STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/1/16 through 3/3/16. Complaints were investigated during this survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey report will follow. The census in this 90 certified bed facility was 63 at the time of the survey. The survey sample consisted of 15 current resident reviews (Residents 1 through 13, #20 and #21) and 6 closed record reviews (Residents #14 through #19).	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative	F 157	**F157** Resident #14 is no longer a resident of this facility. Resident #7's physician and RP have been notified of the nose bleed by DON on 12/4/15 with documentation in the clinical record. The RP for resident # 4 was made aware of the canceled psychiatrist appointment by the hall nurse LPN on 2/22/16. Resident #4 psychiatrist's appointment was rescheduled for 3/29/16 with RP notification by MDS Coordinator/RN on 3/17/16 with documentation in the clinical record. RECEIVED APR 0 6 2016 VDH/OLC	April 15, 2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Crystal A Bowles, Admin.	Admin	3/24/16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 157	Continued From page 1 or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to ensure the physician and RP (responsible party) were notified of a change in condition for three of 21 residents in the survey sample, Resident #7, #4 and #14. 1. The facility staff failed to notify the physician and RP of Resident #7's nosebleeds on 11/26/15, 12/1/15, and failed to notify the RP of Resident #7's nosebleed on 12/2/15. 2. The facility staff failed to notify the RP when Resident #4's psychiatrist canceled an appointment and the resident was not able to be seen by the psychiatrist. 3. The facility staff failed to notify the responsible party (RP) of Resident # 14's new medication orders for Klonopin* and Effexor**. The findings include:	F 157	A 100 % audit of residents to include resident #7 and #4 progress notes, physician orders, and appointments were completed by the Corporate Nurse Consultant to ensure the RP and/or MD has been notified of any change in condition to include nose bleeds, cancelled appointments, and new medications completed on 3/17/16. The RP and/or MD was notified of any identified areas of concern during the audit by the director of nursing, Assistant Director of Nursing and/or SDC/quality improvement nurse by 3/31/16 with documentation in the medical records. The staff development coordinator initiated an in-service on 3/15/16 for 100% of licensed nursing staff, to include LPN #2 and #4 regarding timely notification of the RP and MD to include notification of changes in condition, new medications, cancelled appointments, and documentation. The social worker was in service by Administrator regarding the requirements of RP notification of cancelled psychiatrist appointments on 3/24/16. All newly hired license nurses will be in serviced regarding timely notification of the RP and MD to include notification of changes in condition, new ordered medications, cancelled appointments, and documentation by the staff facilitator during orientation. Administrative Nursing staff (ADON, SDC or Treatment Nurse) will review progress notes, scheduled appointments, and physician orders weekly x 8 weeks then monthly x 1 month to ensure the RP and/or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 157	Continued From page 2 1. The facility staff failed to notify the physician and RP of Resident #7's nosebleeds on 11/26/15, 12/1/15, and failed to notify the RP of Resident #7 ' s nosebleed on 12/2/15. Resident #7 was admitted to the facility on 3/13/14 and was readmitted on 3/16/15 with diagnoses that included but were not limited to: heart failure, anemia, liver failure, high blood pressure, colon cancer and a history of nosebleeds. Resident #7's most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 11/24/15 coded the resident as having a 15 out of 15 on the BIMS (brief interview of mental status) indicating the resident was cognitively intact to make decisions of daily living. The resident was coded as requiring assistance for all activities of daily living. Review of Resident #7's face sheet documented that the resident's daughter was the RP, power of attorney and emergency contact. Review of the resident's care plan initiated on 3/30/15 and revised on 12/2/15 did not evidence documentation regarding the resident's nose bleeds. Review of the nurse's notes on 11/26/15 at 1:15 a.m. documented, "Resident sitting in w/c (wheelchair) at sink with nose bleeding bright red blood. Large amt (amount) of blood noted in trash can. Ice pack applied to back of neck and instructed resident to pinch nostrils. Bleeding subsided in approx. (approximately) 15-20 min. (minutes)." The note did not evidence	F 157	MD has been notified of any change in condition to include nose bleeds, cancelled appointments, and new medications with documentation in the medical records utilizing a notification QI Tool. The MD and/or RP will be notified and immediate retraining will be conducted for the licensed nurse for any identified areas of concern by Administrative Nursing staff (ADON, SDC or Treatment Nurse). The DON will review and initial the QI notification Tool for compliance and to ensure all areas of concern were addressed weekly x 8 weeks then monthly X1 month. The Director of Nursing will compile the results of the QI notification tools and present to the Quality Improvement Committee Meeting monthly x 3 months. Subsequent plans of action will be developed by the Committee when required. Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 157	Continued From page 3	F 157		

documentation that the physician or RP were notified. Further review of the nurse's notes from 11/26/15 at 11:15 a.m. and 2:00 p.m. did not evidence documentation that the physician or RP was notified.

Review of the nurse's notes on 12/1/15 at 6:36 a.m. documented, "Resident rang bell for assistance with r (right) nostril bleeding. Blood was running profusely. He has a paper towel applying pressure. He said as soon as his feet hit the floor it started bleeding. No blood in bed noted. Have been applying cool rags to back of neck and forehead. Bleeding has almost stopped." The nurse's notes did not evidence any documentation that the physician or RP were notified.

Review of the nurse's notes on 12/2/15 at 10:15 p.m. documented, "Resident's call light is one (sic). Resident is sitting at sink, in his room, having a nose bleed. Nose is bleeding a large amount. Ice pack applied to back of neck and to side of nose. Resident also spitting up blood that he stated was running down his throat." Further review of the nurse's notes documented at 10:40 p.m. that the physician was notified.

Review of the nurse's notes dated 12/4/15 at 3:40 p.m. documented, "NP (nurse practitioner) aware of frequent nose bleeds. CBC* (complete blood count) orders. RP made aware of frequent nose bleeds and new order for lab (laboratory) work."

Review of Resident #7's progress notes dated and signed on 2/23/16 at 9:29 a.m. documented, "Nosebleeds were a problem in the fall believed to be due to nasal dryness or inflammation."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 157	Continued From page 4 An interview was conducted on 3/2/16 at 2:25 p.m. with ASM (administrative staff member) #2, the director of nursing. ASM #2 was asked if the physician and RP should be notified when a resident had a nosebleed. ASM #2 stated, "I would expect them to call within a reasonable hours, not to call during the middle of the night, but reasonable (length of time)." When asked what a reasonable amount of time was, ASM #2 stated, "Within 24 hours." When asked if the physician should have been notified, ASM #2 stated, "Yes." ASM #2 was made aware of the findings at that time. An interview was conducted on 3/2/16 at 4:15 p.m. with LPN (licensed practical nurse) #4, regrading physician and RP notification. LPN #4 stated, "Falls with or without injury, a change in condition, not eating, any acute episodes." When asked why they notified the family, LPN #4 stated, "To let the family know what's going on, it's a good nursing home and family relationship." When asked why they notified the physician, LPN #4 stated, "He should be aware of his resident's condition." When Resident #7 ' s notes dated 11/26/15, 12/1/15 and 12/2/15 were reviewed with LPN #4, LPN #4 stated, "I see what you're saying, he does have a history of nose bleeds. Because it was that time of night I would give report (to the next nurse) to follow up in the morning. The RP should have been called the next morning." On 3/3/16 at 11:09 a.m. ASM # 1 presented the following policy: NOTIFICATION OF CHANGES: "The facility will inform the resident; consult with the resident's physician; and if known notify the resident's legal representative or an interested family member when there is:	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 157	Continued From page 5 *An accident which results in injury and has the potential for requiring physician intervention; * A significant change in the resident's physical, mental, or psychosocial status; * The need to alter treatment or to commence a new treatment; or * A decision to transfer or discharge the resident." Review of the facility's policy titled, "NOTIFICATION OF PHYSICIAN FOR CHANGE IN RESIDENT'S CONDITION, It is the policy of the facility to notify the physician when a significant change in a resident's condition occurs with documentation contained within the medical record." No further information was provided prior to exit. In Basic Nursing, Essential for Practice, 6th edition (Potter and Perry, 2007, pages 56-59), was a reference source for physician's orders and notification. Failure to monitor the patient's condition appropriately and communicate that information to the physician or health care provider are causes of negligent acts. The best way to avoid being liable for negligence is to follow standards of care, to give competent health care, and to communicate with other health care providers. The physician or health care provider is responsible for directing the medical treatment of a patient. *A complete blood count (CBC) test measures the following: The number of red blood cells (RBC count <./003644.htm>) The number of white blood cells (WBC count <./003643.htm>). The total amount of hemoglobin <./003645.htm> in the	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 157	Continued From page 6 blood. The fraction of the blood composed of red blood cells (hematocrit <./003646.htm>). https://www.nlm.nih.gov/medlineplus/ency/article/003642.htm 2. The facility staff failed to notify the RP when Resident #4's psychiatrist canceled an appointment and the resident was not able to be seen by the psychiatrist. Resident #4 was admitted to the facility on 7/17/15 and readmitted on 1/26/16 with diagnoses that included but were not limited to: arthritis, anemia, diabetes, depression, schizophrenia* and bipolar disease**. Resident #4's most recent MDS (minimum data set), a 30 day assessment, with an ARD (assessment reference date) of 2/23/16 coded the resident's BIMS (brief interview of mental status) as a 15 out of 15 indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance with activities of daily living. In Section D -- Mood, under D0200. Resident Mood Interview the resident was coded under "B. Feeling down, depressed, or hopeless. Symptom Presence, 1 (indicating the resident felt these feelings). Under Symptom Frequency 2 (indicating the resident had these feelings 7-11 days (half or more of the days)." In Section I -- Active Diagnoses, the resident was coded as having depression, manic depression (bipolar disease) and schizophrenia. An observation was made on 3/2/16 at 11:00 a.m. of Resident #4. The resident was lying in bed and was awake and alert. The resident was receiving wound care. The resident did not engage in	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 157	Continued From page 7 conversation during this observation. An observation was made on 3/2/16 at 12:00 p.m. of the resident. The resident was sitting quietly in a chair in his room receiving medications. An observation was made on 3/2/16 at 3:00 p.m. of the resident. The resident was up in a wheelchair sitting quietly in the dayroom. A review of the nurse's notes dated and timed, 2/11/16 at 4:54 p.m. documented, "Note Text: staff reported to this writer that at approximately 4:25 (p.m.) resident stated, "I have to kill myself" writer spoke to resident and he did not state this to her, DON (director of nursing) made aware, Md (medical doctor) paged as well, writer to request something for resident (sic) depression and anxiety, resident currently on Seroquel (an antipsychotic medication*^) 50 mg (milligrams) po (by mouth) @ hs (hour of sleep), writer awaiting response from Md." A review of the clinical record documented a titled, "goDocs (the name of the facility's physician group). 2/11/16, (name of resident), DOB (date of birth), Facility (name of facility), Chief Complaint, Resident stated he is going to kill himself. Resident currently on Seroquel 50 mg PO @ HS for anxiety. May we have an order for something else please as resident is extremely depressed. MD gave verbal order to (arrow pointing up) Seroquel to 100 mg PO @ HS PRN." Further review of the nurse's notes dated and timed, 2/11/16 documented, "Md returned writers call, verbal order given to d/c (discontinue) Seroquel 50 mg po Q (every) hs PRN (as needed) and start Seroquel 100 mg po Q hs	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 157	Continued From page 8 PRN, RP (name of RP) called and made aware of new order, RP stated she wants facility to call his psychiatrist (sic) in (name of town) in the am (a.m.) and make them aware of whats (sic) going on, note to be left for DON." Review of the nurse's notes for February 2016 did not evidence further reference to the resident's suicide threat or that the resident had been seen by the psychiatrist. Review of the physician's and psychiatrist's notes from 7/15 to 3/16 did not evidence documentation that the resident was suicidal. The psychiatrist's note of 8/15 did not evidence documentation that the resident was suicidal. Review of the social worker's note for 2/23/16 at 1:56 p.m. documented, "During the residents (sic) assessment, writer asked (name of resident) if he was feeling down, or depressed. (Name of resident) answer (sic) depressed. He has an upcoming appt. (appointment) with the Psychiatrist in (name of town)." A review of the "Residents (sic) Weekly Appointments, February 22, - February 26, 2016." documented, "Tues. 2/23/16, (name of resident), TIME OF APT (appointment) 1:15 p.m., TIME LEAVING FACILITY 12:00 p.m., SPECIAL COMMENTS, (name of psychiatrist) - (name of town) - (name of transportation company)." There was a line drawn through the entry. Review of the nurse's notes for 2/23/16 did not evidence documentation that the RP had been notified that the resident was not able to be seen by the psychiatrist.	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 157	Continued From page 9 On 3/3/16 at 8:00 a.m. a typed note was left for this writer documenting, "On February 12th I called (name of doctor) office to make (name of resident) an appointment for increase in depression and verbalizing he feels like wants to die the earliest available they had was February 23rd at 1:15 p.m." It was signed and dated by OSM #6, the appointment coordinator. An interview was conducted on 3/3/16 at 8:50 a.m. with ASM (administrative staff member) #2, the director of nursing. ASM #2 was made aware of the findings at that time. On 3/3/16 at 10:30 a.m. a typed note documented, "I (name of employee) received a call on 2/22/2016 from (name of physician) stating that she could not see (name of resident) on 2/23/2016. I reported to the nurse that she needed to call (name of resident's) RP (responsible party) to let them know that the Dr. (doctor) canceled the appointment. I also called transport to let them know that we did not need them to pick up (name of resident)." This was signed by OSM (other staff member) #4, unit secretary. On 3/3/16 at 3:10 p.m. ASM #1, the administrator was made aware of the findings. No further information was provided prior to exit. According to Mosby's Basic Skills and Procedures, Fifth Edition 2003, page 11; "Making a Referral for Health Care Services; Often clients require the services of various departments within an agency or the services of a different facility	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 157	Continued From page 10 altogether. Whatever type of referral is needed, it is important that the nurse collaborate with members of other disciplines so that the client's individual needs are met *^Seroquel is an antipsychotic medication used for the treatment of schizophrenia. Drug Information Handbook for Nursing 2007 8th edition, Turkoski, Lance, Bonfiglio- Lexi-Comp Corp Hudson Ohio page 1055-1056). *Schizophrenia is a serious brain illness. People who have it may hear voices that aren't there. They may think other people are trying to hurt them. Sometimes they don't make sense when they talk. The disorder makes it hard for them to keep a job or take care of themselves. <https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=schizophrenia> **Bipolar disorder is a serious mental illness. People who have it go through unusual mood changes. They go from very happy, "up," and active to very sad and hopeless, "down," and inactive, and then back again. They often have normal moods in between. The up feeling is called mania. The down feeling is depression <https://www.nlm.nih.gov/medlineplus/depression.html>. 3. For Resident # 14 the facility staff failed to notify the responsible party (RP) of new medication orders for Klonopin* and Effexor**. Resident # 14 was admitted to the facility on 1/16/15 with diagnoses that included but not limited to hyperlipidemia, aortic aneurysm, osteoporosis, diabetes, hypothyroidism,	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 157	Continued From page 11 congestive heart failure, hypertension, and coronary artery disease. At the time of the complaint Resident # 14's MDS (minimum data set), an initial assessment, with an ARD (assessment reference date) of 1/27/15 coded the resident as being understood and able to understand others. The resident had a BIMS (Brief Interview for Mental Status) of 15 out of 15 indicating that she was cognitively intact. Review of Resident # 14's clinical record revealed a handwritten physician order [identified by ASM (Administrative Staff Member) # 1, the administrator, as being handwritten by the physician]. This order was signed and dated by the physician on 1/20/15. This order documented: "1/20/15 Clonazepam 0.5 mg (milligrams) PO (by mouth) X (times) 7 days then reduce to 0.5 mg PO q HS (every hour of sleep) X 14 days then D/C (discontinue). Report to MD (medical doctor) if insomnia or anxiety exacerbates upon discontinuation." Also, located in the clinical record was the following physician order signed by the physician on 7/28/15: "7/28/15 ...Effexor ER 37.5 mg PO q AM X 7 days, then increase to 75 mg PO q AM (anxiety)." Review of the clinical record revealed no documentation that the RP (responsible party) was notified that either of these medications was ordered. During an interview on 3/3/16 at 7:45 a.m. with LPN (Licensed Practical Nurse) # 2 notification of changes in treatment or condition was discussed. LPN # 2 stated that the RP would be notified; she further stated that since she was on the 11 to 7	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 157	Continued From page 12 shift that she would pass the information onto day shift and that they would notify the RP. When asked where she would document any notification LPN # 2 responded that it would be documented in the nurse's notes. During an interview on 3/3/16 at 8:05 a.m. with RN (Registered Nurse) # 2 notification of changes in treatment or condition was discussed. RN # 2 stated that the RP would be notified of any changes. When asked where she would document any notification RN # 2 responded that it would be documented in the nurse's notes. During an interview on 3/3/16 at 10:40 a.m. with ASM # 2, the director of nurses, notification of the RP discussed. A request for a facility policy was made and ASM # 2 stated that she did not think there was a policy for notification of the RP. On 3/3/16 at 11:00 a.m. ASM # 1 stated that the facility had no policy for the notification of the RP but did present the following facility policy: "NOTIFICATION OF PHYSICIAN FOR CHANGES IN RESIDENT'S CONDITION " documented: "It is the policy of the facility to notify the physician when a significant change in a resident's condition occurs with documentation contained within the medical record." On 3/3/16 at 11:09 a.m. ASM # 1 presented the following policy: NOTIFICATION OF CHANGES: "The facility will inform the resident; consult with the resident's physician; and if known notify the resident's legal representative or an interested family member when there is: *An accident which results in injury and has the potential for requiring physician	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 157	Continued From page 13 intervention; * A significant change in the resident's physical, mental, or psychosocial status; * The need to alter treatment or to commence a new treatment; or * A decision to transfer or discharge the resident." During an interview on 3/3/16 at 3:10 p.m. with ASM # 1, and ASM # 2, this concern was again reviewed. Nothing further was provided prior to exit. * Clonazepam --Klonopin® ... Clonazepam is used alone or in combination with other medications to control certain types of seizures. It...of extreme fear and worry about these attacks). Clonazepam is in a class of medications called benzodiazepines. ... https://www.nlm.nih.gov/medlineplus/druginfo/meds/a682279.html - **Effexor® ... Effexor® XR ... Venlafaxine is used to treat depression. Venlafaxine extended-release (long-acting) capsules are also used to treat generalized anxiety disorder (GAD; excessive worrying that is difficult to control), ... https://www.nlm.nih.gov/medlineplus/druginfo/meds/a694020.html	F 157		
F 225 SS=D	COMPLAINT DEFICIENCY 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 225	Continued From page 14 had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, facility document review, and review of a Facility Reported Incident (FRI), it was determined that the facility staff failed to immediately report an	F 225	**F225** March 30, 2016 Resident #19 is no longer a resident of this facility. CNA #8 and CNA #9 is no longer an employee of the facility. The allegation of abuse was reported to the Department of Health Professions, Enforcement Division on March 7, 2016 by the Administrator. All other allegations/investigations of abuse for the past year have been audited by the Administrator and reviewed by the Corporate Nursing Consultant to ensure appropriate reporting was made to all required agencies on March 16, 2016. Resident abuse interviews were conducted will all alert and oriented residents on 3/17/16-3/21/16 by the Social Worker and MDS Coordinator/RN to ensure that all allegations of abuse have been reported to the Administrator and addressed. All facility department managers (including maintenance, MDS, Activities, AP/Payroll, DON, Therapy Director, Medical Records, Housekeeping/Laundry Supervisor, Admissions/Social worker, AR bookkeeper, Supply Clerk, SDC, Dietary Manager) to include the Administrator and Director of Nursing were re-educated on the requirement of reporting to regulatory agencies by the Corporate Nursing Consultant on March 9, 2016. All facility staff to include CNAs, license nurses, dietary department, housekeeping department, and therapy department were	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 225	Continued From page 15 allegation of abuse to the administrator and to other officials in accordance with State law through established procedures (including to the State survey and certification agency) for 1 of 21 residents in the survey sample; Resident #19. On 6/18/15 CNA (certified nursing assistant) #9 witnessed staff member (CNA #8) being verbally abusive, and threatened physical abuse, of Resident #19. CNA #9 did not immediately report this allegation of abuse to the administrator; the allegation was not reported to the administrator and state agency until 6/29/15. The allegation of abuse by CNA #8 and findings were not reported to the department of health professionals. The findings include: Resident #19 was admitted to the facility on 1/2/14 and discharged on 7/3/15, with the diagnoses of but not limited to hip fracture, high blood pressure, diabetes, anxiety, depression, and dementia. The most recent MDS (Minimum Data Set) prior to discharge was a quarterly assessment with an ARD (Assessment Reference Date) of 6/21/15. The resident was coded as being severely cognitively impaired in ability to make daily life decisions. The resident was coded as being total care for bathing; extensive assistance for hygiene, transfers, dressing, and toileting; limited assistance for eating; and was incontinent of bowel and bladder. The review of a FRI dated 6/29/15 for an incident that occurred on 6/18/15, was conducted. This FRI documented that "Employee reported today 6/29/15 that during her first day of work on the floor as an orientee (CNA #9) on 6/18/15 that she witnessed staff member (CNA #8) to tell resident	F 225	inserviced regarding the policy of immediately reporting allegations of abuse to their supervisor, DON, and Administrator by Administrator on or before 3/30/16. All newly hired CNAs, license nurses, dietary department, housekeeping department, and therapy department will be inserviced on the policy of immediately reporting allegations of abuse to their supervisor, DON, and Administrator during orientation by the staff development coordinator or department manager. Social Worker or Administrative Nurse (DON/ADON/SDC/MDS Nurses) will conduct resident interviews weekly x 8 weeks then monthly x 1 month to ensure all allegations of abuse have been reported timely and addressed utilizing the resident abuse interview QI Tool. The Administrator will review and initial the resident abuse interview tool for compliance and to ensure all areas of concern were addressed weekly x 8 weeks then monthly X1 month. The Corporate Nurse Consultant will review and initial all Facility reported incidents monthly x 3 months to ensure all allegations of abuse were reported timely to the Administrator and reported to the appropriate agency using the Abuse Reporting Monitoring Tool.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 225	Continued From page 16 to shut up and put her hand over his mouth. She then stated if he "didn't stop she would pop him up side of his head." Employee action initiated: "alleged perpetrator permitted to give statement; drug tested and suspended pending investigation completion...." In the box for notifying interested parties, next to "DHP" (Department of Health Professionals) was documented, "dependent upon investigation results." The follow up report to this FRI, undated, but contained a fax receipt indicating a date of 7/3/15, documented, under "Employee action initiated or taken" that "alleged perpetrator (CNA #8) was permitted to give a statement was drug tested and suspended pending investigation. (CNA #9) was permitted to give a statement, was drug tested and suspended for delayed reporting, failure to follow abuse policy. Employee (CNA #8) was terminated as a result of the investigation...." Under "Investigation Summary" was documented, "Resident (#19) is demented and unable to state if alleged incident occurred, he does report, "you know when people don't like you." No other resident reported concerns of (CNA #8); however (CNA #9) had no prior interactions with employee and no reason to make a false report. Unable to substantiate that exact allegation occurred but not able to prove staff member didn't have inappropriate interaction with resident. Employee (CNA #8) terminated." CNA #8 was drug tested. Results of the drug test, dated 7/10/15, documented that CNA #8 tested positive for illegal drugs. In addition, other statements obtained during the	F 225	The Administrator will compile the results of the resident abuse interview tools and the Abuse Monitoring tools present to the Quality Improvement Committee Meeting monthly x 3 months. Subsequent plans of action will be developed by the Committee when required. Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 225	Continued From page 17	F 225		

