		AND H AN SERVICES			FORM	1: 03/15/2016 1APPROVED
		& MEDICAID SERVICES				<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	.E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495226	B. WING		C 03/03/2016	
NAME OF PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
WAYLAN	ID NURSING AND RE	HABILITATION CENTER		30 LUNENBURG HIGHW (EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	. (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	F 000			A DARRAGA DA VA SERBADA DA LEGA DA VA DE LA CALLA DA VA
F 157 SS=D	survey was conducted Complaints were in Corrections are requested. The requirements. The report will follow. The census in this sat the time of the succonsisted of 15 curi (Residents 1 throug closed record review #19). 483.10(b)(11) NOTI (INJURY/DECLINE) A facility must immedent with the result with the result with the result with the result injury and has the printervention; a significant physical, mental, or deterioration in head status in either life to clinical complication significantly (i.e., and existing form of treatment); or a decident from the \$483.12(a). The facility must also and, if known, the resident from the status in known, the resident from the status in known, the resident from the status in the st	ediately inform the resident; ident's physician; and if esident's legal representative mily member when there is an eneresident which results in estential for requiring physician ficant change in the resident's espectosocial status (i.e., a lith, mental, or psychosocial chreatening conditions or eas); a need to alter treatment eneed to discontinue an eatment due to adverse to commence a new form of cision to transfer or discharge the facility as specified in	F 157	Resident #14 is no longer a reside facility. Resident #7's physician have been notified of the nose ble DON on 12/4/15 with documenta clinical record. The RP for reside made aware of the canceled psych appointment by the hall nurse LP 2/22/16. Resident #4 psychiatrist' appointment was rescheduled for with RP notification by MDS Coordinator/RN on 3/17/16 with documentation in the clinical recordinates appointment was rescheduled for WITH WITH APR 0 6 2016 VDH/OLC	and RP and RP and RP and the set by and the set # 4 was aniatrist N on s 3/29/16 ord.	April 15, 2016
/ \	_	ER/SUPPLIER REPRESENTATIVE'S SIGN COLICUS, Odymu		ODYNIĆ	3l;	911PC

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

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

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

				(2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		495226		B. WING		C 03/03/2016		
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER				7.	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW (EYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 157	or interested family change in room or specified in §483. resident rights und regulations as specthis section. The facility must rethe address and properties and properties and properties. This REQUIREME by: Based on staff intereview, clinical receast a complaint investion the facility staff fails. RP (responsible pain condition for threst and RP of Resident 41. The facility staff and RP of Resident 12/1/15, and failed 47's nosebleed on 2. The facility staff Resident #4's psycappointment and the seen by the psychical staff party (RP) of Resident for Klonopin orders for Klonopin specifical staff party (RP) of Resident for Klonopin specifical specifical staff party (RP) of Resident for Klonopin specifical specifical staff party (RP) of Resident for Klonopin speci	member when there is a roommate assignment as 15(e)(2); or a change in er Federal or State law or cified in paragraph (b)(1) of ecord and periodically update none number of the resident's e or interested family member. NT is not met as evidenced erview, facility document ord review and in the course of gation, it was determined that ed to ensure the physician and arty) were notified of a change ee of 21 residents in the survey 47, #4 and #14. failed to notify the physician at #7's nosebleeds on 11/26/15, to notify the RP of Resident 12/2/15. If failed to notify the RP when thiatrist canceled an an eresident was not able to be atrist. failed to notify the responsible lent # 14's new medication and Effexor**.	F	157	A 100 % audit of residents to include resident #7 and #4 progress notes, phy orders, and appointments were completed. Corporate Nurse Consultant to entitle RP and/or MD has been notified a change in condition to include nose be cancelled appointments, and new medications completed on 3/17/16. The and/or MD was notified of any identification of nursing, Assistant Director Nursing and/or SDC/quality improver nurse by 3/31/16 with documentation medical records. The staff development coordinator initian in-service on 3/15/16 for 100% of licensed nursing staff, to include LPN and #4 regarding timely notification of changes in condition, new medications cancelled appointments, and document The social worker was in service by Administrator regarding the requirement RP notification of cancelled psychiatric appointments on 3/24/16. All newly his license nurses will be in serviced regardinely notification of changes in condition, cancelled appointments on 3/24/16. All newly his license nurses will be in serviced regardinely notification of changes in condition of changes in cond	eted by sure of any deeds, he RP fied he of hent in the stated #2 of the station. Into of station, he SDC ess		
	The findings includ	₽,			physician orders weekly x 8 weeks the	n		

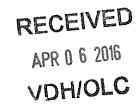
FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KMLK11

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monthly x 1 month to ensure the RP and/or

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

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

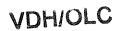
	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILD		COMPLETED			
		495226	B. WING	B. WING			C 03/03/2016	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947					
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F 157	1. The facility staff and RP of Resident 12/1/15, and failed 1s nosebleed on 1 Resident #7 was a 3/13/14 and was rediagnoses that incheart failure, anempressure, colon canosebleeds. Resident #7's mosset), a quarterly as (assessment refer the resident as ha (brief interview of resident was cogn of daily living. The requiring assistance Review of Resident that the resident's attorney and emer Review of the resident's attorney and revised documentation regulation regulation. Review of the nurse documented, (wheelchair) at sin blood. Large amt (can. Ice pack applinstructed resident subsided in approximation and representation of the pack applinstructed resident subsided in approximation and representation regulations.	failed to notify the physician of #7's nosebleeds on 11/26/15, It to notify the RP of Resident #7 2/2/15. Indmitted to the facility on eadmitted on 3/16/15 with luded but were not limited to: nia, liver failure, high blood ancer and a history of the recent MDS (minimum data assessment, with an ARD rence date) of 11/24/15 coded wing a 15 out of 15 on the BIMS mental status) indicating the litively intact to make decisions resident was coded as the for all activities of daily living.	F 1	57	MD has been notified of any change condition to include nose bleeds, can appointments, and new medications documentation in the medical record utilizing a notification QI Tool. The and/or RP will be notified and immeretraining will be conducted for the l nurse for any identified areas of conc Administrative Nursing staff (ADON or Treatment Nurse). The DON will and initial the QI notification Tool for compliance and to ensure all areas of concern were addressed weekly x 8 withen monthly X1 month. The Director of Nursing will compileresults of the QI notification tools and present to the Quality Improvement Committee Meeting monthly x 3 mo Subsequent plans of action will be developed by the Committee when redentification of any potential trends used to determine the need for action frequency of continued monitoring	ncelled with is MD diate icensed cern by N, SDC review or f weeks e the id nths. equired. will be		

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Facility ID: VA0050

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DEPARTMENT OF HEALTH AND H "AN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 495226 B. WING 03/03/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER **KEYSVILLE, VA 23947** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 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."

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

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	DING	(X3)	COMPLETED			
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NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIAT	(X5) COMPLETION E DATE		
F 157	An interview was cop.m. with ASM (adrithe director of nursing physician and RP stresident had a nose would expect them hours, not to call do but reasonable (lerwhat a reasonable stated, "Within 24 highly physician should has stated, "Yes." ASM findings at that time. An interview was cop.m. with LPN (lice regrading physician stated, "Falls with condition, not eating asked why they not "To let the family known asked why they not "To let the family known asked why they not "To let the family known asked why they not "To let the family known asked why they not "To let the family known asked why they not "To let the family known asked why they not "To let the family known asked why they not "To let the family known asked why they not "To let the family known asked why they not "To let the family known asked why they not "To let the family known asked why they not "To let the family known asked why they not "To let the family known asked why they not "To let the family known asked why they not "To let the family known asked why they not "To let the family known asked why they not "To let the family known asked why they not "To let the family known asked why they not "To let the family known asked why they not "To let the family known asked why they not "To let the family known asked why they not "To let the family known asked why they not "To let the family known asked why they not "To let the family known asked why they not "To let the family known asked why they not "To let the family known asked why they not "To let the family known asked why they not "To let the family known asked why they not "To let the family known asked why they not "To let the family known asked why they not "To let the family known asked why they not "To let the family known asked why they not "To let the family known asked why they not "To let the family known asked why they not "To let the family known asked why they not "To let the family known asked why they not "To let the family known asked why they not "To let the family known asked	onducted on 3/2/16 at 2:25 ministrative staff member) #2, ing. ASM #2 was asked if the should be notified when a sebleed. ASM #2 stated, "I to call within a reasonable uring the middle of the night, agth of time)." When asked amount of time was, ASM #2 mours." When asked if the ave been notified, ASM #2 #2 was made aware of the extension and RP notification. LPN #4 or without injury, a change in g, any acute episodes." When iffied the family, LPN #4 stated now what's going on, it's a extension and family relationship." They notified the physician, LPN wild be aware of his resident's tesident #7 's notes dated and 12/2/15 were reviewed with ated, "I see what you're saying tory of nose bleeds. Because it ght I would give report (to the extension) with the morning. The RP called the next morning." a.m. ASM # 1 presented the OTIFICATION OF CHANGES: orm the resident; consult with ician; and if known notify the resentative or an interested		157				

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

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
		495226	B. WING		03	C / 03/2016	
	PROVIDER OR SUPPLIER ID NURSING AND REI	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
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F 157	*An accident which potential for requirir intervention; * A significant changmental, or psychoso * The need to alternew treatment; or * A decision to trans Review of the facilit "NOTIFICATION Of IN RESIDENT'S COTTO the facility to notify significant change is with documentation record." No further information in Basic Nursing, Election (Potter and I was a reference so notification. Failure condition appropriate	ge 5 results in injury and has the ng physician ge in the resident's physical, ocial status; treatment or to commence a sifer or discharge the resident."	F 15	DEFICIENCY)	PROPRIALE		
	way to avoid being follow standards of care, and to commu providers. The physis responsible for di of a patient. *A complete blood of the following: The n count <./003644.htr blood cells (WBC cells)	of negligent acts. The best iable for negligence is to care, to give competent health unicate with other health care ician or health care provider recting the medical treatment count (CBC) test measures umber of red blood cells (RBC n>) The number of white bunt <./003643.htm>). The noglobin <./003645.htm> in the					

(X2) MULTIPLE CONSTRUCTION

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DEPARTMENT OF HEALTH AND HOAN SE	ERVICES
CENTERS FOR MEDICARE & MEDICAID SE	RVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495226	B. WING		03	C 03/03/2016	
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 157	blood cells (hemate https://www.nlm.nil 003642.htm 2. The facility staff Resident #4's psycappointment and the seen by the psychic Resident #4 was ac 7/17/15 and readmediagnoses that incluarthritis, anemia, dischizophrenia* and Resident #4's most set), a 30 day asset (assessment referent the resident's BIMS status) as a 15 out	of the blood composed of red porit <./003646.htm>). h.gov/medlineplus/ency/article/ failed to notify the RP when hiatrist canceled an he resident was not able to be atrist. dmitted to the facility on itted on 1/26/16 with uded but were not limited to: labetes, depression,	F 1				
	with activities of da under D0200. Resi resident was coded depressed, or hope (indicating the resid Symptom Frequench had these feelings days)." In Section I resident was coded depression (bipolar An observation was of Resident #4. The was awake and ale	oded as requiring assistance ily living. In Section D Mood, dent Mood Interview the funder "B. Feeling down, eless. Symptom Presence, 1 dent felt these feelings). Under cy 2 (indicating the resident 7-11 days (half or more of the Active Diagnoses, the las having depression, manic disease) and schizophrenia. The resident was lying in bed and crt. The resident was receiving esident did not engage in					

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DEPARTMENT OF HEALTH AND HOAN SERVICES	
CENTERS FOR MEDICARE & MEDICALD SERVICES	

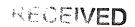
AND PLAN OF CORRECTION (X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION ING	0	(X3) DATE SURVEY COMPLETED			
and a property of the second		495226	B. WING			C 03/03/3046		
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			03/03/2016		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BI HE APPROPRIA			
F 157	An observation was of the resident. The a chair in his room An observation was of the resident. The wheelchair sitting quality of the resident. The wheelchair sitting quality of the nurse 2/11/16 at 4:54 p.m. staff reported to this 4:25 (p.m.) resident writer spoke to resident writer spoke to resident of the polysical doctor) pasomething for resident cuantipsychotic medical doctor) pasomething for resident cuantipsychotic medical (by mouth) @ hs (horesponse from Md.) A review of the clinititled, "goDocs (the physician group). 2. DOB (date of birth) Chief Complaint, Rekill himself. Resident PO @ HS for anxies something else pleadepressed. MD gave pointing up) Seroquel Further review of the timed, 2/11/16 docucall, verbal order gis Seroquel 50 mg po	g this observation. Is made on 3/2/16 at 12:00 p.m. a resident was sitting quietly in receiving medications. Is made on 3/2/16 at 3:00 p.m. a resident was up in a uietly in the dayroom. Is se's notes dated and timed, documented, "Note Text: is writer that at approximately it stated, "I have to kill myself" dent and he did not state this or of nursing) made aware, Md iged as well, writer to request ent (sic) depression and irrently on Seroquel (an cation*^) 50 mg (milligrams) po our of sleep), writer awaiting	F 1	157				

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	V. /	
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTR
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING

(X3) DATE SURVEY

/	CONTROLON	IDEITH ICATION NOMBER.	A. BUILDII	ING _		COM	PLEIED
495226		495226	B. WING _				03/2016
NAME OF F	PROVIDER OR SUPPLIER			Sī	FREET ADDRESS, CITY, STATE, ZIP CODE		
MANAVI AN	D MISDOMO AND DEI	IADU ITATION CENTED		73	30 LUNENBURG HIGHW		
WAYLAND NURSING AND REHABILITATION CENTER				K	EYSVILLE, VA 23947		
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F 157	PRN, RP (name of new order, RP state psychiatrist (sic) in (a.m.) and make the on, note to be left for Review of the nurse not evidence further suicide threat or that by the psychiatrist. Review of the physifrom 7/15 to 3/16 di that the resident was note of 8/15 did not the resident was sure Review of the social 1:56 p.m. document assessment, writer was feeling down, or resident) answer (si upcoming appt. (ap Psychiatrist in (name A review of the "Res Appointments, Febric documented, "Tues TIME OF APT (apple LEAVING FACILITY COMMENTS, (name	RP) called and made aware of ad she wants facility to call his (name of town) in the ame aware of whats (sic) going or DON." It's notes for February 2016 did reference to the resident's at the resident had been seen cian's and psychiatrist's notes don't evidence documentation is suicidal. The psychiatrist's evidence documentation that icidal. I worker's note for 2/23/16 at ted, "During the residents (sic) asked (name of resident) if he or depressed. (Name of ic) depressed. He has an pointment) with the e of town)." Isidents (sic) Weekly that year 22, - February 26, 2016." 1.2/23/16, (name of resident), pointment) 1:15 p.m., TIME of 12:00 p.m., SPECIAL e of psychiatrist) - (name of the protested in the prote	F 19	/*************************************	DEFICIENCY)		
	evidence document	e's notes for 2/23/16 did not ation that the RP had been dent was not able to be seen					

		AND H AN SERVICES				FORM	0: 03/15/2016 1 APPROVED 0: 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION	CON	TE SURVEY MPLETED
		495226	B. WING	;		- 1	C / 03/2016
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		7:	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW (EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 157	On 3/3/16 at 8:00 at this writer documer called (name of docresident) an appoin depression and verdie the earliest avait 23rd at 1:15 p.m." I OSM #6, the appoint An interview was caum. with ASM (admitted director of nursion of the findings at the Con 3/3/16 at 10:30 documented, "I (na call on 2/22/2016 frostating that she counter the context of the stating that she counter the counter the context of the stating that she counter the context of the stating that she counter the counte	a.m. a typed note was left for onting, "On February 12th I ctor) office to make (name of trent for increase in balizing he feels like wants to diable they had was February to was signed and dated by natment coordinator. Inducted on 3/3/16 at 8:50 ninistrative staff member) #2, ang. ASM #2 was made aware at time. a.m. a typed note me of employee) received a om (name of physician) ald not see (name of resident) orted to the nurse that she	F	1157			

secretary.

