		AND HI N SERVICES & MEDICAID SERVICES			PRINTED: 02/16/2017 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495226	B. WING		C <b>02/09/2017</b>
	PROVIDER OR SUPPLIER  D NURSING AND RE	HABILITATION CENTER	;	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	1 02100/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 000	INITIAL COMMENT	rs	F 000	ı	
	survey was conducted Complaints were in Corrections are requested for the consumer of the successive o	Medicare/Medicaid standard ted 2/7/17 through 2/9/17. Vestigated during this survey. Vestigated for compliance with 42 and Long Term Care Life Safety Code survey  O certified bed facility was 54 arvey. The survey sample rent resident reviews ph 12, #19 and #20) and 6 ws (Residents #13 through			
F 167 SS=D	(g)(10) The resident (i) Examine the resofthe facility condusurveyors and any respect to the facility (g)(11) The facility residents, the result the facility.  (ii) Have reports with certifications, and contents.	t has the right to- sults of the most recent survey cted by Federal or State clan of correction in effect with y; and must eadily accessible to residents, s and legal representatives of its of the most recent survey of th respect to any surveys, complaint investigations made	F 167	The notice of the availability of the preceding three years of survey results available for any individual to review upon request was poster in the survey result book in the front lobby on 2/7/17 by Administrator. Three years of survey results was added to the survey results notebook located in the Administrator's office on 2/7/17 by Administrator.  The Social Worker reviewed the posting of the availability of the preceding three years of survey results and the availability upon request of survey results with all alert and oriented residents on	l ed
	respecting the facili	ty during the 3 preceding of correction in effect with		2/28/17.	

RECEIVED LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 0 2 2017

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which has the finding of the 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.

respect to the facility, available for any individual

to review upon request; and

TITLE

(X6) DATE

## DEPARTMENT OF HEALTH AND HUNN SERVICES

PRINTED: 02/16/2017

	1112111				<b>\</b>	FURM APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			C	MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILC	DING		COMPLETED
						С
		495226	B. WING	<u> </u>		02/09/2017
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>	<u> </u>	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
				730 L	UNENBURG HIGHW	
WAYLAN	D NURSING AND RE	HABILITATION CENTER		KEYS	SVILLE, VA 23947	
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	
PRÉFIX TAG	<b>\</b>	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	
<b>-</b> 407			_			
F 167	Continued From pa	ige 1	F 1	167	The Administrator and Director of	
					Nursing was in-service by the	
		he availability of such reports in			Facility Consultant on 2/22/17	
		that are prominent and			regarding the requirements for	
	accessible to the pu	ublic.			survey results posting and	
	// A The feetite elect				accessibility.	
		Il not make available identifying			The Director of Nursing will monitor	•
		complainants or residents.			to ensure the notice of the	
		NT is not met as evidenced			availability of the preceding three	
	by:	tion and staff interview, it was			years of survey results available for	
		e facility staff failed to post a			any individual to review upon	
		ailable upon request the			request is posted and results are	
		ars of the survey results.			preceding three years of survey	
	proceding under you	are or the survey results.			results are available weekly x 8	
	A notice was not po	osted to the residents and			weeks then monthly x 1 month	
		that the results of the previous			utilizing a Survey Posting QI Audit	
		ey results, with the plan of			Tool. The notice will be posted	
		vailable for review upon			and/or survey results made	
		cility did not have the results			available for any identified areas of	
	available for review				concern during the audit by the	
					DON. The Administrator will initial	
	The findings include	e:			and review the Survey Posting QI	
					Audit Tools weekly x 8 weeks then	
					monthly x 1 month for completion	
		nade of the survey results book			and to ensure all areas of concern	
		n 02/07/17 at 12:15 p.m. The			were addressed.	
		n a wall mounted file holder			were addressed.	
		"Survey Results." The cover			The Executive QI committee will	
		ented, "Survey By The Virginia			meet monthly and review the	
		Of Health Facilities			Survey Posting QI Audit Tools and	
		er observation of the wall			address any issues, concerns and/or	
		and the binder failed to			trends and to make changes as	
		of the availability of the			needed, to include continued	
		rs of survey results available			frequency of monitoring x 3	•
	Tor any individual to	review upon request. The				

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book in the wall mounted file holder contained the survey results and plan of corrections from the annual survey ending on 03/21/16. Further observation of the contents of the book failed to

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months.

	MENT OF HEALTH	AND HUN SERVICES				02/16/201 APPROVEI 0938-039
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE COM	E SURVEY PLETED
		495226	B. WING	~~~~	ı	C <b>09/2017</b>
	PROVIDER OR SUPPLIER  ID NURSING AND RE	HABILITATION CENTER	-	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(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 X (EACH CORRECTIVE ACTION SHO CROS 3-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 167	evidence the surve corrections for the An interview was considerative staff administrative staff administrator, on 2 who is responsible ASM #1 stated, "I assurveys were to be responsible parties survey." When ask regulations that we	y results and plan of previous three years.  onducted with ASM f member) #1, the /7/17 at 3:10 p.m. When asked for posting the survey results, im." When asked which posted for the residents and , ASM #1 stated, "The last ed if she was aware of the new nt into effect on 11/28/16, ASM aware of a new regulation	F 1	67		
	staff member) # 1, the director of nurs director of nursing,	0 p.m. ASM (administrative the administrator, ASM # 2, ing, ASM # 3, the assistant and ASM # 4, facility ade aware of the findings.				
F 252 SS=E	483.10(e)(2)(i)(1)(i)	ion was obtained prior to exit. (ii) MFORTABLE/HOMELIKE	F 2	The gouge and unpainted A-side wall no		3/25/17

**ENVIRONMENT** 

- (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.
- (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
- (i) This includes ensuring that the resident can receive care and services safely and that the

of the bed in room #103 was repaired and painted by Maintenance on/or before 3/25/17. The wall on the right side of the room as you enter extending from the A-side to the B-side of the room peeling wall paper in room #104 was repaired by maintenance on/or before 3/25/17. The black marks and unpainted area of B-side on the wall next to the head of the bed in room #109 was repaired and painted by Maintenance on/or before 3/25/17. The black marks on the lower portion of the wall next to the right side of the bed on the A-side of resident in room #112 was repaired by maintenance on/or before 3/25/17. The unfinished plaster patch and unpainted area next to the HOB on the A-side of resident room #113 was repaired and painted by

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Facility ID: VA0050

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MAR 0 2 2017

## DEPARTMENT OF HEALTH AND HUNN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

	PRINTED: 02/16/2017
	FORM APPROVED
<i>i</i>	OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI B. WING		(X3) DATE SURVEY COMPLETED C 02/09/2017
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND RE			02/09/2017	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION

### F 252 Continued From page 3

physical layout of the facility maximizes resident independence and does not pose a safety risk.

(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview and facility document review, it was determined that the facility staff failed to maintain resident rooms in good repair in 11 of 61 resident rooms, (Resident rooms # 103A, # 104A & B, # 109B, # 112A, # 113A, # 114A, # 117A & B, # 200B, # 205A, # 207B, and # 210B).

### The findings include:

Observations during the days of the survey, 02/07/17 at 3:50 p.m.; 02/08/17 at 11:50 a.m. and on 02/09/17 at 8:00 a.m., revealed the following: The A-side wall next to the head of the bed (HOB) was observed to be gouged and unpainted in resident room # 103.

The wall on the right side of the room as you enter, extending from the A-side to the B-side of the room was observed with numerous areas of wall paper peeling off the wall in resident room # 104.

The B-side wall next to the head of the bed (HOB) was observed to have several black marks, with an unpainted area in resident room # 109.

Several black marks were observed on the lower portion of the wall next to the right side of the bed on the A-side of resident room # 112.

A plastered patch area next to the HOB was unfinished and unpainted on the A-side of

F 252

maintenance on/or before 3/25/17. The gouge and unpainted A-side wall next to the head of the bed in room #114 was repaired and painted by maintenance on/or before 3/25/17. The gouge and unpainted A-side wall next to the head of the bed and area under the window on the B-side in room #117 was repaired and painted by maintenance on/or before 3/25/17. The gouge and unpainted B-side wall next to the head of the bed in room #200 was repaired and painted by maintenance on/or before 3/25/17. The black marks and unpainted area of B-side on the wall next to the head of the bed in room #205 was repaired and painted by maintenance on/or before 3/25/17. The gouge and unpainted B-side wall next to the head of the bed in room #207 was repaired and painted by maintenance on/or before 3/25/17. The gouge and unpainted B-side wall next to the head of the bed in room #210 was repaired and painted by maintenance on/or before 3/25/17.

100% observation of the facility to include all resident's rooms to include rooms #103, #104, #109, #112, #113, #114, #117, #200, #205, #207, and #210 was completed on 2/13/17 by Administrator to ensure all areas and rooms are in good repair. Work orders were completed on 2/23/17 by Administrator for notification to Maintenance for any identified areas of concern. The Maintenance Director will correct all identified areas of concerns from the audit by 3/25/17.

The Maintenance Director was in-service by the Administrator on 2/24/17 regarding ensuring rooms are in good repair. All license nurses, nursing assistants, dietary staff, housekeeping staff, therapy staff, and department managers were in-service by Staff Development Coordinator on/or before 3/25/17 to notify Maintenance of any areas in the facility in need of repair or painting to include resident rooms by completing a work order slip. All newly hired license nurses, nursing assistants, dietary staff, housekeeping

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resident room # 113.

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Facility ID: VA0050

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**ADH/OFC** 

## DEPARTMENT OF HEALTH AND HUNN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 02/16/2017 FORM APPROVED OMB NO. 0938-0391

	CENTERS FOR MEDICARE	& MEDICAID SERVICES		***	OMR M	<i>J.</i> 0938-0391	
E	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		495226	B. WING		0;	C <b>2/09/2017</b>	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP C	ODE		
	WAYLAND NURSING AND RE	HABILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
	PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COF X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
1							

### F 252 Continued From page 4

The A-side wall next to the head of the bed (HOB) was observed with a gouged and unpainted area in resident room # 114.

The A-side wall next to the head of the bed (HOB) was observed with a gouged and unpainted area. Also an area under the window on the B-side was gouged and unpainted in resident room # 117.

The B-side wall next to the head of the bed (HOB) was observed with a gouged and unpainted area in resident room # 200.

The B-side wall next to the head of the bed (HOB) was observed to have several black marks and an unpainted area in resident room # 205.

The B-side wall next to the head of the bed (HOB) was observed with a gouged and unpainted area in resident room # 207.

The B-side wall next to the head of the bed (HOB) was observed with a gouged and unpainted area in resident room # 210.

On 02/09/17 at approximately 9:15 a.m. a tour of resident rooms # 103A, # 104A & B, # 109B, # 112A, # 113A, # 114A, # 117A & B, # 200B, # 205A, # 207B, and # 210B was conducted with OSM (other staff member) # 7, director of maintenance. After visually inspecting resident rooms' # 103A, # 104A & B, # 109B, # 112A, # 113A, # 114A, # 117A & B, # 200B, # 205A, # 207B, and # 210B, OSM # 7 acknowledged the resident rooms were in in need of repair. No further information was provided from OSM # 7.

On 02/09/17 at 10:15 a.m. ASM (administrative staff member) # 1, the administrator, ASM # 2, the director of nursing, and ASM # 4, facility consultant, were made aware of the findings.

No further information was obtained prior to exit.

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staff, therapy staff, and department managers will be in-service by the staff facilitator regarding to notify Maintenance of any areas in the facility in need of repair or painting to include resident's rooms by completing a work order slip during orientation.

The maintenance director will monitor all areas of the facility to include 100% of all resident rooms, to include rooms #103, #104, #109, #112, #113, #114, #117, #200, #205, #207, and #210 to ensure rooms are in good repair weekly x 8 weeks then monthly x 1 utilizing a Homelike Environment QI Audit tool and complete a work order slip for all identified areas of concerns. The Maintenance Director will immediately address any identified areas of concern during the audit. The Administrator will review the Home like Environment QI Audit Tool weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed.

The Executive QI committee will meet monthly and review the Homelike Environment QI Audit Tool and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.

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# DEPARTMENT OF HEALTH AND HU SERVICES

PRINTED: 02/16/2017 **FORM APPROVED** 

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				<u> </u>	IB NO.	<u>0938-0391</u>
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(	(X3) DATE COMP	SURVEY PLETED
						- 1	C	;
		495226	B. WING	·			02/0	9/2017
NAME OF F	PROVIDER OR SUPPLIER		<u></u>	s	STREET ADDRESS, CITY, STATE, ZIP CODE			
WAYLAN	ID NURSING AND RE	HABILITATION CENTER		Į.	730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΊX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD E	BE	(X5) COMPLETION DATE
F 278 SS=D	(g) Accuracy of Ass	SSMENT RDINATION/CERTIFIED sessments. The assessment lect the resident's status.	F	278	A modification of resident #6 MD: for section 00250 was completed on 2/27/17 by MDS fill-in/support person to reflect the Influenza Vaccine.			3/15/17
	(h) Coordination A registered nurse each assessment of participation of head  (i) Certification  (1) A registered number assessment is  (2) Each individual	must conduct or coordinate with the appropriate lith professionals.  The must sign and certify that completed.  Who completes a portion of the sign and certify the accuracy of			100% audit was completed of all resident's current MDS's for section O0250 comparing the coding of the MDS to the resident's immunization records to ensure the MDS's are coded accurately for immunization on/or before 3/5/17 by the MDS fill-in/support person. MDS modifications will be completed for section O0250 for any identified areas of concern during the audit by MDS fill-in/support person on/or before 3/15/17.	ne on ns		
	who willfully and kr (i) Certifies a mater resident assessme penalty of not more assessment; or (ii) Causes another and false statement	e and Medicaid, an individual nowingly- rial and false statement in a nt is subject to a civil money than \$1,000 for each rindividual to certify a material at in a resident assessment is oney penalty or not more than			The MDS Nurse was in-serviced re: accurate coding to include accurately coding immunizations under section O0250 of the MDS on/or before 3/5/17 by the facility consultant.  The Administrator will audit 10% of current residents MDS to include resident #6, to ensure accurate coding for immunizations under section O0250 of the MDS utilizing the MDS audit tool weekly x 8			
	material and false	ement does not constitute a statement.  NT is not met as evidenced						

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Based on staff interview, facility documentation

review and clinical record review, it was

by:

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Facility ID: VA0050

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	MENT OF HEALTH	AND HU SERVICES  & MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>*</sup> A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495226	B. WING		02/09/2017	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WAYLAN	D NURSING AND RE	HABILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(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 SHOUND CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
F 278	F 278 Continued From page 6 determined that facility staff failed to maintain an accurate MDS (Minimum data set) assessment for one of 20 residents in the survey sample, Resident #6.  The facility staff failed to properly code Section O0250., "Influenza Vaccine" on Resident #6's annual MDS assessment with an ARD (assessment reference date) of 11/19/16.  The findings include:  Resident #6 was admitted to the facility on 11/27/14 and readmitted on 5/18/16 with diagnoses that included but were not limited to adult failure to thrive, Alzheimer's disease,		F 2	weeks then monthly x 1 more MDS nurse will be reeducated the Administrator and/or DC a modification will be completed for any identified areas of conduring the audit. The DON wereview and initial the MDS at tool weekly x 8 weeks then rex 1 month for completion and ensure all areas of concern vaddressed.  The Executive QI committee meet monthly and review the audit tools and address any concerns and/or trends and	nted by DON and pleted concern will audit n monthly and to n were	
	and depression.  Resident #6's most set) was an annual (assessment refere Resident #6 was co cognitively impaired decisions, scoring (interview for menta was coded as requione person physical (activities of daily lillocomotion, dressir hygiene; independed dependent on staff	recent MDS (minimum data assessment with an ARD ence date) of 11/19/16. Oded as being moderately in the ability to make daily 07 out of 15 on the BIMS (brief I status) exam. Resident #6 iring extensive assistance with al assist with most ADLS ving) including transfers, and, toileting, and personal ent with meals, and totally with bathing.		make changes as needed, to include continued frequency monitoring x 3 months.	1	