investigation revealed one staff member documented, regarding CNA #8, "she has an attitude with the residents, and talking to them any kind of way. She's rude." A second staff member statement documented, "She has (an) attitude."

The written statement by CNA #9 dated 6/29/15, documented, "I saw (CNA #8) put her hand over (Resident #19) mouth and told him to shut up. She also told him if he didn't she would pop him upside of his head. This took place on 6/18/15. This was my first day of orientation. I was scared to report it. However, I know I needed to and met with (Administrator) as soon as I could after.

A documented interview with CNA #9, (undated and unsigned) documented, "How did you respond to this incident? I did not say anything. I just dropped my jaw." "What was resident's response? He told her she can't do that." "Did she smack him? No, but she raised her hand." "What time did this happen? Right at bed time. Around 8 or 8:30." "Why did you wait so long to report? I was worried that I'd get in trouble for reporting. That because she has been here longer that I may get fired." "How long have you known (CNA #8)? I met her the day I walked through the door on 6/18 (2015)." "Have you had any other concerns about her interactions with residents? I'm just worried that her anger or attitude may affect the care residents get. I don't want her to hit a resident."

A written statement dated 6/29/15 from CNA #8, the alleged perpetrator, documented, "(Resident #19) refuses his care sometimes, he fights don't want to pull of clothes at bedtime, not wanting to go to bedtime. I get a little firm with my voice

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 225	Continued From page 18 saying look (Resident #19) you got to put on your gown. But then he give in and let me do what I got to do then he would tell me he feel so much better. When he cries I would ask him whats [sic] wrong but he just keep crying. He never say whats [sic] wrong he just mumbles, he makes whimper noise. I have need {sic} touch (Resident #19) in anyway no more than taking care of him, I have need {sic} yelled at (Resident #19)." Further review of the FRI failed to reveal any evidence that the allegation of abuse was reported to the state board of nursing following the termination of CNA #8 for observed verbal, threatened physical abuse of Resident #19, for CNA #8's termination for "inappropriate interaction" with Resident #19. On 3/2/16 at 3:26 p.m., in an interview with the Administrator (ACS #1 - Administrative/Corporate Staff), she stated that because the resident had dementia and was unable to corroborate the allegation, she was unable to substantiate that abuse had occurred. She stated the facility "decided that we were unaware if (CNA #9) may have previously known (CNA #8) and may make a false report." This was not documented anywhere in the investigation. The investigation specifically documented that CNA #9 "had no prior interactions with employee and no reason to make a false report" and per CNA #9's own written statement, was documented, "How long have you known (CNA #8)? I met her the day I walked through the door on 6/18 (2015)" (which was the alleged date of the incident.) An interview was conducted on 3/2/16 at 7:05 a.m. with LPN #2. When asked what she would do if she witnessed resident abuse LPN #2 stated	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 225	Continued From page 19 that she would remove the resident from the situation, ensure that the resident was safe and report it to her supervisor. On 3/2/16 at approximately 2:00 p.m., interviews were conducted with LPN (licensed practical nurse) #1 and CNA #1 and #2 regarding resident abuse. All staff stated that allegations of abuse should be reported immediately after making sure the resident is safe, and document the incident. A review of the employee file for CNA #8 revealed that on 10/23/14, she signed a copy of "Federal Bill of Rights for Nursing Facility Residents" which documented, "If you are a nursing facility resident, it is your right by federal and state law:....To be free from mental, verbal, sexual, or physical abuse, and physical punishment." The employee record also contained a signed statement, signed on 10/23/14, for "Resident Abuse / Neglect Policy" which documented, "Verbal, sexual, mental, or physical abuse, neglect, or mistreatment of residents to include involuntary seclusion or corporal punishment, and/or misappropriation of residents' property by staff will not be tolerated. It is every employee's responsibility to immediately report any incident of resident abuse or suspected resident abuse to his or her supervisor. The supervisor and/or employee must then report immediately to the Administrator. If the immediate supervisor is the alleged perpetrator, the report is to be made to the Administrator or Director of Nursing. Any employee who fails to immediately report suspected mistreatment, abuse including injuries of unknown sources, neglect, and/or misappropriation of property of a resident will face disciplinary action up to and including termination	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 225	Continued From page 20 of employment...." A review of the "Nursing Assistant" job description contained in the employee record and signed on 10/23/14 by CNA #8 documented, "Major duties and responsibilities:....37) report any resident abuse immediately to the licensed nurse (i.e. harsh/abusive language, unnecessary roughness, etc.)" A review of the facility policy, "Abuse, Neglect, or Misappropriation of Resident Property" documented, "The facility believes that our residents have the right to be free from abuse, neglect, involuntary seclusion, or misappropriation of property. The facility will do whatever is in its control to prevent mistreatment, neglect, and abuse of our residents or misappropriation of their property. Any employee who witnesses or suspects that abuse, neglect, or misappropriation of property has occurred will immediately report the alleged incident to their supervisor, who will immediately report the incident to the Administrator. Failure to report any concern related to neglect, abuse, or misappropriation of property will result in disciplinary action and possible termination of employment. The Administrator is responsible to ensure that complaints of abuse, neglect, or misappropriation of property and injuries of unknown origin are investigated. Measures will be initiated to prevent any further potential abuse while the investigation is in progress. The Administrator is responsible to review the results of the investigation and report the alleged incident to the appropriate agencies in accordance with state and federal regulations. The facility will not employ individuals that have been found guilty of abusing, neglecting, or mistreating residents by a	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 225	Continued From page 21 court of law or who have had a finding entered into this state's Nurse Aide Registry concerning abuse, neglect, or misappropriation of their property. The facility will report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to this state's Nurse Aide Registry or licensing boards and/or registries.....Reporting/Response: The Administrator is responsible to ensure that incidents, as indicated, are reported to the appropriate local / state / federal agencies, including the state Nurse Aide Registry. On 3/3/16 at 3:10 p.m., during the end of day meeting, the Administrator (ACS #1) and the Director of Nursing (ACS #2) were made aware of the findings. No further information was provided by the end of the survey.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, facility document review, and review of a Facility Reported Incident (FRI), it was determined that the facility staff failed to implement policies for the reporting of an allegation of abuse in accordance with established procedures and state laws to all	F 226	**F226** : March 30, 2016 Resident #19 is no longer a resident of this facility. CNA #8 and CNA #9 is no longer an employee of the facility. The allegation of abuse was reported to the Department of Health Professions, Enforcement Division on March 7, 2016 by the Administrator. All other allegations/investigations of abuse for the past year have been audited by the Administrator and reviewed by the Corporate Nursing Consultant to ensure appropriate reporting was made to all required agencies on March 16, 2016. Resident abuse interviews were conducted will all alert and oriented residents on March 17 & 21, 2016 by Social Worker and MDS Coordinator/RN to ensure that all allegations of abuse have been reported to the Administrator and addressed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 226	Continued From page 22 the required state agencies for 1 of 21 residents in the survey sample; Resident #19. On 6/18/15 CNA (certified nursing assistant) #9 witnessed staff member (CNA #8) being verbally abusive, and threatened physical abuse, of Resident #19. CNA #9 did not immediately report this allegation of abuse to the administrator; the allegation was not reported to the administrator and state agency until 6/29/16. CNA #8 was terminated as a result of the investigation. The allegation and findings were not reported to the state board of nursing. The findings include: Resident #19 was admitted to the facility on 1/2/14 and discharged on 7/3/15, with the diagnoses of but not limited to hip fracture, high blood pressure, diabetes, anxiety, depression, and dementia. The most recent MDS (Minimum Data Set) prior to discharge was a quarterly assessment with an ARD (Assessment Reference Date) of 6/21/15. The resident was coded as being severely cognitively impaired in ability to make daily life decisions. The resident was coded as being total care for bathing; extensive assistance for hygiene, transfers, dressing, and toileting; limited assistance for eating; and was incontinent of bowel and bladder. The review of a FRI dated 6/29/15 was conducted. This FRI documented that "Employee reported today 6/29/15 that during her first day of work on the floor as an orientee (CNA #9) on 6/18/15 that she witnessed staff member (CNA #8) to tell resident to shut up and put her hand over his mouth. She then stated if he "didn't stop she would pop him up side of his head."	F 226	All facility department managers (including maintenance, MDS, Activities, AP/Payroll, DON, Therapy Director, Medical Records, Housekeeping/Laundry Supervisor, Admissions/Social worker, AR bookkeeper, Supply Clerk, SDC, Dietary Manager) to include the Administrator and Director of Nursing were re-educated on the requirement of reporting to regulatory agencies by the Corporate Nursing Consultant on March 16, 2016. All facility staff to include CNAs, license nurses, dietary department, housekeeping department, and therapy department were in-serviced regarding the policy of immediately reporting allegations of abuse to their supervisor, DON, and Administrator by Administrator on or before March 30, 2016. All newly hired CNAs, license nurses, dietary department, housekeeping department, and therapy department will be in serviced on the policy of immediately reporting allegations of abuse to their supervisor, DON, and Administrator during orientation by the staff development coordinator or department manager.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 226	Continued From page 23 Employee action initiated: "alleged perpetrator permitted to give statement, drug tested and suspended pending investigation completion...." In the box for notifying interested parties, next to "DHP" (Department of Health Professionals) was documented, "dependent upon investigation results." The follow up report to this FRI documented, under "Employee action initiated or taken" that "alleged perpetrator (CNA #8) was permitted to give a statement, was drug tested and suspended pending investigation. (CNA #9) was permitted to give a statement, was drug tested and suspended for delayed reporting, failure to follow abuse policy. Employee (CNA #8) was terminated as a result of the investigation...." Under "Investigation Summary" was documented, "Resident (#19) is demented and unable to state if alleged incident occurred, he does report, "you know when people don't like you." No other resident reported concerns of (CNA #8); however (CNA #9) had no prior interactions with employee and no reason to make a false report. Unable to substantiate that exact allegation occurred but not able to prove staff member didn't have inappropriate interaction with resident. Employee (CNA #8) terminated." CNA #8 was drug tested. Results of the drug test, dated 7/10/15, documented that CNA #8 tested positive for illegal drugs. In addition, other statements obtained during the investigation revealed one staff member documented, regarding CNA #8, "she has an attitude with the residents, and talking to them any kind of way. She's rude." A second staff	F 226	Social Worker or Administrative Nurse (DON/ADON/SDC/MDS Nurses) will conduct resident interviews weekly x 8 weeks then monthly x 1 month to ensure all allegations of abuse have been reported timely and addressed utilizing the resident abuse interview QI Tool. The Administrator will review and initial the resident abuse interview tool for compliance and to ensure all areas of concern were addressed weekly x 8 weeks then monthly X1 month. The Corporate Nurse Consultant will review and initial all Facility reported incidents monthly x 3 months to ensure all allegations of abuse were reported timely to the Administrator and reported to the appropriate agency using the Abuse Reporting Monitoring Tool. The Administrator will compile the results of the resident abuse interview tools and the Abuse Monitoring tools present to the Quality Improvement Committee Meeting monthly x 3 months. Subsequent plans of action will be developed by the Committee when required. Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 226	Continued From page 24 member statement documented, "She has (an) attitude." The written statement by CNA #9 dated 6/29/15, documented, "I saw (CNA #8) put her hand over (Resident #19) mouth and told him to shut up. She also told him if he didn't she would pop him upside of his head. This took place on 6/18/15. This was my first day of orientation. I was scared to report it. However, I know I needed to and met with (Administrator) as soon as I could after. A documented interview with CNA #9, (undated and unsigned) documented, "How did you respond to this incident? I did not say anything. I just dropped my jaw." "What was resident's response? He told her she can't do that." "Did she smack him? No, but she raised her hand." "What time did this happen? Right at bed time. Around 8 or 8:30." "Why did you wait so long to report? I was worried that I'd get in trouble for reporting. That because she has been here longer that I may get fired." "How long have you known (CNA #8)? I met her the day I walked through the door on 6/18 (2015)." "Have you had any other concerns about her interactions with residents? I'm just worried that her anger or attitude may affect the care residents get. I don't want her to hit a resident." A written statement dated 6/29/15 from CNA #8, the alleged perpetrator, documented, "(Resident #19) refuses his care sometimes, he fights don't want to pull of clothes at bedtime, not wanting to go to bedtime. I get a little firm with my voice saying look (Resident #19) you got to put on your gown. But then he give in and let me do what I got to do then he would tell me he feel so much better. When he cries I would ask him whats [sic]	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 226	Continued From page 25	F 226		

wrong but he just keep crying. He never say whats [sic] wrong he just mumbles, he makes whimper noise. I have need {sic} touch (Resident #19) in anyway no more than taking care of him, I have need {sic} yelled at (Resident #19)."

