PRINTED: 09/14/2017 FORM APPROVED

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB_	<u>OMB NO. 0938-039</u>	
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		DATE SURVEY COMPLETED
		49E075	B. WING				C 09/07/2017
NAME OF	PROVIDER OR SUPPLIER		1	STF	REET ADDRESS, CITY, STATE, ZIP C	ODE '	00/01/2011
CICY INT	- TERRACE OCLUVIUS	A # 6 Pm			BOX 558		
SKYLINE	E TERRACE CONV HO	JME	-	WC	OODSTOCK, VA 22664		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	F 0	00			
	one complaint was survey. Corrections						
F 157 SS=D	at the time of the su consisted of 13 curr (Residents 1 throug reviews (Residents	FY OF CHANGES	F 18	57			
	(g)(14) Notification of Changes.				w will corrective action complished for those		
	consult with the resi	mediately inform the resident; dent's physician; and notify,			nts found to be affected edeficient practice?		
	representative(s) wh	or her authority, the resident nen there is-			D and RP for resident #1	(09/15/17
	results in injury and	(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;		was notified that the resident's blood pressure medication was held on 07/16/17 and 07/17/17.			
	(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial		0,	,, 1,,			
		status in either life-threatening conditions or clinical complications);				RECE	VED
	(C) A pood to alt +	contradit significantly (that)				SEP 21	2017
	a need to discontinutreatment due to ad-	reatment significantly (that is, le an existing form of verse consequences, or to our of treatment); or				VDH/(DLC

LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Rebecea Klimb, ATT Weanne & Graft, administration 9/18/17

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 lastructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES			FORM APPROVI	ΕI
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	9
		49E075	B. WING_		09/07/2017	
	PROVIDER OR SUPPLIER E TERRACE CONV H	⊃h <i>d⊑</i>		STREET ADDRESS, CITY, STATE, ZIP PO BOX 558	CODE	
				WOODSTOCK, VA 22664		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	IN SHOULD BE COMPLETIC E APPROPRIATE DATE	N
F 157	Continued From pa	ge 1	F 15	7		
	resident from the far §483.15(c)(1)(ii). (ii) When making not (14)(i) of this section all pertinent information is available and prophysician. (iii) The facility must resident and the resident and the resident there is— (A) A change in room as specified in §483	, , , ,	oth pot san DOI med block the the	How will the facility identify er residents having the ential to be affected by the ne deficient practice? Nor designee will audit the dical records of residents on od pressure medications for last 7 days to ensure that MD and RP were notified if re was a need to hold blood ssure medications.	10/10/17	
	State law or regulating (e)(10) of this section (iv) The facility must update the address phone number of the This REQUIREMENT by: Based on staff internand clinical record returned the facility staff failed RP (responsible part reatment for one of sample, Resident #1).	record and periodically (mailing and email) and eresident representative(s). T is not met as evidenced view, facility document review eview, it was determined that d to notify the physician and tay) of a need to alter 15 residents in the survey .	into mad prad DON facil MD a re	What measures will be put place or systemic changes le to ensure the deficient ctice will not reoccur? Nor designee educated ity staff on notifying the and RP of any needs to hold sident's blood pressure lication.	10/10/17 SEP 21 2017	
	physician and RP wt	nen the resident's blood was held on 7/16/17 and			OHOLC	