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annual assessment with an ARD (assessment reference date) of 11/19/16 coded Resident #6 in Section B0700 "Makes Self Understood" as "Usually understood" and section B0800 "Able To Understand Others" as "Understands - clear

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Facility ID: VA0050

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DEPARTMENT OF HEALTH AND HUN	SERVICES
CENTERS FOR MEDICARE & MEDICAID	SERVICES

		AND HO A SERVICES					FURM APPROVED
CENTER	S FOR MEDICARE	& MEDICAID SERVICES				<u>OM</u>	IB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		ONSTRUCTION	(	X3) DATE SURVEY COMPLETED
		495226	B. WING				C <b>02/09/2017</b>
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CO	DE	
WAYLAN	D NURSING AND RE	HABILITATION CENTER			UNENBURG HIGHW SVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD E	
F 278	Continued From pa	ae 7	F	278			:
	comprehension." S Vaccination" coded Skip to 00250C, if state reason." Und	Section O0250 "Influenza resident # 6 a "0 (zero). No influenza vaccine not received, ler section O0250C a "-" dash ng that this area was not					
	an "Immunization F record documented being refused for 2	t # 6's clinical record revealed Record". The immunization I the influenza vaccination as 016-2017. No date was this record of when the used.					
	in part, the following Authorization Flu Vounless medically coadministration of the educational materia and benefits given was documented un Flu Vaccination was	ent/release form documented g: "Flu Vaccination accines are given annually ontraindicated. I authorize the eflu vaccine based upon als which includes the risks by the facility." A check mark nder "NO" indicating that the s not consented. The POA signed this form on 12-3-14.					
	conducted with LPI When asked what LPN #6 stated that was not assessed. Section O0250C w	o.m., an interview was N (licensed practical nurse) #6. dashes meant on the MDS, dashes meant that the section LPN#6 confirmed that as not assessed. LPN #6 as the RAI manual as a mpleting the MDS.					
	member) #1, the ac	o.m., ASM (administrative staff dministrator, ASM #2, the DON g), and ASM #4, the facility					

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consultant were made aware of the above concerns. No further information was presented

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Facility ID: VA0050

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	MENT OF HEALTH				PRINTED: 02/16/2017 FORM APPROVED
STATEMENT	RS FOR MEDICARE  OF DEFICIENCIES  F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		495226	B. WING_		C 02/09/2017
NAME OF F	PROVIDER OR SUPPLIER		<u>'                                    </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	
WAYLAN	D NURSING AND RE	HABILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLETION
F 278	Continued From pa	ge 8	F 2	78	
	prior to exit.				
	manual documente Steps for Assessment. Review the resid determine whether received in the facil vaccination season unknown, proceed 2. Ask the resident influenza vaccine of year's influenza vaccine of year's influenza vaccination of the guardian and/or prinfluenza vaccination proceed to the next 4. If influenza vaccination the resident according to Coding Instructions receive the influenza vaccine influen	ent's medical record to an influenza vaccine was lity for this year's influenza. If vaccination status is to the next step. if he or she received an utside of the facility for this ecination season. If vaccination wn, proceed to the next step. unable to answer, then ask the ne responsible party/legal mary care physician. If on status is still unknown, to step. ination status cannot be lister the influenza vaccine to ling to standards of clinical status on this facility for this			

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vaccine received

vaccine received (O0250B).

influenza vaccine in this facility during this year's influenza season. Continue to Date influenza

Coding Instructions for O0250B, Date influenza

o Enter the date that the influenza vaccine was

Event ID: 6PZJ11

Facility ID: VA0050

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DEPARTMENT	OF HEALT	H AND H	IL N	SERVICES
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	INENI OF HEALIN	<b>V</b>			<b>.</b>		FORM APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				O	MB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	-	(X3) DATE SURVEY COMPLETED
		495226	B. WING	i			02/09/2017
NAME OF	PROVIDER OR SUPPLIER		-	STRE	EET ADDRESS, CITY, STATE, ZIP C	ODE	
WAYLAN	ID NURSING AND REI	HABILITATION CENTER			LUNENBURG HIGHW /SVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	4 SHOULD	BE COMPLETION
F 278	- If the month conta first box of the mon January 17, 2014 st 01-17-2014 If the day only confirst box of the day of October 6, 2013 shipper 10-06-2013. A full 8 - A full 8 character of unknown or the information of the information of the information of the resident has revaccine for this year season (i.e., O0250 the following list: o Code 1, Resident year's influenza vaccination season o Code 2, Received includes influenza vaccination season o Code 2, Received includes influenza vaccine for this year's influenza vaccine influenza vaccine influenza vaccine ocontraindications. Care not limited to; all other vaccine comporeservative), previous of the vaccine comporeservative), previous ocontraindication, previous occurrence ocontraindication, previous occurrence ocontraindication, previous occurrence	ave any boxes blank.  Ains only a single digit, fill in the th with a "0". For example, hould be entered as  Atains a single digit, then fill the with the "0". For example, ould be entered as A character date is required. Adate is required. If the date is formation is not available, only as to be entered in the first box. Afor O0250C, If influenza A, state reason A treceived the influenza Ar's influenza vaccination A=0), code the reason from  Anot in this facility during this accination season: resident was aring this year's influenza		278			

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vaccination.

immunize, moderate to severe illness with or without fever, and/or history of Guillain-Barré Syndrome within 6 weeks of previous influenza

o Code 4, Offered and declined: resident or

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	MENT OF HEALTH	AND HUN SERVICES			PRINTED: 02/16/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495226	B. WING	·	C 02/09/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE
WAYLAN	D NURSING AND RE	HABILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE COMPLÉTION
F 278	Continued From pa	ge 10	F:	278	
F 280 SS=D	informed of the risk influenza vaccine a vaccination. o Code 5, Not offer party/legal guardiar vaccine. o Code 6, Inability to a declared shorts this facility due to a shortage. o Code 9, None of reasons describe who the administered. The answer." 483.10(c)(2)(i-ii,iv, weight of the particulation of care, including the right to particulating t	egal guardian has been as and benefits of receiving the end chooses not to accept ed: resident or responsible anot offered the influenza of obtain influenza vaccine due age: vaccine is unavailable at declared influenza vaccine the above: if none of the listed thy the influenza vaccine was this code is also used if the end of the	F	280 Resident #6 care plan was and revised on 2/22/17 to the resident by the DON. R #6 no longer has a stage II ulcer.  A 100% audit of all care pla conducted by the Administ nurses (DON/ADON/SDC/N Coordinator/MDS fill-in), ir care plans for residents #6 residents with pressure ulc	reflect desident pressure ans was crative MDS acluding and

(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the

plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

A 100% audit of all care plans was conducted by the Administrative nurses (DON/ADON/SDC/MDS Coordinator/MDS fill-in), including care plans for residents #6 and residents with pressure ulcers to ensure that all areas of the care plan reflect the resident's individual needs on/or before 3/25/17. Any deficient care plans were updated to reflect the resident on/or before 3/25/17 by the responsible interdisciplinary care plan team member.

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES				OMB N	O. 0938-0391
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		495226	B. WING	·		0	2/09/2017
NAME OF F	PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODI	E	
WAYLAN	D NURSING AND RE	HABILITATION CENTER		1	UNENBURG HIGHW SVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	EIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 280	right to sign after sign of care.  (c)(3) The facility sign of the participate is shall support the replanning process in the facilitate the incresident representation of the participate is shall support the replanning process in the planning in the plan	the care plan, including the ignificant changes to the plan thall inform the resident of the in his or her treatment and esident in this right. The nust clusion of the resident and/or ative.  It is sment of the resident's disc.  It resident's personal and is in developing goals of care.  It is care plans we care plan must be-	F	280	The interdisciplinary care plan team members (Dietary manage MDS Coordinator, Social Service Director and Activities Director have been re-educated on the requirements for completing a comprehensive care plan for expected and to review and review and review and review as needed by the Administrator on/or before 3/25/17.  An audit will be completed of a completed of all resident's care plans to include care plans for resident weekly x 8 weeks then monthly month by the DON and/or ADC ensure that the care plans accurately reflects the resident utilizing the QI Care Plan Audit The interdisciplinary care plan members will be retrained and	ger, ces c) ach rise #6 y x 1 DN to t Tool. team	
	(i) Developed withithe comprehensive	n 7 days after completion of eassessment.			care plan will be revised immediately by the responsible introduction in the responsible introduction in the responsibilities of the responsibilities of the responsibilities of the revised in the revis		
	includes but is not				interdisciplinary care plan tear member for any identified are- concern. The Administrator wi review and initial the QI Care F	as of II	
	resident.	rse with responsibility for the			Audit Tool weekly x 8 weeks the monthly x 1 month for compliand to ensure all areas of concludes the second conclu	nen ance	
	(C) A nurse aide w resident.	ith responsibility for the			THE AMERICAN AND AND AND AND AND AND AND AND AND A		

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(D) A member of food and nutrition services staff.

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	CENTERS FOR MEDICARI	E & MEDICAID SERVICES			JMB NO. 0938-039
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
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1		495226	B. WING		02/09/2017
	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
	WAYLAND NURSING AND RE	EHABILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947	
	PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTI ( (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
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### F 280 Continued From page 12

- (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
- (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
- (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

This REQUIREMENT is not met as evidenced by:

Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to revise the comprehensive care plan for one of 20 residents in the survey sample, Resident #6.

The facility staff failed to revise Resident #6's care plan after a Stage II [1] pressure ulcer of the sacrum was found on 4/8/16.

The findings include:

Resident #6 was admitted to the facility on 11/27/14 and readmitted on 5/18/16 with diagnoses that included but were not limited to adult failure to thrive, Alzheimer's disease, dementia, hypertension, atrial fibrillation, anxiety and depression. Resident #6's most recent MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of

F 280

The Executive QI committee will meet monthly and review the QI Care Plan Audit Tools and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.

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		& MEDICAID SERVICES		0	MB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		495226	B. WING_		C <b>02/09/2017</b>
	OVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLETION

### F 280 Continued From page 13

11/19/16. Resident #6 was coded as being moderately cognitively impaired in the ability to make daily decisions, scoring 07 out of 15 on the BIMS (brief interview for mental status) exam. Resident #6 was coded as requiring extensive assistance with one person physical assist with most ADLS (activities of daily living) including transfers, locomotion, dressing, toileting, and personal hygiene; independent with meals, and totally dependent on staff with bathing.

Review of Resident #6's nursing notes revealed the following note dated 4/8/16: "Resident noted with a new stage 2 pressure ulcer to sacral area. 2.6 cm (centimeters) X (by) 1.0 cm, 100 % (percent) pink, healthy tissue. Ordered Duoderm [2] dressing changes and Vitamin C and Zinc po (by mouth) X (times) 14 days. RP (Responsible Party) aware. MD (Medical Doctor) aware."

Review of the Wound Ulcer Flowsheet dated 4/8/16, documented the following: "Site: 53) Sacrum Type: Pressure Length: 2.6 cm Width: 1.0cm Stage II."

Review of the physician's telephone orders dated 4/8/16 for Resident #6 documented the following orders: "Apply duoderm to sacral St (stage) 2 ulcer. Change Q (every) 7 days and PRN (as needed). Zinc [3] 220 mg (milligrams) po (by mouth) TID (Three times a day) x 14 days, Vit (Vitamin) C [4] 500 mg po BID (two times a day) x 14 days wound healing."

Review of Resident #6's skin care plan dated 12/3/14, with a reviewed date of 8/29/16, documented skin interventions prior to the development of the Stage II pressure ulcer. The care plan did not address Resident #6's Stage II

F 280

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## DEPARTMENT OF HEALTH AND HUNN SERVICES

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		495226	B. WING	i			C <b>02/09/2017</b>	
NAME OF F	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	<u></u>		
					LUNENBURG HIGHW			
WAYLAN	D NURSING AND RE	HABILITATION CENTER		ŀ	SVILLE, VA 23947			
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F 280	Continued From pa	nge 14	F:	280				
. =00	•	e sacrum. There was no		-00				
		are plan was reviewed to						
		is implemented after the						
		Stage II sacral pressure ulcer						
	on 4/8/16.							
	On 2/8/17 at 3:05 n	.m., an interview was						
		N (licensed practical nurse) #6,						
		nen asked who uses the care						
	plan for each reside	ent, LPN #6 stated that						
		the care plan. When asked						
		was updated, LPN #6 stated						
		vas updated for any changes in						
		of care such as new falls, etc.						
		pressure areas would be on #6 stated, "Yes." LPN #6						
		tion of the ulcer and when it						
		be on the care plan. LPN #6						
		pressure ulcer identified on						
	•	cumented on Resident #6's						
		stated, "I wasn't here back in						
		ave documented the ulcer						
		wn." When asked who was						
		lating the care plan for a new						
		stated, "The DON (Director of						
		urse would update it." LPN #6 the only MDS nurse currently						
	at the facility.	, and only mide name our only						
	conducted with ASI	a.m., an interview was M #2, the DON. She stated art on the floor until July of						

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findings.

On 2/8/17 at 5:01 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #4, the facility consultant were made aware of the above

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495226	B. WING		C <b>02/09/2017</b>
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
WAYLAN	ND NURSING AND RE	HABILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ILD BE COMPLETION
F 280	The facility policy to documents in part, of the facility to procare plan based on	age 15 tled, "Resident Care Pan," the following: "It is the policy vide an Interdisciplinary written the physician's orders and the resident needs. Development		280	
	of an interdisciplina completion of a cor each discipline. The for conference with admission. Review plan will be done at	ary plan will occur after mprehensive assessment by the resident will be scheduled ain twenty-one days following and/or modification of the tleast quarterly and as needed the direction of the RN			

No further information was presented prior to exit.

coordinator/designee. the resident care plan will be an ongoing process and will include current problems and/or needs identified from a complete assessment including MDS and CAAs relevant to the resident's response to aging, illness, and his/her health general health status. Any new problem or need of resident which is identified between his/her scheduled care plan review will be addressed on the care plan by the concerned disciplines and brought to the next scheduled care plan meeting to inform disciplines of the

Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan communicates nursing care priorities to other health care professionals. The care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it

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addition."