(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

On 3/3/16 at 3:10 p.m. ASM #1, the administrator

No further information was provided prior to exit.

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

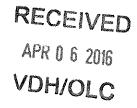
was made aware of the findings.

According to Mosby's Basic Skills and

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Facility ID: VA0050

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

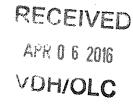
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
The same of the sa	495226		B. WING_				C 03/2016	
	PROVIDER OR SUPPLIE	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIF 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	CODE	001	00/20 TO	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD I HE APPROPR	BE	(X5) COMPLETION DATE	
F 157	altogether. What is important that it members of other individual needs at *^Seroquel is an afor the treatment Information Hand edition, Turkoski, Corp Hudson Ohi *Schizophrenia is who have it may have it may have it may have them. Sometimes they talk. The diskeep a job or take https://vsearch.ry-meta?v%3Apro=medlineplus-bur**Bipolar disorder People who have changes. They go active to very sad inactive, and then normal moods in called mania. The https://www.nlm.html>. 3. For Resident # notify the response medication orders. Resident # 14 wa 1/16/15 with diagrilimited to hyperlip	ever type of referral is needed, it he nurse collaborate with disciplines so that the client's	F 16					

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Event ID: KMLK11

Facility ID: VA0050

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

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495226	B. WING	j		C / 03/2016	
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	,			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	· · · · · · · · · · · · · · · · · · ·	ULD BE	(X5) COMPLETION DATE	
F 157	congestive heart facoronary artery discomplaint Resident set), an initial asse (assessment refere the resident as bei understand others. (Brief Interview for indicating that she Review of Resident a handwritten physical (Administrative State administrator, as be physician]. This or the physician on 1/documented: "1/20 (milligrams) PO (by reduce to 0.5 mg FX 14 days then D/0 (medical doctor) if exacerbates upon Also, located in the following physician on 7/28/15: "7/28/AM X 7 days, then (anxiety)." Review of the clinic documentation that was notified that ei ordered. During an interview LPN (Licensed Prachanges in treatme LPN # 2 stated tha	ailure, hypertension, and sease. At the time of the at # 14's MDS (minimum data essment, with an ARD ence date) of 1/27/15 coded ing understood and able to . The resident had a BIMS Mental Status) of 15 out of 15 was cognitively intact. It # 14's clinical record revealed sician order [identified by ASM aff Member) # 1, the being handwritten by the reder was signed and dated by /20/15. This order 0/15 Clonazepam 0.5 mg y mouth) X (times) 7 days then PO q HS (every hour of sleep) C (discontinue). Report to MD insomnia or anxiety	F 1	157			

		AND H AN SERVICES & MEDICAID SERVICES			FORM	9: 03/15/2016 1 APPROVED 9: 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION DING		TE SURVEY MPLETED
		495226	B. WING	i	03	C / 03/2016
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	E	
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORREIX (EACH CORRECTIVE ACTION SECRETARY CROSS-REFERENCED TO THE APDEFICIENCY)	(X5) COMPLETION DATE	
F 157	shift that she would shift and that they wasked where she w LPN # 2 responded in the nurse's notes During an interview RN (Registered Nu	pass the information onto day would notify the RP. When would document any notification that it would be documented	F 1	157		

potential for requiring physician
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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

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

*An accident which results in injury and has the

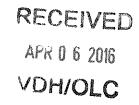
contained within the medical record."

family member when there is:

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DEPARTMENT OF HEALTH AND HAN SERVI	CES
CENTERS FOR MEDICARE & MEDICAID SERVI	CES

	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	IG		COMPLETED		
		495226	B. WING_		0	C 3/03/2016		
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP COE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		5/05/2010		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 157	intervention; * A significant changemental, or psychoso and the result of the result	ge in the resident's physical, ocial status; treatment or to commence a sfer or discharge the resident." on 3/3/16 at 3:10 p.m. with # 2, this concern was again provided prior to exit. onopin® Clonazepam is mbination with other trol certain types of seizures, and worry about these am is in a class of medications	F 15					
	to treat depression. (long-acting) capsul generalized anxiety worrying that is diffi	.gov/medlineplus/druginfo/me		• Out of the control				
F 225 SS=D	483.13(c)(1)(ii)-(iii), INVESTIGATE/REF ALLEGATIONS/IND The facility must no been found guilty of	(c)(2) - (4) PORT DIVIDUALS It employ individuals who have fabusing, neglecting, or	F 22	5				
	mistreating resident	ts by a court of law; or have						

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		AND H AN SERVICES			FORM	: 03/15/2016 APPROVED
STATEMENT	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l .	LE CONSTRUCTION	(X3) DAT	. 0938-0391 E SURVEY APLETED
		495226	B. WING			C /03/2016
	PROVIDER OR SUPPLIER D NURSING AND RE	HABILITATION CENTER	7	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETION DATE
F 225	registry concerning of residents or misa and report any know court of law against indicate unfitness for other facility staff to or licensing authority. The facility must entinvolving mistreatm including injuries of misappropriation of immediately to the atto other officials in a through established State survey and control of the facility must have a state of the facility must have a state of the facility must have a state of all into the administrator representative and with State law (includent, and if the state of the facility and if the state of the sta	ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; whedge it has of actions by a san employee, which would or service as a nurse aide or the State nurse aide registry ries. sure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law procedures (including to the entification agency). ve evidence that all alleged ughly investigated, and must ential abuse while the rogress.	F 225	Resident #19 is no longer a resident facility. CNA #8 and CNA #9 is no an employee of the facility. The all of abuse was reported to the Depart Health Professions, Enforcement Di on March 7, 2016 by the Administra All other allegations/investigations for the past year have been audited Administrator and reviewed by the Corporate Nursing Consultant to en appropriate reporting was made to a required agencies on March 16, 201 Resident abuse interviews were con will all alert and oriented residents of 3/17/16-3/21/16 by the Social Work MDS Coordinator/RN to ensure the allegations of abuse have been reportine Administrator and addressed. All facility department managers (in maintenance, MDS, Activities, AP/DON, Therapy Director, Medical R Housekeeping/Laundry Supervisor, Admissions/Social worker, AR book Supply Clerk, SDC, Dietary Managinclude the Administrator and Director Nursing were re-educated on the requirement of reporting to regulator.	of this longer egation ment of ivision ator. of abuse by the sure all 6. ducted on ter and t all rted to including Payroll, ecords, which is to cord of the cord o	farch 30, 201

by:

This REQUIREMENT is not met as evidenced

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

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agencies by the Corporate Nursing

dietary department, housekeeping

Consultant on March 9, 2016. All facility

department, and therapy department were

staff to include CNAs, license nurses,

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DEPARTMENT OF HEALTH AND HOAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					
		(X1) PROVIDER/SUPPLIER/CLIA	(X		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	495226		B. WING			C 03/03/2016		
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, Z 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	IP CODE	<u> </u>	5072010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE	
F 225	other officials in a through established State survey and oresidents in the survey and oresidents in the survey and threat survey, and threat Resident #19. Chathis allegation was not and state agency abuse by CNA #8 to the department. The findings including the finding the f	e to the administrator and to occordance with State law ed procedures (including to the certification agency) for 1 of 21 urvey sample; Resident #19. certified nursing assistant) #9 ember (CNA #8) being verbally atened physical abuse, of IA #9 did not immediately report abuse to the administrator; the irreported to the administrator until 6/29/15. The allegation of and findings were not reported of health professionals.	F 2	inserviced regarding the pimmediately reporting all to their supervisor, DON, by Administrator on or be newly hired CNAs, licens department, housekeeping therapy department will be policy of immediately report abuse to their supervisor Administrator during oried development coordinator manager. Social Worker or Administrator (DON/ADON/SDC/MDS) conduct resident interview weeks then monthly x 1 mallegations of abuse have timely and addressed utilizabuse interview QI Tool. will review and initial the interview tool for compliant all areas of concern were ax 8 weeks then monthly X Corporate Nurse Consultatinitial all Facility reported x 3 months to ensure all all were reported timely to the and reported to the appropriate Abuse Reporting Moni	legations of and Admin efore 3/30/1 se nurses, dig department of inserviced porting alleg or, DON, an entation by the or department of the Administrative Nurses) will be en reported zing the resident abunce and to enaddressed with the incidents of endministrative agency	istrator 6. All etary it, and d on the ations d he staff ent se ll 8 ure all ed dent istrator use ensure eekly ne w and conthly abuse ator using		

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witnessed staff member (CNA #8) to tell resident

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RECEIVED

	MENT OF HEALTH	AND H AN SERVICES & MEDICAID SERVICES				FORM	: 03/15/2016 APPROVED : 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		TE SURVEY MPLETED
		495226	B. WING				C / 03/2016
	PROVIDER OR SUPPLIER D NURSING AND REI	HABILITATION CENTER		73	REET ADDRESS, CITY, STATE, ZIP CODE O LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 225	to shut up and put if then stated if he "di up side of his head." alleged perpetrator drug tested and sus completion" In the parties, next to "DH Professionals) was upon investigation in The follow up report contained a fax recodocumented, under taken" that "alleged permitted to give a and suspended per was permitted to give a and suspended per was permitted to give a suspended per was permitted to give as and suspended per was permitted to give as and suspended invested and suspended investigation"	ner hand over his mouth. She dn't stop she would pop him " Employee action initiated: r permitted to give statement; spended pending investigation ne box for notifying interested P" (Department of Health documented, "dependent results." It to this FRI, undated, but eipt indicating a date of 7/3/15, "Employee action initiated or perpetrator (CNA #8) was statement was drug tested ading investigation. (CNA #9) we a statement, was drug led for delayed reporting, se policy. Employee (CNA	F2		The Administrator will compile the re of the resident abuse interview tools a Abuse Monitoring tools present to the Quality Improvement Committee Mee monthly x 3 months. Subsequent planaction will be developed by the Commwhen required. Identification of any potential trends will be used to determ the need for action and/or frequency continued monitoring.	and the eting s of mittee	

(CNA #8) terminated."

tested positive for illegal drugs.