Further review of the FRI failed to reveal any evidence that the allegation of abuse was reported to the state board of nursing following the termination of CNA #8 for observed verbal, threatened physical abuse of Resident #19, for CNA #8's termination for "inappropriate interaction" with Resident #19, and for testing positive for illegal drugs.

On 3/2/16 at 3:26 p.m., in an interview with the Administrator (ASM #1 - administrative staff member), she stated that because the resident had dementia and was unable to corroborate the allegation, she was unable to substantiate that abuse had occurred. She stated the facility "decided that we were unaware if (CNA #9) may have previously known (CNA #8) and may make a false report." This was not documented anywhere in the investigation. The investigation specifically documented that CNA #9 "had no prior interactions with employee and no reason to make a false report" and per CNA #9's own written statement, was documented, "How long have you known (CNA #8)? I met her the day I walked through the door on 6/18 (2015)" (which was the alleged date of the incident.)

An interview was conducted on 3/2/16 at 7:05 a.m. with LPN #2. When asked what she would do if she witnessed resident abuse LPN #2 stated that she would remove the resident from the situation, ensure that the resident was safe and report it to her supervisor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 226	Continued From page 26 On 3/2/16 at approximately 2:00 p.m., interviews were conducted with LPN (licensed practical nurse) #1 and CNA #1 and #2 regarding resident abuse. All staff stated that allegations of abuse should be reported immediately after making sure the resident is safe, and document the incident A review of the employee file for CNA #8 revealed that on 10/23/14, she signed a copy of "Federal Bill of Rights for Nursing Facility Residents" which documented, "If you are a nursing facility resident, it is your right by federal and state law:....To be free from mental, verbal, sexual, or physical abuse, and physical punishment." The employee record also contained a signed statement, signed on 10/23/14, for "Resident Abuse / Neglect Policy" which documented, "Verbal, sexual, mental, or physical abuse, neglect, or mistreatment of residents to include involuntary seclusion or corporal punishment, and/or misappropriation of residents' property by staff will not be tolerated. It is every employee's responsibility to immediately report any incident of resident abuse or suspected resident abuse to his or her supervisor. The supervisor and/or employee must then report immediately to the Administrator. If the immediate supervisor is the alleged perpetrator, the report is to be made to the Administrator or Director of Nursing. Any employee who fails to immediately report suspected mistreatment, abuse including injuries of unknown sources, neglect, and/or misappropriation of property of a resident will face disciplinary action up to and including termination of employment...." A review of the "Nursing Assistant" job description	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 226	Continued From page 27 contained in the employee record and signed on 10/23/14 by CNA #8 documented, "Major duties and responsibilities:....37) report any resident abuse immediately to the licensed nurse (i.e. harsh/abusive language, unnecessary roughness, etc.)" A review of the facility policy, "Abuse, Neglect, or Misappropriation of Resident Property" documented, "The facility believes that our residents have the right to be free from abuse, neglect, involuntary seclusion, or misappropriation of property. The facility will do whatever is in its control to prevent mistreatment, neglect, and abuse of our residents or misappropriation of their property. Any employee who witnesses or suspects that abuse, neglect, or misappropriation of property has occurred will immediately report the alleged incident to their supervisor, who will immediately report the incident to the Administrator. Failure to report any concern related to neglect, abuse, or misappropriation of property will result in disciplinary action and possible termination of employment. The Administrator is responsible to ensure that complaints of abuse, neglect, or misappropriation of property and injuries of unknown origin are investigated. Measures will be initiated to prevent any further potential abuse while the investigation is in progress. The Administrator is responsible to review the results of the investigation and report the alleged incident to the appropriate agencies in accordance with state and federal regulations. The facility will not employ individuals that have been found guilty of abusing, neglecting, or mistreating residents by a court of law or who have had a finding entered into this state's Nurse Aide Registry concerning abuse, neglect, or misappropriation of their	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 226	Continued From page 28 property. The facility will report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to this state's Nurse Aide Registry or licensing boards and/or registries.....Reporting/Response: The Administrator is responsible to ensure that incidents, as indicated, are reported to the appropriate local / state / federal agencies, including the state Nurse Aide Registry. On 3/3/16 at 3:10 p.m., during the end of day meeting, the Administrator (ASM [administrative staff member] #1) and the Director of Nursing (ASM #2) were made aware of the findings. No further information was provided by the end of the survey.	F 226		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is	F 278	**F278** : April 15, 2016 MDS for resident #9 was corrected and a corrected MDS was submitted to the state on March 23, 2016 by the MDS Coordinator. A 100% audit of all resident's most recent MDS and most recent comprehensive MDS, including resident #9 was conducted by Administrator or Administrative nurse (DON, ADON, or SDC) to ensure accuracy of coding to include section C(cognition) and section F (preferences for customary routine and activities). Any deficient records identified were corrected with modifications or significant correction of the prior assessment by the MDS Coordinator, Social Worker, Dietary Manager, and Activities Director as indicated by RAI Manual by April 15, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 278	Continued From page 29 subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review it was determined that the facility staff failed to ensure a complete and accurate MDS (minimum data set) assessment for 1 of 21 residents in the survey sample; Resident #9. The facility staff failed to accurately code Section C Cognition and Section F Preferences for Customary Routine and Activities, on Resident #9's 10/6/15 significant change MDS assessment and the 1/6/16 quarterly MDS assessment. The findings include: Resident #9 was admitted to the facility on 9/23/15 with the diagnoses of but not limited to seizures, Huntington's, psychosis, dysphagia, and liver disease. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 1/6/16. The resident was coded as being severely cognitively impaired in ability to make daily life decisions. The resident	F 278	The interdisciplinary care plan team members (Dietary manager, MDS Coordinator, Social Services Director and Activities Director) have been re-educated on the RAI manual for accurately coding and completing the MDS and assessment of residents by the Corporate MDS Consultant on March 10 & 24, 2016. The Director of Nursing, Assistant Director of Nursing and/or SDC will review resident's current scheduled MDS assessments to include for resident # 9 weekly x 8 weeks then monthly x 1 month to ensure that all areas on the MDS are coded accurately to include sections C cognition and section F Preferences utilizing a MDS Monitoring QI Tool. All identified areas of concern will be addressed immediately by the MDS Nurse. The Administrator will review and initial the MDS Monitoring QI Tool weekly x 8 weeks then monthly x 1 month for compliance and to ensure all identified areas of concern were corrected. The Administrator will compile the results of the MDS Monitoring QI Tools and present to the Quality Improvement Committee Meeting monthly x 3 months. Subsequent plans of action will be developed by the Committee when required. Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 278	Continued From page 30 was coded as requiring total care for all areas of activities of daily living; and was incontinent of bowel and bladder. A review of the significant change MDS dated 10/6/15, revealed that the resident was coded in Section B "Hearing, Speech, and Vision" as usually able to make himself understood (Section B-0700). This section was coded as a "1" (0 - Understood / Understands; 1 - Usually understood / Usually understands; 2 - Sometimes understood / sometimes understands; 3 - rarely/never understood / rarely/never understands). In Section C "Cognition" was documented, "C0100 Should Brief Interview for Mental Status be Conducted? Attempt to conduct interview with all residents." This section contained a box in which to code if the resident should be interviewed or not by coding "0. No (resident is rarely/never understood) - skip to and complete C0700 - C1000, Staff Assessment for Mental Status" or "1. Yes - Continue to C0200, Repetition of Three Words." The resident was coded as "0" rarely/never understood which was in contrast to what was coded in Section B (above). The interview was not attempted. Section C for the resident interview was not attempted. All boxes were blank. The staff assessment was completed instead. However, in Section "C0600 Should the Staff Assessment for Mental Status be Conducted?" there was a box to mark whether or not the staff assessment should be completed, by coding "0. No (resident was able to complete interview) - Skip to C1300, Signs and Symptoms of Delirium" or "1. Yes (resident was unable to complete interview) - Continue to C0700, Short-term Memory OK" the box was left empty	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 278	Continued From page 31	F 278		

and neither scenario was coded. In addition, Section C0700 for Short-term Memory OK and C0800 for Long-term Memory OK were both dashed (-) out as being not assessed.

Also on this MDS assessment, for Section F Preferences for Customary Routine and Activities was documented, "F0300. Should Interview for Daily and Activity Preferences be Conducted? - Attempt to interview all residents able to communicate. If resident is unable to complete, attempt to complete interview with family member or significant other." This section contained a box for coding "0. No (resident is rarely/never understood and family/significant other not available) - Skip to and complete F0800, Staff Assessment of Daily and Activity Preferences." or "1. Yes - Continue to F0400, Interview for Daily Preferences." The box was coded with a "1". However, all the boxes in the section for the questions relating to preferences were all dashed out as not assessed. The staff assessment was completed instead.

Also noted on the quarterly MDS dated 1/6/16, in Section B the resident was coded as a "2" in B0700 and the Cognition interview was attempted but the resident was unable to complete it. The staff assessment was completed instead. However, for Section C0700 "Short-term Memory OK" was dashed out as not being assessed.

On 3/2/16 at 12:40 p.m., the Social Worker (OSM, Other Staff Member #1) was interviewed. She stated she could not recall why she coded these MDS assessments this way (Section C) but that it was incorrect.

On 3/2/16 at 12:48 p.m., an interview was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 278	Continued From page 32 conducted with the Activities Director (OSM #2). She stated that at the time of the October 6, 2015 MDS, it was one of her first MDS assessments and she coded it wrong. She stated she had since been educated on how to code them. According to the RAI manual, Version 3.0, July 2010, page C-3, "When cognitive impairment is incorrectly diagnosed or missed, appropriate communication, worthwhile activities and therapies may not be offered." According to the CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) MDS 3.0 Manual, page 3-2 documents, "The CMS Long-Term Care Facility Resident Assessment Instrument User's Manual is the primary source of information for completing an MDS assessment." Section C of the RAI Users Manual documents the following information on page C-1: "Most residents are able to attempt the Brief Interview for Mental Status. A structured cognitive test is more accurate and reliable than observation alone for observing cognitive performance." Page C-3 documents, "Direct or performance based testing of cognitive function decreases the chance of incorrect labeling of cognitive ability and improves detection of delirium." CMS's RAI (Centers for Medicaid and Medicare Services Resident Assessment Instrument) Version 3.0 Manual CH 3: MDS Items [C] states: "C0200-C0500: Brief Interview for Mental Status (BIMS)... Steps for Assessment 1. Determine if the resident is rarely/never understood verbally or in writing. If rarely/never	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 278	Continued From page 33 understood, skip to C0700 - C1000, Staff Assessment of Mental Status... Coding Instructions · Record whether the cognitive interview should be attempted with the resident. · Code 0, no: if the interview should not be attempted because the resident is rarely/never understood or an interpreter is needed but not available. Skip to C0700, Staff Assessment of Mental Status. · Code 1, yes: if the interview should be attempted because the resident is at least sometimes understood verbally or in writing, and if an interpreter is needed, one is available. Coding Tips... · Nonsensical responses should be coded as zero. · Rules for stopping the interview before it is complete: - Stop the interview after completing (C0300C) "Day of the Week" if: · all responses have been nonsensical (i.e., any response that is unrelated, incomprehensible, or incoherent; not informative with respect to the item being rated), OR · there has been no verbal or written response to any of the questions up to this point, OR · there has been no verbal or written response to some questions up to this point and for all others, the resident has given a nonsensical response. - If the interview is stopped, do the following: · Code -, dash in C0400A, C0400B, and C0400C. · Code 99 in the summary score in C0500. · Code 1, yes in C0600 Should the Staff Assessment for Mental Status (C0700-C1000) be Conducted? · Complete the Staff Assessment for Mental	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 278	Continued From page 34 Status..." According to the CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) MDS 3.0 Manual, Section F of the RAI Users Manual documents the following on page F-1 through F-3: "Obtaining information about preferences directly from the resident....is the most reliable and accurate way of identifying preferences....Quality of life can be greatly enhanced when care respects the resident's choice regarding anything that is important to the resident. Interviews allow the resident's voice to be reflected in the care plan.....A lack of attention to lifestyle preferences can contribute to depressed mood and increased behavior symptoms." On 3/2/16 at 5:59 p.m., during the end of day meeting, the Administrator (ASM [administrative staff member] #1) and the Director of Nursing (ASM #2) were made aware of the findings. When asked about a policy, the Administrator stated the facility uses the RAI manual. No further information was provided by the end of the survey.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's	F 279	F279 Resident #2 care plan was updated on March 2, 2016 to reflect dental by MDS Coordinator/RN. Resident #6 care plan was updated on March 1, 2016 to reflect pain by MDS Coordinator/RN. A comprehensive care plan was developed for resident # 5 to reflect mastectomy and any restrictions related to the mastectomy on March 3, 2016 by MDS Coordinator/RN.	March 30, 2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 279	Continued From page 35 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to develop a comprehensive care plan for 3 of 21 residents in the survey sample; Residents #2, #6, and #5. 1. The facility staff failed to care plan CAA triggered areas (Dental) from Resident #2's 10/5/15 annual comprehensive MDS. 2. The facility staff failed to care plan CAA triggered areas (Pain) from Resident #6's 6/26/15 admission MDS. 3. The facility staff failed to develop a comprehensive care plan to address Resident #5's mastectomy and any restrictions related to the mastectomy. The findings include:	F 279	A 100% audit of all care plans was conducted by the Administrator, including care plans for residents #2, #5, and #6 to ensure that all triggered CAA items are addressed on the care plan on or before March 30. 2016. Any deficient care plans were updated utilizing the CAA's from last comprehensive assessment and progress notes, to ensure that the care plans address the resident's individual needs by the MDS Coordinator/RN on or before March 30, 2016. The interdisciplinary care plan team members (Dietary manager, MDS Coordinator, Social Services Director and Activities Director) have been re-educated on the requirements for completing a comprehensive care plan for each resident and ensuring that all triggered CAA items are care planned by RAI Reimbursement Auditor by March 23, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 279	Continued From page 36 1. The facility staff failed to care plan CAA triggered areas (Dental) from Resident #2's 10/5/15 annual comprehensive MDS. Resident #2 was most recently readmitted to the facility on 2/12/16 with the diagnoses of but not limited to gastrointestinal bleed, cataracts, osteoporosis, stroke, pain, contractures, high blood pressure, hemiplegia, bladder dysfunction, obesity, apnea and diabetes. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 1/5/16. The resident was coded as being moderately impaired in ability to make daily life decisions. The resident was coded as requiring total care for all areas of activities of daily living; and was incontinent of bowel and bladder. A review of the clinical record revealed the most recent comprehensive MDS was an annual MDS with an ARD of 10/5/15. Under Section V (the CAA Summary section), "Cognitive Loss/Dementia", "Visual Function", "Urinary Incontinence and Indwelling Catheter", "Mood State", "Falls", "Nutritional Status", "Dental Care", and "Pressure Ulcer", was documented as being a triggered area as evidenced by an "X" in the box for column "A - Care Area Triggered." Under column B "Care Planning Decision" each of these items were checked as being care planned." Further review of the clinical record revealed the care plan. Review of the care plan failed to reveal any evidence of the triggered area of dental being care planned. {Note: On resident's MDS of 10/5/15, Section L "Oral/Dental Status", resident was coded with an "x" in the box next to	F 279	An audit will be completed of 10% of care plans to include care plans for resident #2, #5, and #6 weekly x 8 weeks then monthly x 1 month by Director of Nursing and/or Assistant Director of Nursing to ensure all triggered areas of the CAAs are care planed, comprehensive care plans have been developed accordingly, and that the care plans accurately reflects the resident utilizing the QI Care Plan Audit Tool. The care plan will be updated immediately by the MDS Coordinator for any identified areas of concern. The Administrator will review and initial the QI Care Plan Audit Tool weekly x 8 weeks then monthly x 1 month for compliance and to ensure all areas of concern have been addressed. The Administrator will compile the results of the QI Care Plan Audit Tool and present to the Quality Improvement Committee Meeting monthly x 3 months. Subsequent plans of action will be developed by the Committee when required. Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 279	Continued From page 37 "B. No natural teeth or tooth fragment(s) (edentulous)."} On 3/2/16 at 10:50 a.m., in an interview with RN #1 (Registered Nurse #1, the MDS nurse), she stated it was not care planned. She stated she "could not find it but made one now." A review of the facility policy, "Resident Care Plans" documented, "It is the policy of the facility to provide an interdisciplinary written care plan based on the physician's orders and the assessment of the resident needs. Development and implementation of the care plan will occur by participating disciplines available in the facility at a team conference under the direction of the RN Coordinator. Development of an interdisciplinary plan will occur after completion of a comprehensive assessment by each discipline....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 general health status...." On 3/2/16 at 5:59 p.m., during the end of day meeting, the Administrator (ASM [administrative staff member] #1) and the Director of Nursing (ASM #2) were made aware of the findings. No further information was provided by the end of the survey. The following is taken from Section V of the MDS-Version 3.0: "Section V: Care Area Assessment: V0200. CAAs and Care Planning 1. Check column A if Care Area is triggered. 2. For each triggered Care Area, indicate	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 279	Continued From page 38 whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. The Addressed Care Plan column must be completed within 7 days of completing the RAI [MDS and CAA(s)]. Check column B if the triggered care area is addressed in the care plan." 2. The facility staff failed to care plan CAA triggered areas (Pain) from Resident #6's 6/26/15 admission MDS. Resident #6 was admitted on 6/19/15 with the diagnoses of but not limited to cataracts, gout, depression, pulmonary embolism, heart disease, high blood pressure, and chronic obstructive pulmonary disease. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 12/26/15. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident required total care for bathing; extensive assistance for transfers, dressing, and hygiene; supervision for eating; and was incontinent of bowel and bladder. A review of the clinical record revealed the most recent comprehensive MDS was an admission MDS assessment with an ARD of 6/26/15. Under Section V (the CAA Summary section), "ADL Functional/Rehabilitation Potential", "Urinary Incontinence and Indwelling Catheter", "Falls", "Nutritional Status", "Pressure Ulcer", "Psychotropic Drug Use", and "Pain" was documented as being a triggered area as evidenced by an "X" in the box for column "A -	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 279	Continued From page 39 Care Area Triggered." Under column B "Care Planning Decision" each of these items were checked as being care planned." Further review of the clinical record revealed the care plan. Review of the care plan failed to reveal any evidence of the triggered area of pain being care planned. {Note: On resident's MDS of 6/26/15, Section J "Health Conditions", resident was coded in J0400 Pain Frequency as a "2" for "Frequently" and in section J0500 Pain Effect on Function, the resident was coded as a "1" for "yes" in question B "Ask resident: "Over the past 5 days, have you limited your day-to-day activities because of pain?"} On 3/2/16 at 1:42 p.m., in an interview with RN #1 (Registered Nurse #1, the MDS nurse), she stated it was not care planned. She provided one developed on 3/1/16 after the survey chart review was completed, and stated that it was developed per MDS review of the MARs (Medication Administration Record), stating that the resident had received pain medication. When asked if the pain care plan should have been developed before 3/1/16, as a triggered area on the 6/26/15 MDS assessment, she stated it should have been care planned, and was an oversight. On 3/2/16 at 5:59 p.m., during the end of day meeting, the Administrator (ASM [administrative staff member] #1) and the Director of Nursing (ASM #2) were made aware of the findings. No further information was provided by the end of the survey. 3. The facility staff failed to develop a	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 279	Continued From page 40 comprehensive care plan to address Resident #5's mastectomy and any restrictions related to the mastectomy. Resident #5 was admitted to the facility on 1/24/11 and was readmitted on 10/2/14 with diagnoses that included but were not limited to: urinary tract infection, mental retardation, diabetes, high blood pressure, left mastectomy* and back pain. Resident #5's most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 2/19/16 coded the resident's BIMS (brief interview for mental status) as 10 out of 15 indicating the resident was moderately impaired to make daily decisions. The resident was coded as requiring assistance from staff for activities of daily living. In Section I -- Active Diagnoses did not evidence documentation of the resident's mastectomy. On the front of Resident #5's chart was a sticker labeled, "Allergy." On that label it was documented, "No BP (blood pressure) in Left Arm." Review of the physician's orders dated and signed on 2/24/16 documented the resident's history of a left mastectomy but did not evidence documentation that no blood pressure should be taken in the left arm. Review of the February 2016 medication administration record did evidence documentation that no blood pressure should be taken in the left arm. Review of the resident's care plan initiated on	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 279	Continued From page 41	F 279		

10/18/13 and revised on 3/1/16 did not evidence documentation that the resident had had a mastectomy or any restrictions related to the mastectomy.