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	MENT OF HEALTH	AND HU SERVICES & MEDICAID SERVICES			PRINTED: 02/16/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		495226	B. WING		C <b>02/09/2017</b>
	PROVIDER OR SUPPLIER  D NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE COMPLETION
F 280	If the patient's status nursing diagnosis a no longer appropriate plan. An out of date compromises the quality of the present of the presenting as a shapink wound bed, with as an intact or oper Further description Presents as a shing slough or bruising. The present of the pre	are from one nurse to another. It is has changed and the and related interventions are ate, modify the nursing care it is or incorrect care plan utility of nursing care.  The change is of dermis allow open ulcer with a red thout slough. May also present infruptured serum-filled blister. It is stage should not be atin tears, tape burns, perineal ation or excoriation. Suspected deep tissue injury. It is obtained from National insory Panel.  The properties of the interpretation of t	F 2		

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[3] Zinc-"Zinc helps maintain the integrity of skin and mucosal membranes. Patients with chronic leg ulcers have abnormal zinc metabolism and low serum zinc levels, and clinicians frequently treat skin ulcers with zinc supplements." This

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DEPARTMENT OF HEALTH AND HUN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

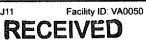
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CENTER	(2 LOK MEDICAKE	A MEDICAID SERVICES			V	IND INO. 0830-038
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NAME OF F	PROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE	
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F 280	Continued From pa	200 17	<b>-</b> /	200		
F 20U	Continued From pa	~	F 2	280		
		tained from The National				
	Institutes of Health					
	essional/	ov/factsheets/Zinc-HealthProf				
	[4] Vitamin C-"Vitar	min C is required for the				
	• •	agen, L-carnitine, and certain				
	neurotransmitters;	vitamin C is also involved in				
		[1, 2]. Collagen is an essential				
		ective tissue, which plays a				
		healing." This information was				
		National Institutes of Health.				
	Professional/.	ov/factsheets/VitaminC-Health				
F 282		RVICES BY QUALIFIED	F:	282	Resident #6 heel boots and heel floats	
	PERSONS/PER C				were applied while resident was in bed as identified on the plan of care on	3/25/17
00 2					2/23/17 by the DON. Resident #19 was	
	(b)(3) Comprehens	ive Care Plans			served the physician-ordered/care	
	•	ded or arranged by the facility,			planned ground meat diet during supper	
	•	comprehensive care plan,			on 2/8/17	
	must-				100% audit was conducted by the	
	(ii) Be provided by	qualified persons in			Administrative Nurses	
		qualified persons in ach resident's written plan of			(DON/ADON/SDC/MDS Nurse/MDS fill-	
	care.	2011 TOSIGOTILO WITEOTI PIGIT OF			in) on/or before 3/25/17 comparing all	
		NT is not met as evidenced			residents care plans to actual observations of all residents to include	
	by:				resident #6, to ensure services are being	
		tion, staff interview, facility			provided in accordance to the written	
		nd clinical record review, it			care plan to include heel boots and heel	
		at facility staff failed to follow			floats . The Administrative Nurses	
		care for two of 20 residents in			(DON/ADON/SDC/MDS Nurse/MDS fill- in) immediately addressed all areas of	
	the survey sample,	resident #0,			concern during the audit. 100% audit	
	1 The facility staff	failed to follow Resident #6's			was conducted by the Dietary Manager	
		ly heel boots and float her			on/or before 3/25/17 comparing all	
	heels while she wa				residents physician-ordered/care planned diets to actual meals	
					planned diets to actual meals	· u
	2. The facility staff	failed to serve the				

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES				OMB NO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MI	TIDIE	CONSTRUCTION	(X3) DATE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	1 ' '			COMPLETED
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		495226	B. WING	3		02/09/2017
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				1	LUNENBURG HIGHW	
WAYLAN	D NURSING AND RE	HABILITATION CENTER		KE'	YSVILLE, VA 23947	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 282	2/8/17 for Resident The findings include 1. Resident #6 was 11/27/14 and readn diagnoses that included adult failure to thriving dementia, high blocanxiety and depress recent MDS (minimal assessment with article adult failure to thriving dementia, high blocanxiety and depress recent MDS (minimal assessment with article adult) of 11/19/16. It being moderately cability to make daily 15 on the BIMS (brexam. Resident #6 extensive assistance assist with most AD including transfers, toileting, and persomeals, and totally distributed bathing.  On 2/8/17 at 8:00 as in bed. Her blanker	ground meat diet at lunch on #19.  admitted to the facility on nitted on 5/18/16 with uded but were not limited to e, Alzheimer's disease, od pressure, atrial fibrillation, sion. Resident #6's most um data set) was an annual a ARD (assessment reference Resident #6 was coded as ognitively impaired in the decisions, scoring 07 out of lef interview for mental status) is was coded as requiring the with one person physical DLS (activities of daily living) locomotion, dressing, and hygiene; independent with lependent on staff with	F	282	observations to include resident #19 to ensure the physician ordered/care planned diet is followed. The Dietary manager immediately addressed all areas of concern during the audit.  100% of license nurses to include LPN #2, LPN #7, and RN #1 and nursing assistants to include CNA #4 were reeducated by Administrative Nurses (DON/ADON/SDC/MDS Nurse/MDS fillin) on/or before 3/25/17 regarding following the resident's care plan/ care guide to ensure all necessary services for the resident, including heel boots and float heels, are provided as identified. 100% of all license nurses, nursing assistants, and dietary staff to include the cook were in serviced regarding ensuring that residents are provided the physician ordered /care planned diet during meals. All newly hired license nurses and CNAs will be in serviced during orientation regarding following the resident's care plan/ care guide to ensure all necessary services for the resident, including heel boots and float heels, are provided as identified. All newly hired license nurses, CNAs, and dietary staff will be in serviced during orientation regarding ensuring that residents are provided the physician ordered /care planned diet	
	On 2/8/17 at 8:40 a in bed. Her blanke	.m., Resident #6 was sleeping t covered her legs but her directly on the bed. No boots			physician ordered /care planned diet during meals.	
	On 2/8/17 at 9:26 a	.m., Resident #6 was sleeping				

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in bed. Her blanket covered her legs but her heels were resting directly on the bed. No boots

were observed in place on her feet.

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DEPARTMENT OF HEALTH AND HUI CENTERS FOR MEDICARE & MEDICAID	SERVICES
CENTERS FOR MEDICARE & MEDICAID	<b>SERVICES</b>

DEPART	MENT OF HEALTH	AND HUN SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT	RS FOR MEDICARE  OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495226	B. WING		C 02/09/2017
	PROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE COMPLETION
F 282	and updated on 8/2 following interventing Guide: Heel Protect and float heels as a Review of Resider Daily Living) tracked closet, documente "Equipment/Instructions of the second secon	t #6's care plan dated 11/28/14 29/16 documented the on under area "Resident Care ction: bunny boots to both feet		The Administrative Nurses (DON/ADON/SDC/MDS Nurse/MDS firin) will complete resident rounds to include resident # 6 using the QI Care Plan/ Care Guide Audit Tool weekly x weeks then monthly x 1 month to ensure residents are provided service to include heel boots and floats in accordance with the written care plan The Administrative Nurses (DON/ADON/SDC/MDS Nurse/MDS firin) will address any identified areas or concern immediately during the audit by ensuring interventions are in place and retraining with the staff member.	8 es n. ill- f t

Review of Resident #6's February 2017 MARs (medication administration record) and TAR (treatment administration record) revealed that heel boots were not on the MARs or TARS.

On 2/8/17 at 10:03 a.m., an interview was conducted with CNA (certified nursing assistant) #4, the CNA who worked with Resident #6. When asked how she determined a resident's needs for skin protection, care etc., CNA #4 stated that a care tracker card was in the inside of each resident's closet. When asked if Resident #6 had any special instructions while she was in bed, CNA #4 stated that Resident #6 was supposed to have heel boots on while in bed. When asked if Resident #6 had heel boots on, CNA #4 stated, "I don't know, but I can check." This surveyor followed CNA #4 to Resident #6's room. CNA #4 lifted up Resident #6's blanket. Heel boots were not in place to Resident #6's feet. Resident #6's feet were not elevated or floated. Resident #6's heels were normal in color. No redness was noted. CNA #4 stated, "That is something night duty was supposed to put on. I haven't looked at her yet." When asked if this

resident meals, to include meals for resident #19, to ensure residents are being provided the physician ordered /care planned diet. The Dietary Manager will address any identified areas of concern immediately by ensuring correct meal provided and retraining with the staff member. The Administrator or DON will review and initial the QI Care Plan/ Care Guide **Audit Tools and Meal Observation Tools** weekly x 8 weeks then monthly x 1 month for completion and to ensure all identified areas of concern were addressed.

The Executive QI committee will meet monthly and review the QI Care Plan/ Care Guide Audit Tools and Meal Observation Tools and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.

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	MENT OF HEALTH	AND HU SERVICES & MEDICAID SERVICES			PRINTED: 02/16/2017 FORM APPROVED DMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED C
		495226	B. WING		02/09/2017
	PROVIDER OR SUPPLIER  D NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	AND A MERCOCKIOCO TO THE ADDODO	D BE COMPLETION
F 282	#6, CNA #4 stated, is supposed to have in her closet. I'll go When asked how or residents, CNA #4 on 2/8/17 at 3:15 p conducted with LPI When asked who ustated that everyon CNAs. When asked plan, LPN #2 stated care for that particular in the property of the conducted with LPI when asked who ustated that everyon CNAs. When asked plan, LPN #2 stated care for that particular in the conducted with LPI when asked who used the conducted with LPI when asked who used the conducted with the c	he had rounded on Resident "Yes this is the first time. She e them on. Her boots are not get her a pair of booties." often CNAs rounded on stated, "Two times a shift."  o.m., an interview was N (licensed practical nurse) #2. uses the care plan, LPN #2 he uses the care plan even ed the purpose of the care d that it was to tell staff how to ular resident. When asked if a	F2	282	

On 2/9/17 at 8:15 a.m., further observation of Resident #6's heels was conducted with LPN (licensed practical nurse) #7. Resident #6's heels had no redness and were blanchable to the touch. When asked why Resident #6 needed bunny boots and her heels floated, LPN #6 stated it was to protect her skin.

care plan, should heel boots be in place, LPN #2 stated, "Yes. If they were not on, I would go and put them on." When asked who was responsible for ensuring skin protective measures were in place, LPN #2 stated that the wound care nurse and CNAs were responsible for ensuring ted hose, boots and other skin protective measures

On 2/9/17 at 8:30 a.m., an interview was conducted with RN (registered nurse) #1, the wound care nurse. When asked who was responsible for ensuring skin protective measures like heel boots were in place, RN #1 stated, "I would check to see if they are still on in the mornings when residents are still in bed. The

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were in place.

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING		DATE SURVEY COMPLETED
		495226	B. WING		1	C <b>02/09/2017</b>
NAME OF F	ROVIDER OR SUPPLIER		T	STREET ADDRESS, CITY, STATE,		
WAYLAN	D NURSING AND RE	HABILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	ANACA SEESENIAS TO	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 282	Continued From pa	nge 21	F 2	82		
	aides usually go in	and put heel boots on."				
		I #2, the DON (Director of #4, the facility consultant were	<b>)</b>			
	documents in part, of the facility to pro care plan based or assessment of the of an interdisciplina	, "Resident Care Plan" the following: "It is the policy vide an Interdisciplinary writte the physician's orders and the resident needs. Development ary plan will occur after mprehensive assessment by	е			
	No further informat	tion was presented prior to exi	t.			
	3/17/14 with diagnostic lack of bone de Schizophrenia (1) a On the most recen significant change assessment refere #19 was coded as impaired for makin coded as requiring from one staff mer	as admitted to the facility on oses including, but not limited ensity, difficulty swallowing, and dementia with behaviors. It MDS (minimum data set), a assessment with an ence date of 12/9/16, Resident being moderately cognitively a daily decisions. She was a limited physical assistance mber for eating. She was een ordered a mechanically physician.				
	revealed the follow	nt #19's clinical record ving physician's order, most the physician on 1/7/17: "Diel	·•			

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Regular, ground meats, thin liquids."

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		· & MIETH CALL SERVICES			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		495226	B. WING		02/09/2017
	OVIDER OR SUPPLIER NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	
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### F 282 Continued From page 22

A review of the registered dietician-approved facility menu for lunch on 2/8/17 revealed, in part, the following: "Reg (Regular) Ground/Mech (Mechanical) Soft: Grd (Ground) Sausage/Pepp (Peppers)/Onions."

On 2/8/17 at 12:45 p.m., observation was made of the tray line for the lunch meal. At this time, OSM (other staff member) #2, the cook, was observed preparing Resident #19's tray. OSM #2 had been observed to serve the last of the ground meat option of sausage, peppers and onions at approximately 12:35 p.m. As OSM #2 prepared Resident #19's tray, she placed a whole piece of boneless, skinless chicken breast on Resident#19's tray. Using the side of the serving spoon, OSM #2 cut the chicken breast into large chunks. OSM #2 served mashed potatoes, cornbread and green peas on the plate, and placed the plate on the lunch tray for Resident #19.

On 2/8/17 at 1:25 p.m., observation was made of Resident #19 in the dining room. She had eaten less than 50% of the food on her tray. Approximately half of the chicken breast remained on the tray. Resident #19 showed no signs of coughing. Observation of the resident's meal ticket revealed, in part, the following: "Texture: Regular, ground meats."

Attempts to interview Resident #19 regarding the lunch tray and meat consistency were unsuccessful.

On 2/8/17 at 1:30 p.m., OSM (other staff member) #2 was interviewed. When asked about the availability of the ground meat option for all residents, OSM #2 stated: "I ran out of the

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		MENT OF HEALTH	AND HUN SERVICES  & MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
	STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			495226	B. WING		C 02/09/2017
		PROVIDER OR SUPPLIER  D NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	
-	(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE COMPLETION
	F 282	remembered what OSM #2 stated: "T she served Reside by the physician, O stated that ordinari there to help prepa asked what she sh	When asked if she she served Resident #19, he chicken." When asked if nt #19 ground meat as ordered SM #2 stated, "No." She ly, the second shift cook will be re what is needed. When ould have done for Resident #2 stated: "I should have put		282	

On 2/8/17 at 1:35 p.m., OSM #1, the dietary manager, was interviewed. She stated that OSM #2 had not served the physician-ordered therapeutic diet to Resident #19. OSM #1 stated: "I did not know we were out of the ground option." When asked if the facility staff had followed Resident 19's care plan for nutrition, OSM #1 stated: "No. We did not. I know she is care planned for ground meats."

On 2/8/17 at 3:35 p.m., CNA (certified nursing assistant) #1 was interviewed. CNA #1 stated: "If we hand out a tray, we are supposed to make sure what's on the plate matches the meal ticket." She stated the information regarding the physician-ordered diet is on both the meal ticket and the resident guide on the computer.

A review of the comprehensive care plan for Resident #19 dated 12/30/15 and updated on 2/7/17 revealed, in part, the following: "Diet as ordered (Ground).

On 2/8/17 at 5:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, facility consultant, were informed of these concerns.

