gradually remove the ventilator if possible. After the hole is made, a plastic tube is placed in the hole to keep it open. A ribbon is tied around the neck to keep the tube in place. This information was obtained from the website: Tracheostomy care: MedlinePlus Medical Encyclopedia</p> |                                                                                              |                                                 |

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| F 0640<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>Based on staff interview and clinical record review it was determined that the facility staff failed to electronically submit a completed MDS (minimum data set) resident assessment for one of 44 residents in the survey sample, Resident #19. The findings include: For Resident #19 (R19), the facility staff failed to electronically submit the discharge MDS (minimum data set) with the ARD (assessment reference date) of 1/18/26. Review of the clinical record revealed a list of Resident 19's MDS assessments. The list revealed that a discharge MDS was completed on 1/18/26. Section A of the assessment documented Resident R19 as death in facility. As of the date of the survey of 3/11/26, the assessment's status was documented as in progress and did not have an accepted date which would have indicated the assessment had been electronically submitted. On 3/11/26 at 10:06 am., RN (registered nurse) #3, MDS coordinator was interviewed. When asked what triggers her to complete a discharge MDS, she answered that she was notified in the morning meetings, by the social worker or in the electronic medical records. She stated a discharge MDS should be completed within 7 days. She stated it should say production accepted when it has been transmitted and accepted. She further stated they use the RAI manual as guidance to complete the MDS assessments. RN#3 was shown R19's MDS in electronic medical record and said that it was probably overlooked and needed to be sent. According to the RAI Manual, Version 3.0, dated October 2025, section 2.6 documented that a discharge assessment is to be electronically submitted no later than the MDS completion date plus 14 calendar days, making the required date of electronic submission for this assessment on or approximately 2/1/26. On 3/11/26 at approximately 2:02p.m., Administrator, Director of Nursing, Regional [NAME] President of Operation, and Regional Director of Clinical Services were notified of the findings. No further information was provided prior to exit.</p> |                                                                                              |                                                 |

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| F 0641<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Ensure each resident receives an accurate assessment.</p> <p>Based on staff interview and clinical record review, the facility staff failed to accurately complete an annual minimum data set (MDS) assessment for 1 of 44 residents, Resident #105. The findings included: For Resident #105 (R105), the facility staff failed to code Section A1510 (Level II Preadmission Screening and Resident Review) of an annual MDS assessment to indicate the resident had a diagnosis of intellectual disability. R105's diagnoses included mild intellectual disabilities and bipolar disorder. Section C (cognitive patterns) of R105's annual MDS assessment with an assessment reference date (ARD) of 04/01/25 included a brief interview for mental status (BIMS) score of 13, indicating R105 was cognitively intact. Section A1510 was not coded to indicate R105 had been diagnosed with mild intellectual disability. R105's comprehensive care plan included the focus areas psychosocial well-being resident requires a level II PASRR (preadmission screening and resident review) related to intellectual disability and impaired cognitive function/impaired thought processes related to mild disability. R105's clinical record included a level II screening completed on 02/22/23. On 03/10/2026 at 2:35 p.m., during an interview with Registered Nurse (RN) #1 this staff reviewed R105's annual MDS and confirmed the diagnosis of intellectual disability had not been coded on Section A1510 of the annual MDS assessment and stated they would modify the assessment. On 03/10/2026 at approximately 5:00 p.m., during an end of the day meeting with the Administrator, Regional Director of Clinical Services, Director of Nursing, and Assistant Director of Nursing the above issue was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference.</p> |                                                                                              |                                                 |