Review of the resident's care guide used by the CNA's (certified nursing assistants) did not evidence documentation that the resident should not have blood pressures taken in her left arm.

An interview was conducted on 3/3/16 at 8:40 a.m. with ASM (administrative staff member) #2, the director of nursing, regarding the sticker on the front of Resident #5's chart documenting no blood pressure was to be taken in the left arm. ASM #2 stated, "That's because she's had a left mastectomy." When asked how staff knows not to take the blood pressure in the left arm, ASM #2 stated, "It should be on the care plan." When the care plan was reviewed with ASM #2, ASM #2 stated, "No, it's not here." When asked how the CNAs know what to do for residents, ASM #2 stated, "They get the care guide from the care plan, care guides can only pull over information that is on the care plan." When ASM #2 reviewed Resident #5's vital sign sheet where blood pressures taken in the left arm had been documented, ASM #2 stated, "That would be not the standard of care when you have a mastectomy."

An interview was conducted on 3/3/16 at 9:10 a.m. with CNA #3, the CNA caring for Resident #5. When asked if she took blood pressures, CNA #3 stated, "Yes, once in a while." When asked how staff knew how to care for a resident, CNA #3 stated, "We look at the plan of care inside the closet door (the care guide was taped to the inside of Resident #5's closet door)." When

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 279	Continued From page 42 asked if there were any restrictions on taking the resident's blood pressure, CNA #3 stated, "No ma'am." An interview was conducted on 3/3/16 at 9:15 a.m. with LPN (licensed practical nurse) #1, the nurse caring for Resident #5. When asked what if any nursing considerations would be implemented for a resident with a mastectomy, LPN #1 stated, "No blood pressures in the left arm." LPN #1 reviewed the February 2016 medication administration record and stated that she would, "Write it in (no blood pressure in left arm)." An interview was conducted on 3/3/16 at 9:30 a.m. with RN (registered nurse) #1, the MDS coordinator. When asked if a care plan should be developed for Resident #5 who has had a mastectomy, RN #1 stated, "It should have. I suppose I overlooked that portion because she's been here for years." When asked why blood pressures are not taken on the mastectomy side, RN #1 stated, "Because when they remove that breast it could have cut the lymph nodes. You're cutting off circulation with a blood pressure, it could damage the nerves." When asked who used the care plan and what its purpose was, RN #1 stated, "It's to direct, it drives the care of the resident. So staff knows how to care for them." On 3/3/16 at 3:10 p.m. ASM (administrative staff member) #1, the administrator was made aware of the findings. No further information was provided prior to exit. According to Fundamentals of Nursing Lippincott	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 279	Continued From page 43 Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." (1) (1) Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia pages 65-77. 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 easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care." *A mastectomy is surgery to remove a breast or part of a breast. It is usually done to treat breast cancer <https://www.nlm.nih.gov/medlineplus/breastcanc	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 279	Continued From page 44 er.html>.	F 279		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to review and revise the comprehensive care plan for four of 21 residents in the survey sample, Resident(s) #4, #5, #7 and #10. 1. The facility staff failed to review and revise the comprehensive care plan after Resident #4 threatened to kill himself.	F 280	**F280** April 15, 2016 Resident #4 care plan was reviewed and revised on March 17, 2016 to reflect suicidal ideations by RN/MDS Coordinator. Resident #5 care plan was updated on March 3, 2016 to reflect falls by RN/MDS Coordinator. Resident #7 care plan was updated on March 17, 2016 to reflect nose bleeds by RN/MDS Coordinator. Resident #10 care plan was updated on March 3, 2016 to reflect AV shunt by RN/MDS Coordinator. A 100% audit of all care plans was conducted by the administrative nurses DON, ADON, SDC or Tx Nurse and/or Administrator, including care plans for residents #4, #5, #7 and #10 to ensure that all areas of the care plan reflect the residents. Any deficient care plans were updated by the MDS Coordinator utilizing the CAA's from last comprehensive assessment, progress notes, and incident reports to ensure that the care plans address the resident's individual needs.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 280	Continued From page 45 2. The facility staff failed to update the comprehensive care plan after Resident #5 fell on 2/28/16. 3. The facility staff failed to update the comprehensive care plan after the Resident #7 sustained nose bleeds. 4. The facility staff failed to update the comprehensive care plan after Resident #10 had an arteriovenous (AV)* shunt implanted. The findings include: 1. The facility staff failed to review and revise the comprehensive care plan after Resident #4 threatened to kill himself. Resident #4 was admitted to the facility on 7/17/15 and readmitted on 1/26/16 with diagnoses that included but were not limited to: arthritis, anemia, diabetes, depression, schizophrenia* and bipolar disease**. Resident #4's most recent MDS (minimum data set), a 30 day assessment, with an ARD (assessment reference date) of 2/23/16 coded the resident's BIMS (brief interview of mental status) as a 15 out of 15 indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance with activities of daily living. A review of the nurse's notes dated and timed, 2/11/16 at 4:54 p.m. documented, "Note Text: staff reported to this writer that at approximately 4:25 (p.m.) resident stated, "I have to kill myself" writer spoke to resident and he did not state this	F 280	The interdisciplinary care plan team members (Dietary manager, MDS Coordinator, Social Services Director and Activities Director) have been re-educated on the requirements for completing a comprehensive care plan for each resident, ensuring that all triggered CAA items are care planned and to review and revise the care plan for each resident change in condition as needed by RAI Reimbursement Auditor by March 24, 2016. An audit will be completed of 10% of care plans to include care plans for resident #4, #5, and #6 (#10) weekly x 8 weeks then monthly x 1 month by Director of Nursing/Assistant Director of Nursing or SDC to ensure all triggered areas of the CAAs are care planed, comprehensive care plans have been developed accordingly, and that the care plans accurately reflects the resident utilizing the QI Care Plan Audit Tool. The care plan will be updated immediately by the MDS Coordinator for any identified areas of concern. The Administrator will review and initial the QI Care Plan Audit Tool weekly x 8 weeks then monthly x 1 month for compliance and to ensure all areas of concern have been addressed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 280	Continued From page 46 to her, DON (director of nursing) made aware, Md (medical doctor) paged as well, writer to request something for resident (sic) depression and anxiety, resident currently on Seroquel 50 mg (milligrams) po (by mouth) @ hs (hour of sleep), writer awaiting response from Md." A review of the clinical record documented a titled, "goDocs. 2/11/16, (name of resident), DOB (date of birth), Facility (name of facility), Chief Complaint, Resident stated he is going to kill himself. Resident currently on Seroquel (an antipsychotic medication*^) 50 mg PO @ HS for anxiety. May we have an order for something else please as resident is extremely depressed. MD gave verbal order to (arrow pointing up) Seroquel to 100 mg PO @ HS PRN." Further review of the nurse's notes dated and timed, 2/11/16 documented, "Md returned writers call, verbal order given to d/c (discontinue) Seroquel 50 mg po Q (every) hs PRN (as needed) and start Seroquel 100 mg po Q hs PRN, RP (name of RP) called and made aware of new order, RP (responsible party) stated she wants facility to call his psychiatrist (sic) in (name of town) in the am (a.m.) and make them aware of whats (sic)going on, note to be left for DON. Review of Resident #4's care plan initiated on 10/21/15 and revised on 2/26/16 did not evidence documentation regarding the resident's threat to kill himself. An interview was conducted on 3/2/16 at 4:15 with LPN (licensed practical nurse) #4. When asked what documentation would be expected when a resident threatened suicide, LPN #4 stated, "It should be documented in the nurse's	F 280	The Administrator will compile the results of the QI Care Plan Audit Tool and present to the Quality Improvement Committee Meeting monthly x 3 months. Subsequent plans of action will be developed by the Committee when required. Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 280	Continued From page 47	F 280		

notes." When asked if she expected the care plan be updated, LPN #4 stated, "Yes, I would expect it to be." When asked why it was important for the care plan to be revised, LPN #4 stated, "So the whole staff could know what's going on."

An interview was conducted on 3/2/16 at 5:35 p.m. with OSM (other staff member) #1, the social worker, regarding the process staff followed if a resident threatens suicide. OSM #1 stated, "Make sure the resident is safe at that moment and then call the MD." When asked what was considered safe. When asked if this information would be documented, OSM #1 stated, "Yes, in the nurse's note." When asked if this information would be added to the care plan, OSM #1 stated, "Oh gosh, yes ma'am. I would add a problem that the resident vocalized they're depressed and (the depression) is escalating. I would let everyone know."

An interview was conducted on 3/3/16 at 8:50 a.m. with ASM (administrative staff member) #2, the director of nursing. When asked how staff decides what needs to be in the care plan, ASM #2 stated, "If something significant has happened to a resident." ASM #2 was made aware of the findings at that time.

An interview was conducted on 3/3/16 at 9:50 a.m. with RN (registered nurse) #1, the MDS coordinator. When asked who used the care plan, RN #1 stated, "All of the staff." When asked why was it important to review and revise the care plan, RN #1 stated, "So staff know how to take care of them (the residents)." When asked if she was aware that Resident #4 had threatened suicide, RN #1 stated, "No, I didn't know that." When asked what she would have done, RN #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 280	Continued From page 48 stated, care plan him for the suicidal statement, to have him watched by staff a little closer. Make sure he gets seen by somebody (psychiatrist). Make sure staff knows he's made that statement. He's already in a room in a busy path so he's seen often." On 3/3/16 at 3:10 p.m. ASM (administrative staff member) #1, the administrator was made aware of the findings. A review of the facility's policy titled, " RESIDENT CARE PLAN " documented in part, "Any new problem or need of the 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 addition." No further information was provided prior to exit. According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." (1) (1) Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia pages 65-77.	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 280	Continued From page 49	F 280		

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 easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care."

*^Seroquel is an antipsychotic medication used for the treatment of schizophrenia. Drug Information Handbook for Nursing 2007 8th edition, Turkoski, Lance, Bonfiglio- Lexi-Comp Corp Hudson Ohio page 1055-1056).
*Schizophrenia is a serious brain illness. People who have it may hear voices that aren't there. They may think other people are trying to hurt them. Sometimes they don't make sense when they talk. The disorder makes it hard for them to keep a job or take care of themselves. https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=schizophrenia
**Bipolar disorder is a serious mental illness. People who have it go through unusual mood changes. They go from very happy, "up," and active to very sad and hopeless, "down," and inactive, and then back again. They often have normal moods in between. The up feeling is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 280	Continued From page 50 called mania. The down feeling is depression <https://www.nlm.nih.gov/medlineplus/depression.html>. 2. The facility staff failed to update the comprehensive care plan after Resident #5 fell on 2/28/16. Resident #5 was admitted to the facility on 1/24/11 and was readmitted on 10/2/14 with diagnoses that included but were not limited to: urinary tract infection, mental retardation, diabetes, high blood pressure, left mastectomy* and back pain. Resident #5's most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 2/19/16 coded the resident's BIMS (brief interview for mental status) as 10 out of 15 indicating the resident was moderately impaired to make daily decisions. The resident was coded as requiring assistance from staff for activities of daily living. Review of the nurse's notes dated 12/28/16 documented that the resident fell in the bathroom and sustained an abrasion to the forehead. Review of Resident #5's comprehensive care plan did not evidence documentation that the care plan had been reviewed or revised following the fall. An interview was conducted on 3/2/15 at 4:15 p.m. with LPN (licensed practical nurse) #4, regarding situations for updating a resident care plan. LPN #4 stated, "Falls with or without injury, change in condition, not eating." When asked	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 280	Continued From page 51	F 280		

who updates the care plans, LPN #4 stated, "I let the MDS lady know, if I see a change in condition, I let her know and she documents it in the care plan."

An interview was conducted on 3/3/15 at 9:10 a.m. with LPN #1. When asked how staff knew how to care for the residents LPN #1 stated they use the care plan.

An interview was conducted on 3/3/16 at 9:30 a.m. with RN (registered nurse) #1, the MDS coordinator. When asked who used the care plan, RN #1 stated, "All of the staff." When asked why was it important to review and revise the care plan, RN #1 stated, "So staff know how to take care of them (the residents)." When asked about Resident #5's fall on 12/28/15, RN #1 stated, "That was on December 28th. She fell over the weekend. I looked over the report on Monday. (Name of resident) has had lots of interventions (for falls); we discussed what we needed to do next." When asked what if any documentation should have been done, RN #1 stated, "The nurses probably should have documented that the resident had several falls and interventions and cannot come up with anything appropriate to add."

On 3/2/16 at 5:30 p.m. ASM (administrative staff member) #2, the director of nursing was made aware of the findings.

On 3/3/16 at 3:10 p.m. ASM #1, the administrator was made aware of the findings.