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

inappropriate interaction with resident. Employee

CNA #8 was drug tested. Results of the drug test, dated 7/10/15, documented that CNA #8

In addition, other statements obtained during the

able to prove staff member didn't have

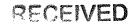
	TH AND H AN SERVICES			FORM.	03/15/2016 APPROVED
CENTERS FOR MEDICA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	0938-0391 SURVEY PLETED
	495226	B. WING			03/2016
NAME OF PROVIDER OR SUPPLI	R		STREET ADDRESS, CITY, STATE, ZIP CODE		
WAYLAND NURSING AND REHABILITATION CENTER			730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
PRÉFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERICIENCY)	D BE	(X5) COMPLETION DATE
documented, regattitude with the any kind of way. member statement attitude." The written state documented, "I see (Resident #19) in She also told him upside of his hear This was my first to report it. How with (Administration of the interpolation of the inter	realed one staff member larding CNA #8, "she has an residents, and talking to them She's rude." A second staff ent documented, "She has (an) ment by CNA #9 dated 6/29/15, aw (CNA #8) put her hand over nouth and told him to shut up. If he didn't she would pop him lad. This took place on 6/18/15. It day of orientation. I was scared ever, I know I needed to and met or) as soon as I could after. Iterview with CNA #9, (undated becomented, "How did you lacident? I did not say anything. I jaw." "What was resident's lold her she can't do that." "Did No, but she raised her hand." his happen? Right at bed time. ""Why did you wait so long to be oried that I'd get in trouble for because she has been here get fired." "How long have you? I met her the day I walked on 6/18 (2015)." "Have you had his about her interactions with list worried that her anger or cot the care residents get. I don't	F 225			

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

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		AND H AN SERVICES & MEDICAID SERVICES				FORM	: 03/15/2016 APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DAT	. 0938-0391 E SURVEY IPLETED
		495226	B. WING			1	C /03/2016
NAME OF PROVIDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP CODE			
WAYLAN	D NURSING AND REI	HABILITATION CENTER			EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE	(X5) COMPLETION DATE
F 225	saying look (Reside gown. But then he got to do then he we better. When he cruying but he just ke whats [sic] wrong he whimper noise. I ha #19) in anyway no rhave need {sic} yell. Further review of the evidence that the all reported to the state the termination of Contreatened physical CNA #8's termination interaction" with Re. On 3/2/16 at 3:26 p. Administrator (ACS Staff), she stated the dementia and was a allegation, she was abuse had occurred "decided that we we have previously known a false report." This anywhere in the invispecifically docume prior interactions will make a false report written statement, whave you known (Contractions will make you known (Contractions will will make you known (Contractions will make you known (Contractio	ent #19) you got to put on your give in and let me do what I ould tell me he feel so much ies I would ask him whats [sic] eep crying. He never say e just mumbles, he makes ave need {sic} touch (Resident more than taking care of him, I ed at (Resident #19)." e FRI failed to reveal any legation of abuse was e board of nursing following ENA #8 for observed verbal, abuse of Resident #19, for on for "inappropriate sident #19. .m., in an interview with the #1 - Administrative/Corporate that because the resident had unable to corroborate the unable to substantiate that d. She stated the facility ere unaware if (CNA #9) may own (CNA #8) and may make s was not documented estigation. The investigation ented that CNA #9 "had no the employee and no reason to "and per CNA #9's own was documented, "How long NA #8)? I met her the day I door on 6/18 (2015)" (which	F 2	225			

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

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION		E SURVEY PLETED
		495226	B. WING				C 03/2016
	PROVIDER OR SUPPLIER ID NURSING AND REI	HABILITATION CENTER		7:	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW (EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	:	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 225	that she would remark situation, ensure the report it to her super On 3/2/16 at approximate conducted with nurse) #1 and CNA abuse. All staff star should be reported the resident is safe. A review of the empthat on 10/23/14, starting that on 10/23/14, starting that on the starting that the resident is safe.	ove the resident from the at the resident was safe and	F2	2225			

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

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



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	TMENT OF HEALTH	AND H AN SERVICES & MEDICAID SERVICES				FORM	03/15/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
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	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW (EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	of employment" A review of the "Nurcontained in the em 10/23/14 by CNA #8 and responsibilities abuse immediately harsh/abusive languetc.)" A review of the facil Misappropriation of documented, "The residents have the neglect, involuntary misappropriation of whatever is in its coneglect, and abuse misappropriation of who witnesses or simisappropriation of immediately report supervisor, who will incident to the Adm concern related to misappropriation of disciplinary action a	rsing Assistant" job description aployee record and signed on 8 documented, "Major duties37) report any resident to the licensed nurse (i.e. uage, unnecessary roughness, lity policy, "Abuse, Neglect, or Resident Property" facility believes that our right to be free from abuse, seclusion, or property. The facility will do ontrol to prevent mistreatment, of our residents or their property. Any employee uspects that abuse, neglect, or property has occurred will the alleged incident to their immediately report the inistrator. Failure to report any	F:	225			

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



		AND H AN SERVICES & MEDICAID SERVICES			FORM	03/15/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		E SURVEY IPLETED
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	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 225	court of law or who into this state's Nur abuse, neglect, or r property. The facili has of actions by a employee, which we service as a nurse at this state's Nurse A boards and/or regis The Administrator is incidents, as indicate appropriate local / services.	have had a finding entered se Aide Registry concerning misappropriation of their ty will report any knowledge it court of law against an ould indicate unfitness for aide or other facility staff to ide Registry or licensing triesReporting/Response: a responsible to ensure that ted, are reported to the state / federal agencies, Nurse Aide Registry.	F 225			
	meeting, the Admin Director of Nursing of the findings. No provided by the end 483.13(c) DEVELO ABUSE/NEGLECT, The facility must depolicies and proced mistreatment, negle	P/IMPLMENT ETC POLICIES Evelop and implement written	F 226	F226 Resident #19 is no longer a resident facility. CNA #8 and CNA #9 is not an employee of the facility. The also of abuse was reported to the Depart Health Professions, Enforcement Don March 7, 2016 by the Administra	t of this o longer legation tment of Division rator.	30, 2016

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

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

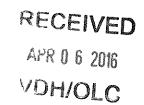
Administrator and addressed.

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

Event ID: KMLK11

Facility ID: VA0050

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495226	B. WING				C 03/2016
	PROVIDER OR SUPPLIE	EHABILITATION CENTER		7	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW (EYSVILLE, VA 23947	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPRICIENCY)	BE	(X5) COMPLETION DATE
F 226	the required state in the survey sam On 6/18/15 CNA (witnessed staff m abusive, and three Resident #19. Che this allegation of a allegation was not and state agency terminated as a reallegation and find state board of nur. The findings inclusive state board of state board of nur. The findings inclusive state board of stat	agencies for 1 of 21 residents ple; Resident #19. (certified nursing assistant) #9 ember (CNA #8) being verbally atened physical abuse, of NA #9 did not immediately report abuse to the administrator; the treported to the administrator until 6/29/16. CNA #8 was esult of the investigation. The dings were not reported to the resing.	F 2	226	All facility department managers (inclimaintenance, MDS, Activities, AP/Par DON, Therapy Director, Medical Recomposition of the Housekeeping/Laundry Supervisor, Admissions/Social worker, AR bookk Supply Clerk, SDC, Dietary Manager) include the Administrator and Directo Nursing were re-educated on the requirement of reporting to regulatory agencies by the Corporate Nursing Consultant on March 16, 2016. All facts staff to include CNAs, license nurses, dietary department, housekeeping department, and therapy department we serviced regarding the policy of immereporting allegations of abuse to their supervisor, DON, and Administrator by Administrator on or before March 30, All newly hired CNAs, license nurses, dietary department, housekeeping department, and therapy department win serviced on the policy of immediate reporting allegations of abuse to their supervisor, DON, and Administrator of orientation by the staff development coordinator or department manager.	yroll, ords, eeper, to rof cility ere indiately 2016.	

she would pop him up side of his head."

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

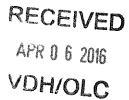
PRIN	TED:	03/15	5/2016
FC	DRM /	APPR	OVED
OMB	NO.	0938	-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		495226 B. WING			C 03/03/2016		
	PROVIDER OR SUPPLIE D NURSING AND F	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 226	permitted to give suspended pending the box for not "DHP" (Department documented, "deresults." The follow up repunder "Employee "alleged perpetragive a statement, pending investigating give a statement, for delayed report policy. Employee result of the investigating "Resident (#19) is if alleged incident know when people resident reported (CNA #9) had no and no reason to substantiate that able to prove staff inappropriate interest, dated 7/10/1 tested positive for the investigation, other investigation reveal to get the prove documented, regreatitude with the resident with the resident with the resident with the resident to give the positive for the provident to give the provident to give the positive for the provident to give the provid	initiated: "alleged perpetrator statement, drug tested and ng investigation completion" ifying interested parties, next to ent of Health Professionals) was pendent upon investigation out to this FRI documented, action initiated or taken" that tor (CNA #8) was permitted to was drug tested and suspended ation. (CNA #9) was permitted to was drug tested and suspended ting, failure to follow abuse (CNA #8) was terminated as a stigation" ion Summary" was documented, ademented and unable to state to occurred, he does report, "you le don't like you." No other concerns of (CNA #8); however prior interactions with employee make a false report. Unable to exact allegation occurred but not if member didn't have traction with resident. Employee atted." It tested. Results of the drug 5, documented that CNA #8	F 2	Social Worker or Administrate (DON/ADON/SDC/MDS Nu conduct resident interviews we weeks then monthly x 1 mont allegations of abuse have been timely and addressed utilizing abuse interview QI Tool. The will review and initial the resi interview tool for compliance all areas of concern were addressed to the x 8 weeks then monthly X1 m Corporate Nurse Consultant we initial all Facility reported incoming a months to ensure all allegates were reported timely to the Administrator will compited the Abuse Reporting Monitorial The Administrator will compited the resident abuse interview. Abuse Monitoring tools present Quality Improvement Committ monthly x 3 months. Subsequent action will be developed by the when required. Identification potential trends will be used to the need for action and/or frequential monitoring.	rses) will reekly x 8 th to ensure all reported the resident readministrator dent abuse and to ensure ressed weekly tonth. The rill review and idents monthly ations of abuse dministrator reagency using fing Tool. The results readministrator reagency using fing Tool. The results readministrator reagency using fing Tool. The results readministrator reagency using fing Tool.		

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Facility ID: VA0050

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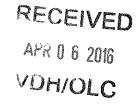
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	(X3) DA	TE SURVEY MPLETED
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NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND RE			STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
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attitude." The written statem documented, "I sat (Resident #19) mo She also told him i upside of his head This was my first of to report it. However, with (Administrator A documented interespond to this inclipated documented interespond to this inclination. It is a statement to the inclination in the in	ent by CNA #9 dated 6/29/15, w (CNA #8) put her hand over uth and told him to shut up. f he didn't she would pop him. This took place on 6/18/15. lay of orientation. I was scared ver, I know I needed to and met o) as soon as I could after. Erview with CNA #9, (undated tumented, "How did you ident? I did not say anything. I w." "What was resident's I her she can't do that." "Did No, but she raised her hand." I happen? Right at bed time. "Why did you wait so long to red that I'd get in trouble for cause she has been here set fired." "How long have you I met her the day I walked in 6/18 (2015)." "Have you had is about her interactions with the worried that her anger or the care residents get. I don't	F 22			

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]

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		AND H AN SERVICES & MEDICAID SERVICES			FORI	D: 03/15/2016 M APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	TIPLE CONSTRUCTION	(X3) DA	D. 0938-0391 ATE SURVEY MPLETED
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NAME OF F	PROVIDER OR SUPPLIER		· · · · · · · · · · · · · · · · · · ·	STREET ADDRESS, CITY, STATE, ZIP CODI		
WAYLAN	D NURSING AND REI	HABILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 226	whats [sic] wrong he whimper noise. I ha #19) in anyway no rehave need {sic} yell. Further review of the evidence that the all reported to the state the termination of Contreatened physical CNA #8's termination interaction" with Repositive for illegal discrete for interactions with anywhere in the investment for interactions with the properties of the interactions with the statement, where you known (Ciwalked through the was the alleged data.)	eep crying. He never say e just mumbles, he makes ave need {sic} touch (Resident more than taking care of him, I ed at (Resident #19)." e FRI failed to reveal any flegation of abuse was e board of nursing following CNA #8 for observed verbal, abuse of Resident #19, for on for "inappropriate sident #19, and for testing rugs. m., in an interview with the I #1 - administrative staff ed that because the resident was unable to corroborate the unable to substantiate that d. She stated the facility ere unaware if (CNA #9) may own (CNA #8) and may make s was not documented estigation. The investigation ented that CNA #9 "had no th employee and no reason to " and per CNA #9's own vas documented, "How long NA #8)? I met her the day I door on 6/18 (2015)" (which	F 22	26		

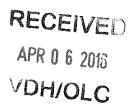
report it to her supervisor.

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

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		AND H AN SERVICES & MEDICAID SERVICES			FORM	: 03/15/2016 APPROVED : 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		E SURVEY APLETED
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WAYLAN	D NURSING AND RE	HABILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 226	Continued From pa	ge 26	F 22	26		
	were conducted with nurse) #1 and CNA abuse. All staff star should be reported the resident is safe. A review of the empthat on 10/23/14, shall of Rights for Nudocumented, "If you resident, it is your rilaw:To be free from the conduction of the same than the conduction of the	kimately 2:00 p.m., interviews h LPN (licensed practical #1 and #2 regarding resident ted that allegations of abuse immediately after making sure, and document the incident bloyee file for CNA #8 revealed he signed a copy of "Federal rsing Facility Residents" which a are a nursing facility ight by federal and state om mental, verbal, sexual, or diphysical punishment."				
	statement, signed of Abuse / Neglect Po "Verbal, sexual, me neglect, or mistreat involuntary seclusic and/or misappropria staff will not be tole responsibility to immare resident abuse or sor her supervisor. employee must the Administrator. If the	rd also contained a signed on 10/23/14, for "Resident licy" which documented, intal, or physical abuse, ment of residents to include on or corporal punishment, ation of residents' property by rated. It is every employee's mediately report any incident of uspected resident abuse to his The supervisor and/or in report immediately to the e immediate supervisor is the 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

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

of unknown sources, neglect, and/or

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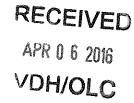
DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	1		PRINTED: 03/15/2016 FORM APPROVED DMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
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		495226	B. WING			C /03/2016
NAME OF PROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE, ZIP CODE			
				730 LUNENBURG HIGHW		
WAYLAN	D NURSING AND RE	HABILITATION CENTER		KEYSVILLE, VA 23947		
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	be initiated to prever while the investigation Administrator is resoff the investigation to the appropriate a state and federal re- employ individuals to abusing, neglecting	investigated. Measures will ent any further potential abuse on is in progress. The ponsible to review the results and report the alleged incident gencies in accordance with gulations. The facility will not that have been found guilty of , or mistreating residents by a				
	into this state's Nur	have had a finding entered se Aide Registry concerning		WINDS TO A STATE OF THE STATE O		

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DEPARTMENT OF HEALTH AND H	٩N	SERVICES
CENTERS FOR MEDICARE & MEDICA	ΙD	SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	1 03/	103/2010
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F 278 SS=D	property. The fact has of actions by employee, which is service as a nurse this state's Nurse boards and/or reg The Administrator incidents, as indic appropriate local / including the state. On 3/3/16 at 3:10 meeting, the Admistaff member] #1) (ASM #2) were may further information survey. 483.20(g) - (j) ASS ACCURACY/COCT The assessment in resident's status. A registered nurse each assessment participation of her A registered nurse assessment is contained by the contained by	ility will report any knowledge it a court of law against an would indicate unfitness for a aide or other facility staff to Aide Registry or licensing istriesReporting/Response: is responsible to ensure that ated, are reported to the state / federal agencies, Nurse Aide Registry. p.m., during the end of day nistrator (ASM [administrative and the Director of Nursing ade aware of the findings. No awas provided by the end of the SESSMENT PRDINATION/CERTIFIED must accurately reflect the with the appropriate alth professionals. In must sign and certify that the mpleted. In completes a portion of the sign and certify the accuracy of	F 27	F278	nd a state on ator. ecent MDS, by e curacy tion) nary records cations Social ities	pril 15, 2016