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<u> </u>	TO F OT CIVIL DION IT CL	A MEDICAID SERVICES	, · · · · · · · · · · · · · · · · · · ·	<u>VIB NO. 0938-0391</u>			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED			
		49E075	B. WING	C 09/07/2017			
	PROVIDER OR SUPPLIER TERRACE CONV HO)ME	STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 558 WOODSTOCK, VA 22664				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE OF CORRECTION OF CORRECT	BE COMPLETION			
F 157	Continued From pa The findings include		F 157				
	9/20/16. Resident 7 were not limited to: hypertension (high I #1's most recent MI quarterly assessme reference date) of 6	Imitted to the facility on #1's diagnoses included but Alzheimer's disease (1) and blood pressure). Resident DS (minimum data set), a nt with an ARD (assessment /19/17, coded the resident's aily decision making as	 4. How does the facility plan to monitor it's performance to make sure that the solutions are sustained? DON or designee will audit the medical record of 5 residents 3x/week for 2 weeks to ensure 	10/10/17			
	Review of Resident #1's clinical record revealed a physician's order dated 6/27/17 for metoprolol succinate (2) 100 milligrams- one tablet by mouth at bedtime.		that the MD and RP were notified of any needs to hold a resident's blood pressure medication.				
	metoprolol succinate #1 due to a low block nurse's note dated of metoprolol succinate #1 due to a low block review of Resident #1 the above nurses' n	d 7/16/17 documented e was not given to Resident of pressure of 92/42. A 7/17/17 documented e was not given to Resident of pressure of 92/56. Further #1's clinical record (including otes) failed to reveal Resident RP was made aware the d.	DON will report results to the QA committee. Findings and results will be reflected in the QA minutes	10/10/17			
	on 9/20/16 document has hypertension (HMEDICATIONSMo	rehensive care plan initiated inted, "(Name of Resident #1) ITN) AND IS TAKING HTN pointor/record use/side effects ort to MD (medical doctor) as					
	The nurse who docu unavailable for inter	umented the above notes was view.	as .				
	On 9/7/17 at 3:44 p.	m. an interview was	CECEIVE				



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CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES				OMB NO	O. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DA	ATE SURVEY DMPLETED
		49E075	B. WING			0:	C 9/07/2017
	PROVIDER OR SUPPLIER E TERRACE CONV HO			PO E	EET ADDRESS, CITY, STATE, ZIP CODE BOX 558 ODSTOCK, VA 22664		310112011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 157	LPN #1 was asked resident's blood prepressure medication that resident. LPN should be held and called. LPN #1 state physician via fax and LPN #1 was asked documented. LPN medication was held and physician/nursing progress not on 9/7/17 at 4:45 pmember) #1 (the activation of nursing) above findings. The facility policy tit Responsible Party Non Purpose: To ensure condition and medicate family and physician of changes, administrational changesDocumer legible and entered timely manner" No further information of depenentia is a brain a person's ability to	N (licensed practical nurse) #1. I what should be done if a essure is low and a blood on is due for administration to #1 stated the medication If the physician should be sted she also notifies the end calls the resident's family. If if this information should be #1 stated she documents the lid, why the medication was plantly notification in the otes in the computer system. D.M. ASM (administrative staff dministrator) and ASM #2 (the were made aware of the were made aware of the sicianFacility staff will notify es in condition or medication		157			

https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=

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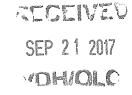
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ł	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		49E075	B. WING _		C 09/07/2017
	NAME OF PROVIDER OR SUPPLIER SKYLINE TERRACE CONV HOME			STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 558 WOODSTOCK, VA 22664	1 00/01/2071
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 279	_ga=2.139266234.6 20270.1477942321 (2) Metoprolol succ blood pressure. Th from the website: http://www.heart.org hBloodPressure/Pre dPressure/Types-of	Advery=alzheimers+disease& 302717078.1504827321-1391 inate is used to treat high is information was obtained as o	F 15		
SS=D	483.20 (d) Use. A facility massessments compmonths in the resideresults of the asses	nust maintain all resident leted within the previous 15 ent's active record and use the sments to develop, review ent's comprehensive care	be res	How will corrective action accomplished for those idents found to be affected the deficient practice?	
		develop and implement a	for res	e comprehensive care plan resident #8 reflects the ident's need for dration/fluid maintenance.	09/11/17
	each resident, cons set forth at §483.10 includes measurabl to meet a resident's and psychosocial ne	son-centered care plan for istent with the resident rights (c)(2) and §483.10(c)(3), that e objectives and timeframes medical, nursing, and mental eeds that are identified in the	for res	e comprehensive care plan resident # 13 reflects the ident's psychosocial Ilbeing and mood.	09/11/17
	care plan must desc (i) The services that	essment. The comprehensive cribe the following - are to be furnished to attain dent's highest practicable		e comprehensive care plan resident #5 includes falls.	09/08/17