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| F 0644<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>Based on staff interview and clinical record review, the facility staff failed to ensure a level II PASARR (preadmission screening and resident review) was completed for 1 of 44 residents, Resident #7. The findings included: For Resident #7 (R7), the facility staff failed to ensure a level II PASARR was completed. A Level I PASARR's was completed on 02/12/26 and referred this resident for a level II. R7's diagnoses included schizoaffective disorder, anxiety disorder and major depressive disorder. Section C (cognitive patterns) of R7's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 02/24/26 included a brief interview for mental status (BIMS) score of 15, indicating R7 was cognitively intact. During the clinical record review, the surveyor was unable to locate a level I PASARR. On 03/10/26 at 2:25 p.m., the facility Social Worker (SW) provided the surveyor with a copy of a level I PASARR completed on 02/12/26. Under the heading of RECOMMENDATION the box that read Refer for Level II evaluation had been marked. The SW stated they had sent referrals to the company that completed the level II PASARR's on 02/12/26, 02/23/26, and 02/26/26 as they did not complete level II's at the facility. On 03/10/2026 at approximately 5:00 p.m., during an end of the day meeting with the Administrator, Regional Director of Clinical Services, Director of Nursing, and Assistant Director of Nursing the issue with the level II PASARR not being completed was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference.</p> |                                                                                              |                                                 |

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| <p>F 0688</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide services to prevent a decrease in range of motion (ROM) for one of 44 current residents in the survey sample, Resident #11. The findings include: The facility failed to provide ROM services after identification of weakness and impaired mobility on admission for Resident #11 (R11). R11 was admitted to the facility on [DATE]. R11 diagnoses included but were not limited to: CKD (chronic kidney disease), DM (diabetes mellitus), osteoarthritis and convulsions. R11's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 2/28/26, coded the resident as scoring 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. MDS Section G- Functional Status: coded the resident as maximum assistant with bed mobility, transfers, dressing, personal hygiene and bathing; range of motion: upper limb-impaired one side. A review of R11's comprehensive care plan dated 9/27/24 revealed, PROBLEM: ADL (activities of daily living) FUNCTION / REHABILITATION POTENTIAL / PERSONAL HYGIENE: resident needs assistance from staff to maintain an appearance at satisfactory level and to complete ADLs. APPROACH: Right resting hand splint to improve Right hand function. A review of the physician orders dated 11/5/24 revealed, Patient was fitted with a right resting hand splint to reduce contracture and improve finger extension for use independent transfers. wearing instructions and precautions provided. Patient can remove splint but need staff to assist with applying it. A review of the MARs (medication administration records) for February and March 2026 revealed, splint on/off-coded off on following dates and shifts: day shift- 2/13, 3/11; evening shift- 2/1-2/13, 2/15-2/19, 2/21-2/28, 3/1, 3/3-3/10 and night shift- 2/1-2/17, 3/3-3/10/26. A review of the OT's progress note dated 9/2/25 and 11/26/25 revealed, Patient and Caregiver Training: instructed patient and primary caregivers in compensatory strategies in positioning maneuvers. Goal: Patient will be consistent with wearing RUE (right upper extremity) orthosis to prevent further contractures. R11 observed on 3/10/26 at 8:30 AM, 12:15 PM and 3/11/26 8:35 AM without splint on right hand. On 3/11/26 at 8:35 AM, R11 was observed without splint on right hand, when asked about right hand contracture, R11 stated, I am to wear a splint on the hand. The splint helps my hand stay open more. I do not know where the splint is. On 3/11/26 at 8:40 AM, LPN (licensed practical nurse) #5 stated, the splint was not on his right hand, it would be checked on after med pass. On 3/11/26 at 8:45 AM, LPN #6, the unit manager went to R11's room, looked in bedside cabinet top drawer and found the splint then put splint on resident with their help. On 3/11/26 at 8:55 AM, an interview was conducted with OSM (other staff member) #5, the occupational therapist (OT). The occupational therapist described R11's need for the splint, as he needs help putting it on, trying to get his fingers straightened out. Nursing has been informed multiple times about the need for assistance, but there are many staff across different shifts. On 3/11/26 at 2:00 PM, the administrator and director of nursing were made aware of the concerns. A review of the facility's Splint Issuance policy revealed, Splints shall be issued or fabricated with a provider's order and therapist must evaluate patient to determine need for splint, fit and issuance. Client will be instructed in wearing schedule, precautions and splint care. Patient splint schedule will be communicated to the multi-disciplinary team and documented in the care plan. No further information was provided on exit.