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

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NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	ZIP CODE	timental to the second	
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F 278	subject to a civil m \$1,000 for each as willfully and knowir to certify a materia resident assessment penalty of not more assessment. Clinical disagreem material and false This REQUIREME by: Based on staff interview, and clinical determined that the complete and acculassessment for 1 csample; Resident at C Cognition and Sc Customary Routine #9's 10/6/15 signifi and the 1/6/16 quant The findings included Resident #9 was a 9/23/15 with the disseizures, Huntingto liver disease. The most recent M quarterly assessment Reference Date) or coded as being set as will be a civil material and the seizures and coded as being set as will make the code as will make the coded as being set as will make the coded as will make the coded as will make the coded as being set as will make the coded as will	oney penalty of not more than sessment; or an individual who agly causes another individual and false statement in a ent is subject to a civil money e than \$5,000 for each ent does not constitute a statement. NT is not met as evidenced erview, facility document record review it was a facility staff failed to ensure a erate MDS (minimum data set) of 21 residents in the survey end and Activities, on Resident cant change MDS assessment rterly MDS assessment.	F 2	The interdisciplinary care members (Dietary manage Coordinator, Social Service Activities Director) have been on the RAI manual for acceptant and completing the MDS aresidents by the Corporate on March 10 & 24, 2016. The Director of Nursing, of Nursing and/or SDC with current scheduled MDS include for resident # 9 then monthly x 1 month areas on the MDS are conclude sections C cognit Preferences utilizing a M Tool. All identified areas addressed immediately by The Administrator will remain MDS Monitoring QI Tool then monthly x 1 month to ensure all identified area corrected. The Administrator will confirm the MDS Monitoring Q present to the Quality Imp Committee Meeting mont Subsequent plans of action developed by the Committed Identification of any poten used to determine the need frequency of continued members.	Assistant Dill review resistant and assessment weekly x 8 to ensure the oded accuration and sec DS Monitoriof concern by the MDS iview and initial weekly x 8 for compliant as of concern the oded accuration and sec DS Monitoriof concern by the MDS iview and initial weekly x 8 for compliant as of concern the ode of co	ated ang ent of ultant irector ident's ats to weeks hat all tely to tion F ing QI will be Nurse. tial the weeks ce and an were sults ths.	

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED			
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NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP (730 LUNENBURG HIGHW KEYSVILLE, VA 23947	~~~			
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F 278	activities of daily he bowel and bladder A review of the signormal section B "Hearing usually able to mall B-0700). This section be understood / Understood / Usually usually usually able to mall be understood / Usually usually usually able to mall be understood / Usually usually like the bowel and bladderstood / Usually like the bowel and bladder bladderstood / Usually like the bowel and bladder bladderstood / Usually like the bowel and bladder bladde	niring total care for all areas of ring; and was incontinent of mificant change MDS dated that the resident was coded in g. Speech, and Vision" as see himself understood (Section tion was coded as a "1" (0 - erstands; 1 - Usually lly understands; 2 - Sometimes	F 2	278				
	rarely/never undersunderstands). In Section C "Cogr"C0100 Should Bribe Conducted? At all residents." This which to code if the interviewed or not rarely/never unders C0700 - C1000, St Status" or "1. Yes of Three Words." rarely/never underswhat was coded in interview was not a resident interview were blank. The scompleted instead Should the Staff As Conducted?" there not the staff asses coding "0. No (resi interview) - Skip to of Delirium" or "1. complete interview	stood / rarely/never stempt to conduct interview with a section contained a box in a resident should be by coding "0. No (resident is stood) - skip to and complete aff Assessment for Mental Continue to C0200, Repetition The resident was coded as "0" stood which was in contrast to Section B (above). The attempted. Section C for the was not attempted. All boxes taff assessment was However, in Section "C0600 assessment for Mental Status be awas a box to mark whether or sment should be completed, by dent was able to complete C1300, Signs and Symptoms Yes (resident was unable to) - Continue to C0700, y OK" the box was left empty						

		AND H AN SERVICES & MEDICAID SERVICES					FORM	03/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		STRUCTION		(X3) DAT COM	E SURVEY IPLETED
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NAME OF F	PROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STA	TE, ZIP CODE		
WAYLAN	D NURSING AND REI	HABILITATION CENTER			IENBURG HIGHW ILLE, VA 23947			
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F 278	Section C0700 for SC0800 for Long-term dashed (-) out as be Also on this MDS as Preferences for Cuswas documented, "Daily and Activity Preferences for Cuswas documented, "Daily and Activity Preferences." If reattempt to complete or significant other. for coding "0. No (reunderstood and famavailable) - Skip to Assessment of Dail "1. Yes - Continue to Preferences." The However, all the body questions relating to out as not assessed completed instead. Also noted on the question B the resident was staff assessment with However, for Section OK" was dashed out On 3/2/16 at 12:40 (OSM, Other Staff Modern Cost of	o was coded. In addition, Short-term Memory OK and m Memory OK were both eing not assessed. ssessment, for Section F stomary Routine and Activities F0300. Should Interview for references be Conducted? - vall residents able to sident is unable to complete, einterview with family member 'This section contained a box esident is rarely/never nily/significant other not and complete F0800, Staff y and Activity Preferences." or o F0400, Interview for Daily box was coded with a "1". xes in the section for the preferences were all dashed d. The staff assessment was	F 2	778				

that it was incorrect.

these MDS assessments this way (Section C) but

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

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE					RINTED: 03/15/2016 FORM APPROVED MB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED
	495226	B. WING			C 03/03/2016
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
WAYI AND NURSING AND REHARM ITATION CENTER			730 LUNENBURG HIGHW		

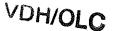
KEYSVILLE, VA 23947 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 278 | Continued From page 32 F 278 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 Determine if the resident is rarely/never understood verbally or in writing. If rarely/never

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		AND H AN SERVICES & MEDICAID SERVICES			FORM	: 03/15/2016 APPROVED : 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION 3	(X3) DAT	E SURVEY IPLETED
		495226	B. WING		1	C 03/2016
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY).	ULD BE	(X5) COMPLETION DATE
F 278	Assessment of Mer Coding Instructions Record whethe should be attempte Code 0, no: if the attempted because understood or an in available. Skip to Comental Status. Code 1, yes: if attempted because sometimes understif an interpreter is not attempted because sometimes understif an interpreter is not coding Tipe. Nonsensical research. Rules for stopp complete: Stop the interview "Day of the Week" in all responses that is or incoherent; not in item being rated), Counter the has been to any of the questions of the response that is or incoherent; not in item being rated).	C0700 - C1000, Staff ntal Status If the cognitive interview d with the resident. The interview should not be the resident is rarely/never terpreter is needed but not 0700, Staff Assessment of the interview should be the resident is at least good verbally or in writing, and eeded, one is available. Substituting the interview before it is the interview before it is the wafter completing (C0300C) for the interview interview before it is the wafter completing (C0300C) for the interview with respect to the interview with respect wi	F 278			

Conducted?

C0400C.

If the interview is stopped, do the following: Code -, dash in C0400A, C0400B, and

Code 99 in the summary score in C0500.
 Code 1, yes in C0600 Should the Staff
 Assessment for Mental Status (C0700-C1000) be

Complete the Staff Assessment for Mental

	MENT OF HEALTH	AND H AN SERVICES & MEDICAID SERVICES			FORM	: 03/15/2016 APPROVED : 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		E SURVEY IPLETED
		495226	B. WING		1	C 03/2016
	PROVIDER OR SUPPLIER ID NURSING AND REI	HABILITATION CENTER	7	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW (EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 278	Continued From pa Status"	ge 34	F 278			No. o vera verz verz verz verz verz verz verz verz
	Medicaid Services) Instrument) MDS 3 RAI Users Manual of page F-1 through F about preferences of the most reliable ar preferencesQual enhanced when car choice regarding ar resident. Interviews be reflected in the of to lifestyle preferences	MS (Centers for Medicare and RAI (Resident Assessment .0 Manual, Section F of the documents the following on .3: "Obtaining information directly from the residentis and accurate way of identifying ity of life can be greatly re respects the resident's nything that is important to the sallow the resident's voice to care planA lack of attention ces can contribute to and increased behavior				
	meeting, the Admin staff member] #1) a (ASM #2) were mad When asked about stated the facility us	.m., during the end of day istrator (ASM [administrative and the Director of Nursing de aware of the findings. a policy, the Administrator ses the RAI manual. No was provided by the end of the		F279	Marc	ch 30, 2016

F 279 483.20(d), 483.20(k)(1) DEVELOP

SS=D | COMPREHENSIVE CARE PLANS

comprehensive plan of care.

A facility must use the results of the assessment

The facility must develop a comprehensive care

plan for each resident that includes measurable

objectives and timetables to meet a resident's

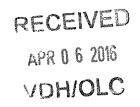
to develop, review and revise the resident's

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F 279

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Resident #2 care plan was updated on March

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

2, 2016 to reflect dental by MDS

by MDS Coordinator/RN.

		AND H AN SERVICES & MEDICAID SERVICES			FORM	: 03/15/2016 I APPROVED : 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495226	B. WING		03/03/2016	
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COINT CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
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.		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 completi comprehensive care plan for each and ensuring that all triggered Care care planned by RAI Reimbu Auditor by March 23, 2016.	ng a h resident AA items	

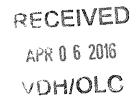
2. The facility staff failed to care plan CAA triggered areas (Pain) from Resident #6's 6/26/15 admission MDS.

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:

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DEPARTMENT	OF HEALT	H AND H	ΆN	SERVICES
CENTERS FOR	R MEDICAR	E & MEDICA	<u>ÁID</u>	SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495226	B. WING		_	C 03/03/2016	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STA 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	ATE, ZIP CODE	00/00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD B D TO THE APPROPRI CIENCY)		_
F 279	1. The facility staft triggered areas (D 10/5/15 annual confection of the confection	f failed to care plan CAA ental) from Resident #2's mprehensive MDS. nost recently readmitted to the with the diagnoses of but not testinal bleed, cataracts, ke, pain, contractures, high emiplegia, bladder dysfunction, d diabetes. The most recent ata Set) was a quarterly an ARD (Assessment of 1/5/16. The resident was oderately impaired in ability to cisions. The resident was of total care for all areas of ving; and was incontinent of c. nical record revealed the most sive MDS was an annual MDS /5/15. Under Section V (the	F 2	An audit will be complans to include care #5, and #6 weekly x 8 1 month by Director of Assistant Director of triggered areas of the comprehensive care p developed accordingly plans accurately reflect utilizing the QI Care I care plan will be updathe MDS Coordinator areas of concern. The review and initial the Tool weekly x 8 week month for compliance of concern have been The Administrator wi of the QI Care Plan A to the Quality Improve Meeting monthly x 3 plans of action will be Committee when requany potential trends we determine the need for frequency of continue.	plans for resident at 8 weeks then mont of Nursing and/or Nursing to ensure CAAs are care play plans have been y, and that the care cts the resident Plan Audit Tool. The ated immediately be a for any identified Administrator will QI Care Plan Audit Administrator will addressed. Ill compile the result and to ensure all addressed. Ill compile the result and present Committee months. Subseque edeveloped by the paired. Identification will be used to raction and/or	#2, hly x all aned, e The by ll it 1 areas alts sent nt	

resident was coded with an "x" in the box next to

DEPARTMENT OF HEALTH AND HOAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM	03/15/2016 APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION	(X3) DATI	0938-0391 E SURVEY PLETED
		495226	B. WING	i		E .	C 03/2016
	PROVIDER OR SUPPLIER D NURSING AND REI	HABILITATION CENTER		7	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	(edentulous)."} On 3/2/16 at 10:50 #1 (Registered Nurs stated it was not ca "could not find it but A review of the facil Plans" documented to provide an interd based on the physic assessment of the r and implementation participating discipli a team conference Coordinator. Devel plan will occur after comprehensive ass disciplineThe res ongoing process an problems and/or ne assessment includi the resident's respo his/her general hea On 3/2/16 at 5:59 p meeting, the Admin staff member] #1) at (ASM #2) were mad further information v survey.	a.m., in an interview with RN se #1, the MDS nurse), she re planned. She stated she it made one now." ity policy, "Resident Care, "It is the policy of the facility isciplinary written care plancian's orders and the resident needs. Development of the care plan will occur by the available in the facility at under the direction of the RN opment of an interdisciplinary completion of a essment by each ident care plan will be an id will include current eds identified from a complete ng MDS and CAAs relevant to onse to aging, illness, and	F2	279			

and Care Planning

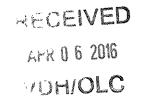
"Section V: Care Area Assessment: V0200. CAAs

Check column A if Care Area is triggered.
 For each triggered Care Area, indicate

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	MENT OF HEALTH	AND H AN SERVICES & MEDICAID SERVICES			0		FORM.	03/15/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRU	ICTION			SURVEY PLETED
		495226	B. WING				03/0) 3 <mark>/2016</mark>
NAME OF F	PROVIDER OR SUPPLIER				RESS, CITY, STATE, Z Burg Highw	IP CODE		
WAYLAN	D NURSING AND RE	HABILITATION CENTER			E, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CH CORRECTIVE ACT SS-REFERENCED TO DEFICIENC	TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 279	whether a new care continuation of curr address the probler assessment of the Care Plan column r days of completing	e plan, care plan revision, or ent care plan is necessary to m(s) identified in your care area. The Addressed must be completed within 7 the RAI [MDS and CAA(s)].	F 2'	79				
	triggered areas (Pa admission MDS. Resident #6 was addiagnoses of but not depression, pulmor high blood pressure pulmonary disease. (Minimum Data Set with an ARD (Asses 12/26/15. The reside cognitively intact in decisions. The resibathing; extensive a dressing, and hygie was incontinent of the clinical stress of the cl	failed to care plan CAA in) from Resident #6's 6/26/15 Imitted on 6/19/15 with the ot limited to cataracts, gout, hary embolism, heart disease, e, and chronic obstructive The most recent MDS) was a quarterly assessment esment Reference Date) of dent was coded as being ability to make daily life ident required total care for assistance for transfers, he; supervision for eating; and bowel and bladder. cal record revealed the most ive 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 -