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Event ID: N2KF11

Facility ID: VA0226

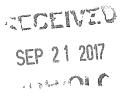
If continuation sheet Page 5 of 20



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CENTER	S FOR MEDICARE	& MEDICAID SERVICES	OMB NO. 0938-0391					
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		NSTRUCTION		DATE SURVEY COMPLETED	
		49E075	B. WING_				C 09/07/2017	
NAME OF P	ROVIDER OR SUPPLIER		1	STREE	T ADDRESS, CITY, STATE. ZIP CODE			
				РО ВО	X 558			
SKYLINE	SKYLINE TERRACE CONV HOME			WOOL	OSTOCK, VA 22664			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 270	Continued From pa	ae 5	F 2	70				
1 213	•	nd psychosocial well-being as	1 2	1 5				
		3.24, §483.25 or §483.40; and						
	under §483.24, §48 provided due to the	at would otherwise be required 33.25 or §483.40 but are not resident's exercise of rights uding the right to refuse 83.10(c)(6).	oʻ	ther res otentia	will the facility identify sidents having the I to be affected by the ficient practice?			
	rehabilitative service provide as a result recommendations. findings of the PAS	services or specialized es the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical, record.	re e p d	esident' nsure th lans ref ehydrat	designee will audit s medical records to ne comprehensive care lect resident's tion/fluid maintenance, ocial wellbeing, mood		10/10/17	
	(iv)In consultation versident's representation version (iv)	vith the resident and the tative (s)-		nd fall r	needs. measures will be put			
	(A) The resident's desired outcomes.	goals for admission and	ir m	nto plac nade to	e or systemic changes ensure the deficient			
	(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.		D C N	ON or o oordina Janager ompreh	will not reoccur? designee educated MDS ator, ADON and Unit rethat the mensive care plans must		10/10/17	
	plan, as appropriat requirements set for section. This REQUIREME by:	s in the comprehensive care e, in accordance with the orth in paragraph (c) of this NT is not met as evidenced erview, facility document review	m W fo	nainten	ehydration/fluid ance, psychosocial g, mood and fall needs ents.			
	and clinical record	review, it was determined that ed to develop a comprehensive						

care plan for three of 15 residents in the survey



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		AND HOMAN SERVICES			FORM APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
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NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/01/2011
SKYLINE	TERRACE CONV HO	OME		PO BOX 558 WOODSTOCK, VA 22664	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLÉTION
F 279	Continued From pa		F 27	79	
	area of dehydration V CAA (care area a	e plan for the triggered care Ifluid maintenance in section assessment) of Resident #8's t with an ARD (assessment	to m	How does the facility plan monitor it's performance to ake sure that the solutions e sustained?	
	areas of psychosod Resident #13's ann assessment with ar date) of 4/23/17. 3. The facility staff comprehensive car	e plan for the triggered care sal wellbeing and mood on ual MDS (minimum data set) in ARD (assessment reference failed to develop a e plan for the triggered care	co re to de ps ar	ON or designee will audit the mprehensive care plan of 5 sidents 3x/week for 2 weeks ensure that the reflect hydration/fluid maintenance, ychosocial wellbeing, mood d fall needs for residents are the care plan.	10/10/17
	(minimum data set)	sident #5's admission MDS assessment with an ARD ence date) of 2/9/17.	D(Q/	DN will report results to the A committee. Findings and	10/10/17
	area of dehydration	failed to develop a e plan for the triggered care /fluid maintenance in section		sults will be reflected in the A minutes.	
•		ssessment) of Resident #8's twith an ARD (assessment			

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impaired.

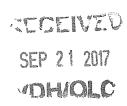
reference date) of 11/20/16.