No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 280	Continued From page 52 3. The facility staff failed to update the comprehensive care plan after the Resident #7 sustained nose bleeds. Resident #7 was admitted to the facility on 3/13/14 and was readmitted on 3/16/15 with diagnoses that included but were not limited to: heart failure, anemia, liver failure, high blood pressure, colon cancer and a history of nosebleeds. Resident #7's most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 11/24/15 coded the resident as having a 15 out of 15 on the BIMS (brief interview of mental status) indicating the resident was cognitively intact to make decisions of daily living. The resident was coded as requiring assistance for all activities of daily living. Review of the nurse's notes on 11/26/15 at 1:15 a.m. documented, "Resident sitting in w/c (wheelchair) at sink with nose bleeding bright red blood. Large amt (amount) of blood noted in trash can. Ice pack applied to back of neck and instructed resident to pinch nostrils. Bleeding subsided in approx. (approximately) 15-20 min. (minutes)." Review of the nurse's notes on 12/1/15 at 6:36 a.m. documented, "Resident rang bell for assistance with r (right) nostril bleeding. Blood was running profusely. He has a paper towel applying pressure. He said as soon as his fee hit the floor it started bleeding. No blood in bed noted. Have been applying cool rags to back of neck and forehead. Bleeding has almost stopped."	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 280	Continued From page 53 Review of the nurse's notes on 12/2/15 at 10:15 p.m. documented, "Resident's call light is one (sic). Resident is sitting at sink, in his room, having a nose bleed. Nose is bleeding a large amount. Ice pack applied to back of neck and to side of nose. Resident also spitting up blood that he stated was running down his throat." Review of the resident's comprehensive care plan initiated on 3/30/15 and revised on 12/2/15 did not evidence documentation regarding the resident's nose bleeds. An interview was conducted on 3/2/16 at 4:15 p.m. with LPN (licensed practical nurse) #4. When asked who updates the care plan, LPN #4 stated, "I let the MDS lady know if I see a change in condition. I let her know and she documents it in the care plan. When asked who used the care plan, LPN #4 stated, "All of us." When asked why it was important to review and revise the care plan, LPN #4 stated, "So the whole staff could know what's going on." When asked if the care plan would be updated if the resident had nose bleeds LPN #4 stated yes. An interview was conducted on 3/3/16 at 9:30 a.m. with RN (registered nurse) #1, the MDS coordinator. When asked who used the care plan, RN #1 stated, "All of the staff." When asked why was it important to review and revise the care plan, RN #1 stated, "So staff know how to take care of them (the residents)." On 3/2/16 at 5:30 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 280	Continued From page 54 No further information was provided prior to exit. 4. The facility staff failed to update the comprehensive care plan after Resident #10 had an arteriovenous (AV)* shunt implanted. Resident #10 was admitted to the facility on 6/16/15 with diagnoses that included but were not limited to: end stage renal disease requiring dialysis, hallucinations, diabetes, high blood pressure and anemia. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 2/23/16 coded the resident's BIMS (brief interview of mental status) as 15 out of 15 indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance from staff for all activities of daily living except for eating which the resident could do after having the meal tray prepared. In section O --Special Treatments, Procedures and Programs, the resident was coded as receiving dialysis. A review of discharge instructions dated and signed 8/4/15 at 1:25 p.m. documented, "Procedure specific discharge instruction sheet provided. Left Arm AV (arteriovenous) graft." A review of Resident #10's care plan initiated 6/19/15 and with a target date (for review) of 5/11/16 did not evidence documentation that about the resident's AV shunt. An interview was conducted on 3/2/16 at 4:15 p.m. with LPN (licensed practical nurse) #4.	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 280	Continued From page 55 When asked who updates the care plan, LPN #4 stated, "I let the MDS lady know if I see a change in condition. I let her know and she documents it in the care plan. When asked who used the care plan, LPN #4 stated, "All of us." When asked why it was important to review and revise the care plan, LPN #4 stated, "So the whole staff could know what's going on." An interview was conducted on 3/3/16 at 9:30 a.m. and at 1:20 p.m. with RN (registered nurse) #1, the MDS coordinator. When asked who used the care plan, RN #1 stated, "All of the staff." When asked why was it important to review and revise the care plan, RN #1 stated, "So staff know how to take care of them (the residents)." When asked if she was aware that Resident #10 had an AV shunt, RN #1 stated, "No, I thought they were still using her port. I probably should have known." When asked if the care plan would be updated when a resident had a shunt implanted, RN #1 stated yes. When asked why this would be important, RN #1 stated, "(The nurses) need to check the thrill and bruit at least every shift to make sure it's functioning." On 3/3/16 at 2:00 p.m. ASM (administrative staff member) #2, the director of nursing, was made aware of the findings. *A vascular access is a hemodialysis patient's lifeline. A vascular access makes life-saving hemodialysis treatments possible. Hemodialysis is a treatment for kidney failure that uses a machine to send the patient's blood through a filter, called a dialyzer, outside the body. The access is a surgically created vein used to remove and return blood during hemodialysis. <http://www.niddk.nih.gov/health-information/heal	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 280	Continued From page 56 th-topics/kidney-disease/vascular-access-for-hemodialysis/Pages/index.aspx> **Bruits are rushing sounds heard over large and medium-sized arteries as a result of vibration in the vessel wall caused by turbulent blood flow. Thrills are a palpable venous systolic thrill and murmur. http://www.ncbi.nlm.nih.gov/pubmed/3958354	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and in the course of a complaint investigation the facility staff failed to follow professional standards for three of 21 residents in the survey sample, Residents # 14, #3 and Resident #4. 1. Resident # 14 had a physician's order for a medication that she was allergic to and facility staff failed to clarify the order. 2. Resident # 3 had a physician's order for sliding scale insulin that was not clear and facility staff failed to clarify the order. 3. Resident # 4 had a physician's order for Seroquel*^ (an antipsychotic medication) 100 mg (milligrams) po (by mouth) PRN (as needed) at HS (hour of sleep) without parameters for when the medication should be administered and	F 281	**F281- Services provided meet professional standards** 1. Resident #14 is no longer a resident of the facility. The MD was contacted for Resident #3 and sliding scale order was clarified on March 24, 2016 by RN/DON. The MD was contacted for Resident # 4 on March 24, 2015 by the RN/Director of Nursing and the order for Seroquel was clarified with parameters for when the medication should be administered. 2. A 100% audit will be completed of all resident's to include resident #14, #3, and #10 current MARs by RN/SDC nurse to ensure medications are not being administered that residents are allergic to, orders are clear to include sliding scale insulins, and that all ordered medications to include PRN medications have parameters for when the medications should be administered. All areas of concern will be addressed by RN/SDC	4/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 281	Continued From page 57 facility staff failed to clarify the order. The findings include: 1. Resident # 14 had a physician's order for a medication that she was allergic to and facility staff failed to clarify the order. Resident # 14 was admitted to the facility on 1/16/15 with diagnoses that included but not limited to hyperlipidemia, aortic aneurysm, osteoporosis, diabetes, hypothyroidism, congestive heart failure, hypertension, and coronary artery disease. At the time of the complaint Resident # 14's MDS (minimum data set), an initial assessment, with an ARD (assessment reference date) of 1/27/15 coded the Resident as being understood and able to understand others. The Resident had a BIMS (Brief Interview for Mental Status) of 15 out of 15 indicating that she was cognitively intact. Review of Resident # 14's clinical record revealed a physician order sheet (POS) dated 1/16/15 and signed by the physician on 1/20/15. Near the bottom of this form is a section to list the allergies. In this section was documented: "Benzodiazepines* ..." This form (POS) was faxed to the pharmacy on 1/16/2015 at 16:32. A copy of this form was faxed from the pharmacy on 3/3/2016 at 12:42 PM. Also, located in the clinical record was a handwritten physician order [identified by ASM (Administrative Staff Member) # 1, the administrator, as being handwritten by the physician]. This order was signed and dated by	F 281	Nurse during the audit with MD notification and order clarification. 3. All licensed nurses to include LPN #2, LPN #3, and RN # 2 will be in-serviced by RN/SDC regarding notifying the physician and clarifying physician orders if the resident is allergic to a medication, an order is not clear, or an order does not have parameters for when to administer a medication by the SDC/RN on or before April 10, 2016. All newly hired license nurses will be in-serviced regarding notifying the physician and clarifying physician orders if the resident is allergic to a medication, an order is not clear, or an order does not have parameters for when to administer a medication during orientation. 4. The Administrative Nurses (DON, ADON, SDC, MDS or Treatment Nurse) will review all newly written physician orders for all residents to include resident #14, #3, and #4 and compare to the resident's Medication Administration records weekly x 8 weeks then monthly x 1 month to ensure medications are not being administered that residents are allergic to, all orders are clear to include sliding scales, and all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 281	Continued From page 58 the physician on 1/20/15. This order documented: "1/20/15 Clonazepam** 0.5 mg (milligrams) PO (by mouth) X (times) 7 days then reduce to 0.5 mg PO q HS (every hour of sleep) X 14 days then D/C (discontinue). Report to MD (medical doctor) if insomnia or anxiety exacerbates upon discontinuation." During an interview on 3/3/16 at 7:45 a.m. with LPN # 2 when asked about allergies LPN # 2 stated checks the orders against allergies and if there was a problem give the doctor a call. One would also pass this information onto day shift and probably would call the pharmacy. During an interview on 3/3/16 at 8:05 a.m. RN (Registered Nurse) # 2 was asked to explain the process for sending orders to the pharmacy. RN # 2 stated that the doctors order are written on the POS by one nurse then another nurse comes behind and checks - both nurses sign the POS. Allergies and diagnoses are also checked. This POS is faxed to the pharmacy. When the doctor comes he reads and signs the copy of the POS. If he writes an order for a medication that a Resident is allergic to the nurse would call the doctor and let him know. During the end of day interview on 3/2/16 at approximately 6:00 p.m.,with ASM (Administrative Staff Member) # 1, the administrator, this concern was discussed. At this time it was revealed that there was no facility policy on clarification of physician orders. In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419. "The physician is responsible for directing medical treatment. Nurses are	F 281	ordered medications have parameters for when medications should be administered utilizing an Order Clarification QI Tool. The Administrative Nurse (DON, ADON, SDC, MDS or Treatment Nurse) will immediately contact the physician for clarification an order during the audit for any identified areas of concern. The DON will review and initial the Order Clarification QI Tool weekly x 8 weeks the monthly x 1 month for compliance and to ensure that all areas of concern have been addressed. The Director of Nursing will compile the results of the Order Clarification QI Tool and present to the Quality Improvement Committee Meeting monthly x 3 months. Subsequent plans of action will be developed by the Committee when required. Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 281	Continued From page 59 obligated to follow physician's orders unless they believe the orders are in error or would harm clients. Therefore all orders must be assessed if one is found to be erroneous or harmful further clarification from the physician is necessary." The following quotation is found in Potter and Perry's Fundamentals of Nursing 6th edition (2005, p. 477): "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice. Information in the client record provides a detailed account of the level of quality of care delivered to the clients." Potter and Perry (2005) also includes the following information: "As members of the health care team, nurses need to communicate information about clients accurately and in a timely, effective manner." According to "Fundamentals of Nursing-Lippincott, Williams and Wilkins 2007 page 169, "After you receive a written medication order, transcribe it onto a working document approved by your health care facility...read the order carefully, concentrate on copying it correctly, check it when you're finished. Be sure to look for order duplications that could cause your patient to receive a medication in error...." * Benzodiazepines are depressants that produce sedation, induce sleep, relieve anxiety and muscle spasms, and prevent seizures. www.dea.gov/druginfo/drug_data_sheets/Benzodi	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 281	Continued From page 60 azepines.pdf <http://www.dea.gov/druginfo/drug_data_sheets/Benzodiazepines.pdf> ** Clonazepam --Klonopin® ... Clonazepam is used alone or in combination with other medications to control certain types of seizures. It ...of extreme fear and worry about these attacks). Clonazepam is in a class of medications called benzodiazepines. ... https://www.nlm.nih.gov/medlineplus/druginfo/meds/a682279.html - COMPLAINT DEFICIENCY 2. Resident # 3 had a physician's order for sliding scale insulin that was not clear and facility staff failed to clarify the order. Resident # 3 was admitted to the facility on 2/2/11 and readmitted on 4/2/15 with diagnoses that included but were not limited to anemia, depression, diabetes, hyperlipidemia, hypertension, cerebral vascular accident, cataracts, and peptic ulcer with hemorrhage. Resident # 3's most recent MDS (minimum data set), an annual assessment, with an ARD (assessment reference date) of 1/3/16 coded the Resident as being rarely/never understood and as usually understanding. The Resident was severely impaired cognitively. During a review of the physician order sheet, signed by the physician on 2/3/16, revealed documentation of an order for Sliding Scale Insulin: "Humalog* 100/ML 150-199 = 2 UNITS, 200-249=4 UNITS, 250-300=6 UNITS, 300 OR	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 281	Continued From page 61 GREATER = 8 UNITS, IF OVER 400 CALL MD, 6AM, 1130A, 430P, 9PM." This order was originally written on 4/30/15. During an interview on 3/2/16 at 2:30 p.m. with LPN (Licensed Practical Nurse) # 3 this order was reviewed. LPN # 3 was asked how much insulin would be given if the blood sugar was "300". LPN # 3 stated that one would have to call the doctor and get clarification for this order. During an interview on 3/2/16 at 2:35 p.m. with RN (Registered Nurse) # 2 this order was reviewed. RN # 2 was asked how much insulin would be given if the blood sugar was "300". RN # 2 stated the order would have to be clarified with the doctor. Review of Resident # 3's care plan documented under "Will be free from any signs/symptoms of hyper/hypoglycemia" initiated on 3/5/15 and most recently revised on 1/26/16 included: "Medication as ordered by the physician." During an interview on 3/2/16 at 3:45 p.m. with ASM (Administrative Staff Member) # 2, the Director of Nurses, the physician order for sliding scale insulin was reviewed. ASM # 2 stated that the order should be clarified. At this time the facility policy on clarification of orders was requested. During the end of day interview on 3/2/16 at approximately 6:00 p.m.,with ASM (Administrative Staff Member) # 1, the administrator, this concern was discussed. At this time it was revealed that there was no facility policy on clarification of physician orders.	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 281	Continued From page 62 Prior to exit a copy of a physician order form documenting that the sliding scale order was clarified was presented. In Potter-Perry, Fundamentals of Nursing, 6th edition, page 841, a noted standard of practice is: "When medications are first ordered, the nurse compares the medication recording form or computer orders with the prescriber's written orders." On page 852, regarding the administration of oral medications, "Check accuracy and completeness of each MAR or computer printout with prescriber's written medication order." In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients. Therefore all orders must be assessed if one is found to be erroneous or harmful further clarification from the physician is necessary." According to "Fundamentals of Nursing- Lippincott, Williams and Wilkins 2007 page 169, "After you receive a written medication order, transcribe it onto a working document approved by your health care facility...read the order carefully, concentrate on copying it correctly, check it when you're finished. Be sure to look for order duplications that could cause your patient to receive a medication in error...." *Humalog® -- Insulin used to treat type 1 diabetes (condition in which the body does not produce insulin ... their diabetes. https://www.nlm.nih.gov/medlineplus/druginfo/me	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 281	Continued From page 63 ds/a697021.html - 3. Resident # 4 had a physician's order for Seroquel*^ (an antipsychotic medication) 100 mg (milligrams) po (by mouth) PRN (as needed) at HS (hour of sleep) without parameters for when the medication should be administered and facility staff failed to clarify the order. Resident # 4 had a physician's order for Seroquel*^ (an antipsychotic medication) 100 mg (milligrams) po (by mouth) PRN (as needed) at HS (hour of sleep) without parameters for when the medication should be administered. Resident #4 was admitted to the facility on 7/17/15 and readmitted on 1/26/16 with diagnoses that included but were not limited to: arthritis, anemia, diabetes, depression, schizophrenia* and bipolar disease**. Resident #4's most recent MDS (minimum data set), a 30 day assessment, with an ARD (assessment reference date) of 2/23/16 coded the resident's BIMS (brief interview of mental status) as a 15 out of 15 indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance with activities of daily living. In Section D -- Mood, under D0200. Resident Mood Interview the resident was coded under "B. Feeling down, depressed, or hopeless. Symptom Presence, 1 (indicating the resident felt these feelings). Under Symptom Frequency 2 (indicating the resident had these feelings 7-11 days (half or more of the days)." In Section I -- Active Diagnoses, the resident was coded as having depression, manic depression (bipolar disease) and schizophrenia. An observation was made on 3/2/16 at 11:00 a.m.	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 281	Continued From page 64 of Resident #4. The resident was lying in bed and was awake and alert. The resident was receiving wound care. The resident did not engage in conversation during this observation. An observation was made on 3/2/16 at 12:00 p.m. of the resident. The resident was sitting quietly in a chair in his room receiving medications. An observation was made on 3/2/16 at 3:00 p.m. of the resident. The resident was up in a wheelchair sitting quietly in the dayroom. A review of the nurse's notes dated and timed, 2/11/16 at 4:54 p.m. documented, "Note Text: staff reported to this writer that at approximately 4:25 (p.m.) resident stated, "I have to kill myself" writer spoke to resident and he did not state this to her, DON (director of nursing) made aware, Md (medical doctor) paged as well, writer to request something for resident (sic) depression and anxiety, resident currently on Seroquel 50 mg (milligrams) po (by mouth) @ hs (hour of sleep), writer awaiting response from Md." A review of the clinical record documented a titled, "goDocs (the name of the facility's physician group). 2/11/16, (name of resident), DOB (date of birth), Facility (name of facility), Chief Complaint, Resident stated he is going to kill himself. Resident currently on Seroquel 50 mg PO @ HS for anxiety. May we have an order for something else please as resident is extremely depressed. MD gave verbal order to (arrow pointing up) Seroquel to 100 mg PO @ HS PRN." Further review of the nurse's notes dated and timed, 2/11/16 documented, "Md returned writers call, verbal order given to d/c (discontinue)	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 281	Continued From page 65 Seroquel 50 mg po Q (every) hs PRN (as needed) and start Seroquel 100 mg po Q hs PRN, RP (name of RP) called and made aware of new order, RP stated she wants facility to call his psychiatrist (sic) in (name of town) in the am (a.m.) and make them aware of whats (sic) going on, note to be left for DON." During the end of day interview on 3/2/16 at approximately 6:00 p.m., with ASM (Administrative Staff Member) # 1, the administrator, the concern for clarification of physician orders to include parameters was discussed with ASM #1 by another surveyor. At this time it was revealed that there was no facility policy on clarification of physician orders. An interview was conducted on 3/3/16 at 8:50 a.m. with ASM (administrative staff member) #2, the director of nursing. ASM #2 was made aware of the findings at that time. No further information was provided prior to exit. In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients. Therefore all orders must be assessed if one is found to be erroneous or harmful further clarification from the physician is necessary." *^Seroquel is an antipsychotic medication used for the treatment of schizophrenia. Drug Information Handbook for Nursing 2007 8th	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 281	Continued From page 66 edition, Turkoski, Lance, Bonfiglio- Lexi-Comp Corp Hudson Ohio page 1055-1056). *Schizophrenia is a serious brain illness. People who have it may hear voices that aren't there. They may think other people are trying to hurt them. Sometimes they don't make sense when they talk. The disorder makes it hard for them to keep a job or take care of themselves. <https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=schizophrenia> **Bipolar disorder is a serious mental illness. People who have it go through unusual mood changes. They go from very happy, "up," and active to very sad and hopeless, "down," and inactive, and then back again. They often have normal moods in between. The up feeling is called mania. The down feeling is depression <https://www.nlm.nih.gov/medlineplus/depression.html>.