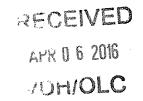
	MENT OF HEALTH	AND H AN SERVICES & MEDICAID SERVICES			0		FORM.	03/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		ISTRUCTION		(X3) DATE COM	E SURVEY PLETED
		495226	B. WING			-	03/0	C 0 3/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STAT	TE, ZIP CODE		
WAYLAN	D NURSING AND RE	HABILITATION CENTER			NENBURG HIGHW /ILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFIC	ACTION SHOULD	BE	(X5) COMPLETION DATE
F 279	Planning Decision" checked as being c	d." Under column B "Care each of these items were are planned." e clinical record revealed the	F 2	79				
	reveal any evidence being care planned of 6/26/15, Section was coded in J0400 "Frequently" and in Function, the reside "yes" in question B	of the care plan failed to e of the triggered area of pain . {Note: On resident's MDS J "Health Conditions", resident of Pain Frequency as a "2" for section J0500 Pain Effect on ent was coded as a "1" for "Ask resident: "Over the past mited your day-to-day activities						
near of the second seco	(Registered Nurse a stated it was not can developed on 3/1/16 was completed, and per MDS review of Administration Received pain in pain care plan should before 3/1/16, as a	.m., in an interview with RN #1 #1, the MDS nurse), she re planned. She provided one 6 after the survey chart review d stated that it was developed the MARs (Medication ord), stating that the resident nedication. When asked if the all have been developed triggered area on the 6/26/15 she stated it should have been was an oversight.						
b.	meeting, the Admin staff member] #1) a (ASM #2) were made	.m., during the end of day istrator (ASM [administrative and the Director of Nursing the aware of the findings. No was provided by the end of the						

3. The facility staff failed to develop a

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CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(3) DATE SURVEY COMPLETED
		495226	B. WING			C 03/03/2016
	PROVIDER OR SUPPLIER D NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, 2 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD BI THE APPROPRIA	
F 279	comprehensive car #5's mastectomy at the mastectomy. Resident #5 was a 1/24/11 and was rediagnoses that inclurinary tract infection diabetes, high blood and back pain. Resident #5's mosset), a quarterly as (assessment reference the resident's BIMS status) as 10 out of moderately impaired resident was coded staff for activities of Active Diagnoses of documentation of the Company of the Polysigned on 2/24/16 history of a left mad documentation that taken in the left arm. Review of the Februadministration recommendation recom	dmitted to the facility on eadmitted on 10/2/14 with uded but were not limited to: on, mental retardation, and pressure, left mastectomy* It recent MDS (minimum data sessment, with an ARD ence date) of 2/19/16 coded (brief interview for mental f 15 indicating the resident was ed to make daily decisions. The das requiring assistance from f daily living. In Section I did not evidence he resident's mastectomy. Sident #5's chart was a sticker On that label it was BP (blood pressure) in Left sician's orders dated and documented the resident's stectomy but did not evidence to blood pressure should be		279		
	Review of the resid	lent's care plan initiated on				Form 1 to 1 controls

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	MENT OF HEALTH	AND HOAN SERVICES				FORM	: 03/15/2016 1APPROVED : 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	COV	TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		73	REET ADDRESS, CITY, STATE, ZIP CODE TO LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	;	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 279	documentation that mastectomy or any mastectomy. Review of the resid CNA's (certified nurevidence documen not have blood present the director of nurs the front of Resider blood pressure was ASM #2 stated, "The mastectomy." Whe to take the blood prestated, "It should be care plan was reviewed.	age 41 and on 3/1/16 did not evidence at the resident had had a restrictions related to the dent's care guide used by the raing assistants) did not tation that the resident should assures taken in her left arm. Conducted on 3/3/16 at 8:40 ministrative staff member) #2, ing, regarding the sticker on the #5's chart documenting no as to be taken in the left arm. The hat's because she's had a left on asked how staff knows not ressure in the left arm, ASM #2 as on the care plan." When the left arm asked how the left arm asked	F2	279			

mastectomy."

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

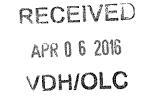
An interview was conducted on 3/3/16 at 9:10 a.m. with CNA #3, the CNA caring for Resident #5. When asked if she took blood pressures, CNA #3 stated, "Yes, once in a while." When asked how staff knew how to care for a resident, CNA #3 stated, "We look at the plan of care inside the closet door (the care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

the standard of care when you have a

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495226	B. WING				03/0	C 03/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRES	S, CITY, STATE, ZIP CODE	=		
WAYLAN	D NURSING AND RE	HABILITATION CENTER		730 LUNENBUR KEYSVILLE, V				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH (VIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO EFERENCED TO THE APP DEFICIENCY)	OULD	BE	(X5) COMPLETION DATE
F 279	Continued From pa	ge 42	F 2	79				
	asked if there were	any restrictions on taking the essure, CNA #3 stated, "No					STATE AND A STATE	
	a.m. with LPN (licer nurse caring for Re any nursing conside implemented for a r LPN #1 stated, "No arm." LPN #1 review medication adminis	onducted on 3/3/16 at 9:15 nsed practical nurse) #1, the sident #5. When asked what if erations would be resident with a mastectomy, blood pressures in the left wed the February 2016 tration record and stated that in (no blood pressure in left						
	a.m. with RN (regis coordinator. When developed for Resid mastectomy, RN #1 suppose I overlook been here for years pressures are not to RN #1 stated, "Becauting off circulatio could damage the rused the care plan #1 stated, "It's to die	tered nurse) #1, the MDS asked if a care plan should be dent #5 who has had a I stated, "It should have. I ed that portion because she's b." When asked why blood aken on the mastectomy side, ause when they remove that cut the lymph nodes. You're n with a blood pressure, it nerves." When asked who and what its purpose was, RN rect, it drives the care of the nows how to care for them."						
		.m. ASM (administrative staff Iministrator was made aware						

No further information was provided prior to exit.

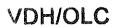
According to Fundamentals of Nursing Lippincott

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RECEIVED



	MENT OF HEALTH	AND HOAN SERVICES			FORM	D: 03/15/2016 MAPPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495226	B. WING		03	C 8 /03/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WAYLAN	ID NURSING AND RE	HABILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 279	Williams and Wilkin documented, "A writ communication too members that helps care The nursing of information about the and goals. It contates and is used to direct revise and update there are changes with new orders" (1) Fundamentals of the wilkins 2007 Lipp pages 65-77. Basic Nursing, Ess (Potter and Perry, 2 reference for care payritten guideline for promoting continuit criteria to be used if care. The written conursing care prioriti professionals. The coordinates resources are a correctly for easy to continue call the patient's status nursing diagnosis and longer appropriagian. An out of data	ns 2007 pages 65-77 Itten care plan serves as a I among health care team Is ensure continuity of Care plan is a vital source of The patient's problems, needs, This detailed instructions for The established for the patient The careexpect to review, The care plan regularly, when The condition, treatments, and	F 279			

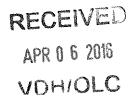
*A mastectomy is surgery to remove a breast or part of a breast. It is usually done to treat breast

https://www.nlm.nih.gov/medlineplus/breastcanc

Event ID: KMLK11

Facility ID: VA0050

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DEPARTMENT	OF HEALTH AND	H AN	SERVICES
CENTERS FOR	MEDICARE & ME	-DicAID	SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION NG	COV	TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER D NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		,00,2010
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F 279 F 280 SS=E	er.html>. 483.20(d)(3), 483.1 PARTICIPATE PLA The resident has the incompetent or other incapacitated under participate in plannic changes in care and A comprehensive of within 7 days after the comprehensive associated in the resident, and disciplines as deter and, to the extent puther resident, the resident, the resident participate in the resident participate in the resident. This REQUIREMENT by: Based on staff interest and clinical record refacility staff failed to comprehensive care in the survey sample #10.	O(k)(2) RIGHT TO NNING CARE-REVISE CP e right, unless adjudged erwise found to be r the laws of the State, to ng care and treatment or d treatment. are plan must be developed the completion of the ressment; prepared by an m, that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs, racticable, the participation of sident's family or the resident's e; and periodically reviewed am of qualified persons after NT is not met as evidenced rview, facility document review review, it was determined the e plan for four of 21 residents e, Resident(s) #4, #5, #7 and failed to review and revise the e plan after Resident #4	F 27	F280	ed and ect suicidal r. on March S was ect nose Resident ch 3, 2016 erses ind/or s for ure that were tilizing e	ril 15, 2016

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

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
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NAME OF I	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP CO		/03/2016
WAYLAN	ID NURSING AND RI	EHABILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 280	comprehensive ca 2/28/16. 3. The facility staff comprehensive ca sustained nose ble 4. The facility staff comprehensive ca an arteriovenous (The findings included 1. The facility staff comprehensive can arteriovenous (The findings included 1. The facility staff comprehensive can arteriovenous (The findings included 1. The facility staff comprehensive can threatened to kill have a facility and read the facility and read the facility and read the facility and	if failed to update the are plan after Resident #5 fell on a failed to update the are plan after the Resident #7 feeds. If ailed to update the are plan after Resident #10 had AV)* shunt implanted. If ailed to review and revise the are plan after Resident #4 failed to review and revise the are plan after Resident #4 failed to the facility on the facility of the facility on the facility on the facility of facil	F 2	The interdisciplinary care plan members (Dietary manager, M Coordinator, Social Services D Activities Director) have been on the requirements for comple comprehensive care plan for each resident charcare planned and to review and care plan for each resident charcondition as needed by RAI Re Auditor by March 24, 2016. An audit will be completed of plans to include care plans for 1 #5, and #6 weekly x 8 weeks the 1 month by Director of Nursing Director of Nursing or SDC to triggered areas of the CAAs are comprehensive care plans have developed accordingly, and that plans accurately reflects the resutilizing the QI Care Plan Audit care plan will be updated immethe MDS Coordinator for any icareas of concern. The Administrative wand initial the QI Care Plan audit care plan will be updated immethe MDS Coordinator for any icareas of concern. The Administrative wand initial the QI Care Plan audit care plan will be updated immethe MDS Coordinator for any icareas of concern. The Administrative wand initial the QI Care Plan Audit care plan will be updated immethe MDS Coordinator for any icareas of concern. The Administrative wand initial the QI Care Plan Audit care plan will be updated immethe MDS Coordinator for any icareas of concern. The Administrative wand initial the QI Care Plan Audit care plan will be updated immethe MDS Coordinator for any icareas of concern. The Administrative wand initial the QI Care Plan Audit care plan will be updated immethe MDS Coordinator for any icareas of concern. The Administrative wand initial the QI Care Plan Audit care plan will be updated immethe MDS Coordinator for any icareas of concern. The Administrative wand initial the QI Care Plan Audit care plan will be updated immethe MDS Coordinator for any icareas of concern. The Administrative wand initial the QI Care Plan Audit care plan will be updated immethem MDS Coordinator for any icareas of concern.	pirector and re-educated eting a anch resident, a items are revise the age in simbursement. 10% of care resident #1, are monthly x y/Assistant ensure all a care planed, been to the care ident to Tool. The diately by dentified rator will alan Audit anthly x 1 sure all areas	
	staff reported to th	is writer that at approximately nt stated, "I have to kill myself"				

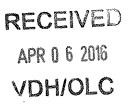
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writer spoke to resident and he did not state this

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		AND H AN SERVICES			FORM	: 03/15/2016 APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DAT	. 0938-0391 E SURVEY IPLETED
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	PROVIDER OR SUPPLIER D NURSING AND RE	HABILITATION CENTER	7	TREET ADDRESS, CITY, STATE, ZIP CODE '30 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	(medical doctor) pasomething for resident cut (milligrams) po (by writer awaiting responsors). A review of the clinititled, "goDocs. 2/1" (date of birth), Facil Complaint, Resident cantipsychotic medicanxiety. May we haplease as resident if gave verbal order to 100 mg PO @ H. Further review of the timed, 2/11/16 doct call, verbal order gir Seroquel 50 mg poneeded) and start SPRN, RP (name of new order, RP (responsors) in the am (of whats (sic)going).	or of nursing) made aware, Md aged as well, writer to request ent (sic) depression and arrently on Seroquel 50 mg mouth) @ hs (hour of sleep), conse from Md." cal record documented a 1/16, (name of resident), DOB lity (name of facility), Chief at stated he is going to kill urrently on Seroquel (an cation*^) 50 mg PO @ HS for ve an order for something else is extremely depressed. MD or (arrow pointing up) Seroquel	F 280	The Administrator will compile the resof the QI Care Plan Audit Tool and proto the Quality Improvement Committee Meeting monthly x 3 months. Subseque plans of action will be developed by the Committee when required. Identification and potential trends will be used to determine the need for action and/or frequency of continued monitoring.	esent e ent e	

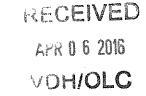
kill himself.