Resident #8 was admitted to the facility on 8/14/03. Resident #8's diagnoses included but were not limited to: seizures and urinary tract infection. Resident #8's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/24/17, coded the resident's cognition as moderately

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Facility ID: VA0226

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CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-03					
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		49E075	B. WING			C 09/07/2017			
NAME OF F	PROVIDER OR SUPPLIER		,	ST	REET ADDRESS, CITY, STATE, ZIP CODE				
SKYLINE	TERRACE CONV HO	OME			9 BOX 558 DODSTOCK, VA 22664				
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F 279	Continued From pa	ge 7	F2	279					
	was an annual asset 11/20/16. Section of documented an "X" dehydration/fluid matthe area would be of Resident #8's compon 8/3/17 failed to of	recent comprehensive MDS essment with an ARD of V CAA (care area assessment) beside the care area of aintenance and documented care planned. orehensive care plan revised document information on/fluid maintenance.							
	On 9/7/17 at 1:44 p conducted with RN MDS coordinator). developed on admirannual MDS assess computer system g trigger on the CAAs areas are document was asked to identification maintenance area of On 9/7/17 at 2:27 p area of dehydration documented on Restated she reference Medicare and Medicassessment instruments.	.m. an interview was (registered nurse) #1 (the RN #1 stated CAAs are ssion, significant change and sments. RN #1 stated the enerates the care areas that and then she makes sure the sted on the care plan. RN #1 fy the dehydration/fluid on Resident #8's care planm. RN #1 confirmed the care /fluid maintenance was not sident #8's care plan. RN #1 es the CMS (Centers for caid Services) RAI (resident nent) manual when developing in the CAAs on the MDS							
	member) #1 (the ac	.m. ASM (administrative staff dministrator) and ASM #2 (the were made aware of the							
		led, "Care Plan Policy" edure: Care plans will be							

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initiated at the time of admission. Care plans will

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Facility ID: VA0226

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CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-0391					
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		49E075	B. WING			C 09/07/2017			
NAME OF PROVIDER OR SUPPLIER SKYLINE TERRACE CONV HOME				POI	EET ADDRESS, CITY, STATE, ZIP CODE BOX 558 ODSTOCK, VA 22664				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION			
F 279	"Coding Instructions - Facility staff are to mechanism to deter require review and a triggered care areas "Care Area Triggere each triggered care and current standar or expert-endorsed resources to conductore area. Docume information regardir Chapter 4 of this mainstructions on the Cand documentation For each triggered Planning Decision" new care plan, care of the current care p the issue(s) identified care area. The "Camust be completed	ed on the CAA" Just documented the following: a for V0200A, CAAs use the RAI triggering raine which care areas additional assessment. The sare checked in Column A and in the CAAs section. For area, use the CAA process d of practice, evidence-based clinical guidelines and at further assessment of the ant relevant assessment ag the resident's status. In the CAA process, care planning, care area, Column B "Care is checked to indicate that a plan revision, or continuation of the assessment of that are Planning Decision" column within 7 days of completing d by the date in V0200C2,	F 2	279					
	decision(s) were corresident's care plan No further information 2. The facility staff to comprehensive care areas of psychosoci Resident #13's annuments.	mpleted and that the was completed." on was presented prior to exit.							

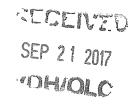
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date) of 4/23/17.

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-0391
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		49E075	B. WING			C 09/07/2017
NAME OF	PROVIDER OR SUPPLIER		<u>'</u>	STREET ADDRESS	S, CITY, STATE, ZIP CODE	1 00/01/2011
CIZVLINE	TEDDAGE COMMUN	>8.8F		PO BOX 558		
SKYLINE	TERRACE CONV HO	JIVIE		WOODSTOCK,	VA 22664	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH C	VIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOU EFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 279	Continued From pa	ge 9 admitted to the facility on	F 2	79		
	3/1/16 with diagnoses that included, but were not limited to; anxiety, urinary tract infection, high levels of lipids in the blood stream, dementia and psychotic disorder.					
	Resident #13's most (minimum data set) an ARD (assessme revealed, in part, theight out of a possil interview of mental					
	to make daily decis					
	assessment with an Section V - Care Ar "07. Mood State and Well-Being" were cl areas under column	hecked as triggered care n "A" and also checked under				
	instruction provided each triggered Care care plan, care plan current care plan is problem(s) identified	anning Decision." The in Section V states, "2. For e Area, indicate whether a new in revision, or continuation of necessary to address the d in your assessment of the column B if the triggered care				
	area is addressed in A review of Resider	n the care plan." at #13's comprehensive care				
	plan, dated 7/29/13,					
	conducted with RN	.m. an interview was (registered nurse) #1, the RN #1 was asked to describe				