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of	F 309	F 309- 1) The MD was notified on March 24, 2016 that resident #7 did not have vitals taken as per order by the DON. Resident #10 AV shunt was assessed on March 4, 2016 and documented in the medical record by the floor nurse/LPN.	4/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 309	Continued From page 67 complaint investigation, it was determined that the facility staff failed to provide care and services to maintain the highest level of well-being for two of 21 residents in the survey sample, Resident # 7, and Resident #10. 1. The facility staff failed to monitor Resident #7's blood pressure and pulse as ordered by the physician. 2. The facility staff failed to care for Resident #10's AV (arteriovenous shunt)* graft used for dialysis. The findings include: 1. The facility staff failed to monitor Resident #7's blood pressure and pulse as ordered by the physician. Resident #7 was admitted to the facility on 3/13/14 and was readmitted on 3/16/15 with diagnoses that included but were not limited to: heart failure, anemia, liver failure, high blood pressure, colon cancer and a history of nosebleeds. Resident #7's most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 11/24/15 coded the resident as having a 15 out of 15 on the BIMS (brief interview of mental status) indicating the resident was cognitively intact to make decisions of daily living. The resident was coded as requiring assistance for all activities of daily living. In Section I -- Active Diagnosis, the resident was coded as having high blood pressure. A review of the physician's orders signed and	F 309	2) 100% of all residents MARs from Nov. 2015 to present with ordered vital sign monitoring to include resident #7 were audited to ensure vital signs were being obtained per physician order by Administrator, on March 22, 2016. All concerns were addressed with MD notification. 100% audit of residents to include resident # 10 with AV shunts was completed by Corporate Nursing Consultant to ensure that documentation was present verifying shunt assessment on 3/16/16. The resident was assessed by the hall nurse with documentation in the medical record for any identified areas of concern. 3) 100% of the license nurses were in-serviced on following MD orders to include obtaining vital signs and documentation and AV shunt assessment and care, documentation of thrill/bruit and documentation using the dialysis progress note in the electronic medical record by the RN/SDC initiated on 3/16/16. All newly hired licensed nurses will receive in-servicing regarding following MD orders to include obtaining vital signs and documentation and AV shunt assessment and care, documentation of thrill/bruit and documentation using the dialysis progress note in the electronic medical record in orientation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 309	Continued From page 68 dated, 3/2/16, documented, "BP (blood pressure) & HR (heart rate) WEEKLY, On Wednesday." Review of the MAR (medication administration record) for November 2015 documented the blood pressures and heart rate four out of five opportunities. Review of the MAR for December 2015 documented the blood pressure one time out of four opportunities and the heart rate was documented twice out of four opportunities. Review of the care plan created on 1/15/16 documented, "Potential for bleeding R/T (related to) Thrombocytopenia*. Interventions. Monitor vital signs per facilty (sic) protocol and/or ordered by the physician." An interview was conducted on 3/2/16 at 4:15 p.m. with LPN (licensed practical nurse) #4. When asked why staff followed the physician's orders, LPN #4 stated, "Because they're the doctor, they have the knowledge, but we have the right to question them because we're with our residents every day, the doctors ' just visit." When asked would staff take a resident's blood pressure and pulse every Wednesday if it was ordered by the physician, LPN #4 stated, "Oh yes, definitely that's a doctor's order." An interview was conducted on 3/2/16 at 2:25 p.m. with ASM #2, the director of nursing. When asked if staff were expected to follow the physician's orders, ASM #2 stated yes. The findings were reviewed at that time. On 3/3/16 at 3:10 p.m. ASM #1, the administrator was made aware of the findings.	F 309	4) The Administrative Nurses (DON/ADON/SDC/MDS Coordinator and/or Tx Nurse) will monitor all resident MARs and electronic medical records with physician orders to obtain vital signs to include resident # 7 and all progress notes for residents who receive dialysis to include resident # 10 to ensure vital signs and obtained per physician order and documented and to assure shut sites are assessed and documented weekly x 8 weeks then monthly x 1 month utilizing a vital sign/shunt site QI Tool. Retraining will be immediately conducted with the license nurse by Administrative Nurses (DON/ADON/SDC/MDS Coordinator and/or Tx Nurse for any identified areas of concern. The DON will review and initial the Vital Sign/shunt Site QI Tool weekly x 8 weeks the monthly x 1 month for compliance and to ensure that all areas of concern have been addressed. The Director of Nursing will compile the results of the Vital Sign/Shunt Site QI Tool and present to the Quality Improvement Committee Meeting monthly x 3 months. Subsequent plans of action will be developed by the Committee when required. Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 309	Continued From page 69 No further information was provided prior to exit. In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients." *Thrombocytopenia (THROM-bo-si-to-PE-ne-ah) is a condition in which your blood has a lower than normal number of blood cell fragments called platelets (PLATE-lets). Platelets are made in your bone marrow along with other kinds of blood cells. They travel through your blood vessels and stick together (clot) to stop any bleeding that may happen if a blood vessel is damaged. Platelets also are called thrombocytes (THROM-bo-sites) because a clot also is called a thrombus.http://www.nhlbi.nih.gov/health/health-topics/topics/thcp/ 2. The facility staff failed to care for Resident #10's AV (arteriovenous shunt)* graft used for dialysis. Resident #10 was admitted to the facility on 6/16/15 with diagnoses that included but were not limited to: end stage renal disease requiring dialysis, hallucinations, diabetes, high blood pressure and anemia. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 2/23/16 coded the resident's	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 309	Continued From page 70 BIMS (brief interview of mental status) as 15 out of 15 indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance from staff for all activities of daily living except for eating which the resident could do after having the meal tray prepared. In section O --Special Treatments, Procedures and Programs, the resident was coded as receiving dialysis. Review of the nurse's note on 8/4/15 at 5:10 a.m. documented, "Resident has left facility with regular transport for shunt placement. All instructions followed for this procedure. A review of discharge instructions dated and signed 8/4/15 at 1:25 p.m. documented, "Procedure specific discharge instruction sheet provided. Left Arm AV (arteriovenous) graft. Additional Instructions: Ok to get L (left) arm wet 8/5/15 (there is clear glue on incision. Continue Diet + meds (medications) as prior." Review of the nurses' notes from 8/4/15 to 3/2/16 in the section title, "Dialysis Bruit & Thrill**: =/- Site:" out of 66 opportunities there were 41 times that "none" or the area was left blank. A review of the physician's orders signed and dated, 2/28/16 did not evidence documentation around the care of the AV graft. A review of Resident #10's care plan initiated 6/19/15 and with a target date (for review) of 5/11/16 did not evidence documentation around the care of the resident's AV graft. A review of the medication administration record for February 2016 did not evidence	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 309	Continued From page 71 documentation that the AV graft in the left arm should be checked for a bruit and a thrill every shift or that the resident should not have blood pressures taken in the left arm. A review of Resident #10's vital signs from 8/5/15 to 3/2/16 showed 11 blood pressures, of those seven blood pressures indicated which arm was used. On 11/23/15 and 2/15/16 the blood pressures were documented as being taken on the left arm. An interview was conducted on 3/3/16 at 1:10 p.m. with LPN (licensed practical nurse) #3, the nurse caring for the resident. When asked if Resident #10 had an AV graft, LPN #3 stated, "Yes, she has a left upper arm shunt, it's fairly new to her, just in the last week or two." When asked if there were any considerations to take in caring for the graft, LPN #3 stated, "I'm not very familiar with the types of shunts. When she comes back from dialysis we have an assessment." When asked if the bruit and thrill of the graft were checked, LPN #3 stated, "No." An interview was conducted on 3/3/16 at 1:20 p.m. with RN (registered nurse) #1, the MDS coordinator. When asked if she was aware that Resident #10 had an AV graft, RN #1 stated, "No, I thought they were still using her port. I probably should have known." When asked if the care plan would be updated when a resident had a graft implanted, RN #1 stated yes. When asked why this would be important, RN #1 stated, "(The nurses) need to check the thrill and bruit at least every shift to make sure it's functioning." On 3/3/16 at 1:32 p.m. RN #1 approached this writer and stated, "I just checked on the resident.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 309	Continued From page 72 She has a permacath**. The resident said they started using it (the AV graft) on Monday. There's no documentation that they're (the nurses) are checking the bruit and thrill. They should have and protected it (the graft)." An interview was conducted on 3/3/16 at 2:00 p.m. with ASM (administrative staff member) #2, the director of nursing regarding care of an AV graft. ASM #2 stated, "They should be documenting it, the bruit and the thrill every shift when being used." When asked what nursing standard they used, ASM #2 stated, "I'm not absolutely sure, I think its Lippincott but I'm not sure." ASM #2 returned stating they didn't use an actual book (for their nursing standards) but that there was collaboration between staff, physicians and pharmacy. On 3/3/16 at 3:10 p.m. ASM #1, the administrator was made aware of the findings. An interview was conducted on 3/3/16 at 3:15 p.m. with LPN #4 regarding caring for a resident with an AV graft. LPN #4 stated, "To be honest with you, I haven't cared for one in a long time. I'd check the policy." A review of the facility's policy titled, RESIDENTS THAT RECEIVE DIALYSIS SERVICES", documented in part, "Facility staff should be aware of the care of shunts/fistulas, infection control..." No further information was provided prior to exit. Medical Surgical Nursing made Incredibly Easy, Lippincott Williams & Wilkins copyright 2004 page	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 309	Continued From page 73 565 Dialysis Monitoring and Aftercare: ·After completion of hemodialysis, monitor the vascular access site for bleeding. If bleeding is excessive, maintain pressure on the sited and notify the doctor. ·To prevent clotting or other problems with blood flow, make sure that the arm used for vascular access isn't used for any other procedure, including I.V. line insertion, blood pressure monitoring, and venipuncture. ·At least four times per day, assess circulation at the access site by auscultating for the presence of bruits and palpating for thrills. Unlike most other circulatory assessments, bruits and thrills should be present here. Lack of a bruit at a venous access site may indicate a blood clot requiring immediate surgical attention. *A vascular access is a hemodialysis patient's lifeline. A vascular access makes life-saving hemodialysis treatments possible. Hemodialysis is a treatment for kidney failure that uses a machine to send the patient's blood through a filter, called a dialyzer, outside the body. The access is a surgically created vein used to remove and return blood during hemodialysis. <http://www.niddk.nih.gov/health-information/health-topics/kidney-disease/vascular-access-for-hemodialysis/Pages/index.aspx> **Bruits are rushing sounds heard over large and medium-sized arteries as a result of vibration in the vessel wall caused by turbulent blood flow. Thrills are a palpable venous systolic thrill and murmur. <http://www.ncbi.nlm.nih.gov/pubmed/3958354> ***PermCath is a dual-lumen silicone catheter for permanent venous access for hemodialysis.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
/AYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 309	Continued From page 74	F 309	F 319	
	http://www.ncbi.nlm.nih.gov/pubmed/1509580			
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to provide interventions for the psychosocial wellbeing of one of 21 residents in the survey sample, Resident #4. The facility staff failed to obtain a psychiatric consult following Resident # 4's statement of suicide. The findings include: Resident #4 was admitted to the facility on 7/17/15 and readmitted on 1/26/16 with diagnoses that included but were not limited to: arthritis, anemia, diabetes, depression, schizophrenia* and bipolar disease**. Resident #4's most recent MDS (minimum data set), a 30 day assessment, with an ARD (assessment reference date) of 2/23/16 coded the resident's BIMS (brief interview of mental status) as a 15 out of 15 indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance with activities of daily living. In Section D -- Mood, under D0200. Resident Mood Interview the	F 319	1) Resident #4 has an appointment with psychiatrist on 3/29/16, and RP was made aware of scheduled appointment on 3/17/16. Resident #4 care plan was updated on March 17, 2016 to include resident's signs and symptoms of depression and his suicidal vocalizations. 2) Audit of 100% of residents progress notes to include resident #4 for the past 60 days who have the psychiatric diagnosis, for example, depression, bipolar, schizophrenia etc. charts were reviewed for any suicidal vocalizations or s/s of depression that were not addressed was completed by the Corporate Nursing Consultant on March 22, 2016. MD/ADM and SW were immediately notified of any concerns that were noted from audit.	4/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 319	Continued From page 75 resident was coded under "B. Feeling down, depressed, or hopeless. Symptom Presence, 1 (indicating the resident felt these feelings). Under Symptom Frequency 2 (indicating the resident had these feelings 7-11 days (half or more of the days)." In Section I -- Active Diagnoses, the resident was coded as having depression, manic depression (bipolar disease) and schizophrenia. An observation was made on 3/2/16 at 11:00 a.m. of Resident #4. The resident was lying in bed and was awake and alert. The resident was receiving wound care. The resident did not engage in conversation during this observation. An observation was made on 3/2/16 at 12:00 p.m. of the resident. The resident was sitting quietly in a chair in his room receiving medications. An observation was made on 3/2/16 at 3:00 p.m. of the resident. The resident was up in a wheelchair sitting quietly in the dayroom. A review of the nurse's notes dated and timed, 2/11/16 at 4:54 p.m. documented, "Note Text: staff reported to this writer that at approximately 4:25 (p.m.) resident stated, "I have to kill myself" writer spoke to resident and he did not state this to her, DON (director of nursing) made aware, Md (medical doctor) paged as well, writer to request something for resident (sic) depression and anxiety, resident currently on Seroquel (an antipsychotic medication*^) 50 mg (milligrams) po (by mouth) @ hs (hour of sleep), writer awaiting response from Md." A review of the clinical record documented a titled, "goDocs (the name of the facility's physician group). 2/11/16, (name of resident),	F 319	3) 100% of licensed nurses, CNAs, and the social worker were in-serviced by the Administrator and/or SDC which was initiated on 3/16/16 on initiating interventions when residents verbalize thoughts of suicide or harming one's self. They will notify the charge nurse, SW/ADM and DON immediately, notify the RP, placing with the resident a one on one constant observation sitter, ensuring resident safety by removing any objects that the resident can use to harm oneself, schedule a psychiatric consultation if appropriate and sending resident to ER if needed. All newly hired licensed nurses and CNA's will be in-serviced on initiating interventions when residents verbalize thoughts of suicide or harming one's self to include notifying the charge nurse, SW/ADM and DON immediately, notifying the RP, placing with the resident a one on one constant observation sitter, ensuring resident safety by removing any objects that the resident can use to harm oneself, schedule a psychiatric consultation if appropriate and sending resident to ER if needed by the SDC during orientation. 4) The Social Worker and/or Administrator will review all resident's progress notes to include resident #4 weekly x 8 weeks then	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 319	Continued From page 76 DOB (date of birth), Facility (name of facility), Chief Complaint, Resident stated he is going to kill himself. Resident currently on Seroquel 50 mg PO @ HS for anxiety. May we have an order for something else please as resident is extremely depressed. MD gave verbal order to (arrow pointing up) Seroquel to 100 mg PO @ HS PRN." Further review of the nurse's notes dated and timed, 2/11/16 documented, "Md returned writers call, verbal order given to d/c (discontinue) Seroquel 50 mg po Q (every) hs PRN (as needed) and start Seroquel 100 mg po Q hs PRN, RP (name of RP) called and made aware of new order, RP stated she wants facility to call his psychiatrist (sic) in (name of town) in the am (a.m.) and make them aware of whats (sic) going on, note to be left for DON." Review of Resident #4's care plan initiated on 10/21/15 and revised on 2/26/16 did not evidence documentation of the resident's depression or suicidal threat. Review of the resident's care plan initiated on 11/2/15 and revised on 2/11/16 documented, "Use of psychotropic drugs....or/due to diagnosis of: bipolar disorder, depression, schizophrenia...Interventions: Monitor resident's mental status functioning on ongoing basis. Monitor resident's mood/behaviors....Notify physician of any significant changes." There was no documentation on behavior monitoring sheets for Resident #4 regarding suicidal ideation. Review of the nurse's notes for February 2016 did not evidence further reference to the resident's	F 319	monthly x 1 month to ensure any resident with vocalizations or s/s of suicidal ideations were addressed with interventions to include psychiatric consult utilizing a suicidal ideation QI tool. An intervention will be initiated and the MD contacted at the time of the audit for any identified areas of concern. The DON will review and initial the Suicidal Ideation QI tool weekly x 8 weeks then monthly x 1 month for compliance to ensure that all areas of concern have been addressed. The Director of Nursing will compline the results of the Suicidal Ideation QI tool and present to the QI committee monthly for 3 months. Subsequent plans of action will be developed by the QI committee when required. Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 319	Continued From page 77 suicide threat or that the resident had been seen by the psychiatrist. Review of the physician's and psychiatrist's notes from 7/15 to 3/16 did not evidence documentation that the resident was suicidal. The psychiatrist's note of 8/15 did not evidence documentation that the resident was suicidal. Review of the social worker's note for 2/23/16 at 1:56 p.m. documented, "During the residents (sic) assessment, writer asked (name of resident) if he was feeling down, or depressed. (Name of resident) answer (sic) depressed. He has an upcoming appt. (appointment) with the Psychiatrist in (name of town)." A review of the "Residents (sic) Weekly Appointments, February 22, - February 26, 2016." documented, "Tues. 2/23/16, (name of resident), TIME OF APT (appointment) 1:15 p.m., TIME LEAVING FACILITY 12:00 p.m., SPECIAL COMMENTS, (name of psychiatrist) - (name of town) - (name of transportation company)." There was a line drawn through the entry. Review of the nurse's notes for 2/23/16 did not evidence documentation that the RP had been notified that the resident was not able to be seen by the psychiatrist. Review of Resident #4's care plan initiated on 10/21/15 and revised on 2/26/16 did not evidence documentation of the resident's depression or suicidal threat. An interview was conducted on 3/2/16 at 4:15 p.m. with LPN (licensed practical nurse) #4, regarding the process staff followed if a resident	F 319		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
/AYLAND NURSING AND REHABILITATION CENTER	**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) COMPLETION DATE
F 319	Continued From page 78	F 319		

