SKYLINE
NURSING AND REHABILITATION CENTER
a Consulate Health Care Center

August 3, 2016

Mr. Rodney L. Miller, LTC Supervisor
Office of Licensure and Certification
Division of Long Term Care Services
9960 Mayland Drive, Suite 401
Richmond, VA. 23233

Mr. Miller,

Please find enclosed the plan of correction for the most recent Standard Survey conducted on 7/14/2016 at Skyline Nursing and Rehabilitation. Should you have any questions or require any further information, please do not hesitate to contact me at your earliest convenience.

Respectfully,

Matthew R. Fife, ED, Skyline Nursing and Rehabilitation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495348	A. BUILDING _____ B. WING _____	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLINE NURSING & REHABILITATION CENTER	237 FRANKLIN PIKE ROAD, SE FLOYD, VA 24091

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 7/12/16 through 7/14/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Two complaints were investigated during the survey. The Life Safety Code survey/report will follow. The census in this 90 certified bed facility was 82 at the time of the survey. The survey sample consisted of 14 current Resident reviews (Residents #1 through #14) and 5 closed record reviews (Residents #15 through #19).	F 000	F-155 8-10-16	
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.	F 155	1. For Resident # 3, the Responsible Party and the physician were notified and a new Advanced Directive document was completed to include the necessary areas checked indicating the residents individual incapacity as well as signatures from the RP and the physician. 2. For current residents residing in the center, a review has been completed of Advanced Directive documents by the DCS/Designee to ensure that necessary/required areas on the document are completed and that necessary/required signatures are present on the document. 3. Re-education has been provided by the DCS/Designee to the Social Services Director and the Licensed Nurses regarding ensuring that necessary/required areas on the Advanced Directives document are completed and that required signatures have been obtained and	

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

Erica Quintos, NHA — 8/3/16

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.

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F 155	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to complete an advance directive for 1 of 19 residents (Resident #3). The findings include: The facility staff failed to complete the advance directive for Resident #3. Resident #3 was admitted to the facility on 8/30/15 with diagnoses of Alzheimer's disease, anxiety, hypertension, depression, and adult failure to thrive. The resident was admitted to hospice services on 6/14/16. The significant change Minimum Data set (MDS) with a reference date of 6/28/16 assessed the resident with a cognitive deficit for short and long term memory and requiring extensive assistance with decision making. The resident was assessed requiring extensive assistance of 2 persons for bed mobility, transfers, ambulation,dressing, eating, bathing, and hygiene. The clinical record was reviewed. The record contained the Durable Do Not Resuscitate (DNR) Order signed by the physician and the responsible party for Resident #3 dated 8/30/15. The form was incomplete and did not contain the information the resident had made an informed consent or was incapable of making the decision and a responsible party did so for the resident. The nurse on the unit (LPN#1) was asked about	F 155	are on the document. A review of Advanced Directives documents will be completed by the DCS/Designee for (5) residents per week for (12) weeks to ensure that necessary/required areas on the Advanced Directives document have been completed and that required signatures are present. 4. Results of the reviews conducted by the Director of Clinical Services/Designees will be reviewed at the Quality Assurance/Performance Improvement Committee Meeting each month for (three) months. The QAPI Committee will make recommendations for revisions to the plan as indicated to sustain substantial compliance. Once the QAPI Committee determines that the problem no longer exists, further review will be completed on a random basis.	

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F 155	Continued From page 2 the form on 7/12/16 at 2:00 p.m. and stated she knew the resident was a DNR. The director of clinical services (DCS) was asked about the issue on 7/13/16 at 8:30 a.m. and stated she would look into the matter. The administrator and DCS were informed of the concern during a meeting with the survey team on 7/13/16 at 3:00 p.m. The administrator and DCS stated on 7/14/16 they reviewed all DNR forms weekly for signature, but had forgotten to check the form was complete.	F 155	F-157 1. For resident #10 the responsible party and the resident were contacted to ensure that they were satisfied with the resident's current room. There were no issues with the resident's current room indicated by either party. 2. For residents currently residing in the center, a review of recent room moves in the last (30) days was conducted to ensure that the proper room notification form was filled out, placed on the residents medical record, and that the resident and responsible party were notified promptly prior to the room move or new roommate assignment. 3. Re-education has been provided by the DCS/Designee to the Social Services Director and the Licensed Nurses regarding ensuring that prompt notification is provided to residents and responsible parties prior to a room move or new roommate	8-10-16
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in	F 157		

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resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on family interview, staff interview, clinical record review and facility document review the facility staff failed to notify Resident's RP (responsible party) of a room change in a timely manner for 1 of 19 Residents, Resident #10.