</p> |                                                                                              |                                                 |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to implement safety interventions for one of 44 residents in the survey sample, Resident #103. The findings include: For Resident #103 (R103), the facility staff failed to implement a bolster on the resident's bed. On the following dates and times, R103 was observed lying in bed; a bolster was not observed at any time: 3/9/26 at 1:20 p.m. and 4:22 p.m.; 3/10/26 at 8:25 a.m. and 3:51 p.m. The lack of a bolster was verified on 3/10/26 at 3:51 p.m. by both CNA (certified nursing assistant) #1 and LPN (licensed practical nurse) #1. A review of R103's clinical record revealed the following order dated 9/13/24: Add bolsters to bed for resident safety. On 3/10/26 at 4:50 p.m., LPN #1 was interviewed. She stated R103 had not had a bolster on her bed since the beginning of 2026. She stated: She was switched to an air mattress. She added that the resident had not experienced a fall since July 2025. She explained: We didn't feel like she needed the bolster anymore. On 3/11/26 at 8:32 a.m., RN (registered nurse) #5, R103's unit manager, was interviewed. She stated that bolsters on a resident's bed are used as a fall prevention intervention. She stated the bolsters help define the perimeters of the bed, and in R103's case, were especially helpful because the resident is legally blind. She stated that an air mattress is used to help prevent or treat a resident's skin impairments, and that air mattresses do not take the place of bolsters. She stated: They are for two different things. She stated if there is a provider's order for a bolster, the order should be followed. On 3/11/26 at 2:00 p.m., the Administrator and Director of Nursing were informed of these concerns. A review of the facility policy, Fall Prevention and Management, revealed, in part: If [fall] risks are identified, preventive measures will be put in place. Individualized interventions will be implemented. No additional information was provided prior to exit.</p> |                                                                                              |                                                 |

Department of Health & Human Services  
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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>495249                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                     | (X3) DATE SURVEY<br>COMPLETED<br><br>03/11/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Farmville Health & Rehab Center                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1575 Scott Drive Route 5<br>Farmville, VA 23901 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                              |                                                 |
| (X4) ID PREFIX TAG                                                                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                              |                                                 |
| F 0692<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | Provide enough food/fluids to maintain a resident's health.<br><br>Based on staff interview, clinical record review, and facility document review, the facility staff failed to address a resident's weight loss for one of 44 residents in the survey sample, Resident #106. The findings include: For Resident #106 (R106), the facility staff failed to address the resident's significant weight loss occurring between 03/10/2025 and 09/08/2025. A review of R106's clinical record revealed the following weights: 3/10/25 - 209.9 pounds; 9/8/25 - 188.6 pounds. This represented a 10.15% loss. A further review of R106's clinical record revealed no evidence that the Registered Dietician (RD) had addressed this significant weight loss. This review revealed that after 9/8/25, the resident's weights stabilized. On 3/11/26 at 8:49 a.m., the RD was interviewed. She stated that she goes to the facility once a week on Monday and pulls a weight report for all residents at this time. She stated: I can only see what the report tells me. I would not have picked this [significant loss] up if I pulled the report on a day when it didn't show up. She presented a sample weight report to demonstrate her point. She explained that she only looked at the percentages and number of days between weights for weights taken 30 and 180 days prior running the report; she did not look at the weights themselves to identify other possible losses. She stated if she had known about R106's weight loss that showed on 9/8/25, she would have written a note. She added that for R106, the weight loss was desirable over time. On 3/11/26 at 2:00 p.m., the Administrator and Director of Nursing were informed of these concerns. No additional information was provided prior to exit. |                                                                                              |                                                 |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>495249                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                         | (X3) DATE SURVEY<br>COMPLETED<br><br>03/11/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Farmville Health & Rehab Center                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   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| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   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| (X4) ID PREFIX TAG                                                                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         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| <p>F 0700</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to implement bed rail requirements for three of 44 residents in the survey sample, Residents #25, #40, and #103. The findings include: 1. For Resident #25 (R25), the facility failed to assess the resident for the need for side rails, failed to educate the resident on benefits and risks of using side rails, and failed to obtain informed consent prior to the implementation of side rails. On the following dates and times, R25 was observed