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

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

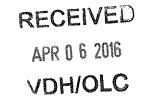
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	PROVIDER OR SUPPLIES	R EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	DE .	00/00/20 10
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	1	SHOULD BE	(X5) COMPLETION E DATE
F 280	notes." When ask be updated, LPN it to be." When as care plan to be re whole staff could an interview was p.m. with OSM (or social worker, reg followed if a residustated, "Make surmoment and then was considered scinformation would stated, "Yes, in the this information would let everyone a.m. with ASM (act the director of nur decides what need a.m. with ASM (act the director of nur decides what need a.m. with RN (regicoordinator. When RN #1 stated, "All was it important to plan, RN #1 stated care of them (the was aware that Resuicide, RN #1 stated suicide, RN #1 stat	ded if she expected the care plan #4 stated, "Yes, I would expect sked why it was important for the exised, LPN #4 stated, "So the know what's going on." conducted on 3/2/16 at 5:35 ther staff member) #1, the parding the process staff ent threatens suicide. OSM #1 the the resident is safe at that a call the MD." When asked what afe. When asked if this I be documented, OSM #1 to enurse's note." When asked if would be added to the care plan, Oh gosh, yes ma'am. I would at the resident vocalized they're the depression) is escalating. I the know." conducted on 3/3/16 at 8:50 dministrative staff member) #2, ring. When asked how staff ds to be in the care plan, ASM ething significant has happened M #2 was made aware of the	F 2	280		

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		AND H AN SERVICES & MEDICAID SERVICES			FORM): 03/15/2016 // APPROVED): 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DA	TE SURVEY MPLETED
		495226	B. WING		03	C /03/2016
WAYLAND NURSING AND REHABILITATION CENTER SHAMARY STATEMENT OF DEFICIENCIES				STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 280	stated, care plan hit to have him watche sure he gets seen hake sure staff knot He's already in a roseen often." On 3/3/16 at 3:10 pmember) #1, the acof the findings. A review of the facil CARE PLAN " docuproblem or need of between his/her sche addressed on the disciplines and broccare plan meeting traddition." No further information. According to Funda Williams and Wilking documented, "A wricommunication tool members that helps careThe nursing of information about the and goals. It contains achieving the goals.	ge 48 In for the suicidal statement, id by staff a little closer. Make by somebody (psychiatrist). It was he's made that statement om in a busy path so he's I.M. ASM (administrative staff diministrator was made aware lity's policy titled, "RESIDENT amented in part, "Any new the resident which is identified neduled care plan review will be care plan by the concerned aght to the next scheduled or inform disciplines of the literature on was provided prior to exit. I.M. ASM (administrative staff diministrator was made aware lity's policy titled, "RESIDENT amented in part, "Any new the resident which is identified neduled care plan review will be care plan by the concerned aght to the next scheduled or inform disciplines of the literature of the patient's problems, needs, and detailed instructions for established for the patient of care, expect to review.	F 28			

pages 65-77.
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with new orders..." (1)

revise and update the care plan regularly, when there are changes in condition, treatments, and

(1) Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia

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Facility ID: VA0050

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DEPARTMENT OF HEALTH	· · · · · · · · · · · · · · · · · · ·		FORM APPROVE
CENTERS FOR MEDICARE	& MEDICAID SERVICES		DMB NO. 0938-039
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED
Manage of the Contract of the			l c
<u> </u>	495226	B. WING	03/03/2016
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	

730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION DATE PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**) 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/guervmeta?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

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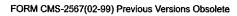
If continuation sheet Page 50 of 104

PRINTED: 03/15/2016





		AND H AN SERVICES & MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
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F 280		ge 50 lown feeling is depression ih.gov/medlineplus/depression	F2	280			
	2. The facility staff comprehensive care 2/28/16.	failed to update the e plan after Resident #5 fell on		· ·			
	1/24/11 and was readiagnoses that inclurinary tract infection	Imitted to the facility on admitted on 10/2/14 with uded but were not limited to: on, mental retardation, d pressure, left mastectomy*		те де			
	set), a quarterly ass (assessment refere the resident's BIMS status) as 10 out of moderately impaired	recent MDS (minimum data sessment, with an ARD nce date) of 2/19/16 coded (brief interview for mental 15 indicating the resident was d to make daily decisions. The as requiring assistance from daily living.		Wester (Textende de canada e i ina ada e indonésia de en de antes i indonésia e indonésia			
	documented that th	e's notes dated 12/28/16 e resident fell in the bathroom brasion to the forehead.		Andreas de la companya de la company			TAANNETAAN TETAANNAMANANAMATATAA
	plan did not evidend	#5's comprehensive care be documentation that the reviewed or revised following					



An interview was conducted on 3/2/15 at 4:15

change in condition, not eating." When asked

p.m. with LPN (licensed practical nurse) #4, regarding situations for updating a resident care plan. LPN #4 stated, "Falls with or without injury,

DEPARTMENT CENTERS FOR		I AND HOAN SERVICES				FORM.	03/15/2016 APPROVED 0938-0391
STATEMENT OF DEFI AND PLAN OF CORRI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION	СОМ	E SURVEY PLETED
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NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER				7:	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW (EYSVILLE, VA 23947		
	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
who u the Mi I let he plan." An int a.m. v how to use th An int a.m. v coordi RN #1 was it plan, I care o Resid "That weeke (Name (for fa next." should nurse:	DS lady knower know and serview was could LPN #1. No care for the e care plan. Berview was could review was could leave to the example of them stated, "All could review to the example of them (the report #5's fall owas on December 1 looked to fresident) lis); we disculted thave been could be probably shower askedd thave been could be probably shower and the example of the examp	age 51 are plans, LPN #4 stated, "I let are plans, LPN #4 stated, "I let are plans, LPN #4 stated, "I let are plans, if I see a change in condition, she documents it in the care conducted on 3/3/15 at 9:10. When asked how staff knew residents LPN #1 stated they conducted on 3/3/16 at 9:30. Stered nurse) #1, the MDS asked who used the care plan, of the staff." When asked why review and revise the care, "So staff know how to take esidents)." When asked about in 12/28/15, RN #1 stated, imber 28th. She fell over the over the report on Monday. has had lots of interventions ssed what we needed to do what if any documentation done, RN #1 stated, "The could have documented that everal falls and interventions	F2	280			

aware of the findings.

was made aware of the findings.

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

On 3/3/16 at 3:10 p.m. ASM #1, the administrator

No further information was provided prior to exit.

add."

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

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495226	B. WING	i			C 03/2016
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	CODE		00/00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD I E APPROPR	BE	(X5) COMPLETION DATE
F 280	3. The facility staff comprehensive ca sustained nose ble Resident #7 was a 3/13/14 and was rediagnoses that incheart failure, anempressure, colon canosebleeds. Resident #7's mosset), a quarterly as (assessment refer the resident as hav (brief interview of resident was cogniof daily living. The requiring assistance Review of the nurse a.m. documented, (wheelchair) at simblood. Large amt (can. Ice pack appliinstructed resident subsided in approximates)." Review of the nurse a.m. documented,	failed to update the re plan after the Resident #7 reds. dmitted to the facility on eadmitted on 3/16/15 with luded but were not limited to: iia, liver failure, high blood nocer and a history of t recent MDS (minimum data sessment, with an ARD ence date) of 11/24/15 coded ring a 15 out of 15 on the BIMS nental status) indicating the tively intact to make decisions resident was coded as re for all activities of daily living. e's notes on 11/26/15 at 1:15 "Resident sitting in w/c k with nose bleeding bright red amount) of blood noted in trash red to back of neck and to pinch nostrils. Bleeding c. (approximately) 15-20 min. e's notes on 12/1/15 at 6:36 "Resident rang bell for	F 2	DEFICIENCY)			
	was running profus applying pressure. the floor it started I noted. Have been	right) nostril bleeding. Blood sely. He has a paper towel He said as soon as his fee hit bleeding. No blood in bed applying cool rags to back of . Bleeding has almost					

(X2) MULTIPLE CONSTRUCTION

		AND H AN SERVICES & MEDICAID SERVICES				FORM	: 03/15/2016 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		495226	B. WING		***************************************	i i	C / 03/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WAYLAN	D NURSING AND RE	HABILITATION CENTER			KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 280	Continued From pa	ge 53	F	280			
	p.m. documented, ' (sic). Resident is sit having a nose bleed amount. Ice pack a side of nose. Resid he stated was running resident on 3/30/15 not evidence document of the resident's nose bleed. An interview was cop.m. with LPN (licer When asked who u stated, "I let the MD in condition. I let he in the care plan. Will plan, LPN #4 stated it was important to plan, LPN #4 stated know what's going of the side of t	onducted on 3/2/16 at 4:15 nsed practical nurse) #4. updates the care plan, LPN #4 DS lady know if I see a change or know and she documents it hen asked who used the care d, "All of us." When asked why review and revise the care d, "So the whole staff could on." When asked if the care ated if the resident had nose					
	a.m. with RN (regis coordinator. When RN #1 stated, "All o was it important to	onducted on 3/3/16 at 9:30 tered nurse) #1, the MDS asked who used the care plan, of the staff." When asked why review and revise the care "So staff know how to take esidents)."			•		
	member) #1, the ac	.m. ASM (administrative staff dministrator and ASM #2, the were made aware of the					THE

findings.

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Facility ID: VA0050

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DEPARTMENT OF HEALTH AND H	N SERVICES
CENTERS FOR MEDICARE & MEDICAL	D SERVICES

PRINTED: (3/15/2016
FORM A	PPROVED
OMB NO. 0	938-0391

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	NG		(X3) DATE SURVEY COMPLETED			
		495226	B. WING		n,	C 3/03/2016		
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 280			F 28	30				
	No further informa	tion was provided prior to exit.						
	comprehensive ca	failed to update the re plan after Resident #10 had AV)* shunt implanted.						
	6/16/15 with diagn limited to: end stag	admitted to the facility on oses that included but were not ge renal disease requiring ions, diabetes, high blood mia.						
	quarterly assessm reference date) of BIMS (brief intervi- of 15 indicating the to make daily deci as requiring exten- activities of daily li- resident could do a prepared. In section	ADS (minimum data set), a ent, with an ARD (assessment 2/23/16 coded the resident's ew of mental status) as 15 out e resident was cognitively intact sions. The resident was coded sive assistance from staff for all ving except for eating which the after having the meal tray on OSpecial Treatments, rograms, the resident was g dialysis.						
	signed 8/4/15 at 1: "Procedure specifi	rge instructions dated and :25 p.m. documented, c discharge instruction sheet AV (arteriovenous) graft."				AND		
	6/19/15 and with a	ent #10's care plan initiated target date (for review) of dence documentation that 's AV shunt.						
		conducted on 3/2/16 at 4:15 ensed practical nurse) #4.	Very construction of the second of the secon	THE PROPERTY OF THE PROPERTY O		A THE STATE OF THE		

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Facility ID: VA0050

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		AND H AN SERVICES & MEDICAID SERVICES				FORM	03/15/2016 APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI		E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		495226	B. WING	}			C 03/2016
	PROVIDER OR SUPPLIER D NURSING AND REI	HABILITATION CENTER		7:	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW (EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 280	stated, "I let the MD in condition. I let he in the care plan. WI plan, LPN #4 stated it was important to plan, LPN #4 stated know what's going of the care plan, LPN #4 stated the care plan, RN #4 When asked why we revise the care plan how to take care of asked if she was aw AV shunt, RN #1 statill using her port. I known." When asked updated when a rese RN #1 stated yes. Wimportant, RN #1 sta	pdates the care plan, LPN #4 PS lady know if I see a change r know and she documents it nen asked who used the care I, "All of us." When asked why review and revise the care I, "So the whole staff could on." Inducted on 3/3/16 at 9:30 m. with RN (registered nurse) nator. When asked who used I stated, "All of the staff." ras it important to review and I, RN #1 stated, "So staff know them (the residents)." When ware that Resident #10 had an ated, "No, I thought they were probably should have red if the care plan would be sident had a shunt implanted, when asked why this would be sident had a shunt implanted, when asked why this would be ated, "(The nurses) need to bruit at least every shift to ioning." Im. ASM (administrative staff rector of nursing, was made	F	280			

remove and return blood during hemodialysis. <a href="http://www.niddk.nih.gov/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-information/health-in

Event ID: KMLK11

Facility ID: VA0050

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DEPARTMENT OF HEALTH AND HOAN SERVICE	S
CENTERS FOR MEDICARE & MEDICAID SERVICES	S

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495226	B. WING			C / 03/2016
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER			7	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW (EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 281 SS=D	th-topics/kidney-dis odialysis/Pages/ind **Bruits are rushing medium-sized arter the vessel wall cause Thrills are a palpab murmur. http://www.ncbi.nlm 483.20(k)(3)(i) SER PROFESSIONAL SER PRO	ease/vascular-access-for-hem ex.aspx> sounds heard over large and ies as a result of vibration in sed by turbulent blood flow. le venous systolic thrill and inih.gov/pubmed/3958354 EVICES PROVIDED MEET STANDARDS led or arranged by the facility onal standards of quality. NT is not met as evidenced ion, staff interview, clinical in the course of a complaint cility staff failed to follow inds for three of 21 residents in Residents # 14, #3 and and a physician's order for a ewas allergic to and facility the order. If a physician's order for sliding as not clear and facility staff	F 281	F281- Services provided meet prestandards 1. Resident #14 is no longer of the facility. The MD was contacted for Resident #3 sliding scale order was claused March 24, 2016 by RN/D MD was contacted for Resident 24, 2015 by the RN/Director of Nursing a order for Seroquel was claused with parameters for when medication should be adm 2. A 100% audit will be comall resident's to include re #14, #3, and #10 current PRN/SDC nurse to ensure medications are not being administered that resident allergic to, orders are clean include sliding scale insult that all ordered medications parameters for when the medications should be administered. All areas of will be addressed by RN/S	a resident vas and arified on ON. The sident # 4 and the arified the ainistered. upleted of sident MARs by s are r to ins, and as to have concern	4/15/16