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## DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

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PRINTED: 02/16/2017 FORM APPROVED OMB NO. 0938-0391

	& MEDICAID SERVICES						
	DESCRICAL INCREMENTATION AND IMPEDI		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	495226	B. WING	***************************************		l .	9/2017	
PROVIDER OR SUPPLIER		L	STRE	ET ADDRESS, CITY, STATE, ZIP CODE			
NOVIDER OR SOL LEEK							
WAYLAND NURSING AND REHABILITATION CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES							
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULI	) BE	(X5) COMPLETION DATE	
Continued From pa	age 24	F	282				
A review of the face Policy" revealed, in menu is written for is modified for the Ground/Mechanica Soft/Regular Ground that are easy to chewing or swallow the regular menu was deemed appropriately as deemed appropriately as the company of the com	lity policy entitled "Menu part, the following: "The the general/regular diets and following diets3) Regular al SoftMechanical nd: The diet consists of foods ew; designed for residents with ving difficulties. Meats from vill be served but will be and vegetable will be served briate."  Ition was provided prior to exit. is a chronic and severe is how a person thinks, feels, formation is taken from the						
483.24, 483.25(k)(FOR HIGHEST W  483.24 Quality of II Quality of life is a fapplies to all care residents. Each refacility must provide services to attain or practicable physics well-being, consist comprehensive as  483.25 (k) Pain Management The facility must estable to the provide services to attain or practicable physics well-being, consist comprehensive as	ife fundamental principle that and services provided to facility esident must receive and the let the necessary care and or maintain the highest al, mental, and psychosocial ent with the resident's sessment and plan of care.	F	309	Resident #6 was assessed for pain by the floor nurse/LPN on 2/8/17 and will be provided non-pharmacological interventions prior to the administration of pain medications. Resident #6 care plan was updated to reflect non-pharmacological interventions to implement prior to the administration of pain medications by the DON on 2/23/17.		3/25/17	
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE  Continued From pa A review of the facil Policy" revealed, in menu is written for is modified for the Ground/Mechanica Soft/Regular Groun that are easy to che chewing or swallow the regular menu w ground. Raw fruits as deemed approp  No further informat  (1) "Schizophrenia disorder that affect and acts." This inf website https://www.nimh.r zophrenia-booklet/ 483.24, 483.25(k)( FOR HIGHEST W  483.24 Quality of life Quality of life is a f applies to all care is residents. Each re facility must provid services to attain of practicable physica well-being, consist comprehensive as  483.25 (k) Pain Managem The facility must e provided to residen	PROVIDER OR SUPPLIER  D NURSING AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 24  A review of the facility policy entitled "Menu Policy" revealed, in part, the following: "The menu is written for the general/regular diets and is modified for the following diets3) Regular Ground/Mechanical SoftMechanical Soft/Regular Ground: The diet consists of foods that are easy to chew; designed for residents with chewing or swallowing difficulties. Meats from the regular menu will be served but will be ground. Raw fruits and vegetable will be served as deemed appropriate."  No further information was provided prior to exit.  (1) "Schizophrenia is a chronic and severe disorder that affects how a person thinks, feels, and acts." This information is taken from the website https://www.nimh.nih.gov/health/publications/schi zophrenia-booklet/index.shtml. 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care.  483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services,	A BUILD  A95226  B. WING  ROVIDER OR SUPPLIER  D NURSING AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 24  A review of the facility policy entitled "Menu Policy" revealed, in part, the following: "The menu is written for the general/regular diets and is modified for the following diets3) Regular Ground/Mechanical SoftMechanical Soft/Regular Ground: The diet consists of foods that are easy to chew; designed for residents with chewing or swallowing difficulties. Meats from the regular menu will be served but will be ground. Raw fruits and vegetable will be served as deemed appropriate."  No further information was provided prior to exit.  (1) "Schizophrenia is a chronic and severe disorder that affects how a person thinks, feels, and acts." 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The facility must ensure that pain management is provided to residents who require such services,	ROVIDER OR SUPPLIER  D NURSING AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYMS INFORMATION)  Continued From page 24  A review of the facility policy entitled "Menu Policy" revealed, in part, the following: "The menu is written for the general/regular diets and is modified for the following diets3) Regular Ground/Mechanical SoftMechanical Soft	A BUILDING  49526  ROVIDER OR SUPPLIER  D NURSING AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  COntinued From page 24  A review of the facility policy entitled "Menu Policy" revealed, in part, the following: "The menu is written for the general/regular diets and is modified for the following diets3) Regular Ground/Mechanical SoftMechanical Soft/Regular Ground/Mechanical SoftMechanical Soft/Regular Ground, Raw fruits and vegetable will be served as deemed appropriate."  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DEPARTMENT OF HEALTH	I AND HUI SERVICES	
CENTERS FOR MEDICARE		

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES				MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED
		495226	B. WING			C <b>02/09/2017</b>
NAME OF P	ROVIDER OR SUPPLIER			S1	TREET ADDRESS, CITY, STATE, ZIP CODE	
		HABILITATION CENTER			30 LUNENBURG HIGHW EYSVILLE, VA 23947	
	OLIMANA DV CTA	TEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORRECTION	)N (X5)
(X4) ID PREFIX TAG	(FACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION PRIATE DATE
E 300	Continued From pa	oge 25	F.3	309	100% of all residents receiving p	
F 309	•	<del></del>	, ,	,,,,	pain medications, to includ	
	the comprehensive	person-centered care plan,			Resident #6, MARs were reviewe	ed
	and the residents	goals and preferences.			to ensure non-pharmacologic	
	(I) Dialysis The fa	cility must ensure that			interventions were implement	ed
	residents who requ	ire dialysis receive such			with documentation in the medic	
	services, consister	nt with professional standards			records prior to the administration	on
	of practice, the con	nprehensive person-centered			of pain medication. The care plant	an
	care plan, and the	residents' goals and			was updated to reflect no	ก-
	preferences.				pharmacological interventions	to
		NT is not met as evidenced			implement prior to t	he
	by:				administration of pain medicatio	ns
•	Based on observa	tion, staff interview, facility			on/or before 3/25/17	by
		iew and clinical record review, that facility staff failed to			Administrative Nurs	es
	provide the necess	sary care and services to attain			(DON/ADON/SDC/MDS Nurse/Mi	DS
	or maintain the hid	hest level of wellbeing for one			fill-in) for all residents who recei	ve
	of 20 residents in t	he survey sample, Resident			prn pain medications.	
	#6.				All license nurses to include LPN	#1
	The facility staff fa	iled to implement			and LPN #5 were in serviced on/	'or
	non-pharmacologi	cal interventions prior to the			before 3/25/17 by Administrati	
	administration of p	ain medication to Resident #6,			Nurses (DON/ADON/SDC/M	
		ons in December 2016 and			Nurse/MDS fill-in) to impleme	ent
ļ	January 2017.				non-pharmacological intervention	
					prior to the administration of p	
	The findings include	1e:			•	ith
	Pasidant #6 was a	idmitted to the facility on			documentation in the medi	cal
	11/27/1/ and read	mitted on 5/18/16 with				on-
	diadnoses that inc	luded but were not limited to			pharmacological interventions we	ere
	adult failure to thri	ve, Alzheimer's disease,			reviewed during the in-service.	
	dementia, hyperte	nsion, atrial fibrillation, anxiety			newly hired licensed nurses will	
	and depression. I	Resident #6's most recent MDS			·	
	(minimum data se	t) was an annual assessment			and the second s	
	with an ARD (asset 11/19/16. Resider	essment reference date) of nt #6 was coded as being				

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moderately cognitively impaired in the ability to make daily decisions, scoring 07 out of 15 on the BIMS (brief interview for mental status) exam.

Event ID: 6PZJ11

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### DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING \_\_ R WING

PRINTED: 02/16/2017 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY COMPLETED

02/09/2017

NAME OF PROVIDER OR SUPPLIER

### WAYLAND NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW

**KEYSVILLE, VA 23947** 

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

495226

ŧΩ PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

COMPLETION DATE

### F 309 Continued From page 26

Resident #6 was coded as requiring extensive assistance with one person physical assist with most ADLS (activities of daily living) including transfers, locomotion, dressing, toileting, and personal hygiene; independent with meals, and totally dependent on staff with bathing.

Review of Resident #6's most recently signed POS (physician order sheet) dated 1/31/17 documented the following order, "Ultram Tramadol [1] HCL 50 MG (milligrams) TABS (tablets) 1 by mouth every six hours as needed for pain."

Review of Resident #6's December 2016 and January 2017 MARs (Medication Administration Record) revealed that Resident #6 received Ultram 50 mg on the following dates:

12/5/16, 12/8/16, 12/10/16, 12/11/16, 12/13/16 and 12/24/16, 1/3/17, and 1/6/17.

Review of the December 2016 and January 2017 nursing notes revealed no evidence that non-pharmacological interventions were attempted prior to the administration of Ultram.

Further review of the clinical record failed to show evidence that non-pharmacological interventions were attempted prior to the administration of Ultram.

On 2/8/17 at 2:50 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked the process prior to the administration of a prn (as needed) pain medication, LPN #1 stated that nurses should always attempt non-pharmacological interventions prior to the administration of pain

F 309

in serviced during orientation by the staff facilitator to implement nonpharmacological interventions prior administering medications with documentation in the medical records. Examples of non-pharmacological interventions will be reviewed during the inservice.

10% of resident's receiving prn pain medications to include resident #6, progress notes and MARs will be reviewed by Administrative Nurses (DON/ADON/SDC/MDS Nurse/MDS ensure fill-in) ກດກpharmacological interventions are being provided prior to the administration of pain medications weekly x 8 weeks then monthly x 1 month utilizing a Pain Management QI Tool. The license nurse will be immediately retrained Administrative Nurses (DON/ADON/SDC/MDS Nurse/MDS fill-in) for any identified areas of concern. The Director of Nursing will review and initial the Management QI Audit Tool weekly x 8 weeks then monthly x 1 month for compliance and to ensure all areas of concern have been addressed.

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Event ID: 6PZJ11

Facility ID: VA0050

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	ENT OF HEALTH	AND HUI SERVICES  & MEDICAID SERVICES			FOF	RM APPROVED IO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVID		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NÜMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION NG	) C	C C
		495226	B. WING _	<b>1</b>		02/09/2017
	OVIDER OR SUPPLIER  NURSING AND RE	HABILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947	DE	
(X4) ID		TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI		(X5) COMPLETION

F 309 Continued From page 27 medication.

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On 2/8/17 at 4:00 p.m., an interview was conducted with LPN #5 a nurse who administered Ultram to Resident #6 on three different occasions. LPN #5 was asked about the process staff follows prior to the administration of a prn (as needed) pain medication. LPN #5 stated that she would assess the resident to find out their level of pain by using the 1-10 pain scale and check to see when the last dose of pain medication was administered. LPN #5 stated that she would also follow up on the Resident's pain after the pain medication was administered. When asked if anything would be attempted prior to the administration of pain medication, LPN #5 stated that non-pharmacological interventions such as repositioning would be attempted. When asked where this would be documented, LPN#5 stated that this would be documented in a progress note. When asked if she attempted non-pharmacological interventions prior to administering Ultram to Resident #6, LPN #5 stated, "I can't say I did. She requests her pain medication." When asked if staff should be encouraging residents who request pain medication to try non-pharmacological interventions first, LPN #5 stated, "Yes."

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

On 2/8/17 at 5:01 p.m., ASM (administrative staff member) #1, the Administrator, ASM #2, the DON (Director of Nursing) and ASM #4, the facility consultant were made aware of the above concerns. A policy could not be provided regarding non-pharmacological pain interventions prior to administering prn pain medication.

[1] Tramadol/Ultram- analgesic used to treat

F 309

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TAG

The Executive QI committee will meet monthly and review the Pain Management QI Audit Tools and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring monthly 3 months.

CROSS-REFERENCED TO THE APPROPRIATE

**DEFICIENCY**)

PRINTED: 02/16/2017

DATE

Event ID: 6PZJ11

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Facility ID: VA0050



	MENT OF HEALTH					FORM APPROVED
CENTER	S FOR MEDICARE	& MEDICAID SERVICES			O	MB NO. 0938-0391
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		495226	B. WING			C <b>02/09/2017</b>
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
WAYLAN	D NURSING AND RE	HABILITATION CENTER			LUNENBURG HIGHW SVILLE, VA 23947	
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F 309	Continued From pa	age 28	F	309		:
, 555	moderate to severe	pain. This information was s's Drug Guide for Nurses,				
F 314 SS=D	483.25(b)(1) TREA		F	314	Resident #6 heel boots and heel floats were applied while resident was in bed as identified on the plan of care on	3/25/17
	(b) Skin Integrity -				2/23/17 by DON. Resident #6 skin was assessed on2/8/17 by Tx Nurse/RN with	
	(1) Pressure ulcers	. Based on the			no observations of pressure sores.	
	comprehensive ass facility must ensure	sessment of a resident, the ethat-			100% audit was completed by facility consultant and DON on 2/22/17 of all residents at high risk for pressure ulcers	
	professional standa	ves care, consistent with ards of practice, to prevent			or with actual pressure ulcers to include resident #6 to ensure preventive	
	ulcers unless the ir	d does not develop pressure ndividual's clinical condition they were unavoidable; and			measures to prevent pressure sores to include heel boots and heel floats are applied and weekly wound	
		pressure ulcers receives			measurements and staging of pressure ulcers are documented. The DON corrected all identified areas of	
	professional standa	nt and services, consistent with ards of practice, to promote			concerns during the audit.	
	from developing.	fection and prevent new ulcers  NT is not met as evidenced			100% of license nurses to include RN #3, RN #1, LPN #2, LPN #6, LPN #7 and	
	by:	ntion, staff interview, facility			nursing assistants to include CNA #4 were re-educated by Administrative Nurses (DON/ADON/SDC/QI/TX nurse	
	documentation rev	iew, and clinical record review, that facility staff failed to			and/or MDS coordinator) on/or before 3/25/17 regarding ensuring preventive measure to prevent pressure sores,	
	provide treatment a pressure ulcers for survey sample, Re	and services to prevent or heal r one of 20 residents in the esident #6.			including heel boots and float heels, are provided per the resident care guide/care plan. The treatment nurse	
	wound measureme	ff failed to provide weekly ents and staging of a stage two that was found on Resident 3/16.				

1b. The facility staff failed to implement skin

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1	FORM APPROVE
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DEPARTMEN	T OF HEALTH	AND HUN SERVICES  & MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
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		495226	B. WING		02/09/2017
NAME OF PROVID	DER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE
WAYLAND NU	RSING AND RE	HABILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947	
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previous pre	tot applying heateral feet and by the she was findings included. Resident #6 vol. 7/14 and reading noses that included in the she was a second for the she was a second for the she was a	es to prevent pressure sores el boots to Resident #6's y not floating Resident #6's s in bed.		was in serviced by facility consinegarding wound measurement requirements for documentating pressure sores, weekly assess staging and care planning of producers. All newly hired license and nursing assistants will be induring orientation by the Staff Facilitator regarding ensuring preventive measures to preventive and the lateral float heels, are provided per the resident care guide/care plan.  The Administrative Nurses (DON/ADON/SDC/QI and/or float heels, are provided per the residents at high rispressure ulcers and with actual ulcers utilizing the Preventative Interventions QI Tool weekly at them monthly x 1 month to enteresidents are provided interventions and floats in accordance written care plan. The Admininurses (DON/ADON/SDC/QI and/or floats in accordance written care plan. The Admininurses (DON/ADON/SDC/QI and/or floats in accordance written care plan. The Admininurses (DON/ADON/SDC/QI and/or floats in accordance written care plan. The Admininurses (DON/ADON/SDC/QI and/or floats in accordance written care plan. The Admininurses (DON/ADON/SDC/QI and/or floats in accordance written care plan. The Admininurses (DON/ADON/SDC/QI and/or floats in accordance written care plan. The Admininurses (DON/ADON/SDC/QI and/or floats in accordance written care plan. The Admininurses (DON/ADON/SDC/QI and/or floats in accordance written care plan. The Admininurses (DON/ADON/SDC/QI and/or floats in accordance written care plan. The Admininurses (DON/ADON/SDC/QI and/or floats in accordance written care plan. The Admininurses (DON/ADON/SDC/QI and/or floats in accordance written care plan. The Admininurses (DON/ADON/SDC/QI and/or floats in accordance written care plan. The Admininurses (DON/ADON/SDC/QI and/or floats in accordance provided interventions are in place and with the staff member. An auxond documentation will be conducted for all residents we	ats, on of nent, ressure nurses n serviced  Int boots and he  ADS sident sk for al pressure ve x 8 weeks histere ention to lude heel e with the istrative and/or s any himediately diretraining udit of e

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Review of the Wound Ulcer Flowsheet dated

4/8/16, documented the following: "Site: 53)
Sacrum Type: Pressure Length: 2.6 cm Width: 1.0cm Stage II." Event ID: 6PZJ11

Facility ID: VA0050

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DEPARTMENT OF HEAL'	TH AND HUI SERVICES RE & MEDICAID SERVICES			PRINTED: 02/16/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
	495226	B. WING		02/09/2017
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4/8/16 for Resid orders: "Apply dulcer. Change (needed). Zinc [mouth) TID (Thi (Vitamin) C [4] & 14 days wound  Review of Resid August 2016 TA Records) reveathe same treath stage II q (every Review of a skill documented the intact."	nysician's telephone orders dated ent #6 documented the following Loderm to sacral St (stage) 2 Q (every) 7 days and PRN (as B] 220 mg (milligrams) po (by ee times a day) x 14 days, Vit 00 mg po BID (two times a day)	x ng s.	pressure ulcers by Admini Nurses (DON/ADON/SDC/MDS coordinator) weekly then monthly x 1 month a Wound Documentation A ensure wound documentation are weekly assessment, wour measurements, staging of ulcers, and care planning sores. Any concerns will in addressed by the Administ (DON/ADON/SDC/QI and, coordinator) with reeducative treatment nurse and comappropriate wound documents of the QI Wound Documents the QI Wound Documents.	/QI/ and/or  x 8 weeks using a QI udit Tool to ation is ol to include nd f pressure for pressure mmediately be strative Nurses /or MDS ation of the mentation. The al the is QI Tool and

Skin Conditions dated 6/23/16 documented the following: "Site: Sacrum, Description: protectant...Comments Apply Duoderm Q7 days and PRN." No measurements were documented.