lying in bed with bilateral side rails engaged: 3/9/26 at 1:50 p.m. and 4:24 p.m.; 3/10/26 at 8:31 a.m. and 3:52 p.m. (verified by CNA (certified nursing assistant) #1. A review of R25's clinical record revealed no evidence of a side rail assessment, resident education, or consent for side rails. A review of R25's care plan dated 12/19/25 revealed no information related to the use of side rails. On 3/11/26 at 8:32 a.m., RN (registered nurse) #5 was interviewed. She stated that when a resident is admitted to the facility, the physical therapy staff assesses the resident for the need for side rails for bed mobility. If the therapy staff recommends the side rails, the nursing staff completes an Enabler Assessment. The Enabler Assessment assesses the resident's ability to use the side rails safely and provides the opportunity for education on the risks and benefits of use. She stated this assessment is required prior to the implementation of any side rails. On 3/11/26 at 2:00 p.m., the Administrator and Director of Nursing were informed of these concerns. A review of the facility policy, Bed Rail Policy, revealed, in part: 'Bed rails' are adjustable metal or rigid plastic bars that attach to the bed. This also includes grab and enabler bars. If a bed or side rail or bar is used, the facility will evaluate the potential risks associated with the use of bed rails, including the risk of entrapment, prior to bed rail installation. Evaluate the risk versus benefits of using a bed rail and review them with the resident or the resident's representative. Obtain informed consent for the installation and use of bed rails prior to the installation. No additional information was provided prior to exit. 2. For Resident #40 (R40), the facility failed to assess the resident for the need for side rails, failed to educate the resident on benefits and risks of using side rails, and failed to obtain informed consent prior to the implementation of side rails. On the following dates and times, R40 was observed lying in bed with bilateral side rails engaged: 3/9/26 at 1:53 p.m. and 4:26 p.m.; 3/10/26 at 3:53 p.m. (verified by CNA (certified nursing assistant) #1. A review of R40's clinical record revealed no evidence of a side rail assessment, resident education, or consent for side rails. A review of R40's care plan dated 6/24/24 revealed no information related to the use of side rails. On 3/11/26 at 8:32 a.m., RN (registered nurse) #5 was interviewed. She stated that when a resident is admitted to the facility, the physical therapy staff assesses the resident for the need for side rails for bed mobility. If the therapy staff recommends the side rails, the nursing staff completes an Enabler Assessment. The Enabler Assessment assesses the resident's ability to use the side rails safely and provides the opportunity for education on the risks and benefits of use. She stated this assessment is required prior to the implementation of any side rails. On 3/11/26 at 2:00 p.m., the Administrator and Director of Nursing were informed of these concerns. No additional information was provided prior to exit. 3. For Resident #103 (R103), the facility failed to assess the resident for the need for side rails, failed to educate the resident on benefits and risks of using side rails, and failed to obtain informed consent prior to the implementation of side rails. On the following dates and times, R103 was observed lying in bed with bilateral side rails engaged: 3/9/26 at 1:20 p.m. and 4:22 p.m.; 3/10/26 at 8:25 a.m. and 3:51 p.m. (verified by CNA (certified nursing assistant) #1. A review of R103's clinical record revealed no evidence of a side rail assessment, resident education, or consent for side rails. A review of R103's care plan dated 8/14/24 revealed no information related to the use of side rails. On 3/11/26 at 8:32 a.m., RN (registered nurse) #5 was interviewed. She stated that when a resident is admitted to the facility, the physical therapy staff assesses the resident for the need for side rails for bed</p> <p>(continued on next page)</p> |                                                                                              |                                                 |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>495249                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                     | (X3) DATE SURVEY<br>COMPLETED<br><br>03/11/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Farmville Health & Rehab Center                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1575 Scott Drive Route 5<br>Farmville, VA 23901 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                              |                                                 |
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| F 0700<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | mobility. If the therapy staff recommends the side rails, the nursing staff completes an Enabler Assessment. The Enabler Assessment assesses the resident's ability to use the side rails safely and provides the opportunity for education on the risks and benefits of use. She stated this assessment is required prior to the implementation of any side rails. On 3/11/26 at 2:00 p.m., the Administrator and Director of Nursing were informed of these concerns. No additional information was provided prior to exit. |                                                                                              |                                                 |