The findings included:

For Resident #10 the facility staff failed to notify Resident's RP that Resident would be moved from private room into a semi-private room in a timely manner.

Resident #10 was admitted to the facility on 01/27/16. Diagnoses included but not limited to anemia, hypertension, peripheral vascular disease, gastroesophageal reflux disorder, benign prostatic hypertrophy, diabetes mellitus, hyperlipidemia, thyroid disorder, dementia, malnutrition, and dysphagia.

The most recent comprehensive MDS (minimum data set) with an ARD (assessment reference date) of 06/02/16 coded the Resident as 5 out of 15 in Section C, cognitive patterns. This is a significant change MDS.

During initial tour on 07/12/16 at

F 157 assignment. A review of room changes will be completed by the Licensed Social Worker/Designee weekly for (12) weeks to ensure that the room notification form is completed, placed on the chart, and that prompt notification is given to the resident/responsible party prior to a room move or new roommate assignment.

4. Results of the reviews conducted by the Licensed Social Worker/Designee will be reviewed at the Quality Assurance/Performance Improvement Committee Meeting each month for (three) months. The QAPI Committee will make recommendations for revisions to the plan as indicated to sustain substantial compliance. Once the QAPI Committee determines that the problem no longer exists, further review will be completed on a random basis.

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approximately1130, surveyor observed Resident's personal belongings packed up and laying on bed. Family was in room with Resident. Surveyor identified herself, explained her purpose and inquired as to whether Resident was just arriving in facility or preparing to return home. Resident's son, who is also RP, stated to surveyor that Resident was moving back into private room from semi-private room. Son also stated that he was not happy that his father had been moved from his private room to begin with. At this time, facility staff arrived to move Resident.

Resident's clinical record was reviewed on 07/12/16 at approximately 1330. The surveyor could not locate any information in the clinical record that the Resident's RP had been notified prior to room change.

Surveyor spoke with Resident's RP again on 07/13/16 via telephone at approximately 0840. RP stated to surveyor "All this started on July 1st. This was a Friday. I had taken my mother to visit my father. He kept saying he was going to move. As my mother and I were preparing to leave the facility, heard a lot of noise outside my dad's room, and the staff had showed up, ready to move him. Up until then, I knew nothing about it. ...(name omitted), the social worker came in and tells us they have a medical emergency and need to move my father and asked if it was alright. I told them 'no', but they moved him anyway. The next day, I went to see dad and he was very upset, saying somebody was in his room, messing in his stuff and he was going to call the sheriff. When I went to leave, he followed me up the hall begging me to take him with me. The nurse,....(name omitted) came and got dad and talked with him. The next day he was calm as can

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be. I just feel like the whole situation was handled poorly,and that if I had not been there visiting they would have just moved him, then called and told me. If they had just talked to dad before and prepared him better, it wouldn't have been as hard on him."

Surveyor spoke with LPN (licensed practical nurse) #1 on 07/13/16 at approximatley 1020. Surveyor asked LPN #1 if Resident #10 was more confused and upset after the room change and LPN #1 stated "He seemed more confused the first day after moving, thought he was intruding on roommate. Stated his roommate was paying for the room and he (Resident #10) was bothering roommate. Resident #10's son was visiting and as he was leaving, Resident followed him up hall, asking son to take him home. I talked with Resident and also called the DON (director on nursing), who came and took Resident #10 to his room, introduced him to his roommate and explained that they were now sharing a room. After the DON talked with Resident, he was much calmer". Surveyor asked LPN #1 the reason for the room change and LPN #1 stated the reason as being another Resident needed to be placed in isolation and they needed Resident #10's private room in order to do so.

Surveyor spoke with SW (social worker) on 07/13/16 at approximately 1040 regarding Resident #10's room change. SW stated that Resident was moved on the 1st of July due to needing the private room for isolation. SW stated that Resident's son/RP was in the facility at the time of room change and he was notified of the change by SW. SW stated that Resident's son was "not happy" about the room change, but agreed to it with the stipulation that Resident #10

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be moved back into private room when possible. SW provided the surveyor with a "Room Change Notice" form which read in part "Reason for change: Need private room for isolation. Spoke with son in person re: medical necessity. Son noted preference to return to ....when private room becomes available" and "Spoke with (check as many as apply): Resident, Responsible person Date 07/01/16 Time 11am". This document was not included in the clinical record at time of review.