Review of Resident #6's Flowsheet of Non-Ulcer skin conditions dated 7/14/16 documented the following: "Type of skin condition: Stage 2...Site 53) Sacrum...Comments Apply Duoderm to sacral stage II every 7 days and PRN." No measurements were documented.

Further Review of Resident #6's nursing notes revealed the following note dated 8/3/16, "Stage II to sacrum healed, treatment d/c'd (discontinued), RP and MD made aware."

No other notes or Wound Ulcer Flowsheets could

Tool weekly x 8 weeks then monthly x 1 month to ensure compliance.

The Executive QI committee will meet monthly and review the Preventative Interventions QI Tools and the QI Wound Documentation Tools and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.

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DEPARTMENT OF HEALTH AND HUN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

PRINTED: 02/16/2017 FORM APPROVED OMB NO. 0938-0391

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	495226	B. WING		02	/09/2017		
NAME OF PROVIDER OR SUPPLIER  WAYLAND NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947				
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be found documenting measurements of Resident #6's stage II pressure ulcer.

Review of Resident #6's skin care plan dated 12/3/14 and reviewed 8/29/16, documented skin interventions prior to the development of the Stage II pressure ulcer. The care plan did not address Resident #6's Stage II pressure ulcer of the sacrum.

On 2/8/17 at 2:50 p.m., an interview was conducted with RN (registered nurse) #3. When asked the process if a new wound is identified, RN #3 stated, "The treatment nurse will be alerted that the resident has a new skin area and then the treatment nurse will check the area every day. She will measure the wound once a week and document the wound measurements under the assessment tab in the computer." RN #3 stated that CNAs (certified nursing assistants) or nursing should be checking the skin every time they provide care to the resident, and document when there are new changes.

On 2/8/17 at approximately 3:00 p.m., an interview was conducted with RN #1, the wound care nurse. When asked the process if a new wound is identified, RN #1 stated, "If the CNAs find an area during a skin check, they will key it in the computer system which will then alert me to assess the area. I will do measurements and incorporate a treatment. I check the area daily and measure and stage the wound weekly." RN #1 stated that measurements were documented on a wound ulcer flow sheet. When asked if she was the only nurse to do treatments, RN #1 stated, "Most of the time yes but it depends on how often the wound has to be changed. Some wounds are changed two times a day and I am

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Facility ID: VA0050

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## DEPARTMENT OF HEALTH AND HUM SERVICES

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1				····				
F 314	Continued From pa	ige 32	F;	314				
		ening shift. The floor nurses						
		the dressing." RN #1 stated						
		the wound care nurse in						
		hen asked if she could recall all wound, RN #1 stated, "I						
		When asked if she could find						
		nd ulcer flow sheets, RN #1						
	stated, "I can look."	•						
		n.m., an interview was						
		M (administrative staff dministrator and ASM #2, the						
		lursing). ASM #3 stated that						
		esident #6 had the wound						
		was sent out to the hospital on						
	5/17/16 and she ca	me back to the facility on						
		ound documented as healed. as requested by this writer.						
	inat intormation w	as requested by this writer.						
		a.m., observation of Resident						
		as conducted with LPN						
		nurse) #7. Resident #6 had no						
	skin issues noted t	o her sacral area.						
	On 2/9/17 at 8:30 a	a.m., further interview was						
		l #1, the wound care nurse.						
	When asked why it	t was important to measure						
		RN #1 stated that she						
		ges wounds to track healing						
		tated that she will change is no progress and if the						
	current treatment is	s not working to heal the ulcer.						
	When asked if she	had found measurements for						
		sure, RN #1 stated that she						
		additional information. When						
		would know if Resident #6's ctive if weekly wound						
		staging was not documented,						
	Incasurements Of	staging was not accamonica,						

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RN #1 stated, "At that time I couldn't tell you if

Event ID: 6PZJ11

Facility ID: VA0050

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		495226	B. WING			0	2/09/2017
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WAYLAN	D NURSING AND RE	HABILITATION CENTER		KEY	SVILLE, VA 23947		
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F 314	•	-	r J	) <b>1 **</b>			
	treatments were wo	orking or effective.					
	On 2/9/17 at 10:51	a.m., further interview was					
	conducted with ASI	M #3, the DON. ASM #3 was					
	asked when wound	ls should be measured and					
		ated that wounds should be					
		ged weekly. ASM #3 stated					
		would be documented on a					
		ASM #3 also stated that					
		strator, treatment nurse, and Director of Nursing) will have					
		gs to discuss new treatments					
		ents are successful at healing					
		ked if she discussed Resident					
	#6's wounds in the	skin meetings, ASM #3 stated,					
		n't here. I didn't get to the floor					
		"." When asked if she could					
		that Resident #6 went to the					
		with a wound and came back					
		1 5/18/16, ASM #3 stated, "I					
		sing notes documenting that hospital and came back."					
	and went out to the	Hospital and dame back.					
	The nursing notes	documenting that Resident #6					
	went out to the hos	pital on 5/17/16 and arrived					
		on 5/18/16, did not address her	•				
	wound.						
	On 2/8/17 at 5:01 p	om ASM #1 the					
		1 #2, the Director of Nursing,					
		acility consultant were made					
	aware of the above						
	Carility paties, titled	"Droccisco i llocr					
	Facility policy titled	, Pressure cicer ocuments the following: "It is					
		ocuments the following. It is					

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assessed. Pressure Ulcer Flow Sheets and progress notes on ulcers will be maintained in each resident's medical record In addition, upon

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Facility ID: VA0050

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DEPARTMENT OF HEALTH	AND HU SERVICES
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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			***	OMB N	<u>O. 0938-0391</u>
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		495226	B. WING			0	<u>2/09/2017</u>
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WAYLAN	D NURSING AND RE	HABILITATION CENTER			LUNENBURG HIGHW		
			<u>,</u>	KE.	YSVILLE, VA 23947		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	(	(EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR		COMPLETION DATE
IAG	TREODER OTT OTTE		170		DEFICIENCY)	OI THE LIE	
F 314	Continued From pa	ge 34	F 3	14			
	admission or readm	nission of any resident, the					
	facility will photogra	ph any existing ulcers."					
	Facility policy titled	"Wound/Ulcer Treatment"					
		the following: "A pressure is a					
		ne skin and/or underlying					
		a bony prominence, as a					
		or pressure in combination					
		ionStage II- Partial thickness					
	skin loss involving	epidermis, dermis or both,					
	presenting as a sha	allow open ulcer with a					
		d, without slough. May also					
	present as an intac	t or open/ruptured serum-filled					
	blister, an abrasion	, or a shallow center."					
	No further informati	ion was presented prior to exit.					
	According to the U	.S. Department of Health and					
		ublic Health Service, Agency					
		icy and Research, Clinical					
		, Treatment of Pressure					
	Ulcers, Number 15	an AHCPR Publication No.					
		he Clinical Practice					
	Guidelines Treatme	ent of Pressure Ulcers					
	revealed in part the	following information					
		sore treatment: "7.					
		ssure sore healing. Progress					
	_	uld be evaluated weekly. If					
		ioration are observed sooner					
		essing changes), steps to					
		d be taken immediately. 9.					
		reatment Plan and evaluation					
		e ulcer is not healing, the					
		sess the treatment plan and					
	determine whether	it is being followed. In					

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particular the clinician should assess whether tissue load management is adequate and should evaluate the extent of adherence to cleansing and dressing ... Pressure ulcers should be

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DEPART	MENT OF HEALTH	AND HUI SERVICES & MEDICAID SERVICES			PRINTED: 02/16/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED C
		495226	B. WING		02/09/2017
	PROVIDER OR SUPPLIER  ID NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHOUND SHOUND CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 314	amongst staff and of the progress tow [1] Stage II Pressu Stage II: Partial this presenting as a ship pink wound bed, was an intact or ope Further description Presents as a shin slough or bruising used to describe sidermatitis, macera *Bruising indicates	d to facilitate communication to ensure adequate monitoring ward healing."  re-ckness loss of dermis allow open ulcer with a red ithout slough. May also present in/ruptured serum-filled blister.  This stage should not be kin tears, tape burns, perineal action or excoriation.  suspected deep tissue injury. The stage of the suspected deep tissue injury. The stage of the suspected deep tissue injury. The suspected from National visory Panel.	F3	114	
	modern hydrocollomanagement of liquid wounds. DuoDEF easy to use and a different stages of types in a protocohttp://www.convat-portallev1/0/detaig-range.html	sing-DuoDERM® Dressings are bid dressings for the ght to moderately exuding RM® Dressings are versatile, re suitable for managing wound healing and wound of care. ec.com/en/cvtus-duodrrngus/cvt/1/0/1444/1847/duoderm-dressings maintain the integrity of skin obsances. Patients with chronic	:		

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Institutes of Health.

leg ulcers have abnormal zinc metabolism and low serum zinc levels, and clinicians frequently treat skin ulcers with zinc supplements." This information was obtained from The National

https://ods.od.nih.gov/factsheets/Zinc-HealthProf

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	TMENT OF HEALTH RS FOR MEDICARE	I AND HU I SERVICES			PRINTED: 02/16/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		495226	B. WING		C <b>02/09/2017</b>
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
WAYLAN	ID NURSING AND RE	HABILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		ULD BE COMPLETION
F 314	Continued From pa essional/	ige 36	F 3	14	
	biosynthesis of colla neurotransmitters; of protein metabolism component of conn vital role in wound it obtained from The	min C is required for the lagen, L-carnitine, and certain vitamin C is also involved in [1,2]. Collagen is an essential nective tissue, which plays a healing." This information was National Institutes of Health.			
	preventive measure	f failed to implement skin es to prevent pressure areas el boots or floating heels to eral feet.			
	in bed. Her blanket heels were resting of	a.m., Resident #6 was sleeping t covered her legs but her directly on the mattress. No ed in place on her feet.			
	in bed. Her blanket heels were resting of	a.m., Resident #6 was sleeping t covered her legs but her directly on the mattress. No ed in place on her feet.			
	in bed. Her blanket heels were resting of	n.m., Resident #6 was sleeping t covered her legs but her directly on the mattress. No led in place on her feet.			

Review of Resident #6's care plan dated 11/28/14 and updated 8/29/16 documented the following intervention under area "Resident Care Guide:

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	MENT OF HEALTH	AND HU N SERVICES				FC	TED: 02/16/2017 ORM APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3)	NO. 0938-0391 DATE SURVEY COMPLETED
		495226	B. WING				C <b>02/09/2017</b>
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WAYLAN	ID NURSING AND RE	HABILITATION CENTER			30 LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOTT CROSS-REFERENCED TO THE APPLICATION DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 314	Continued From pa	ge 37	F 3	14			
	·	nny boots to both feet and	, 0	•			
	Daily Living) tracker closet, documented "Equipment/Instruct	#6's current ADL (Activity of log that was posted in her lin part, the following; cions/PrecautionsHeel oots to both feet and float both					
	(medication administ (treatment administ	#6's February 2017 MARs stration record) and TAR ration record) revealed that on the MARs or TARS.					
	conducted with CNA #4, the CNA who we When asked how sineeds for skin protestated that a care transfer feach resident's classident #6 had any she was in bed, CNA was supposed to haw When asked if Resich CNA #4 stated, "I do This surveyor follow room. CNA #4 lifted Heel boots were not feet. Resident #6's floated. Resident #6's floated. Resident #6 No redness was not something night dut haven't looked at he	a.m., an interview was A (certified nursing assistant) orked with Resident #6. The determined a resident's action, care etc., CNA #4 acker card was in the inside loset. When asked if y special instructions while A #4 stated that Resident #6 ave heel boots on while in bed. dent #6 had heel boots on, on't know, but I can check." The CNA #4 to Resident #6's I up Resident #6's blanket. It in place to Resident #6's feet were not elevated or the color. The color. I was supposed to put on. I was supposed to put on. I was yet." When asked if this e had rounded on Resident					

#6, CNA #4 stated, "Yes this is the first time. She is supposed to have them on. Her boots are not in her closet. I'll go get her a pair of booties."

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DEPARTMENT OF HEALTH AND HUN SERVICES	;
CENTERS FOR MEDICARE & MEDICAID SERVICES	

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CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES					RM APPROVED <u>NO. 0938-03</u> 91
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) [	DATE SURVEY COMPLETED
		495226	B. WING				C <b>02/09/2017</b>
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	7	
WAYLAN	ID NURSING AND RE	HABILITATION CENTER			LUNENBURG HIGHW YSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 314	Continued From pa	ige 38	F3	314			
		often CNAs rounded on stated, "Two times a shift."					
		o.m., an interview was					
		N (licensed practical nurse) #2. uses the care plan, LPN #2					
	stated that everyone	e uses the care plan even					
	plan, LPN #2 stated	ed the purpose of the care					
	care for that particu	ular resident. When asked if a ervention for heel boots on the					
	care plan if heel boo	ots should be in place, LPN #2					
	stated, "Yes. If they put them on." Whe	y were not on, I would go and en asked who was responsible					
	for ensuring skin pro	otective measures were in					
	place, LPN #2 state and CNAs were res	ed that the wound care nurse sponsible for ensuring ted					
		ner skin protective measures					
		.m., further observation of					
		was conducted with LPN nurse) #7. Resident #6's heels					
	had no redness and	d were blanchable to the					
	bunny boots and he	d why Resident #6 needed er heels floated, LPN #6 stated					
	it was to protect her						
		.m., an interview was					
	wound care nurse. 1	(registered nurse) #1, the When asked who was					
		uring skin protective measures e in place, RN #1 stated, "I					
	would check to see i	if they are still on in the					
		idents are still in bed. The and put heel boots on."					

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On 2/8/17 at 5:01 p.m., ASM #1, the

administrator, ASM #2, the DON (Director of

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	IMENT OF HEALTH	AND HU N SERVICES			PRINTED: 02/16/2017 FORM APPROVED DMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495226	B. WING _		C <b>02/09/2017</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW	1 02/09/2017
WAYLAN	D NURSING AND RE	HABILITATION CENTER		KEYSVILLE, VA 23947	
(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)	D BE COMPLETION
F 314	Continued From pa	ge 39	F 31	4	
	made aware of the 483.60(c)(1)-(7) ME	NUS MEET RES	F 36	3	
SS=D	(c) Menus and nutri	DVANCE/FOLLOWED tional adequacy.		Resident #19 was served the	
	Menus must-			published menu and physician ordered diet for supper on 2/8/17.	3/10/17
	· · · ·	itional needs of residents in tablished national guidelines.;		An audit of 100% of residents was completed on 2/22/17-2/23/17 during lunch and supper by the	
	(c)(2) Be prepared i	n advance;		Facility Consultant and Administrator to ensure the	
	(c)(3) Be followed;			published menu was followed and all residents received the physician	ı
	efforts, the religious	d on a facility's reasonable i, cultural and ethnic needs of iion, as well as input received resident groups;		ordered diet. The Administrator and Facility Consultant ensured the the proper diet was provided for the resident for any identified area of concern.	
	(c)(5) Be updated p	eriodically;		or concern.	
		by the facility's dietitian or fied nutrition professional for r; and		100% of dietary staff to include the cook were trained on or before 2/10/17 by the Administrator on	
	construed to limit the personal dietary cho This REQUIREMEN	s paragraph should be e resident's right to make bices. IT is not met as evidenced		following the published menu, production control to ensure preparation of adequate quantity of foods, and ensuring residents are	
		ion, staff interview, facility nd clinical record review, it		served diets as ordered. 100% of dietary staff will be trained on or before 3/10/17 by the Dietary	

was determined that the facility staff failed to

follow the menu for one of 20 residents in the

survey sample, Resident #19.