threatened to kill themselves. LPN #4 stated, "In the nurse's notes, document follow up on it. Let the doctor know and make the family aware."

An interview was conducted on 3/2/16 at 5:35 p.m. with OSM (other staff member) #1, the social worker. When asked if she had been made aware of Resident #4's threat of suicide, OSM #1 stated, "I never heard of it. If that was me I would have someone sit with him and get the nurse." When asked what process staff followed if a resident threatens suicide, OSM #1 stated, "Make sure the resident is safe at that moment and then call the MD." When asked if this information would be documented, OSM #1 stated, "Yes, in the nurse's notes."

On 3/3/16 at 8:00 a.m. a typed note was left for this writer documenting, "On February 12th I called (name of doctor) office to make (name of resident) an appointment for increase in depression and verbalizing he feels like wants to die the earliest available they had was February 23rd at 1:15 p.m." It was signed and dated by OSM #6, the appointment coordinator.

An interview was conducted on 3/3/16 at 8:50 a.m. with ASM (administrative staff member) #2, the director of nursing. ASM #2 was made aware of the findings at that time. ASM #2 stated that the resident had many psychiatric issues. When asked what staff should have done in this situation, ASM #2 stated that they should have assessed the room to make sure it was safe (that there was nothing the resident could injury self with) and if it was not safe to have a staff member stay with the resident while the physician was being notified. A request for the facility's policy on managing the suicidal resident was requested.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
/AYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 319	Continued From page 79 ASM #2 stated there was no policy. On 3/3/16 at 10:30 a.m. a typed note documented, "I (name of employee) received a call on 2/22/2016 from (name of physician) stating that she could not see (name of resident) on 2/23/2016. I also called transport to let them know that we did not need them to pick up (name of resident)." This was signed by OSM (other staff member) #4, unit secretary. An interview was conducted on 3/3/16 at 9:50 a.m. with RN (registered nurse) #1, the MDS coordinator. When asked what she would if a resident threatened to commit suicide, RN #1 stated, "We would care plan him for suicidal statement, to have him watched by staff little closer and make sure he gets seen by somebody (psychiatrist). Make sure staff knows he's made that statement. He's already in a room in a busy path so he's seen often." On 3/3/16 at 3:10 p.m. ASM #1, the administrator was made aware of the findings. Review of the facility's policy titled, "DOCUMENTATION " documented in part, "6) Acute episodes chart every shift for 24 hours and/or until resolved." No further information was provided prior to exit. According to Mosby's Basic Skills and Procedures, Fifth Edition 2003, page 11; "Making a Referral for Health Care Services; Often clients require the services of various departments within an agency or the services of a different facility altogether. Whatever type of referral is needed, it	F 319		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 319	Continued From page 80 is important that the nurse collaborate with members of other disciplines so that the client's individual needs are met *^Seroquel is an antipsychotic medication used for the treatment of schizophrenia. Drug Information Handbook for Nursing 2007 8th edition, Turkoski, Lance, Bonfiglio- Lexi-Comp Corp Hudson Ohio page 1055-1056). *Schizophrenia is a serious brain illness. People who have it may hear voices that aren't there. They may think other people are trying to hurt them. Sometimes they don't make sense when they talk. The disorder makes it hard for them to keep a job or take care of themselves. <https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=schizophrenia> **Bipolar disorder is a serious mental illness. People who have it go through unusual mood changes. They go from very happy, "up," and active to very sad and hopeless, "down," and inactive, and then back again. They often have normal moods in between. The up feeling is called mania. The down feeling is depression <https://www.nlm.nih.gov/medlineplus/depression.html>.	F 319		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by:	F 333	April 15, 2016 F333 1. Resident #14 is no longer a resident of this facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 333	Continued From page 81 Based on staff interview, facility policy review, clinical record review, and in the course of a complaint investigation the facility staff failed to ensure one of 21 residents in the survey sample, Resident # 14, was free from a significant medication error. Resident # 14 had a documented allergy to a class of medications, benzodiazepines* to which Klonopin (clonazepam) ** belongs. This medication was ordered by the physician and was dispensed by the pharmacy and administered by nursing staff. The findings include: Resident # 14 was admitted to the facility on 1/16/15 with diagnoses that included but not limited to hyperlipidemia, aortic aneurysm, osteoporosis, diabetes, hypothyroidism, congestive heart failure, hypertension, and coronary artery disease. At the time of the complaint Resident # 14's MDS (minimum data set), an initial assessment, with an ARD (assessment reference date) of 1/27/15 coded the Resident as being understood and able to understand others. The Resident had a BIMS (Brief Interview for Mental Status) of 15 out of 15 indicating that she was cognitively intact. Review of Resident # 14's clinical record revealed a physician order sheet (POS) dated 1/16/15 and signed by the physician on 1/20/15. Near the bottom of this form is a section to list the allergies. In this section was documented: "Benzodiazepines..." This form (POS) was faxed to the pharmacy on 1/16/2015 at 16:32. A copy of this form was faxed from the pharmacy on 3/3/2016 at 12:42 PM.	F 333	2. A 100% audit will be completed of all resident's current MARs by RN/SDC nurse on March 11, 2016 to ensure medications are not being administered that residents are allergic to. All areas of concern will be addressed by the RN/SDC during the audit with MD notification, order clarification, and completion of an incident report. 3. All licensed nurses to include LPN #1 and LPN #2 will be in-serviced by RN/SDC regarding notifying the physician and clarifying physician orders if the resident is allergic to a medication prior to the administration of the medication and completing an incident report for medication errors by April 15, 2016. All newly hired license nurses will be in-serviced regarding notifying the physician and clarifying physician orders if the resident is allergic to a medication prior to the administration of the medication and completing an incident report for medication errors during orientation. 4. The Administrative Nurses (DON/ADON/SDC/MDS Coordinator or Treatment Nurse) will review all newly written physician orders for all residents and compare to the resident's allergies and Medication Administration records weekly x 8 weeks then monthly x 1 month to ensure medications are not being administered that residents are allergic to utilizing an Order Clarification QI Tool. The Administrative Nurse will immediately contact the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 333	Continued From page 82 Also, located in the clinical record was a handwritten physician order [identified by ASM (Administrative Staff Member) # 1, the administrator, as being handwritten by the physician]. This order was signed and dated by the physician on 1/20/15. This order documented: "1/20/15 Clonazepam 0.5 mg (milligrams) PO (by mouth) X (times) 7 days then reduce to 0.5 mg PO q HS (every hour of sleep) X 14 days then D/C (discontinue). Report to MD (medical doctor) if insomnia or anxiety exacerbates upon discontinuation." During an interview on 3/3/16 at 11:30 a.m. with ASM # 4, the physician that wrote the above order, this order was reviewed. ASM # 4 stated, "I have a vague image of that, it may have happened but I acted upon it and took action and discontinued the medication." When asked if he was aware that a dose of the medication was given? ASM # 4 stated, "No, the nurse caught it before the medication was given." Review of the pharmacy Packing Slip dated 1/21/15 documented that Klonopin (clonazepam) was sent to the facility for (name of Resident # 14). Review of the MAR (Medication Administration Record) for the month of January 2015 documents that on 1/22/15 at 0900 (9:00 a.m.) Resident # 14 was administered clonazepam 0.5 mg. During an interview on 3/3/16 at 12:55 p.m. with LPN (Licensed Practical Nurse) # 1, the nurse that administered the clonazepam, LPN # 1 was asked if she realized that the Resident was	F 333	physician for an order clarification and complete and incident report as needed during the audit for any identified areas of concern. The DON will review and initial the Order Clarification QI Tool weekly x 8 weeks the monthly x 1 month for compliance and to ensure that all areas of concern have been addressed. The Director of Nursing will compile the results of the Order Clarification QI Tool and present to the Quality Improvement Committee Meeting monthly x 3 months. Subsequent plans of action will be developed by the Committee when required. Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 333	Continued From page 83 allergic to this medication. LPN # 1 stated that she did and that she called the Physician, ASM # 4, to relay this information to him and ask what he wanted her to do. LPN # 1 stated that ASM # 4 told her (LPN # 1) to administer the medication and monitor the Resident for any side effects. LPN # 1 was then asked if she documented this conversation and she (LPN # 1) stated that she had. At this time the nurses notes were reviewed with LPN # 1, and LPN # 1 stated, "I thought I wrote a note but do not see any." LPN # 1 was asked if she remembered the pharmacy calling about this medication and the Resident's allergy to it. LPN# 1 stated that she did not. Further review of the clinical record revealed that on 1/22/16 at 1040 (10:40 a.m.) an order was received to discontinue the clonazepam. No further doses were administered. During an interview on 3/3/16 at 7:35 a.m. with ASM # 1 a request was made for a copy of the medication error incident report. A copy of the medication administration policy was requested. During an interview on 3/3/16 at 7:45 a.m. with LPN # 2 the process for sending orders to the pharmacy was discussed. LPN # 2 stated that the admission orders are transferred onto the Physician Order Sheet (POS) and then this POS is faxed to the pharmacy. When asked about allergies LPN # 2 stated checks the orders against allergies and if there was a problem give the doctor a call. One would also pass this information onto day shift and probably would call the pharmacy. If for some reason a resident received a medication that they were allergic to	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 333	Continued From page 84 one would first get a set of vitals, then call the doctor, document any vitals and any new orders, call the RP (responsible party), and fill out an incident report. The incident report is under the "Risk Management" tab on the computer. All this information would then go to the administrator. During an interview on 3/3/16 at 8:05 a.m. RN (Registered Nurse) # 2 was asked to explain the process for sending orders to the pharmacy. RN # 2 stated that the doctors order are written on the POS by one nurse then another nurse comes behind and checks - both nurses sign the POS. Allergies and diagnoses are also checked. This POS is faxed to the pharmacy. When the doctor comes he reads and signs the copy of the POS. If he writes an order for a medication that a Resident is allergic to the nurse would call the doctor and let him know. If a Resident receives a medication that they are allergic to then one would immediately notify the doctor, monitor the Resident for any adverse reaction and also notify the RP. One would document in the nurses notes and also do an incident report. This report is in the computer system - there is a tab for it, but no paper form. During an interview on 3/3/16 at 9:45 a.m. with ASM # 1 it was revealed that there was no medication error report for this incident. When asked what she (ASM # 1) would have expected, ASM # 1 stated that she would have expected a report and documentation of monitoring the Resident for any reactions also would have expected this information to have been put on the 24 hours report so this error could have been passed on to the next shifts. ASM # 1 stated that she would look for the 24 hours report for that date (1/22/15).	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 333	Continued From page 85 Review of the facility policy: "MEDICATION ADMINISTRATION" documented the following: "G. All medication errors shall be described in detail on a Medication Error Report which shall be filed with the Director of Nursing. The attending physician shall be notified immediately of all significant medication errors." "N. Any deviation from the following principles shall be considered a medication error: 1. To the right resident; 2. Administration of the right medication; 3. In the right dose; 4. By the right method; 5. By the right method; 6. At the right time. All recognized deviations from the above principles shall be reported to the Supervisor, immediately. The Supervisor shall initiate a Medication Error Report which shall be submitted to the Director of Nursing." During a meeting on 3/3/16 at 3:10 p.m. with ASM # 1 and ASM # 2, the director of nurses, this concern was reviewed. ASM # 1 stated that when the 24 hours report was reviewed there was no mention of the medication error. Prior to exit no additional information was provided. * Benzodiazepines are depressants that produce sedation, induce sleep, relieve anxiety and muscle spasms, and prevent seizures. www.dea.gov/druginfo/drug_data_sheets/Benzodiazepines.pdf ** Clonazepam --Klonopin®....Clonazepam is used alone or in combination with other medications to control certain types of seizures. It....of extreme fear and worry about these attacks). Clonazepam is in a class of medications called benzodiazepines.	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 333	Continued From page 86 https://www.nlm.nih.gov/medlineplus/druginfo/meds/a682279.html - According to "Fundamentals of Nursing", Seventh Edition, 2009: by Perry and Potter Chapter 35 "Medication Administration" Chapter 35, pg. 707 read: "Professional standards, such as the American Nurses Association's Nursing: Scope and Standards of Nursing Practice (2004), apply to the activity of medication administration. To prevent medication errors, follow the six rights of medication administration consistently every time you administer medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following: 1. The right medication, 2. The right dose, 3. The right client, 4. The right route, 5. The right time, and 6. The right documentation."	F 333		
F 425 SS=D	COMPLAINT DEFICIENCY 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 425	**F425** Resident #14 is no longer a resident of this facility. A 100% audit was completed of all resident's current MARs by RN/SDC nurse on March 11, 2016 to ensure medications are not being administered that residents are allergic to. All areas of concern noted from the audit will be addressed by the nurse, RN/SDC with MD notification, order clarification, and completion of an incident report. All of the pharmacist' have been re-educated on the monitoring of drug/allergy	March 31, 2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 425	Continued From page 87 The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review, and in the course of a complaint investigation the facility pharmacy failed to clarify a resident's medication allergy prior to dispensing medications for one of 21 Residents in the survey sample, Resident # 14. Resident # 14 had a documented allergy to a class of medications, benzodiazepines* to which Klonopin (clonazepam) ** belongs. This medication was ordered by the physician and was dispensed by the pharmacy. The findings include: Resident # 14 was admitted to the facility on 1/16/15 with diagnoses that included but not limited to hyperlipidemia, aortic aneurysm, osteoporosis, diabetes, hypothyroidism, congestive heart failure, hypertension, and coronary artery disease. At the time of the complaint Resident # 14's MDS (minimum data set), an initial assessment, with an ARD (assessment reference date) of 1/27/15 coded the Resident as being understood and able to understand others. The Resident had a BIMS (Brief Interview for Mental Status) of 15 out of 15 indicating that she was cognitively intact.	F 425	interactions by the Pharmacy Operations Manager by March 31, 2016. At the end of the business day twice weekly for 4 weeks a Neil Medical Group pharmacist in Kinston will compare the orders to be dispensed to Wayland on that date vs. the allergies listed in the pharmacy database. The pharmacist will sign the report indicating that the review has been completed. If a potential drug allergy contraindication that has not been acted upon is identified by the pharmacist at the end of the day, then that pharmacist will create an internal incident report for review by the Pharmacy Quality Assurance team at the Kinston pharmacy. The reviewing pharmacist will also act upon the potential allergy contraindication by contacting a member of the facility's nursing staff and/or take other actions as deemed appropriate per the reviewing pharmacist's professional judgment. The Pharmacy's Quality Assurance team will review the findings of the audits to determine the necessity for, manner of, and frequency of continued audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 425	Continued From page 88 Review of Resident # 14's clinical record revealed a physician order sheet (POS) dated 1/16/15 and signed by the physician on 1/20/15. Near the bottom of this form is a section to list the allergies. In this section was documented: "Benzodiazepines..." This form (POS) was faxed to the pharmacy on: "1/16/2015 at 16:32." A copy of this form was faxed from the pharmacy on: "3/3/2016 at 12:42 PM". Also located in the clinical record was a handwritten physician order [identified by ASM (Administrative Staff Member) # 1, the administrator, as being handwritten by the physician]. This order was signed and dated by the physician on 1/20/15. This order documented: "1/20/15 Clonazepam 0.5 mg (milligrams) PO (by mouth) X (times) 7 days then reduce to 0.5 mg PO q HS (every hour of sleep) X 14 days then D/C (discontinue). Report to MD (medical doctor) if insomnia or anxiety exacerbates upon discontinuation." Review of the pharmacy Packing Slip dated 1/21/15 documented that Klonopin (clonazepam) was sent to the facility for (name of Resident # 14). During an interview on 3/3/16 at 12:30 p.m. with OSM (Other Staff Member) # 8, a pharmacist, revealed that the pharmacy did indeed receive the POS with the allergies listed, as evidenced by the faxed copy he (OSM # 8) provided. When OSM # 8 was asked what the process would be if a physician ordered a medication to which a resident was documented to be allergic. OSM # 8 stated that the medication would flag and when the pharmacist gets a flag the pharmacist would	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 425	Continued From page 89 then contact the facility and ask that the physician be asked to clarify the order. It would be expected that a nurse's note be written and that a clarification order be obtained and faxed to the pharmacy. OSM # 8 stated that when the order of 1/20/15 was faxed to the pharmacy the records show that it flagged because of the allergy. OSM # 8 further stated that he could find no documentation detailing what the pharmacist that received the order did when the flag occurred. During an interview on 3/3/16 at 12:55 p.m. with LPN (Licensed Practical Nurse) # 1, LPN # 1 was asked if she remembered the pharmacy calling about this medication and the Resident's allergy to it. LPN# 1 stated that she did not. During a meeting on 3/3/16 at 3:10 p.m. with ASM # 1 and ASM # 2, the director of nurses, this concern was reviewed. Prior to exit no additional information was provided. * Benzodiazepines are depressants that produce sedation, induce sleep, relieve anxiety and muscle spasms, and prevent seizures. www.dea.gov/druginfo/drug_data_sheets/Benzodiazepines.pdf ** Clonazepam --Klonopin® ... Clonazepam is used alone or in combination with other medications to control certain types of seizures. It ...of extreme fear and worry about these attacks) Clonazepam is in a class of medications called benzodiazepines. ... https://www.nlm.nih.gov/medlineplus/druginfo/meds/a682279.html -	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 425	Continued From page 90 COMPLAINT DEFICIENCY	F 425		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	**F441** LPN #3 was in-serviced regarding sanitizing hands after removing gloves and before applying clean gloves during dressing changes and not taking multi dose treatment creams and solutions to include santyl in the resident's room during a dressing change; ointments and/or solutions must be placed in a cup prior to going in the resident's room by RN/SDC on or before March 31, 2016. 100% observation will be completed with all license nurses to include LPN # 3 to ensure proper sanitation of hands after removing gloves and applying clean gloves during dressing changes, multi dose treatment creams and solutions to include santyl are not taken into resident room during dressing changes to include resident # 4 and ointments and/or solutions are placed in a cup prior to going in the resident's room on or before April 15, 2016 by Administrative Nurses (DON/ADON/SDC/MDS Coordinator and/or Treatment Nurse). Retraining was conducted by Administrative Nurse during the audit for any identified areas of concern.	April 15, 2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 441	Continued From page 91	F 441		

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, it was determined that the facility staff failed to maintain infection control practices for one of 21 residents in the survey sample, Resident #4.

Facility staff failed to sanitize their hands after removing gloves and before applying clean gloves during a dressing change and to sanitize the tube of Santyl*** prior to returning it to the treatment cart.

The findings include:

Resident #4 was admitted to the facility on 7/17/15 and readmitted on 1/26/16 with diagnoses that included but were not limited to: arthritis, anemia, diabetes, depression, schizophrenia* and bipolar disease**.

Resident #4's most recent MDS (minimum data set), a 30 day assessment, with an ARD (assessment reference date) of 2/23/16 coded the resident's BIMS (brief interview of mental status) as a 15 out of 15 indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance with activities of daily living. In Section M -- Skin Conditions. M0100 Determination of Pressure Ulcer Risk. A. Resident has a stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device."