Surveyor spoke with DON on 07/13/16 at approximately 1100 regarding Resident #10. DON stated that Resident was moved due to needing a private room for another Resident to be placed in isolation and the ID (interdisciplinary) team had met prior to the move and made the determination of who was to be moved based on Resident status and compatibility with a roommate. DON also stated that Resident #10 was upset/confused the first day after the move, but that she had talked with him, introduced him to his roommate and allowed them to talk with each other for a while. After this Resident #10 became less upset.

Surveyor was provided a copy of "Virginia Resident's Rights and Responsibilities" which read in part

"Notification of Changes

B. To be notified promptly and if known your legal representative or interested family member when there is:

1. A change in room or roommate assignment."

The concern of not promptly notifying the Resident's RP was brought to the attention of the

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F 157	Continued From page 7 administrative staff during a meeting on 07/13/16 at approximately 1525. No further information was provided prior to exit.	F 157	F-309	8-10-16
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure co-ordination of hospice services for 1 of 19 residents (Resident #3) and also failed to follow physician orders for bowel management for 1 of 19 residents (Resident #4). The findings include: 1. The facility staff failed to ensure hospice services were co-coordinated with the facility for Resident #3. Resident #3 was admitted to the facility on 8/30/15 with diagnoses of Alzheimer's disease, anxiety, hypertension, depression, and adult failure to thrive. The resident was admitted to hospice services on 6/14/16. The significant change Minimum Data set (MDS)	F 309	Coordination of Hospice Services/Following Physician's Orders For Bowel Management: 1.For Resident #3, hospice was contacted and the hospice notes were obtained and placed on the medical record. For Resident #4, there were no adverse effects. The physician and the responsible party were notified. 2. For residents currently residing in the center that have physician's orders for hospice services, a review of the medical record was conducted by the DCS/Designee to ensure that hospice notes are present on the medical record. For current resident's residing in the center, a review of the medical record was completed for the previous (30) days by the DCS/Designee to identify other residents exceeding (3) days without a bowel movement to determine if interventions were implemented per physician's order.	

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F 309	Continued From page 8	F 309	Interventions were implemented by the DCS/Designee as indicated necessary by the review.	

with a reference date of 6/28/16 assessed the resident with a cognitive deficit for short and long term memory and requiring extensive assistance with decision making. The resident was assessed requiring extensive assistance of 2 persons for bed mobility, transfers, ambulation,dressing, eating, bathing, and hygiene.

The clinical record was reviewed. The record contained the hospice plan of care and the hospice consent forms. There were no hospice progress notes or evidence of co-ordination of care for the services.

The hospice certified nursing assistant (CNA#2) was observed on the unit on 7/14/16 at 9:00 a.m. CNA#2 was asked how she wrote her notes on the resident and stated she had a tablet and the notes were electronically sent back to her office.

The nurse on the unit (LPN#1) was asked about the information on 7/12/16 at 2:00 p.m. and stated she knew the resident and was on hospice services. LPN#1 reviewed the record and stated there should be notes from hospice in the clinical record. The director of clinical services (DCS) was asked about the issue on 7/13/16 at 8:30 a.m. and stated she would look into the matter. The DCS returned and stated she had asked hospice to send their information to the facility.

The administrator and DCS were informed of the concern during a meeting with the survey team on 7/13/16 at 3:00 p.m.

2. The facility staff failed to follow physician orders for bowel management for Resident#4.

3. Re-education has been provided by the DCS/Designee to hospice providers currently contracted with the facility, the Social Services Director, and current Licensed Nurses regarding ensuring that progress notes are present on the medical record for hospice visits.
Re-education has been provided by the DCS/Designee to the Licensed Nurses regarding ensuring that interventions are implemented per the physician's order for residents that have not had a bowel movement in a (3) day period. For current residents residing in the center that have physician's orders for hospice services, a review will be conducted weekly for (12) weeks by the DCS/Designee of the medical record to ensure that progress notes from the hospice provider are present.
The DCS/Designee will review the medical record for current residents residing in the center (3) times per week for (12) weeks to identify residents that have not had a bowel

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Resident #4 was admitted to the facility on 3/12/14 with diagnoses of rheumatoid arthritis, pain, hypertension, degenerative joint disease, dementia, schizophrenia, depression, anxiety, and glaucoma.

The current quarterly Minimum Data Set (MDS) with a reference date of 5/10/16 assessed the resident with a cognitive score of "10" of "15". The resident was assessed requiring extensive assistance of 2 persons for toileting, hygiene, bathing, transfers, and bed mobility.

The clinical record was reviewed. The comprehensive care plan was reviewed. The care plan contained a problem listed the resident was at risk for altered bowel elimination related to immobility, and medication side effects. The interventions included to provide toileting assistance as needed.