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Consultant and/or Dietary Manager

on having to make substitutions

and the proper process to follow.

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War and the same	

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	MENT OF HEALTH						FORM AF MB NO. 09	PROVED
CENTER	S FOR MEDICARE	& MEDICAID SERVICES	1				<del>                                     </del>	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION		(X3) DATE S COMPLE	
							С	
		495226	B. WING	·			02/09	/2017
NAME OF F	PROVIDER OR SUPPLIER		•	STR	REET ADDRESS, CITY, STATE, ZIP COI	DE		
		LABILITATION OFNITED		730	LUNENBURG HIGHW			
WAYLAN	D NURSING AND RE	HABILITATION CENTER		KE	YSVILLE, VA 23947			
(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 S CROSS-REFERENCED TO THE AF	HOULD	BE C	(X5) OMPLETION DATE
170		•			DEFICIENCY)			
1								
F 363	Continued From pa	ge 40	F	363	All newly hired dietary staff wil			
	<del>-</del>	ed to serve the published			trained on following the publis			
		peppers and onions and steak			menu, production control to e			
		3/17 to Resident #19. They			preparation of adequate quant			
					foods, and ensuring residents	are		
		9 chicken, mashed potatoes,			served diets as ordered, having	g to		
	and peas.	•			make substitutions and the pro	oper		
					process to follow during orient			
	The findings include	<b>e</b> :			by the Dietary Manager.			
	Resident #19 was a	admitted to the facility on			The distant manager will cond	uct		
		oses including, but not limited			The dietary manager will condu audits of 10% of resident's tray			
	to: lack of bone de	nsity, difficulty swallowing,				-		
	Schizophrenia (1) a	and dementia with behaviors.			the tray line to include residen			
	On the most recent	t MDS (minimum data set), a			for all three meals to ensure th			
	significant change	assessment with an			residents are served the publis			
	assessment refere	nce date of 12/9/16, Resident			menu items and physician orde	ered		
		being moderately cognitively			diet weekly x 8 weeks, then			
		g daily decisions. She was			monthly x 1 month utilizing a			
		limited physical assistance			Dietary QI Audit Tool. The Dieta	ary		
		nber for eating. She was			Manager will retrain the	•		
		een ordered a mechanically			appropriate dietary staff during	g the		
	altered diet by the				audit for any identified areas of			
	altered diet by the [	orry stolari.			concern. The Administrator will			
	A rovious of Poside	nt #19's clinical record			review and initial the Dietary Q			
		ing physician's order, most			Audit Tools weekly x 8 weeks th	•		
	revealed the follow	the physician on 1/7/17: "Diet:			monthly x 1 month for complian			
	Regular, ground m				and to ensure all areas of conce			
	Regular, ground in	eats, titti iiquius.			have been addressed.	2rn		
	A review of the rea	istered dietician-approved			and the second s			
		nch on 2/8/17 revealed, in part,			The Executive QI committee wi	ill		
		(Regular) Ground/Mech			meet monthly and review the			
		Grd (Ground) Sausage/Pepp			Dietary QI Audit Tools and addr	ess		
	(Peppers)/Onions,				any issues, concerns and/or trea			
	(i ehhera)(crimins,	COURTING.			and to make changes as needed			
	On 2/8/17 at 42:45	p.m., observation was made			include continued frequency of			
		he lunch meal. At this time,			monitoring monthly x 3 months			
	OF THE HEAVILLE IOLI	no junion mode. At title tillet			CISHOH C A MICHOR Brown Concession	/*		

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OSM (other staff member) #2, the cook, was observed preparing Resident #19's tray. OSM #2 had been observed to serve the last of the ground meat option of sausage, peppers and onions at

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	FOR MEDICARE	& MEDICAID SERVICES		0	MB NO. 0938-0391	
STATEMENT OF AND PLAN OF CO	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA (X2 IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495226	B. WING_		C 02/09/2017	
	VIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFILIENCY)	BE COMPLÉTION	

#### F 363 Continued From page 41

DEDARTMENT OF LIEALTH AND HILL

approximately 12:35 p.m. As OSM #2 prepared Resident #19's tray, she placed a whole piece of boneless, skinless chicken breast on Resident #19's tray. Using the side of the serving spoon, OSM #2 cut the chicken breast into large chunks. OSM #2 served mashed potatoes, cornbread and green peas on the plate, and placed the plate on the lunch tray for Resident #19.

On 2/8/17 at 1:25 p.m., observation was made of Resident #19 in the dining room. She had eaten less than 50% of the food on her tray. Observation of the resident's meal ticket revealed, in part, the following: "Texture: Regular, ground meats."

Attempts to interview Resident #19 regarding the lunch tray were unsuccessful.

On 2/8/17 at 1:30 p.m., OSM #2 was interviewed. When asked about the availability of the ground meat option for all residents, OSM #2 stated: "I ran out of the ground sausage." When asked if she remembered what she served Resident #19, OSM #2 stated: "The chicken." She stated that ordinarily, the second shift cook will be there to help prepare what is needed if there is not enough of a particular food item. When asked the process to be followed if the facility needs to substitute a meal item, OSM #2 stated: "We will go out and ask the residents if they would like a substitute." She stated that no one from the staff did this for Resident #19.

On 2/8/17 at 1:35 p.m., OSM #1, the dietary manager, was interviewed. OSM #1 stated: "I did not know we were out of the ground option." She stated they did not follow their usual process of asking the residents about a substitute

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Event ID: 6PZJ11 RECEIVED

	MENT OF HEALTH	AND HUN SERVICES				RINTED: 02/16/2017 FORM APPROVED MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED
		495226	B. WING			C <b>02/09/2017</b>
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CIT		
WAYLAN	ID NURSING AND RE	HABILITATION CENTER		730 LUNENBURG HIG KEYSVILLE, VA 23		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD I ENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 363	Continued From pa offering.	ge 42	F3	63		
	Resident #19 dated	prehensive care plan for 12/30/15 and updated 2/7/17 e following: "Diet as ordered				
	member) #1, the ac director of nursing,	.m., ASM (administrative staff Iministrator, ASM #2, the and ASM #4, facility ormed of these concerns.				
	Policy" revealed no	ity policy entitled "Menu information related to the red if the facility runs out of a m.				
	No further informati	on was provided prior to exit.				
	Complaint Deficiend	су				
	disorder that affects	s a chronic and severe how a person thinks, feels, rmation is taken from the				
	https://www.nimh.ni zophrenia-booklet/ir	h.gov/health/publications/schi ndex.shtml.				
F 364 SS=B	•	TRITIVE VALUE/APPEAR,	F 3	64		3/15/17
<b>-</b>	(d) Food and drink			50% of the pi	hat had eaten less than izza, pureed meat, mashed potatoes,	
	Each resident recei	ves and the facility provides-		regular peas,	and pasta were	
	(d)(1) Food prepare nutritive value, flavo	d by methods that conserve ir, and appearance;			stitute by the certified tants and Director of 8/17.	
				the state of the s	the contract of the contract o	

(d)(2) Food and drink that is palatable, attractive,

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Facility ID: VA0050

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# DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	S FOR MEDICARE	& MEDICAID SERVICES				OMB N	O. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION				ATE SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:	1				OMPLETED
			A. BUILDING			l	С
		495226	B. WING	·		o	2/09/2017
NAME OF F	ROVIDER OR SUPPLIER		<u> </u>	STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
10000				730 1	LUNENBURG HIGHW		
WAYLAN	D NURSING AND RE	HABILITATION CENTER		KEY	SVILLE, VA 23947		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	•	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETION DATE
				······································			
E 364	Continued From no	ngo 42	_	364			
F 304	Continued From pa	~	F	304	100% of all alert and oriented		
		appetizing temperature; NT is not met as evidenced			residents were interviewed on or		
		NT IS NOT MET as evidenced			before 3/15/17 by social worker		
	by:	tion, staff interview, facility			regarding are meals served at an		
		and in the course of a			appetizing temperature. A reside		
		ation, it was determined that			concern form will be completed t		
		ed to serve food at an			social worker during the audit for		
	appetizing tempera				any identified areas of concern.		
	The facility staff fai	led to serve pizza, pureed			100% of dietary staff were		
		, mashed potatoes, regular			educated on the appropriate		
		an appetizing temperature			holding temps for foods as well a		
	during lunch on 2/8				the desired serving temperature		
	J				for foods on or before 3/15/17 t	y	
	The findings includ	e:			the Dietary Manager and/or		
	-				Administrator. 100% of License		
		a.m., observation was made			Nurses and CNAs were in service	:d	
		ff member) #2, the cook, took			on passing resident's trays in a		
		nch foods in the holding steam			timely manner to ensure food is		
		mperatures were (all in			served at an appetizing		
		it): pizza 98; pureed meat 155;			temperature. All newly hired dietary staff will be in serviced		
	peas 184; and pas	mashed potatoes 171; regular			regarding holding temps for foo	ds	
	peas 104, and pas	ta 100.			as well as the desired serving	<b>u</b> 3	
	On 2/8/17 at 1:10 r	o.m., after the last resident tray			temperatures for foods during		
		ne tray line, the surveyor			orientation by the dietary mana	ger.	
		ay. At 1:15 p.m., it was			All newly hired license nurses a		
		residents had been served.			CNAs will be in serviced regardi		
		ry manager, and ASM			passing resident's trays in a time	ely	
		ff member) #1, the			manner to ensure food is served		
		ompanied the surveyor to test			an appetizing temperature duri		
	the food on the tes	t tray for temperature and			orientation by the staff facilitate	or.	
	palatability. USM i	#1 took the temperatures,					
		degrees Fahrenheit): pizza 74;					
		ureed peas 72; mashed ar peas 69; and pasta 73. Two					
	pulatues 13, regular	nese items and agreed that					
	outveyors tasted ti	1000 HOLLIS OFFICE ABLACA HIGH					

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they were not at an appetizing temperature. ASM #1 also tasted these items and stated: "It's not

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Facility ID: VA0050

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DEPARTMENT	OF	HEALTH	AND	H(N	SERVICES
CENTERS FOR	ME	DICARE	& ME	EDIČAID	SERVICES

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PRINTED: 02/16/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		405000			С
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	NO. 4555 O.S. O. 1507 455	495226	B. WING		02/09/2017
NAME OF PROVIDER OR SUPPLIER  WAYLAND NURSING AND REHABILITATION CENTER		HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	
	OUR MARRY OTA	TOLICAL OF DECOMENOUS			:0N
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		JLD BE COMPLETION
F 364	Continued From pa	age 44	F:	The dietary manager will co	nduct
	·	n." When asked if she would	•	test tray audits using the Tra	
		not meal, she stated: "It's		Assessment QI Tool to ensur	e that
	warm."	iotifical, cito dialog. Ito		residents are served foods a	
	********			appetizing temperature wee	
	On 2/8/17 at 1:20 p	.m., OSM #1 was asked what		weeks, then monthly x 1 mo	
		to provide meals at an		The dietary Manager will re	
		ture to residents. She stated		dietary staff and/or the Dire	
	the facility does not	have heated plates or trays.		nursing will retrain the licen	se
	0.0047-45.00	A ONA ( a disentational services		nurses or certified nursing	aroas of
		.m., ASM (administrative staff		assistants for any identified	
	,	dministrator, ASM #2, the		concern during the audit. The Administrator will review ar	
		and ASM #4, facility formed of these concerns.		the Tray Assessment QI Too	
	CONSCITATING WOLCH	ormed or trede doricerris.		compliance and to ensure a	ll areas
		lity policy entitled "Food aled no information related to		of concern have been addre	
		appetizing temperature to		The Executive QI committee	: will
	residents.	approximate to		meet monthly and review t	ne Tray
				Assessment QI Tool and add	
	No further informat	ion was provided prior to exit.		any issues, concerns and/or	
				and to make changes as ne	
	COMPLAINT DEFI			include continued frequenc	
	483.60(e)(1)(2) TH PRESCRIBED BY		F:	367 monitoring monthly x 3 mo	nths. 
	(e) Therapeutic Die	ets			3/25/17
	(e)(1) Therapeutic the attending physic	diets must be prescribed by cian.			
		ng physician may delegate to a ed dietitian the task of		Resident #19 was served the physician-ordered/care planned	
		ent's diet, including a		ground meat diet during supper on	
		the extent allowed by State		2/8/17. The cook is no longer	
	law.			employed at Wayland.	
	This REQUIREMENT by:	NT is not met as evidenced		······································	
		tion staff interview facility			

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### DEPARTMENT OF HEALTH AND HUNN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB N	O. 0938-0391	L
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495226	B. WING	}		0	C <b>2/09/2017</b>	
NAME OF I	PROVIDER OR SUPPLIER			\$1	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>_</u>		
				73	30 LUNENBURG HIGHW			
WAYLAN	ID NURSING AND RE	HABILITATION CENTER		K	EYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
					100% audit was conducted by the			_
F 367	Continued From pa	ge 45	F	367	Dietary Manager on/or before	•		
	document review, o	linical record review, and in			3/25/17 comparing all residents			
	the course of a con	nplaint investigation, it was			physician-ordered/care planned			
	determined that the	facility staff failed to serve a			diets to actual meals observations			
		herapeutic diet to one of 20			to include resident #19 to ensure			
	residents in the sur	vey sample, Resident #19.			the physician ordered/care planne	ed		
					diet is followed. The Dietary			
	The facility staff failed to serve ground meat as				manager immediately addressed a	ill		
	ordered by the physical Resident #19.	sician at lunch on 2/8/17 to			areas of concern during the audit.			
		<b>T</b>			100% of all dietary staff were in			
	The findings include:				serviced by the Dietary Manager o			
					Administrator on or before 3/25/1	7		
		admitted to the facility on			regarding ensuring that residents			
	_	ses including, but not limited			are provided the physician ordered			
		nsity, difficulty swallowing,			/care planned diet during meals. A	II		
		and dementia with behaviors.			newly hired dietary staff will be in			
		MDS (minimum data set), a assessment with an			serviced during orientation			
		nce date of 12/9/16, Resident			regarding ensuring that residents			
		being moderately cognitively			are provided the physician ordered	l		
		g daily decisions. She was			/care planned diet during meals.			
		limited physical assistance			The Dietary Manager will observe			
		ber for eating. She was			resident meals, to include meals fo	r		
		en ordered a mechanically			resident #19, to ensure residents	-		
	altered diet by the p				are being provided the physician			
					ordered /care planned diet. The			
	A review of Resider	nt #19's clinical record			Dietary Manager will address any			
		ng physician's order, most			identified areas of concern			
		he physician on 1/7/17: "Diet:			immediately by ensuring correct			
	Regular, ground me	eats, thin liquids."			meal provided and retraining with			
					the staff member. The			
		stered dietician-approved			Administrator or DON will review			
		ich on 2/8/17 revealed, in part, (Regular) Ground/Mech			and initial the QI Care Plan/ Care			
		Grd (Ground) Sausage/Pepp			Guide Audit Tools and Meal			
	(Peppers)/Onions."				Observation Tools weekly x 8 weeks	;		
	(Feppers)/Onions.				then monthly x 1 month for			
	On 2/8/17 at 12:45	p.m., observation was made			completion and to ensure all			

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of the tray line for the lunch meal. At this time,

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Facilit

identified areas of concern were

addressed.