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DEPARTMENT	OF HEALTH A	ND H AN	SERVICES
CENTERS FOR	MEDICARE 8	MEDICAID	SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	495226 B. WING				C 03/2016		
	PROVIDER OR SUPPLIEF	EHABILITATION CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW EYSVILLE, VA 23947		03/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 281	The findings included a large state of the Resident and others (Brief Interview for indicating that she resident as be understand others (Brief Interview for indicating that she resident as be understand others (Brief Interview for indicating that she resident as be understand others (Brief Interview for indicating that she review of Resident a physician order a signed by the physician order as in this some allergies. In this some allergies. In this some allergies in the pharm copy of this form woon 3/3/2016 at 12: Also, located in the handwritten physician order as administrator, as be administrator, as be administrator, as the state of the pharm copy of this form woon 3/3/2016 at 12:	to clarify the order. de: and a physician's order for a se was allergic to and facility by the order. admitted to the facility on oses that included but not demia, aortic aneurysm, setes, hypothyroidism, ailure, hypertension, and sease. At the time of the at # 14's MDS (minimum data essment, with an ARD ence date) of 1/27/15 coded eing understood and able to a The Resident had a BIMS Mental Status) of 15 out of 15 was cognitively intact. at # 14's clinical record revealed sheet (POS) dated 1/16/15 and sician on 1/20/15. Near the is a section to list the ection was documented: * " This form (POS) was nacy on 1/16/2015 at 16:32. A was faxed from the pharmacy	F2	281	Nurse during the audit with MI notification and order clarificat 3. All licensed nurses to include #2, LPN #3, and RN # 2 will be serviced by RN/SDC regarding notifying the physician and clarifying physician orders if the resident is allergic to a medicate an order is not clear, or an order does not have parameters for we to administer a medication by the SDC/RN on or before April 10, 2016. All newly hired license nurses will be in-serviced regar notifying the physician and clarifying physician orders if the resident is allergic to a medicate an order is not clear, or an order does not have parameters for we to administer a medication during orientation. 4. The Administrative Nurses (DC ADON, SDC, MDS or Treatmen Nurse) will review all newly written physician orders for all residents to include resident #1- #3, and #4 and compare to the resident's Medication Administration records weekly weeks then monthly x 1 month ensure medications are not being administered that residents are allergic to, all orders are clear the include sliding scales, and all	ion. LPN e in- ie ion, r hen he ion, r hen or hen ng DN, ent 4, x 8 to	

DEPARTMENT OF HEALTH	AND	H AN	SERVICES
CENTERS FOR MEDICARE	& M	EĎicÁID	SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
)		495226				C 03/2016	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		7:	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW (EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 281	documented: "1/2 (milligrams) PO (breduce to 0.5 mg X 14 days then D/ (medical doctor) if exacerbates upon During an intervied LPN # 2 when as stated checks the there was a problewould also pass thand probably would also pass that the POS by one numbering and check Allergies and diage POS is faxed to the comes he reads all fine writes an ord Resident is allerging doctor and let him During the end of approximately 6:00 Staff Member) # 1 was discussed. At there was no facility physician orders. In "Fundamentals Patricia A. Potter alone; Page 419. "T	/20/15. This order 0/15 Clonazepam** 0.5 mg by mouth) X (times) 7 days then PO q HS (every hour of sleep) C (discontinue). Report to MD insomnia or anxiety discontinuation." w on 3/3/16 at 7:45 a.m. with ked about allergies LPN # 2 orders against allergies and if em give the doctor a call. One his information onto day shift ld call the pharmacy. w on 3/3/16 at 8:05 a.m. RN e) # 2 was asked to explain the hig orders to the pharmacy. RN e doctors order are written on the urse then another nurse comes is - both nurses sign the POS. noses are also checked. This he pharmacy. When the doctor and signs the copy of the POS. er for a medication that a cot the nurse would call the	F	281	ordered medications have parameters for when medication should be administered utilizing Order Clarification QI Tool. The Administrative Nurse (DON, ADON, SDC, MDS or Treatmen Nurse) will immediately contact physician for clarification and orduring the audit for any identificates of concern. The DON will review and initial the Order Clarification QI Tool weekly x weeks the monthly x 1 month from the compliance and to ensure that a areas of concern have been addressed. The Director of Nursing will compile the results of the Order Clarification QI Tool and present the Quality Improvement Committee Meeting monthly x months. Subsequent plans of activity will be developed by the Committee when required. Identification of any potential trends will be used to determinate the determinate of the continued monitoring.	g an he ent ent tthe rder hed l 8 for hill nt to 3 etion	

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	TMENT OF HEALTH RS FOR MEDICARE	AND H AN SERVICES & MEDICAID SERVICES				FORM	: 03/15/2016 APPROVED : 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
		495226	B. WING			j.	C 03/2016
	PROVIDER OR SUPPLIER ID NURSING AND REI	HABILITATION CENTER		7:	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW (EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)) BE	(X5) COMPLETION DATE
F 281	obligated to follow pelieve the orders a clients. Therefore a one is found to be a clarification from the The following quota Perry's Fundamenta (2005, p. 477): "Downten or printed the proof for authorized within a client medianursing practice. Naccurate, compreheretrieve critical data track client outcome standards of nursing client record provide level of quality of capotter and Perry (20 following information about comments of timely, effective marks."	ohysician's orders unless they are in error or would harm all orders must be assessed if erroneous or harmful further e physician is necessary." Ition is found in Potter and als of Nursing 6th edition ocumentation is anything at is relied on as record or persons. Documentation cal record is a vital aspect of ursing documentation must be ensive, and flexible enough to a, maintain continuity of care, es, and reflect current g practice. Information in the es a detailed account of the are delivered to the clients." 2005) also includes the in: "As members of the health need to communicate lients accurately and in a	F2	?81			

"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

* Benzodiazepines are depressants that produce sedation, induce sleep, relieve anxiety and muscle spasms, and prevent seizures.

www.dea.gov/druginfo/drug_data_sheets/Benzodi

receive a medication in error...."

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DEPARTMENT OF HEALTH AND HAN SER	VICES
CENTERS FOR MEDICARE & MEDICAID SER	VICES

AND DUAN OF CODDECTION DENTIFICATION NUMBER.		1 ' '	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495226	B. WING			C /03/2016
	PROVIDER OR SUPPLIE	R EHABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CO 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		30,2020
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF COR IX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 281	** Clonazepam used alone or in o medications to coof extreme fear Clonazepam is in benzodiazepines.	gov/druginfo/drug_data_sheets/.pdf> Klonopin® Clonazepam is combination with other ontrol certain types of seizures. It and worry about these attacks). a class of medications called nih.gov/medlineplus/druginfo/me	F2	281		
	Resident # 3 was and readmitted or included but were depression, diabe hypertension, cer cataracts, and pe Resident # 3's moset), an annual as (assessment refe Resident as being usually understant severely impaired During a review of signed by the phy documentation of Insulin: "Humalogical procession of the control of t	admitted to the facility on 2/2/11 on 4/2/15 with diagnoses that a not limited to anemia, etes, hyperlipidemia, ebral vascular accident, ptic ulcer with hemorrhage. Dest recent MDS (minimum data assessment, with an ARD rence date) of 1/3/16 coded the grarely/never understood and as ading. The Resident was				

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		AND H AN SERVICES & MEDICAID SERVICES			FORM	03/15/2016 APPROVED 0938-0391			
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED			
		495226	B. WING		ı	C 03/2016			
	PROVIDER OR SUPPLIER ID NURSING AND REI	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 281	GREATER = 8 UNI' 6AM, 1130A, 430P, originally written on During an interview LPN (Licensed Prac was reviewed. LPN insulin would be giv "300". LPN # 3 state the doctor and get of During an interview RN (Registered Nur reviewed. RN # 2 v would be given if the # 2 stated the order with the doctor. Review of Resident under "Will be free hyper/hypoglycemia recently revised on as ordered by the puring an interview ASM (Administrative Director of Nurses, scale insulin was rethe order should be facility policy on clair requested.	TS, IF OVER 400 CALL MD, 9PM." This order was .4/30/15. on 3/2/16 at 2:30 p.m. with ctical Nurse) # 3 this order I # 3 was asked how much en if the blood sugar was ted that one would have to call clarification for this order. on 3/2/16 at 2:35 p.m. with rse) # 2 this order was was asked how much insuling the blood sugar was "300". RN would have to be clarified # 3's care plan documented from any signs/symptoms of all initiated on 3/5/15 and most 1/26/16 included: "Medication	F 281						

physician orders.

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

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		AND HOAN SERVICES & MEDICAID SERVICES			FC	TED: 03/15/2016 DRM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		DATE SURVEY COMPLETED
		495226	B. WING _			C 03/03/2016
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER			,	STREET ADDRESS, CITY, STATE, ZIP CO 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 281	documenting that the clarified was present In Potter-Perry, Furthedition, page 841, a "When medications compares the medicomputer orders with orders." On page 8 administration of or accuracy and compare printout with medication order." In "Fundamentals of Patricia A. Potter arthocy Page 419. "The directing medical transcriber to follow publicated to follow publicated to follow publicated to follow publication from the clarification	of a physician order form the sliding scale order was atted. Idamentals of Nursing, 6th Inoted standard of practice is: are first ordered, the nurse cation recording form or th the prescriber's written 52, regarding the all medications, "Check leteness of each MAR or with prescriber's written If Nursing" 6th edition, 2005; and Anne Griffin Perry; Mosby, the physician is responsible for the physician's orders unless they were in error or would harm all orders must be assessed if the physician is necessary." Inamentals of Nursing- and Wilkins 2007 page 169, written medication order, working document approved facilityread the order the on copying it correctly, the finished. Be sure to look for the attended to the sure to look for the could cause your patient to	F 28			

*Humalog® -- Insulin used to treat type 1 diabetes (condition in which the body does not

https://www.nlm.nih.gov/medlineplus/druginfo/me

produce insulin ... their diabetes.

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		AND H AN SERVICES & MEDICAID SERVICES				FOR	D: 03/15/2016 MAPPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495226	B. WING			03	C 3/03/2016
	PROVIDER OR SUPPLIER D NURSING AND REI	HABILITATION CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CO 30 LUNENBURG HIGHW EYSVILLE, VA 23947	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	A THE PROPERTY OF THE PROPERTY	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 281	Seroquel** (an antij (milligrams) po (by HS (hour of sleep) the medication short facility staff failed to Resident # 4 had a Seroquel** (an antij (milligrams) po (by HS (hour of sleep) the medication short he medication short	d a physician's order for psychotic medication) 100 mg mouth) PRN (as needed) at without parameters for when uld be administered and clarify the order. physician's order for psychotic medication) 100 mg mouth) PRN (as needed) at without parameters for when uld be administered.	F 2	81			
	had these feelings 7 days)." In Section I	cy 2 (indicating the resident 7-11 days (half or more of the Active Diagnoses, the as having depression, manic					PARTITION OF THE PARTIT



depression (bipolar disease) and schizophrenia.

An observation was made on 3/2/16 at 11:00 a.m.

		AND H AN SERVICES & MEDICAID SERVICES			FOR	D: 03/15/2016 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	ATE SURVEY OMPLETED
		495226	B. WING			C 3/03/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	Œ	
WAYLAN	D NURSING AND REI	HABILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	· · · · · · · · · · · · · · · · · · ·	HOULD BE	(X5) COMPLETION DATE
F 281	was awake and alex wound care. The reconversation during An observation was of the resident. The a chair in his room. An observation was of the resident. The wheelchair sitting quality A review of the nurs 2/11/16 at 4:54 p.m staff reported to this 4:25 (p.m.) resident writer spoke to resident writer spoke to resident writer spoke to resident writer spoke to resident cuntiligrams) po (by writer awaiting respondent cuntiligrams) po (by writer awaiting respondent cuntiligrams) po (by writer awaiting respondent cuntiligrams). 2/DOB (date of birth), Chief Complaint, Rekill himself. Resider PO @ HS for anxiets something else pleadepressed. MD gavernament of the converse of the claim titled, "goDocs (the physician group). 2/DOB (date of birth), Chief Complaint, Rekill himself. Resider PO @ HS for anxiets something else pleadepressed. MD gavernament of the converse of the claim titled, "goDocs (the physician group). 2/DOB (date of birth), Chief Complaint, Rekill himself. Resider PO @ HS for anxiets something else pleadepressed. MD gavernament of the converse of	e resident was lying in bed and rt. The resident was receiving sident did not engage in a this observation. I made on 3/2/16 at 12:00 p.m. resident was sitting quietly in receiving medications. I made on 3/2/16 at 3:00 p.m. resident was up in a quietly in the dayroom. I write the dayroom. I write that at approximately a stated, "I have to kill myself" dent and he did not state this or of nursing) made aware, Md ged as well, writer to request ent (sic) depression and reently on Seroquel 50 mg mouth) @ hs (hour of sleep),	F 2	281		

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)

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		AND H AN SERVICES		O	FORM): 03/15/2016 1APPROVED): 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		495226	B. WING			C / 03/2016
	PROVIDER OR SUPPLIER ID NURSING AND REI	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		IOULD BE	(X5) COMPLETION DATE
F 281	Seroquel 50 mg po needed) and start S PRN, RP (name of new order, RP state psychiatrist (sic) in	Q (every) hs PRN (as Seroquel 100 mg po Q hs RP) called and made aware of ed she wants facility to call his (name of town) in the am em aware of whats (sic) going	F 2	81		
	approximately 6:00 (Administrative State administrator, the confusion orders to discussed with ASM this time it was reversely 1:00 (Administration or the confusion or the confu		٠			
	a.m. with ASM (adn	onducted on 3/3/16 at 8:50 ninistrative staff member) #2, ing. ASM #2 was made aware at time.				
-	No further informati	ion was provided prior to evit				Antonianiatato

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."