The physician orders were reviewed. The physician signed the facility standing orders for symptom treatment of constipation which included the resident should receive Milk of Magnesia 30 cc by mouth on the third day if no bowel movement and a suppository on the 4th day and to begin oral Senokot twice daily.

The clinical record contained electronic recording of how often the resident had bowel movements. The May 2016 record contained evidence the resident had not had a bowel movement from 5/13/16 through 5/18/16 and also from 5/23/16 trough 5/26/16.

The nursing notes for the time periods were reviewed and no documentation was evident there were any interventions provided. The

F 309 movement in a (3) day period and to ensure that physician's orders were followed. The review will also verify to ensure that the physician was notified and interventions were implemented as indicated by the results of the review.

4. Results of the reviews conducted by the Director of Clinical Services/Designees will be reviewed at the Quality Assurance/Performance Improvement Committee Meeting each month for (three) months. The QAPI Committee will make recommendations for revisions to the plan as indicated to sustain substantial compliance. Once the QAPI Committee determines that the problem no longer exists, further review will be completed on a random basis.

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F 309	Continued From page 10 medication administration record for May 2016 did not contain any documented interventions. The director of clinical services (DCS) was asked on 7/13/16 at 2:00 p.m. where the documentation was located and stated, " only in the electronic record". The DCS stated the unit managers received notification of the residents did not have a bowel movement by the third day and then were expected to intervene. The administrator and DCS were informed of the concern during a meeting with the survey team on 7/13/16 at 3:00 p.m.	F 309		
F 333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure 1 of 19 Residents (Resident #1) was free from a significant medication error involving insulin. Findings: Resident #1's clinical record was reviewed on 7/13/16 at 8:30 AM. The resident was admitted to the facility on 10/5/15. The diagnoses included insulin-dependent diabetes, dementia, hypertension and depression. The latest MDS (minimum data set) assessment, dated 3/31/16 coded the resident as cognitively	F 333	F-333 1. For Resident # 1, there were no adverse effects to the resident resultant from the medication variance. The physician and the responsible party were notified. 2. For current residents residing in the facility with physician's orders for insulin and insulin parameters, a review has been conducted by the DCS/Designee for the previous (30) days to identify discrepancies with the physician's ordered parameter and the insulin administered. 3. Re-education has been provided by the DCS/Designee to the Licensed Nurses regarding following physician's orders for insulin	8-10-16

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SKYLINE NURSING & REHABILITATION CENTER	237 FRANKLIN PIKE ROAD, SE FLOYD, VA 24091

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 11	F 333		

unimpaired. She required staff assistance to accomplish the ADLs (activities of daily living.)

The CCP (comprehensive care plan) updated on 7/7/16 addressed diabetes as a disease process under the focus category "Nutrition/Hydration.) The staff interventions included "Administer medications as ordered. Monitor & report for side effects and effectiveness."

Resident #1 had a physician's order, signed and dated on 7/5/16, for "Novolog Flex Pen Pref Syr 100 units/1 ml (milliliter) insulin pen. Inject 8 units subcutaneously before meals for diabetes mellitus. Hold for glucose < (less than or equal to) 150." There was an additional order for accuchecks before meals and at bedtime for DM (diabetes.)

The MARs (medication administration records) for June and July 2016 were reviewed. On six separate occasions the Novolog was administered when the resident's glucose levels were less than or equal to 150 per the accucheck readings:
6/3/16=132 (date and corresponding accucheck reading)
6/6/16=130
6/19/16=91
6/21/16=93
7/2/16=129
7/12/16=129

The MAR and nursing progress were reviewed but there was no documentation that the insulin had been held per the physician's order. The staff had initialed the MAR indicating the insulin was provided.

parameters as well as administering insulin per physician's order. The physician's orders and medication administration record will be reviewed by the DCS/Designee (3) times per week for (12) weeks for (5) insulin dependent residents to ensure that insulin is administered per the physician's ordered parameter. The DCS/Designee will conduct medication administration observation for (3) Licensed Nurses per week for (12) weeks to ensure that insulin is administered per the physician's ordered parameter.

4. Results of the reviews and med pass observations conducted by the Director of Clinical Services/Designees will be reviewed at the Quality Assurance/Performance Improvement Committee Meeting each month for (three) months. The QAPI Committee will make recommendations for revisions to the plan as indicated to sustain substantial compliance. Once the QAPI Committee determines that the problem no longer exists, further review will be completed on a random basis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495348	A. BUILDING _____ B. WING _____	07/14/2016

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F 333	Continued From page 12 On 7/13/16 at 3:30 PM the director of nursing and administrator were informed of the findings. There was no additional information provided prior to the survey team exit.	F 333		