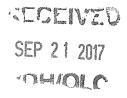
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her process for developing a care plan from the

Event ID: N2KF11

Facility ID: VA0226

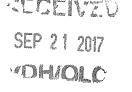
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CENTERS FOR MEDICARE & MEDICAID SERVICES							IO. 0938-0391
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		49E075	B. WING				C 09/07/2017
NAME OF F	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
SKYLINE	TERRACE CONV HO	DME			3OX 558 ODSTOCK, VA 22664		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 279	resident). The CAA admission assessmassessments and a computer generates care plan whatever On 9/7/17 at 2:27 pprovide evidence the inthe areas of psycofor Resident #13. On 9/7/17 at 4:45 pp. ASM (administrative administrator, and Anursing. ASM #1 are of the above concerpolicy regarding carrequested at this time. On 9/7/17 at 4:08 pp. unable to locate any well-being and moon Resident #1. No further information of the survey present administrative and moon Resident #1.	d, "I do an assessment (of the as are developed with tents, significant change nnual assessments. The state triggered areas and I is triggered plus more." Im. RN #1 was asked to at a care plan was developed thosocial well-being and mood Im. a meeting was held with the staff member) #1, the ask #2, the director of and ASM #2 were made aware and this time. A copy of the e plan development was ne. Im. RN #1 stated that she was a vevidence that psychosocial divere care planned for the cocess. Failed to develop a	F 2	279			
	comprehensive care area of falls on Resi	e plan for the triggered care ident #5's admission MDS assessment with an ARD					
	1/30/17 with diagnos	mitted to the facility on ses that included, but were ntia, high blood pressure,					

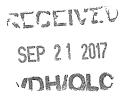
anxiety, cancer, depression and Parkinson's



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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			O	MB NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	į.		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49E075	B. WING			C 09/07/2017
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	
SKYLINE	TERRACE CONV HO	DME			D BOX 558 OODSTOCK, VA 22664	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ıx	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION
F 279	Continued From pa	ae 11	F	279		
	disease, a moveme		, 2	., 0		
	(minimum data set) with an ARD (asses 2/9/17 revealed, in a 15 out of a possibiliterview of mental Resident #5 is cogramake daily decision. Further review of Rassessment with an Section V - Care Ar "11. Falls" was checunder column "A" a column "B. Care Plainstruction provided each triggered Care care plan, care plan current care plan is problem(s) identified	esident #5's admission MDS a ARD of 2/9/17 revealed in ea Assessment (CAA) that cked as a triggered care area and also checked under anning Decision." The in Section V states, "2. For e Area, indicate whether a new a revision, or continuation of necessary to address the d in your assessment of the column B if the triggered care				
	A review of Resider plan, dated 1/30/17 documentation rega					
	conducted with RN MDS coordinator. If her process for dev CAAs. RN #1 state resident). The CAA admission assessments and a	.m. an interview was (registered nurse) #1, the RN #1 was asked to describe eloping a care plan from the d, "I do an assessment (of the as are developed with tents, significant change nnual assessments. The sthe triggered areas and I				

care plan whatever is triggered plus more." RN



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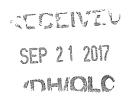
1		A MEDICAID SERVICES			(OMB NO. 0938-039
1	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49E075	B. WING			C 09/07/2017
	PROVIDER OR SUPPLIER E TERRACE CONV HO	DME		РО	REET ADDRESS, CITY, STATE, ZIP CODE BOX 558 DODSTOCK, VA 22664	1 03/01/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION
F 514 SS=D	that a care plan was for Resident #5. On 9/7/17 at 2:27 p not completed a fall. When asked what s completing care pla used the RAI (resident manual.) On 9/7/17 at 4:45 p. ASM (administrative administrator, and A nursing. ASM #1 ar of the above concerpolicy regarding carrequested at this time. No further information of the survey presented of the survey presented at the survey presented	s time to provide evidence is developed in the area of falls i.m. RN #1 stated that she had is care plan for Resident #5. The used as a reference when ins, RN #1 stated that she ent assessment instrument) m. a meeting was held with estaff member) #1, the istaff member) #1, the istaff member made aware in at this time. A copy of the explan development was income as provided prior to the ocess. ETE/ACCURATE/ACCESSIB th accepted professional inces, the facility must cords on each resident that inented; mented; le; and	be re by Th in at ac m	14 Hove according the notervente tempination and tempination a	w will corrective action omplished for those of the second to be affected deficient practice? In-pharmacological entions that were ofted prior to estering anxiety action to resident #7 was ented.	10/10/17
	, , ,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N2KF11