Review of the physician's order dated 3/2/16 documented to cleanse the left heel with soap

100% of license nurses to include LPN #3 and CNAs were in-serviced on or before April 15, 2016 by the RN/SDC regarding proper sanitation of hands after removing gloves and applying clean gloves. 100% of license nurses will also be in-serviced on not taking multi dose treatment creams and solutions to include santyl in the resident's room during a dressing change; ointments and/or solutions must be placed in a cup prior to going in the resident's room. All newly hired license nurses will be in-serviced regarding proper sanitation of hands after removing gloves and applying clean gloves, not taking multi dose treatment creams and solutions to include santyl in the resident's room during a dressing change; ointments and/or solutions must be placed in a cup prior to going in the resident's room and CNAs will also be in-serviced regarding proper sanitation of hands after removing gloves and applying clean gloves by the SDC during orientation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 441	Continued From page 92 and water, to apply Santyl***, cover with 4 inch by 4 inch gauze, apply a bulky dressing and secure it with a gauze wrap. An observation was made on 3/2/16 at 11:00 a.m. of Resident #4's left heel dressing change by LPN (licensed practical nurse) #3 after obtaining the resident's permission. LPN #3 explained the wound care to the resident and asked if he was in any pain. LPN #3 placed waxed paper on the table and then placed the gauzes and tube of Santyl on the paper. LPN #3 washed her hands, put on gloves and removed the dressing from the resident's foot. LPN #3 then removed her gloves and put on another pair without washing her hands. She then washed the resident's heel with soap and water; she then removed her gloves and put on another pair of gloves without washing her hands. LPN #3 then removed the gloves and went to the treatment cart to get a tongue depressor and a medicine cup. Some Santyl (from a tube already in the room) was squeezed into the cup. LPN #3 then used the tongue depressor to scoop the Santyl out of the cup and spread it on the wound. LPN #3 put on gloves without washing her hands and applied the new dressing. LPN #3 then took off the gloves, disposed of the supplies in a trash bag, took the trash bag and the tube of Santyl out of the room. She put the tube of Santyl back into the treatment cart and stood at the medication cart holding the trash bag while a staff member asked her a question. LPN #3 was observed to rub her eye and nose during this time. LPN #3 disposed of the trash bag and washed her hands. An interview was conducted on 3/2/16 at 2:50 p.m. with LPN #3, regarding hand washing during wound care. LPN #3 stated, "At the beginning	F 441	The Administrative Nurse (DON/ADON/SDC/MDS Coordinator and/or Treatment Nurse) will observe 10% of nurses during a resident dressing change to include resident # 4 to ensure sanitation of hands after removing gloves and applying clean gloves during dressing changes, multi dose treatment creams and solutions to include santyl are not taken into the resident's room prior to the dressing changes to include resident # 4 and ointments and/or solutions are placed in a cup prior to going in the resident's room weekly x 8 weeks then monthly x 1 month utilizing a resident care audit tool. Retraining will be immediately conducted with the license nurse by the Administrative Nurse for any identified areas of concern. The DON will review and initial the Resident Care audit Tool weekly x 8 weeks the monthly x 1 month for compliance and to ensure that all areas of concern have been addressed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 441	Continued From page 93 and end." When asked what she should do when she removes gloves, LPN #3 stated, "Wash hands between glove changes. LPN #3 was then asked what process staff follow when taking a tube of Santyl into the resident's room and then returning it to the treatment cart, LPN #3 stated, "I should have squeezed some (of the Santyl) into the cup instead of taking the tube into the room." When asked why, LPN #3 stated, "It (the tube) could have germs on it." An interview was conducted on 3/2/16 at 3:00 p.m. with LPN # 4. When asked what occurs when gloves are removed during wound care, LPN #4 stated, "Wash your hands." When asked why this was done, LPN #4 stated, "For infection control." An interview was conducted on 3/2/16 at 3:15 p.m. with ASM (administrative staff member) #2, the director of nursing. When asked what occurs when gloves are removed during wound care, ASM #2 stated, "Should wash your hands." ASM #2 stated, "Because it's a standard of care and infection control." ASM #2 was asked what process the staff follows if they take a tube of Santyl into a resident's room. ASM #2 stated, "It needs to be cleaned, again because of germs, nosocomial infections**** and infection control." ASM #2 was made aware of the findings at that time. On 3/3/16 at 3:10 p.m. ASM #1, the administrator was made aware of the findings. No further information was obtained prior to exit. In Fundamentals of Nursing, Lippincott Williams and Wilkins, page 140-143, concerning hand	F 441	The Director of Nursing will compile the results of the Resident Care Audit Tool and present to the Quality Improvement Committee Meeting monthly x 3 months. Subsequent plans of action will be developed by the Committee when required. Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 441	Continued From page 94 washing and the use of hand sanitizer: "The hands are conduits for almost every transfer of potential pathogens from one patient to another, from a contaminated object to the patient, or from a staff member to the patient. Hand hygiene is the single most important procedure in preventing infection....typically hands are washed with soap before coming on duty; before and after direct or indirect patient contact;...before preparing or administering medications...always wash your hands with soap after removing gloves...when using hand sanitizer, apply a small amount of the alcohol-based hand rub to all surfaces of the hands. Rub hands together until the entire product has dried (usually about 30 seconds)." *Schizophrenia is a serious brain illness. People who have it may hear voices that aren't there. They may think other people are trying to hurt them. Sometimes they don't make sense when they talk. The disorder makes it hard for them to keep a job or take care of themselves. https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=schizophrenia **Bipolar disorder is a serious mental illness. People who have it go through unusual mood changes. They go from very happy, "up," and active to very sad and hopeless, "down," and inactive, and then back again. They often have normal moods in between. The up feeling is called mania. The down feeling is depression <https://www.nlm.nih.gov/medlineplus/depression.html>. ***Santyl ointment is an enzymatic debriding ointment. It works by breaking down dead skin. ****Nosocomial Hospital acquired infections are a major cause of mortality and morbidity and provide challenge to clinicians. Measures of	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 441	Continued From page 95 infection control include identifying patients at risk of nosocomial infections, observing hand hygiene, following standard precautions to reduce transmission..." http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3963198/	F 441		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to obtain physician ordered laboratory test for one of 21 residents in the survey sample, Resident #5. The facility staff failed to obtain Resident #5's Depakote* level ordered by the physician to be drawn in February 2016. The findings include: Resident #5 was admitted to the facility on 1/24/11 and was readmitted on 10/2/14 with diagnoses that included but were not limited to: urinary tract infection, mental retardation, diabetes, high blood pressure, seizures and back pain. Resident #5's most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 2/19/16 coded	F 502	**F502** April 15, 2016 1. The Depakote level was obtained for resident # 5 on 3/3/16 by Vista Labs. The results of the Depakote level was forwarded to the MD on 3/3/16 by the DON. 2. A 100% audit was completed on or before March 30, 2016 by the RN/Corporate Nurse Consultant of all residents to include resident #5 ordered labs within the last 90 days to ensure labs have been drawn timely per physician's order. All identified areas of concern were immediately corrected by facility Administrative Nurses with physician notification during the audit. 3. An in-service was initiated with 100% of all license nurses to include LPN #1 regarding following physicians orders to include	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 502	Continued From page 96 the resident's BIMS (brief interview for mental status) as 10 out of 15 indicating the resident was moderately impaired to make daily decisions. The resident was coded as requiring assistance from staff for activities of daily living. In Section I -- Active Diagnoses, the resident was coded as having "Seizure Disorder or Epilepsy." Review of the physician's orders dated and signed on 2/5/16 documented, "Clarification of lab (laboratory) orders, HgBA1C** q (every) six months, Depakote q six months, Feb + Oct." Review of the February 2016 medication administration record documented, "5/21/15, DEPAKOTE, DIVALPROEX (generic name) TAB (tablet) 250MG (milligram) DR (delayed release) 1 BY MOUTH EVERY EIGHT HOURS." The Depakote was documented as being given every eight hours on each day. Review of Resident #5's clinical record did not evidence documentation of the Depakote level. An interview was conducted on 3/3/16 at 11:50 a.m. with ASM (administrative staff member) #2, the director of nursing. When asked if the Depakote level had been obtained ASM #2 stated it had not. ASM #2 stated the nurse who took the verbal order for the Depakote did not transfer the order into the laboratory book. An interview was conducted on 3/3/16 at 1 p.m. with LPN (licensed practical nurse) #1, regarding the process for obtaining a laboratory test ordered by the physician, LPN #1 stated, "Put (the order) in the (laboratory) book, they (the laboratory staff) come in every night and look at the book and draw the lab." When asked if there	F 502	obtaining labs timely and the process for obtaining a laboratory test ordered by the physician on or before April 15, 2016 by the SDC or DON. All newly hired license nurses will be in-serviced regarding following physicians orders to include obtaining labs timely and the process for obtaining a laboratory test ordered by the physician by the Staff Facilitator during orientation. 4. All newly ordered labs for all residents to include resident #5 and to include Depakote level will be reviewed by Administrative Nurses (DON/ADON/SDC/MDS Coordinator) weekly x 8 weeks then monthly x 1 month to ensure labs have been drawn timely per physician's order utilizing a Laboratory Monitoring QI tool. All identified areas of concern will immediately be corrected by the Administrative Nurse with retraining with the license nurse and physician notification during the audit. The DON will review and initial the Laboratory Monitoring QI Tool weekly x 8 weeks the monthly x 1 month for compliance and to ensure that all areas of concern have been addressed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 502	Continued From page 97 was a process to follow up that the laboratory specimen had been obtained, LPN #1 stated, "The night shift does, the pink slip (from the doctor's orders) is the one we take out and put on the MAR (medication administration record)." A review of the facility's policy titled, "ROUTINE LABORATORY DETERMINATIONS" documented in part, "In order that certain medications may be regularly monitored for appropriateness of dose, effectiveness and possible toxicity, the following determinations should be done routinely with the approval of the attending physician, for those residents to which they apply. Valproic acid (Depakote), valproic acid level within 1 month, then q (every) 6 months." On 3/3/16 at 3:10 p.m. ASM (administrative staff member) #1, the administrator was made aware of the findings. No further information was provided prior to exit. *Valproic acid is used alone or with other medications to treat certain types of seizures. Therapeutic drug levels are lab tests to look for the presence and the amount of a drug in the blood. https://www.nlm.nih.gov/medlineplus/druginfo/meds/a682412.html **A1C is a lab test that shows the average level of blood sugar (glucose) over the previous 3 months. It shows how well you are controlling your diabetes. https://www.nlm.nih.gov/medlineplus/ency/article/003640.htm	F 502	The Director of Nursing will compile the results of the Laboratory Monitoring QI Tool and present to the Quality Improvement Committee Meeting monthly x 3 months. Subsequent plans of action will be developed by the Committee when required. Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring. The Director of Nursing is responsible for overall compliance.	
F 504 SS=D	483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN	F 504		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 504	Continued From page 98 The facility must provide or obtain laboratory services only when ordered by the attending physician. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility policy review and clinical record review, it was determined the facility staff obtained a laboratory test without a physician's order for one of 21 residents in the survey sample, Resident #10. For Resident #10, facility staff failed to obtain a physician's order prior to obtaining a CBC* (complete blood count) laboratory test. The findings include: Resident #10 was admitted to the facility on 6/16/15 with diagnoses that included but were not limited to: end stage renal disease requiring dialysis, hallucinations, diabetes, high blood pressure and anemia. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 2/23/16 coded the resident's BIMS (brief interview of mental status) as 15 out of 15 indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance from staff for all activities of daily living except for eating which the resident could do after having the meal tray prepared. In section I -- Active Diagnoses, the resident was coded as having anemia. A review of the physician's orders dated 11/2/15	F 504	**F504** April 15, 2016 The MD was notified of obtaining the CBC for resident #10 on March 24, 2016 by the DON. A 100 % audit was conducted by Corporate Nurse Consultant, on or before March 30. 2016 to ensure that all laboratory tests, including blood draws for CBCs, that were collected within the past 30 days were obtained as ordered by the physician or per facility protocol. The MD was notified by Administrative Nurse for any identified areas of concern. All licensed nurses were in-serviced on the need to ensure physician order in place prior to obtaining any lab work, including blood draws for a CBC by Administrative Nurses (DON/ADON/SDC/MDS Coordinator) on or before April 15, 2016. All newly hired license nurses will be in-serviced regarding the need to ensure physician order in place prior to obtaining any lab work, including blood draws for a CBC by the Staff Facilitator during orientation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 504	Continued From page 99 documented that a repeat CBC was to be done in one week. A review of the laboratory results documented CBC results on 11/7/15 and 11/9/15. On 3/3/16 at 2:00 p.m. an interview was conducted with ASM (administrative staff member) #2, the director of nursing. When asked about the order for the 11/7/15 CBC result, ASM #2 stated, "I can't find an order for it, not sure if someone confused the numbers. The order was to recheck in one week, it (the CBC) should have been drawn on 11/9/ (15)." Review of the facility's policy titled, "RECEIPT OF PHYSICIAN'S ORDERS" did not evidence documentation about obtaining laboratory specimens without an order. On 3/3/16 at 3:10 p.m. ASM #1, the administrator was made aware of the findings. No further information was provided prior to exit. *A complete blood count (CBC) test measures the following: The number of red blood cells (RBC count <./003644.htm>), the number of white blood cells (WBC count <./003643.htm>), the total amount of hemoglobin <./003645.htm> in the blood, the fraction of the blood composed of red blood cells (hematocrit <./003646.htm>)	F 504	The Administrative Nurses (DON/ADON/SDC/MDS Coordinator) will conduct an audit of upcoming labs per the lab schedule including those for CBCs, to ensure a physician order was written prior to collection/ and or specimen was obtained for laboratory work per facility protocol of 25% of all residents to include resident # 10 weekly x 8 weeks then monthly x 1 month using a QI Lab Audit Tool. The Administrative Nurse will address any identified areas of concern by ensuring orders are written prior to the lab draw during the audit. The DON will review and initial the QI Lab Audit Tool weekly x 8 weeks then monthly x 1 month for compliance and to ensure that all areas of concern have been addressed. The Director of Nursing will compile the results of the QI Lab Audit Tool and present to the Quality Improvement Committee Meeting monthly x 3 months. Subsequent plans of action will be developed by the Committee when required. Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 514	Continued From page 100 standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff failed to maintain a complete and accurate clinical record for one of 21 residents in the survey sample, Resident # 14. The facility staff failed to document the nurse's conversation with the physician concerning Resident # 14's medication allergy. Resident # 14 had a documented allergy to a class of medications, benzodiazepines* to which Klonopin (clonazepam) ** belongs. This medication was ordered by the physician and was dispensed by the pharmacy and administered by nursing staff. The findings include: Resident # 14 was admitted to the facility on 1/16/15 with diagnoses that included but not limited to hyperlipidemia, aortic aneurysm, osteoporosis, diabetes, hypothyroidism, congestive heart failure, hypertension, and coronary artery disease. At the time of the complaint Resident # 14's MDS (minimum data set), an initial assessment, with an ARD	F 514	April 15, 2016 **F514** Resident # 14 Klonopin was discontinued by the MD on 1/22/15 with a written physician's order. Resident #14 is no longer a resident of this facility. A 100% audit will be completed of all resident's physician orders within the last 90 days comparing to the resident medication allergies by the SDC/RN on March 11, 2016 to ensure if a resident has an allergy to a medication, the physician was notified with documentation of the notification in the clinical record. All areas of concern will be addressed by the nurse during the audit with MD notification, order clarification, completion of an incident report if needed, and documentation in the clinical. All licensed nurses to include LPN #1 will be in-serviced by Administrative Nurses (DON/ADON/SDC/MDS Coordinator) regarding notifying the physician and clarifying physician orders if the resident is allergic to a medication prior to the administration of the medication and documenting the physician notification in the clinical record on. All newly hired license nurses will be in-serviced regarding notifying the physician and clarifying physician orders if the resident is allergic to a medication prior to the administration of the medication and documenting the physician notification in the clinical record during orientation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 514	Continued From page 101 (assessment reference date) of 1/27/15 coded the Resident as being understood and able to understand others. The Resident had a BIMS (Brief Interview for Mental Status) of 15 out of 15 indicating that she was cognitively intact. Review of Resident # 14's clinical record revealed a physician order sheet (POS) dated 1/16/15 and signed by the physician on 1/20/15. Near the bottom of this form is a section to list the allergies. In this section was documented: "Benzodiazepines..." This form (POS) was faxed to the pharmacy on 1/16/2015 at 16:32. A copy of this form was faxed from the pharmacy on 3/3/2016 at 12:42 PM. Also, located in the clinical record was a handwritten physician order [identified by ASM (Administrative Staff Member) # 1, the administrator, as being handwritten by the physician]. This order was signed and dated by the physician on 1/20/15. This order documented: "1/20/15 Clonazepam 0.5 mg (milligrams) PO (by mouth) X (times) 7 days then reduce to 0.5 mg PO q HS (every hour of sleep) X 14 days then D/C (discontinue). Report to MD (medical doctor) if insomnia or anxiety exacerbates upon discontinuation." Review of the clinical record revealed no nurse's documentation for 1/22/15 the date that Resident # 14 received a medication that she was allergic to. During an interview on 3/3/16 at 12:55 p.m. with LPN (Licensed Practical Nurse) # 1, the nurse that administered the clonazepam, LPN # 1 was asked if she realized that the Resident was allergic to this medication. LPN # 1 stated that	F 514	The Administrative Nurses (DON/ADON/SDC/MDS Coordinator) will review all newly written physician orders for all residents to include resident #14 and compare to the resident's allergies weekly x 8 weeks then monthly x 1 month to ensure if a resident has an allergy to a medication, the physician was notified with documentation of the notification in the clinical record utilizing an Order Clarification QI Tool. The Administrative Nurses (DON/ADON/SDC/MDS Coordinator) will immediately contact the physician for an order clarification, document in the clinical record, and retrain the license nurse during the audit for any identified areas of concern. The DON will review and initial the Order Clarification QI Tool weekly x 8 weeks the monthly x 1 month for compliance and to ensure that all areas of concern have been addressed. The Director of Nursing will compile the results of the Order Clarification QI Tool and present to the Quality Improvement Committee Meeting monthly x 3 months. Subsequent plans of action will be developed by the Committee when required. Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 514	Continued From page 102 she did and that she called the Physician, ASM # 4, to relay this information to him and ask what he wanted her to do. LPN # 1 stated that ASM # 4 told her (LPN # 1) to administer the medication and monitor the Resident for any side effects. LPN # 1 was then asked if she documented this conversation and she (LPN # 1) stated that she had. At this time the nurse's notes were reviewed with LPN # 1 and she stated, "I thought I wrote a note but do not see any." During a meeting on 3/3/16 at 3:10 p.m. with ASM # 1 and ASM # 2, the director of nurses, this concern was reviewed. No further information was provided prior to exit. Potter-Perry Fundamentals of Nursing, 6th Edition, page 477 reads: "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice. * Benzodiazepines are depressants that produce sedation, induce sleep, relieve anxiety and muscle spasms, and prevent seizures. www.dea.gov/druginfo/drug_data_sheets/Benzodiazepines.pdf ** Clonazepam --Klonopin®....Clonazepam is used alone or in combination with other medications to control certain types of seizures. It....of extreme fear and worry about these attacks). Clonazepam is in a class of medications called benzodiazepines.	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	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) COMPLETION DATE
F 514	Continued From page 103 https://www.nlm.nih.gov/medlineplus/druginfo/meds/a682279.html -	F 514		