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### RECEIVED

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		AND THE A SERVICES			FORM APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495226	B. WING		C <b>02/09/2017</b>
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD	
WAYLAN	D NURSING AND RE	HABILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		HOULD BE COMPLETION
F 367	Continued From pa	ige 46	F 3	367	
	observed preparing had been observed meat option of saus approximately 12:3 Resident #19's tray boneless, skinless Resident#19's tray spoon, OSM #2 cut chunks. OSM #2 s cornbread and green	ember) #2, the cook, was gresident #19's tray. OSM #2 to serve the last of the ground sage, peppers and onions at 5 p.m. As OSM #2 prepared a she placed a whole piece of chicken breast on. Using the side of the serving the chicken breast into large erved mashed potatoes, en peas on the plate, and the lunch tray for Resident.		The Executive QI committee we meet monthly and review the Observation Tools and address issues, concerns and/or trends to make changes as needed, to include continued frequency of monitoring x 3 months.	e Meal ss any ss and so
	Resident #19 in the less than 50% of the Approximately half remained on the trasigns of coughing.	of the chicken breast ay. Resident #19 showed no Observation of the resident's d, in part, the following:			
	Attempts to intervie lunch tray and mea unsuccessful.	ew Resident #19 regarding the it consistency were			
	Attempts to intervie lunch tray were uns	ew Resident #19 regarding the successful.			
	When asked about meat option for all r ran out of the grour she remembered w	o.m., OSM #2 was interviewed. Ithe availability of the ground residents, OSM #2 stated: "I and sausage." When asked if what she served Resident #19, "The chicken." She stated that			

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ordinarily, the second shift cook will be there to help prepare what is needed if there is not enough of a particular food item. When asked

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	TMENT OF HEALTH	AND HUN SERVICES			PRINTED: 02/16/2017 FORM APPROVED
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495226	B. WING_		C 02/09/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
WAYLAN	ID NURSING AND RE	HABILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' ( (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 367	Continued From pa	ge 47	F 30	67	
	substitute a meal ite go out and ask the	ollowed if the facility needs to em, OSM #2 stated: "We will residents if they would like a ated that no one from the staff t #19.			
	manager, was interdid not know we we She stated they did	.m., OSM #1, the dietary viewed. OSM #1 stated: "I are out of the ground option." not follow their usual process ents about a substitute			
	assistant) #1 was in we hand out a tray, sure what's on the p She stated the infor physician-ordered d	.m., CNA (certified nursing terviewed. CNA #1stated: "If we are supposed to make plate matches the meal ticket." mation regarding the liet is on both the meal ticket ide on the computer.			
	Resident #19 dated	prehensive care plan for 12/30/15 and updated 2/7/17 e following: "Diet as ordered			
	member) #1, the addirector of nursing,	m., ASM (administrative staff ministrator, ASM #2, the and ASM #4, facility ormed of these concerns.			
		ity policy entitled "Menu part, the following: "The			

menu is written for the general/regular diets and is modified for the following diets...3) Regular

Soft/Regular Ground: The diet consists of foods that are easy to chew; designed for residents with chewing or swallowing difficulties. Meats from

Ground/Mechanical Soft...Mechanical

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DEPARTMENT OF HEALTH	AND H N SERVICES
CENTERS FOR MEDICARE	& MEDICAID SERVICES

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	OF DEFICIENCIES OF CORRECTION			TIPLE CO	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		495226	B. WING				C <b>/09/2017</b>
	PROVIDER OR SUPPLIER  ID NURSING AND RE	HABILITATION CENTER		730 L	ET ADDRESS, CITY, STATE, ZIP CODE .UNENBURG HIGHW SVILLE, VA 23947	1 02.	109/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441 SS=B	ground. Raw fruits as deemed appropriate of the complaint Deficience (1) "Schizophrenia in disorder that affects and acts." This information website https://www.nimh.nizophrenia-booklet/ir 483.80(a)(1)(2)(4)(e) PREVENT SPREAD (a) Infection preventand control program a minimum, the following the communicable disease volunteers, visitors, providing services unarrangement based conducted according accepted national stimplementation is Piccipital.	ill be served but will be and vegetable will be served riate."  on was provided prior to exit.  by  s a chronic and severe how a person thinks, feels, rmation is taken from the h.gov/health/publications/schindex.shtml.  c)(f) INFECTION CONTROL, D, LINENS  tion and control program.  cablish an infection prevention of (IPCP) that must include, at owing elements:  venting, identifying, reporting, ontrolling infections and cases for all residents, staff, and other individuals nder a contractual upon the facility assessment of to §483.70(e) and following andards (facility assessment	F 3		A cover was placed on the clean linen in the linen closet on the A wing of the facility on 2/24/17 by the housekeeping/laundry supervisor.  100% audit was conducted of all linen closest to ensure linens are stored in a sanitary manner to include not directly beneath areas of staining on the ceiling on/or before 3/5/17 by the Administrato The Administrator immediately corrected any identified areas of concern during the audit.  100% of license nurses and certifications assistants were in serviced on/or before 3/25/17 by	or.	3/25/17
	(i) A system of surve	illance designed to identify					Ì

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# DEPARTMENT OF HEALTH AND HU SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES		<del>,</del>	<u>U</u>	MB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED
						С
		495226	B. WING	<del>}</del>		02/09/2017
NAME OF F	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE	
1444371 441		LADUITATION OF STEP		730 L	UNENBURG HIGHW	
WAYLAN	D NUKSING AND KE	HABILITATION CENTER		KEYS	SVILLE, VA 23947	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	
PRÉFIX	(— · · · · · · · · · · · · · · · · · · ·	/ MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	,	DEFICIENCY)	NAIL
1						
E 441	Continued From pa	nge 40	_	441		
1 771	•	_	f	<del></del>	Administrative Nurses	
	•	able diseases or infections			(DON/ADON/SDC/MDS Nurse) t	to
		read to other persons in the			ensure linens are stored in a	
	facility;				sanitary manner to include not	
	(ii) Mhan and to wh	sam possible incidents of			directly beneath areas of staining	ng
		nom possible incidents of ease or infections should be			on the ceiling. All newly hired	
	reported;	ease of infections should be			license nurses and certified nur	sing
	reported,				assistants will be in serviced to	
	(iii) Standard and tr	ransmission-based precautions			ensure linens are stored in a	
		event spread of infections;	directly beneath areas of staining on the ceiling during orientation by			
	to be followed to pr	oroni oprodu or unoonoro,				
	(iv) When and how	isolation should be used for a				n by
	resident; including l				the Staff Facilitator.	
	, -				The Housekeeping/Laundry	
		uration of the isolation,			supervisor will audit all linen ro	oms
		e infectious agent or organism			to include on the A wing to ensi	
	involved, and				linens are stored in a sanitary	
		hat the isolation should be the			manner to include not directly	
	•	sible for the resident under the			beneath areas of staining on the	e
	circumstances.				ceiling weekly x 8 weeks then	
	/u) The circumstan	and under which the facility			monthly x 1 month utilizing a Li	nen
		ces under which the facility byees with a communicable			Monitoring QI Audit Tool. The	
		skin lesions from direct			timumakaaning sunanisar and/a	
		nts or their food, if direct			Housekeeping supervisor and/or Administrative Nurses	
	contact will transmi					vill
		or some with water and the			(DON/ADON/SDC/MDS Nurse) v retrain the license nurse or certi	
	(vi) The hand hyoie	ene procedures to be followed			nursing assistant during the aud	
		direct resident contact.			for any identified areas of conce	
	•				The DON will review and initial t	
		cording incidents identified			Linen Monitoring QI Audit Tool	
	•	IPCP and the corrective			weekly x 8 weeks then monthly	x 1
	actions taken by the	e facility.			month for completion and to	
					ensure all areas of concern were	e
		nel must handle, store,			addressed.	
	process, and transp	port linens so as to prevent the				

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spread of infection.

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# DEPARTMENT OF HEALTH AND HUNN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

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CENTE	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES			OMB N	IO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) E	DATE SURVEY COMPLETED
		495226	B. WING	**************************************		C 0 <b>2/09/2017</b>
	PROVIDER OR SUPPLIER  ND NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACH CORRECTIVE ACTIO	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 441	annual review of its program, as necess This REQUIREMEN by: Based on observat document review, it facility staff failed to practices for the sto of three linen closet.  The facility staff faile manner. Clean liner wing of the facility wheneath an area on stains.  The findings include Observations of the A-wing of the facility survey, on 02/08/17 at 8:00 a.m., revealed blankets and sheets and uncovered insic observation of the li on the ceiling contailinen stacked on the A-wing of the facility at 9:35 a.m. with Os director of maintenathousekeeping. Wheresponsible for the I was. After observing the stage of the I was.	The facility will conduct an IPCP and update their sary.  NT is not met as evidenced tion, staff interview and facility t was determined that the primplement infection control orage of resident linens in one ts.  Ited to store linens in a sanitary in the linen closet on the A were observed stored directly in the ceiling containing brown the ceiling containing brown the days of the transport of	F	The Executive QI committed meet monthly and review Monitoring QI Audit Tools address any issues, concestrends and to make chang needed, to include continuous frequency of monitoring amonths.	v the Linen s and erns and\or ges as nued	

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OSM # 9 stated, "The linens could be stored somewhere else or they could be covered."

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	CIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY
							С
		495226	B. WING			02	2/09/2017
	PROVIDER OR SUPPLIER  D NURSING AND RE	HABILITATION CENTER		73	REET ADDRESS, CITY, STATE, ZIP CODI 10 LUNENBURG HIGHW EYSVILLE, VA 23947	<del>-</del>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 441	Continued From pa	age 51	F 4	441			
	Department" document and clothing are stareas easily access  On 02/09/17 at 10: staff member) # 1, the director of nurs	"Standard for Linen mented in part, "Clean linen ored in clean, dry, dust-free sible to the nurses' stations."  15 a.m. ASM (administrative the administrator, ASM # 2, sing, and ASM # 4, facility rade aware of the findings.					
F 465 SS=D	483.90(h)(5)	tion was obtained prior to exit.  AL/SANITARY/COMFORTABL  mental Conditions	F	465	In the resident's whirlpool room loc B-wing, new grout/caulk was applied shower stalls to the areas where the substance was located by Maintena before 3/15/17.	d to the two black	3/25/17
	sanitary, and comfresidents, staff and (h)(5) Establish po applicable Federal regulations, regard and smoking safet non-smoking resid This REQUIREME by:  Based on observation document review a was determined the	licies, in accordance with, State, and local laws and ling smoking, smoking areas, y that also take into account ents.  NT is not met as evidenced ation, staff interview, facility and complaint investigation, it at the facility staff failed to shower stalls in a clean manner			100% observation of all shower stall facility was completed by Housekee Supervisor and Administrator on/or 3/10/17 to ensure shower stalls are in a clean manner and without black Work orders were completed by Ad on/or before 3/10/17 for notificatio housekeeping and/or maintenance identified areas of concern. Housek and/or Maintenance addressed all a concerns from the audit by 3/25/17 100% of Housekeeping Services was the Administrator on or before 3/10 and clean shower stalls daily and to maintenance if areas of discoloration	ping before maintained c substances. ministrator on to for any eeping areas of . s in-service by 0/17 to check notify	
		iled to clean two shower stalls hirlpool room on the B-wing of					

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the facility.

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## DEPARTMENT OF HEALTH AND HI

Vanish of	

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COMPLETION

DATE

CENTER	S FUR MEDICARE	& MEDICAID SERVICES		C	MB NO. 0938-039
	EMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495226	B. WING		C 02/09/2017
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	
WAYLAND	NURSING AND RE	HABILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947	
(X4) ID PREFIX		TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO	(^0)

F 465 Continued From page 52

TAG

The findings include:

Observations of the resident's whirlpool room located on the B-wing of the facility during the days of the survey, on 02/08/17 at 4:30 p.m. and on 02/09/17 at 8:00 a.m., revealed caulk/grout covered in a black substance in the right and left corners of both shower stalls to the height of approximately 18 inches.

REGULATORY OR LSC IDENTIFYING INFORMATION)

An observation of the resident's whirlpool room located on the B-wing of the facility was conducted on 02/09/17 at 9:35 a.m. with OSM (other staff member) # 7, director of maintenance and OSM # 9, director of housekeeping. When asked who was responsible for cleaning the shower stalls, OSM # 9 stated it was housekeeping. When asked how often the shower stalls were cleaned, OSM # 9 stated, "Every day." When asked about the black substance on the caulk/grout in the shower stalls. OSM # 9 stated that the housekeeping staff use brushes for cleaning the tiles and the caulk/grout. OSM # 9 also stated that if the housekeeping staff was unable to get the shower stalls clean they should have been report to her. OSM #9 stated she was unaware of the dirty shower stalls. Further examination of the caulk/grout in the two shower stalls was conducted by OSM # 7 and OSM #9. OSM #7 stated that it appeared the caulk/grout was discolored and couldn't be cleaned but could be scrapped out and reapplied with new grout or caulk. OSM # 9 stated that if she had known about it she would have consulted the maintenance department.

The facility's policy "Procedure For Cleaning A Shower Stall" documented in part, "5. Scrub with F 465

PREFIX

TAG

and unable to be cleaned. All newly hired housekeeping staff will be in serviced by Housekeeping Supervisor during orientation to check and clean shower stalls daily and to notify maintenance if areas of discoloration are noted and unable to be cleaned.

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

The DON and/or ADON will monitor 100% of all shower stalls to include on B-wing for cleanliness to include without black substances weekly x 8 weeks then monthly x 1 utilizing a Shower Stall QI Audit tool. The DON and/or ADON will immediately retrain the housekeeping staff or Maintenance director for any identified areas of concerns during the audit. The Administrator will review the Shower Stall QI Audit Tool weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed.

The Executive QI committee will meet monthly and review the Shower Stall QI Audit Tools and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.