Facility ID: VA0226

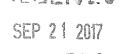
If continuation sheet Page 13 of 20



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	to rore the bronder	WILDIO/ ND OLIVVIOLO			JIVID INO. 0930-039 I
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
					С
	**************************************	49E075	B. WING	<u> </u>	09/07/2017
	PROVIDER OR SUPPLIER TERRACE CONV H	DME		STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 558 WOODSTOCK, VA 22664	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		D BE COMPLETION
F 514	Continued From pa	ge 13	F	514	
	(5) The medical red	ord must contain-			
	(i) Sufficient informa	ation to identify the resident;		The non-pharmacological nterventions that were	10/10/17
	(ii) A record of the r	esident's assessments;		attempted prior to administering anxiety	
	(iii) The comprehensive plan of care and services provided;			medication to resident #5 was documented.	
	and resident review determinations conditions conditions conditions. (v) Physician's, nursiprofessional's program (vi) Laboratory, radiservices reports as This REQUIREMEN by: Based on staff interest and clinical record in the facility staff faile accurate clinical record in the survey sample, 1. The facility staff finon-pharmacological attempted with Residential residential record in the survey sample, 1. The facility staff finon-pharmacological attempted with Residential resid	ducted by the State; se's, and other licensed ress notes; and cology and other diagnostic required under §483.50. IT is not met as evidenced rview, facility document review eview, it was determined that d to maintain a complete and cord for two of 15 residents in Residents #7 and #5. ailed to document al interventions that were	r r r t v	2. How will the facility identify other residents having the cotential to be affected by the same deficient practice? DON or designee will audit the medical record of residents ecciving PRN antianxiety medications for the last 7 days o ensure that non-charmacological interventions were attempted prior to administering antianxiety medications.	10/10/17
		al interventions prior to xiolytic (anti-anxiety)	•		

Facility ID: VA0226



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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		(OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		49E075	B. WING	3	C 09/07/2017
NAME OF F	PROVIDER OR SUPPLIER		<u></u>	STREET ADDRESS, CITY, STATE, ZIP CODE	
SKYLINE	TERRACE CONV HO	DME		PO BOX 558 WOODSTOCK, VA 22664	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	•	DBE COMPLETION
F 514	attempted with Res administration of as	Э :	; ;	3. What measures will be put into place or systemic changes made to ensure the deficient practice will not reoccur?	
	Resident #7 was ac 6/14/17. Resident # were not limited to: pressure and osteo recent MDS (minim assessment with ar date) of 6/21/17, co skills for daily decis impaired. Section received anxiety me days during the look	Imitted to the facility on #7's diagnoses included but urinary retention, high blood porosis. Resident #7's most um data set), an admission ARD (assessment reference ded the resident's cognitive ion making as severely N documented Resident #7 edication two out of seven		DON or designee educated facility staff on documenting mon-pharmacological interventions prior to the administration of PRN antianxiety medications. 4. How does the facility plan to monitor it's performance to make sure that the solutions are sustained?	10/10/17
	physician's order da milligrams- one table as needed for anxie August 2017 and So (medication administersident was administered in August September 2017. Folinical record (includated) failed to reveat attempted non-phar prior to administering	ated 6/26/17 for Ativan (1) 0.5 et by mouth every 12 hours by. Review of Resident #7's eptember 2017 MARs stration records) revealed the istered as needed Ativan 1st 2017 and twice in Further review of Resident #7's real documentation that staff macological interventions ag as needed Ativan to en times in August 2017 and		DON or designee will audit the medical record of 5 residents with orders for PRN antianxiety medications 3x/week for 2 weeks to ensure non-pharmacological interventions were attempted and documented prior to the administration of PRN antianxiety medications.	10/10/17

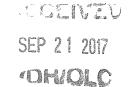
FORM CMS-2567(02-99) Previous Versions Obsolete

Resident #7's comprehensive care plan initiated on 6/14/17 failed to document information

Event ID: N2KF11

Facility ID: VA0226

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE SURVEY COMPLETED
		405075				С
:		49E075	B. WING			09/07/2017
NAME OF PROVIDER OR SUPPLIER SKYLINE TERRACE CONV HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			5	РО ВС	DSTOCK, VA 22664	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 514	to the administration on 9/7/17 at 3:39 p conducted with LPN LPN #3 stated shere (such as changing to offering a warm blat anxiety prior to administration. When non-pharmacological attempts, LPN #3 stated to percent but I do aware that accordin (LPN #3) administer resident on some downs no documentate non-pharmacological attempted. LPN #3 non-pharmacological trace documented the facility was utilizing she was trying to get of the prior of nursing above findings. The facility policy titt Policy" documented receive psychoactive when necessary to diagnosisNon-pharwill be offered and control of the policy will be offered and control of the prior of the policy when necessary to diagnosisNon-pharwill be offered and control of the policy will be offered and control of the policy when necessary to diagnosisNon-pharwill be offered and control of the policy will be offered and control of the policy when necessary to the policy when necessary to the policy will be offered and control of the policy will be offered and contro	macological interventions prior n of as needed Ativan. .m. an interview was N (licensed practical nurse) #3. tries different interventions the environment, food or nket) to lower residents' ninistering as needed anxiety asked if she documents the al interventions that she tated, "I try to. I'm not saying try." LPN #3 was made by to Resident #7's MAR, she red as needed Ativan to the ays in August 2017 but there are stated she attempted al interventions that were astated she attempted al interventions but must not hem. LPN #3 stated the anew computer system and et used to the system. .m. ASM (administrative staff dministrator) and ASM #2 (the were made aware of the led, "Psychoactive Medication II, "Procedure: Residents will be medications, as ordered,	Q re	ON will (A comr	report results to the mittee. Findings and vill be reflected in the stes.	10/10/17
	(1) Ativan is used to	treat anxiety. This				

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO	0.0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI		ONSTRUCTION	(X3) DA	ATE SURVEY OMPLETED
		49E075	B. WING		,	0!	C 9/07/2017
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SKYLINE	TERRACE CONV HO	DME			30X 558 ODSTOCK, VA 22664		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 514	https://medlineplus. tml	tained from the website: gov/druginfo/meds/a682053.h	F!	514			
		al interventions prior to xiolytic (anti-anxiety)					
	1/30/17 with diagno not limited to; deme	Imitted to the facility on ses that included, but were entia, high blood pressure, pression and Parkinson's ant disorder.					
	(minimum data set) with an ARD (asses 2/9/17 revealed, Re possible 15 on her I status), indicating the	recent comprehensive MDS, an admission assessment sment reference date) of sident #5 scored a 15 out of a BIMS (brief interview of mental at Resident #5 is cognitively d to make daily decisions.					
	August 1, 2017 reve order; "Xanax Table	at #5's physician orders dated ealed, in part, the following t 0.25 MG (milligrams). Give very 12 hours as needed for 6/1/17."					
	administration recorrevealed that on the administered Xanax documentation of an	ny non-pharmacological administration; 8/8/17,					

A review of Resident #5's nursing progress notes

did not reveal any documentation of

PRINTED: 09/14/2017

		& MEDICAID SERVICES			FORM APPROVED DMB NO. 0938-0391
	FEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED		
		49E075	B. WING	-	C 09/07/2017
	PROVIDER OR SUPPLIER E TERRACE CONV HO	DME		STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 558 WOODSTOCK, VA 22664	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	• • • • • • • • • • • • • • • • • • • •	D BE COMPLETION
F 514	non-pharmacologic prior to administration A review of Resider plan dated 1/30/201 following document uses anti-anxiety manxiety disorder. Da Interventions: Adminedications as order	al interventions attempted on of Xanax to Resident #5. Int #5's comprehensive care 17 revealed, in part, the ation; "(Name of Resident #5) edications r/t (related to) ate Initiated: 1/30/2017. Inister ANTI-ANXIETY ered by physician. Monitor for ectiveness Q (every) -SHIFT. (2017.)"	F	514	