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Event ID: 6PZJ11

Facility ID: VA0050

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	TMENT OF HEALTH	I AND HUN SERVICES			FORM	02/16/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION	(X3) DATE COMP	E SURVEY PLETED
		495226	B. WING_		02/0	0 <b>9/2017</b>
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (		/
WAYLAN	D NURSING AND RE	HABILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 465	with putty knife. 6.	age 53 pad; scrap stubborn scales Rinse with hot water and wipe Inspect for appearance and	F 46	65		
	staff member) # 1, the director of nursi consultant, were ma	15 a.m. ASM (administrative the administrator, ASM # 2, ing, and ASM # 4, facility ade aware of the findings.				
	Complaint deficience 483.90(h)(3) CORR SECURED HANDR	RIDORS HAVE FIRMLY	F 46	68 F 468-Secured Handrail	s	3/15/17
	(h)(3) Equip corrido handrails on each s This REQUIREMEN by: Based on observat document review, it facility staff failed to repair in one of thre	ors with firmly secured side; and NT is not met as evidenced tion, staff interview and facility t was determined that the ormaintain handrails in good see units.		The handrail between rand #205, #206 and the room on the B wing we secured by Maintenanc before 3/10/17.  100% audit was comple Administrator of all han facility to ensure handra properly secured and in on/or before 3/15/17. Timaintenance director in	e soiled linen re properly e on/or  eted by the d rails in the ails were good repair the nmediately	
	The findings include	<b>e</b> :		repaired the handrails for identified areas of conce the audit.	*	
	hallway handrail bet and # 205, and the	50 a.m., observations of the tween resident rooms # 204 handrail between resident e soiled linen room located on		The Maintenance Direct serviced by the Administ before 3/5/17 regarding	trator on/or	

the B-wing of the facility were conducted and

revealed both handrails were poorly secured to

the wall. The handrail between resident rooms #

204 and # 205 was observed to be pulling away

Event ID: 6PZJ11

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handrails weekly to ensure

maintained in good repair and to

handrails are secure and

If continuation sheet Page 54 of 58



## DEPARTMENT OF HEALTH AND HIM IN SERVICES

PRINTED: 02/16/2017

	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II	TIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	1	DING	COMPLETED
		495226	B. WING		C 02/09/2017
NAME OF F	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	
14/43/21 4.51				730 LUNENBURG HIGHW	
WAYLAN	ID NURSING AND RE	HABILITATION CENTER		KEYSVILLE, VA 23947	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE COMPLETION
E 460	Casting of Francis	54		immediately correct any cond	erns.
F 400	Continued From pa	•	F 4	168 100% of all License nurses, Ch	
		ne handrail between resident		Dietary, housekeeping, thera	ру
		soiled linen room was loose		staff, and department manag	ers
	from the wall moun	t.		was in-service by Administrat	ive
	An observation of the	he hallway handrail between		Nurses (DON/ADON/SDC/MD	S
		04 and # 205, and the handrail		Nurse) on reporting and filling	g out
		oom # 206 and the soiled linen		work orders for equipment in	need
		e B-wing of the facility was		of repair to include handrails.	
	conducted on 02/09/17 at 9:35 a.m. with OSM (other staff member) # 7, director of maintenance. After observing the handrails OSM # 7 acknowledged the handrails were loose and			newly hired License nurses, Ci	NAs,
				Dietary, housekeeping, therap	•
				staff, and department manage	
				will be in serviced regarding o	
	in need of repair.			reporting and filling out work	
				orders for equipment in need	
		15 a.m. ASM (administrative		repair to include handrails du	-
		the administrator, ASM # 2, ing, and ASM # 4, facility		orientation by the staff facilita	
	consultant, were ma	ade aware of the findings.		The housekeeping supervisor	
				audit 100% of all facility hands	
		on was obtained prior to exit.		to include the wall on the B-w	_
F 520	483.75(g)(1)(i)-(iii)(2		F 5		•
SS=D	COMMITTEE-MEM			month to ensure handrails are	•
	QUARTERLY/PLAN	NS		properly secured and in good re	pair
	(-) O 1%			utilizing a Hand Rail QI Audit To	
	(g) Quality assessm	nent and assurance.		work order will be completed, t	he
	(4) A facility must m	sintain a quality accomment		Maintenance Director will be	
	• •	aintain a quality assessment		retrained and the handrail will t	oe e
	minimum of:	mittee consisting at a		immediately repaired for any	
	maramum Ut.			identified areas of concern duri	-
	(i) The director of no	ursina services:		the audit by the Administrator.	
	(1) (1) an actor of 11			Administrator will review and in	
	(ii) The Medical Dire	ector or his/her designee;		the Handrail QI Audit Tools wee	•
				x 8 weeks then monthly x 1 mor	
	(iii) At least three of	her members of the facility's		for completion and to ensure all	
	staff, at least one of	f who must be the		identified areas of concern were	!
	administrator auton	u a baard maanbar ar abar		addressed.	

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administrator, owner, a board member or other

individual in a leadership role; and

Event ID: 6PZJ11
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VDH/OLC

meet monthly and review the Handrail QI Audit Tools and address I sheet Page 55 of 58 any issues, concerns and/or trends and to make changes as needed, to

The Executive QI committee will

include continued frequency of monitoring x 3 months.

DEPARTMENT OF HEALTH AND HU	SERVICES
CENTERS FOR MEDICARE & MEDICAID	<b>SERVICES</b>

PRINTED: 02/16/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE	* & MEDICAID SERVICES		O	<u>VB NO. 0938-039</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		(X3) DATE SURVEY COMPLETED
				C
	495226	B. WING		02/09/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
			730 LUNENBURG HIGHW	
WAYLAND NURSING AND RE	HABILITATION CENTER		KEYSVILLE, VA 23947	
	ATELEPIT OF OFFICIENCIES		PROVIDER'S PLAN OF CORRECTION	N (X5)

(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 520 Continued From page 55

(g)(2) The quality assessment and assurance committee must :

- (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and
- (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
- (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.
- (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:

Based on staff interview and facility document review, it was determined that facility staff failed to ensure quality assurance members all met on a quarterly basis.

The facility staff failed to ensure that the physician attended a QA (quality assurance) meeting in October of 2016.

The findings include:

On 2/9/17 at 11:11 a.m., the QA (quality assurance) program was reviewed.

Event ID: 6PZJ11

F 520 F520

3/25/17

A Quality Assurance meeting will be held on/or before 3/15/17 with the Attendance of Administrator, Medical Director, Quality Improvement Coordinator, Social Worker, Director of Nursing, Pharmacist, Medical Records Director, Dietary Manager, Housekeeping Supervisor to discuss current citations and the QA process.

100% of all previous QA meetings in the past year were review by Administrator on/or before 3/15/17 to ensure required quality assurance members were in attendance to include the medical director. The Administrator will review the information from the quarterly QA meeting with a current update of the area with any required member found not be in attendance by 3/25/17.

The Administrator, DON and QI Nurse were educated by corporate consultant on the QA process to include Meeting with the Quality Assurance members on a

quarterly basis, Requirements for attendance of the Quality Assurance Members to include the Medical Director with signatures on the QA meeting minutes, identifying issues that warrant development, establish a system to monitor the corrections, implement changes when the expected outcome is not achieved, and sustaining an effective QA program, on/or before 3/5/17.

The Administrator will ensure the facility is maintaining an effect QA program with required committee members in attendance to include the medical director with documentation of signatures on the meeting minute form by reviewing and initialing the Executive committee Quarterly meeting minutes Quarterly x2. The Administrator will immediately retrain the QI nurse for any identified areas of concern.

The results of the Quarterly Quality Assurance meeting minutes will be presented during the Executive Committee Quarterly Meeting by the Administrator x 3 Quarters for review and the identification of trends, development of action plans as indicated to determine the need and/or

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DEPARTMENT OF HEALTH AND HUN	SERVICES
CENTERS FOR MEDICARE & MEDICAID	SERVICES

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		AND THE SERVICES					O. 0938-0391
CENTER	S FOR MEDICARE	& MEDICAID SERVICES	1				
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		ATE SURVEY OMPLETED
		495226	B. WING	·		0	C 2/09/2017
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CO	DE	
WAYLAN	D NURSING AND RE	HABILITATION CENTER	·	l	LUNENBURG HIGHW /SVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 520	Continued From pa	age 56	F	520			
		neeting minutes revealed that conducted on 10/19/16.					
		ature sheets for the 10/19/16 to document a signature from					
	conducted with RN nurse. When aske should attend QA r "Quarterly." When the 10/19/16 QA m the QA nurse until could recall if the p	a.m., an interview was I (registered nurse) #3, the QA ed how often the physician meetings, RN #3 stated, asked if the physician attended eeting, "RN #3 stated, "I wasn" October." When asked if she shysician attended the 10/19/16 ated, "I don't think so."	t				
	conducted with AS member) #1, the a attends quarterly 0 "All department mapharmacist, DON, physician). When was required to me ASM #1 stated yes director attended ti #1 stated, "I can't remarks at the conduction of the conductio	a.m., an interview was M (administrative staff dministrator. When asked who A meetings, ASM #1 stated, anagers, myself, the and the medical director (a asked if the medical director eet quarterly for QA meetings, s. When asked if the medical hat 10/19/16 QA meeting, ASM recall one way or the other. I licy on QA meetings was writer.					
	presented by ASM email from the forr physician who wou	p.m., a document was #1. The document was an mer medical director (the ald have attended the 10/19/16 following was documented,					

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

"Attn: (attention) (Name of Administrator), I apologize I was unable to attend the 10/19/16 QA

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Facility ID: VA0050

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DEPARTMENT OF HEALTH	AND HON SERVICES
<b>CENTERS FOR MEDICARE</b>	& MEDICAID SERVICES

PRINTED: 02/16/2017 **FORM APPROVED** 

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495226  NAME OF PROVIDER OR SUPPLIER	A. BUILDING	PLE CONSTRUCTION  G  STREET ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE SUI COMPLET C 02/09/2	ΈD
			l l	047
NAME OF PROVIDER OR SUPPLIED			<u></u>	.V1/
WAYLAND NURSING AND REHABILITATION CENTER	f	730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE CO	(X5) MPLETION DATE
F 520 Continued From page 57 meeting in person, but I have reviewed the business and reports and agree with all the recommendations present" This note was signed by the medical director on 10/26/16.  On 2/9/17 at 11:30 a.m., ASM #1, the administrator was made aware of the above concerns. A policy on QA was not presented as requested. No further information was presented prior to exit.	F 520			

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

Event ID: 6PZJ11

Facility ID: VA0050 RECEIVED

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12VAC5-371-110 B2 cross reference to F167

Infection control. 12VAC5-371-180 C7 cross reference to F441

Maintenance and housekeeping. 12VAC5-371-370A cross reference F465

Policies & procedures. 12VAC5-371-140

Based on staff interview and facility document review, it was determined that the facility staff failed to complete pre hire checks, for four of 25 employee records reviewed.

The findings include:

on/or before 3/5/17 to ensure all criminal background checks were obtained within 30 days of hire and licensure verifications obtained upon hire are in the employee files. Any identified concerns of missing items will be obtained and placed in the employee record by the payroll bookkeeper on/or before 3/25/17.

The hiring managers and rehab director was educated on 2/28/17 by the Administrator regarding state requirements for criminal background checks to be obtained within 30 days of hire and licensure verification to be obtained prior to hire date of new employees.

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

ldministrator

(X6) DATE

STATE FORM

If continuation sheet 1 of 5

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State of V	irginia							
STATEMENT OF DEFICIENCIES (X1) PRO			IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495226		B. WING		02/0	9/2017	
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STAT	TE, ZIP CODE			
WAYLAND	NURSING AND REI	HABILITATION CENTE	730 LUNEN KEYSVILLE	BURG HIGHV , VA 23947	v			
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F 001

F 001 Continued From Page 1

On February 8, 2017 at approximately 2:00 p.m., the employee records for newly hired employees within the past two years were reviewed. Review of the employee records failed to produce evidence that two of the 25 employees hired within the past two years had a Virginia State Police criminal background check within 30 days of hire and license verifications were not completed prior to hire for two of 25 employees hired within the past two years. The facility policy and procedure that was provided on entrance of the survey for hiring new employees and prevention of abuse

The employees identified were:

and neglect was referenced.

OSM (other staff member) # 4, occupational therapist registered had a hire date of 02/22/16. The Virginia State Police criminal background on file was dated 10/26/15.

OSM (other staff member) # 5, physical therapist had a hire date of 04/10/16. The Virginia State Police criminal background on file was dated 01/13/16.

OSM (other staff member) # 6, physical therapist assistant had a hire date of 09/28/15. The Virginia license verification from the Department of Health Professionals on file was dated 01/29/16. LPN (licensed practical nurse) # 7 had a hire date of 02/19/15. The license verification from the Virginia Department of Health Professionals on file was dated 10/07/16.

On 02/8/17 at approximately 3:35 p.m. an interview was conducted with OSM (other staff member) # 8, director accounts payable regarding the license verification from the Virginia Department of Health Professionals for LPN # 7. OSM # 8 stated that the license verification dated 10/07/16 was the only one she had and was

An audit will be conducted by the Payroll Bookkeeper using the New Hire QI Audit Tool prior to new hire orientation for all staff to include therapy staff and license nurses, to proof of licensure verification is present in the employee file and criminal background check is received within 30 days of hire weekly x 8 weeks then monthly x 1 month. The Administrator will immediately retrain the hiring manager and/or therapy director and obtain any missing information for any identified areas of concern during the audit. The Administrator will review and initial the New Hire QI Audit Tool weekly x 8 weeks then monthly x 1 month for completion and to ensure all identified areas of concern were addressed.

The Executive QI committee will meet monthly and review the New Hire QI Audit Tools and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.

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If continuation sheet 2 of 5

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TATEMENT OF DEFICIENCIES (X1) PROV ND PLAN OF CORRECTION IDENT
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X2) MULTIPLE	CONSTRUCTION	

(X3) DATE SURVEY COMPLETED

495226

B. WING

A. BUILDING

02/09/2017

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

#### WAYLAND NURSING AND REHABILITATION CENTE

730 LUNENBURG HIGHW KEYSVILLE, VA 23947

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETE DATE

F 001 Continued From Page 2

F 001

unable to locate the license verification for LPN # 7 at the time of hire.

On 02/9/17 at approximately 10:15 a.m. an interview was conducted with OSM (other staff member) # 3, director of rehabilitation department of (Name of Rehabilitation Company). When asked about the relationship of the rehabilitation department and the facility, OSM # 3 stated the (Name of Rehabilitation Company) was contracted with the facility and all the therapist were subcontracted with (Name of Rehabilitation Company). When asked if she was responsible for maintaining employee records and making sure they met the pre hire requirements, OSM #3 stated, "Employee contract records are kept at the corporate level. We are independent of the facility and we follow our own employee record policy." When asked about a current Virginia State Police criminal background check for OSM # 4 and OSM # 5 and the license verification from the Virginia Department of Health Professionals for OSM # 6. OSM # 3 stated the rehabilitation companies were unable to provide them.

The facility policy "Abuse, Neglect or Misappropriation of Resident Property Policy" documented, "Screening of Employees. Potential employees will be screened by the facility for abuse, neglect or misappropriation of property. This screening process will include the requesting of information from previous and/or current employers and checking with the appropriate licensing boards and/or registries."

Review of the state regulation 12VAC5-371-140 documents "E. Personnel policies and procedures shall include, but are not limited to: 3. An accurate and complete personnel record for each employee including: a. Verification of current professional license, registration, or certificate or completion of

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If continuation sheet 3 of 5

STATE FORM

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State_	of	Vir	<u>qin</u>	<u>ia</u>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE	CONSTRUCTION	
A. BUILDING		

(X3) DATE SURVEY COMPLETED

495226

B. WING

02/09/2017

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

#### WAYLAND NURSING AND REHABILITATION CENTE

730 LUNENBURG HIGHW KEYSVILLE, VA 23947

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETE DATE

F 001 Continued From Page 3

F 001

a required approved training course; b. Criminal record check."

Virginia Nursing Home Regulation 12VAC5-371-150 states that a facility must comply with the requirements of §32.1-126.01: Employment for compensation of persons convicted of certain offenses prohibited; criminal record checks required; suspension or revocation of license. "A nursing home shall, within 30 days of employment, obtain for any compensated employees an original criminal record clearance with respect to convictions for offenses specified in this section or an original criminal history record from the Central Criminal Records Exchange."

State law (§§ 32.1-126.01 and 32.1-162.9:1 Employment for compensation of persons convicted of certain offenses prohibited; criminal records check required; suspension or revocation of license.) requires that each nursing facility, home care or home health organization, and hospice obtain a criminal record background check on new hires within 30 days of employment. The law also requires that these background checks be obtained using the Central Criminal Records Exchange from the Virginia Department of State Police. See Appendix 2 for a copy of each law.

On 02/09/17 at 10:15 a.m. ASM (administrative staff member) # 1, the administrator, ASM # 2, the director of nursing, and ASM # 4, facility consultant, were made aware of the findings.

No further information was obtained prior to exit.

12VAC5-371-340. Dietary and food service program.

Cross reference to F-363, F364, and F-367

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If continuation sheet 4 of 5

State of Virginia			FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	495226	B. WING	02/09/2017

NAME OF PROVIDER OR SUPPLIER

WAYLAND NURSING AND REHABILITATION CENTE

730 LUNENBURG HIGHW

KEYSVILLE, VA 23947

(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)
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F 001

12VAC5-371-250. cross reference to F278, F309, F314

12VAC5-371-220. cross reference to F280, F309

12VAC5-371-200, cross reference to F282

F 001 Continued From Page 4

12VAC5-371-170 cross reference to F520

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