On 9/7/17 at 9:27 a.m. an interview was conducted with LPN (licensed practical nurse) #4, a floor nurse. LPN #4 was asked to describe her process prior to administering an anxiolytic medication to a resident. LPN #4 stated, "I try to calm them down, if they are in a crowded area I remove them to a quiet area. I give them a warm blanket, if nothing works (helps reduce anxiety) I then administer the medication." When asked where the interventions attempted would be documented, LPN #4 stated, "There is a section in the computer for non-pharmacological interventions, we chart prior to the administration and then go back after about an hour to document the effectiveness (of the medication)." At this time LPN #4 reviewed the entries for 8/8/17, 8/9/17, 8/19/17, 8/21/17 and 8/23/17. LPN #4 confirmed that non-pharmacological medications were not documented. LPN #4 further stated, "A lot of times she (Resident #5) is on her way out with family/friend and she comes up to the desk and asks for her anti-anxiety medication." LPN #4 was asked whether or not the nurse should document the situation. LPN #4 stated, "Yes."

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CENTERS FOR MEDICARE & MEDICAID SERVICES						10	MB NO.	. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	TIPLE CONSTRU	JCTION		(X3) DAT	E SURVEY MPLETED
		49E075	B. WING					C /07/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADD	RESS, CITY, STATE,	ZIP CODE		
SKYLINE	E TERRACE CONV HO	DME		PO BOX 558 WOODSTO	3 OCK, VA 22664			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X (EA	PROVIDER'S PLAN O ACH CORRECTIVE AC SS-REFERENCED TO DEFICIEN	CTION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 514	conducted with RN nurse. RN #2 was prior to administerin RN #2 stated, "I che side effects, and he non-pharmacologic where the non-phar would be document progress notes." R documentation comfor administration of #2 was asked if she non-pharmacologic dates. RN #2 state what interventions stated, I tried distract should have documed didn't." On 9/7/17 at 11:04 a conducted with LPN was asked to descriadministering an an	.m. an interview was (registered nurse) #2, a floor asked to describe her process ag an anxiolytic to a resident. Each the behaviors, potential for alp the resident with al interventions." When asked macological interventions ed, RN #2 stated, "In the N #2 was asked to review her apleted on 8/21/17 and 8/23/16 of Xanax to Resident #5. RN	F	514				
	I offer something to comfortable, find ou and try to take their activity, some exerc When asked where non-pharmacologica stated, "In the progr type of things offere	at the medication is used for. make the resident more it the cause of their anxiety mind off of the issue with an ise or to visit other residents." she would document the al interventions, LPN #5 ess notes, I document the d prior to administering the don't want to do anything and						

just want the medication I do try to document it, though it (documentation) doesn't always happen." LPN #5 was asked to review her documentation completed on 8/9/17. LPN #5

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49E075	B. WING	;		C 09/07/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 514	documentation) but think I was trying to "Hasn't been able to not provide the information actually did." A meeting was cond (administrative staff administrator, and Anursing, on 9/7/17 a ASM #2 were made and a policy regarding anxiolytic and non-pand maintaining a companient of the was requested at the "Documentation" redocumentation: The "Documentation" redocumentation: "Puresident's medical rof pertinent facts, filt residents. Proceduinclude, but is not lit resident information notes, diagnostic redocuments.	appear that I tried al interventions (per the I did offer interventions. I indicate that when I wrote, o stop feeling anxious." I did rmation though as to what I ducted with ASM femmember) #1, the ASM #2, the director of at 4:45 p.m ASM #1 and a aware of the above concerning the administration of an obarmacological interventions complete and accurate record its time. Divided specific to the on-pharmacological facility policy titled vealed, in part, the following prose: To ensure the facility's ecord reflects documentation andings and observations about re: Documentation will mited to active and relevant a, assessments, flowsheets, sults, plans of care"		514		
	No further informati end of the survey pr	on was provided prior to the rocess.				