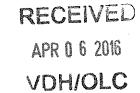
*^Seroquel is an antipsychotic medication used for the treatment of schizophrenia. Drug Information Handbook for Nursing 2007 8th

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Facility ID: VA0050

Event ID: KMLK11

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

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	1`'	NG	(X3) DATE SURVEY COMPLETED	
		495226	B. WING		C 03/03/2016	
	PROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	1 03/03/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTION	
F 281	edition, Turkoski, L Corp Hudson Ohio *Schizophrenia is a who have it may he They may think oth them. Sometimes of they talk. The disor keep a job or take <https: **bipolar="" .html="" <https:="" a="" active="" and="" b="" c="" called="" changes.="" disorder="" go="" have="" i="" if="" in="" inactive,="" mania.="" moods="" normal="" people="" sad="" the="" then="" they="" to="" very="" vsearch.nli="" who="" www.nlm.r="" y-meta?v%3aproje="medlineplus-bunc">. 483.25 PROVIDE of HIGHEST WELL B Each resident mus provide the necess or maintain the hig mental, and psycho accordance with th and plan of care. This REQUIREME by: Based on staff inter</https:>	ance, Bonfiglio- Lexi-Comp page 1055-1056). It serious brain illness. People par voices that aren't there, er people are trying to hurt hey don't make sense when der makes it hard for them to care of themselves. In.nih.gov/vivisimo/cgi-bin/quer. Idea the medine plus & v & 3 A sources illea query = schizophrenia > Is a serious mental illness. If go through unusual mood from very happy, "up," and and hopeless, "down," and back again. They often have etween. The up feeling is down feeling is depression in gov/medline plus/depression.	F 3		taken as ed on the	

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PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED		
		495226	B. WING	j		C 03/03/2016	
	WAYLAND NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STAT 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		3012313	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTIVE CROSS-REFERENCED	OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE	
F 309	complaint investige the facility staff fat to maintain the high of 21 residents in 7, and Resident # 1. The facility staff blood pressure are physician. 2. The facility staff #10's AV (arteriov dialysis. The findings inclusive 1. The facility staff blood pressure are physician. Resident #7 was 3/13/14 and was rediagnoses that incheart failure, anere pressure, colon conosebleeds. Resident #7's moset), a quarterly a (assessment refethe resident as has (brief interview of resident was cognof daily living. The requiring assistant In Section I Acticoded as having Its and the section I Acticoded as having Its and Resident was cognosed to the section I Acticoded as having Its and Resident was cognosed to the section I Acticoded as having Its and Resident was cognosed to the section I Acticoded as having Its and Resident was cognosed to the section I Acticoded as having Its and Resident was cognosed to the section I Acticoded as having Its and Resident was cognosed to the section I Acticoded as having Its and Resident was cognosed to the section I Acticoded as having Its and Resident was cognosed to the section I Acticoded as having Its and Resident was cognosed to the section I Acticoded as having Its and Resident was cognosed to the section I Acticoded as having Its and Resident was cognosed to the section I Acticoded as having Its and Resident was cognosed to the section I Acticoded	gation, it was determined that iled to provide care and services ghest level of well-being for two the survey sample, Resident # 10. If failed to monitor Resident #7's and pulse as ordered by the failed to care for Resident tenous shunt)* graft used for	F3	2015 to present with monitoring to include audited to ensure vita obtained per physicia Administrator, on Ma concerns were address notification. 100% au include resident # 10 completed by Corpor to ensure that docume verifying shunt assess resident was assessed documentation in the identified areas of corporation of the licens serviced on following obtaining vital signs a AV shunt assessment documentation of thri documentation using note in the electronic RN/SDC initiated on hired licensed nurses	e resident #7 were al signs were being an order by arch 22, 2016. All assed with MD adit of residents to with AV shunts was rate Nursing Consultant entation was present sment on 3/16/16. The by the hall nurse with medical record for any neern. The nurses were ing MD orders to include and documentation and and care, and care, and care, and the dialysis progress medical record by the 3/16/16. All newly will receive incollowing MD orders to al signs and V shunt assessment ion of thrill/bruit and the dialysis progress	,	

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

PKIN	I ED:	03/13	7/2016
FC	DRM.	APPR	OVED
OMB	NO.	0938	-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED C 03/03/2016		
							WAYLAND NURSING AND REHABILITATION CENTER
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD B		N
F 309	dated, 3/2/16, doc & HR (heart rate) Review of the MA record) for Novemblood pressures a opportunities. Review of the MA documented the I four opportunities documented twice. Review of the car documented, "Po to) Thrombocytop vital signs per face by the physician." An interview was p.m. with LPN (lick When asked why orders, LPN #4 st doctor, they have right to question to residents every down asked wou pressure and pulsordered by the physician's and an interview was p.m. with ASM #2 asked if staff were physician's orders findings were reviewed.	cumented, "BP (blood pressure) WEEKLY, On Wednesday." AR (medication administration of the second pressure of the second pressure one time out of the second pressure of the second pres	F3	4) The Administrative Nurses (DON/ADON/SDC/MDS Cod and/or Tx Nurse) will monitor MARs and electronic medical physician orders to obtain vita include resident # 7 and all profor residents who receive dialy resident # 10 to ensure vital si obtained per physician order a documented and to assure shur assessed and documented weethen monthly x 1 month utilizing sign/shunt site QI Tool. Retrain immediately conducted with the nurse by Administrative Nurse (DON/ADON/SDC/MDS Cod and/or Tx Nurse for any identiconcern. The DON will review the Vital Sign/shunt Site QI Toweeks the monthly x 1 month compliance and to ensure that concern have been addressed. The Director of Nursing will concern have been addressed. The Director of Nursing will concern have been addressed. The Director of Nursing will concern have been addressed. The Director of Nursing will concern have been addressed. The Director of Nursing will concern have been addressed. The Director of Nursing will concern have been addressed. The Director of Nursing will concern have been addressed. The Director of Nursing will concern have been addressed. The Director of Nursing will concern have been addressed.	ordinator r all reside records w al signs to ogress not ysis to inc gns and and t sites are ekly x 8 w ing a vital ining will he license es ordinator ified areas w and initi fool weekl for all areas compile th t Site QI Torovement x 3 month ill be when requ t rends wi r action ar	vith tes clude eeks be s of ial ly x 8 of ne Fool t is.	

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was made aware of the findings.

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Facility ID: VA0050

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		& MEDICAID SERVICES	T			<u>O</u> 1		0938-0391
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		495226	B. WING_					C 03/2016
AME OF F	PROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STAT	E, ZIP CODE		
WAYLAN	D NURSING AND RE	HABILITATION CENTER			IENBURG HIGHW ILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD	BE	(X5) COMPLETION DATE
F 309	Continued From pa	ge 69	F 30	09				
	No further informati	on was provided prior to exit.						
	Patricia A. Potter ar Inc; Page 419. "Th directing medical tro obligated to follow p	of Nursing" 6th edition, 2005; and Anne Griffin Perry; Mosby, e physician is responsible for eatment. Nurses are physician's orders unless they are in error or would harm						
	is a condition in whithan normal number called platelets (PL in your bone marrow blood cells. They travessels and stick to bleeding that may hamaged. Platelets (THROM-bo-sites)	ich your blood has a lower of blood cell fragments ATE-lets). Platelets are made w along with other kinds of avel through your blood ogether (clot) to stop any pappen if a blood vessel is also are called thrombocytes because a clot also is called a w.nhlbi.nih.gov/health/health-t						
		ailed to care for Resident nous shunt)* graft used for						
	6/16/15 with diagno limited to: end stage	admitted to the facility on uses that included but were not e renal disease requiring ons, diabetes, high blood ia.						
	The most recent Mi	DS (minimum data set), a		during Andreas				and Advanta of An

quarterly assessment, with an ARD (assessment reference date) of 2/23/16 coded the resident's

PRINTED: 03/15/2016

	MENT OF HEALTH	AND H AN SERVICES & MEDICAID SERVICES				FORM	: 03/15/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495226	B. WING	·			C / 03/2016
)	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		7	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
F 309	BIMS (brief intervier of 15 indicating the to make daily decis as requiring extensiactivities of daily living resident could do apprepared. In section Procedures and Procedures of the nurse documented, "Resident transport for instructions followed A review of discharges signed 8/4/15 at 1:2 "Procedure specific provided. Left Arm / Additional Instruction 8/5/15 (there is clear Diet + meds (medical Review of the nurse in the section title, "Site:" out of 66 opport that "none" or the and A review of the physical dated, 2/28/16 did report around the care of 6/19/15 and with a feet of 19/15 and with a feet of	w of mental status) as 15 out resident was cognitively intact ions. The resident was coded ive assistance from staff for all ing except for eating which the fter having the meal tray in OSpecial Treatments, ograms, the resident was dialysis. It's note on 8/4/15 at 5:10 a.m. dent has left facility with reshunt placement. All defor this procedure. It's p.m. documented, discharge instruction sheet and carries on a comment of the facility with responsible to the facility with reshunt placement. All defor this procedure. It's p.m. documented, and carries of the facility with responsible to the facility with reshunt placement. All defor this procedure. It's p.m. documented, and carries of the facility with responsible to the facility with reshunt placement. All discharge instruction sheet are glue on incision. Continue that the facility with responsible to the facility of the facility with responsible to the f	F	309			

A review of the medication administration record

for February 2016 did not evidence

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	MENT OF HEALTH	AND H AN SERVICES & MEDICAID SERVICES			F	NTED: 03/15/2016 FORM APPROVED B NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION ING		3) DATE SURVEY COMPLETED
		495226	B. WING_			C 03/03/2016
MAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O	CODE	
WAYLAN	D NURSING AND REI	HABILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	
F 309	should be checked shift or that the resiperessures taken in the second pressures taken in the second pressures were dood the left arm. An interview was concerned to a second pressures were dood the left arm. An interview was concerned to the left arm. An interview was concerned to had a second pressure to her, just in the second pressure to her, just in the second pressure the graft, familiar with the type comes back from diassessment. When the graft were checked as a left pressure to her the graft were checked as a left pressure that the graft were checked as a left pressure that the graft were checked as a left pressure that the graft were checked as a left pressure that the graft were checked as a left pressure that the graft were checked as a left pressure that the graft were checked as a left pressure that the graft were checked as a left pressure that the graft were checked as a left pressure that the graft were checked as a left pressure that the graft were checked as a left pressure that the graft pressure that	the AV graft in the left arm for a bruit and a thrill every dent should not have blood the left arm. It #10's vital signs from 8/5/15 blood pressures, of those ares indicated which arm was and 2/15/16 the blood cumented as being taken on an annual practical nurse) #3, the resident. When asked if an AV graft, LPN #3 stated, upper arm shunt, it's fairly the last week or two." When any considerations to take in LPN #3 stated, "I'm not very the state of the state of the shunts. When she	F 36	609		

On 3/3/16 at 1:32 p.m. RN #1 approached this writer and stated, "I just checked on the resident.

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		AND H AN SERVICES & MEDICAID SERVICES			FORM	D: 03/15/2016 MAPPROVED	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	FIPLE CONSTRUCTION NG	(X3) DA	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		495226	B. WING_		03	C 3 /03/2016	
1	PROVIDER OR SUPPLIER D NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 309	She has a permaca started using it (the no documentation to checking the bruit a and protected it (the An interview was cop.m. with ASM (adnothed director of nursi graft. ASM #2 state documenting it, the when being used." standard they used absolutely sure, I the sure." ASM #2 returned actual book (for the	ath**. The resident said they AV graft) on Monday. There's hat they're (the nurses) are and thrill. They should have be graft)." Inducted on 3/3/16 at 2:00 Ininistrative staff member) #2, and regarding care of an AV	F 30				
	An interview was cop.m. with LPN #4 rewith an AV graft. LI with you, I haven't co	onducted on 3/3/16 at 3:15 egarding caring for a resident PN #4 stated, "To be honest cared for one in a long time.					
	THAT RECEIVE DI documented in part	ity's policy titled, RESIDENTS ALYSIS SERVICES", , "Facility staff should be f shunts/fistulas, infection					

No further information was provided prior to exit.

Medical Surgical Nursing made Incredibly Easy, Lippincott Williams & Wilkins copyright 2004 page

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CENTERS FOR MEDICARE & MEDICAID SERVICES				O	<u>MB NO.</u>	0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 03/03/2016	
		495226	B. WING	i			
)	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER	•	7:	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW (EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΙX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	· After completion of vascular access site excessive, maintain notify the doctor. · To prevent clotting flow, make sure the access isn't used for including I.V. line in monitoring, and very of bruits and palpart other circulatory as should be present I venous access site requiring immediate. *A vascular access lifeline. A vascular access lifeline. A vascular is a treatment for k machine to send the filter, called a dialyz access is a surgical remove and return http://www.niddk.rth-topics/kidney-disodialysis/Pages/ind **Bruits are rushing medium-sized arter the vessel wall cauthrills are a palpab murmur. http://www.ncbi.nl ***PermCath is a disparate the vessel wall sa disparate the vessel wall sa disparate the vessel wall cauthrills are a palpab murmur.	oring and Aftercare: If hemodialysis, monitor the Ite for bleeding. If bleeding is It pressure on the sited and It or other problems with blood It the arm used for vascular It or any other procedure, It is sertion, blood pressure Inipuncture. It per day, assess circulation at It auscultating for the presence Iting for thrills. Unlike most It is sessments, bruits and thrills It is may indicate a blood clot It is a hemodialysis patient's blood through a It is patient that uses a It is patient tha	F	309			

DEPARTMENT OF HEALTH AND HOAN SERVICES

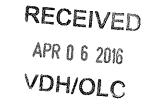
Event ID: KMLK11

Facility ID: VA0050

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PRINTED: 03/15/2016

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	IMENT OF HEALTH	AND HOAN SERVICES			FORM	: 03/15/201 APPROVE : 0938-039
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3) DAT COM	E SURVEY MPLETED
		495226	B. WING		I	C / 03/2016
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309 F 319 SS=D	http://www.ncbi.nlm 483.25(f)(1) TX/SV MENTAL/PSYCHO Based on the comp resident, the facility who displays mental difficulty receives a services to correct	n.nih.gov/pubmed/1509580 C FOR SOCIAL DIFFICULTIES orehensive assessment of a must ensure that a resident all or psychosocial adjustment ppropriate treatment and the assessed problem.	F 30		3/29/16, and of scheduled /16. Resident lated on March esident's signs pression and	4/15/16
	by: Based on observation document review a facility staff failed to psychosocial wellbothe survey sample, The facility staff fail	tion, staff interview, facility and clinical record review, the provide interventions for the eing of one of 21 residents in Resident #4. ed to obtain a psychiatric esident # 4's statement of		2) Audit of 100% of residen progress notes to include #4 for the past 60 days w the psychiatric diagnosis, example, depression, bips schizophrenia etc. charts reviewed for any suicidal	resident ho have for olar, were	Transaction of the control of the co

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**.

suicide.

The findings include:

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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

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vocalizations or s/s of depression

Nursing Consultant on March 22,

2016. MD/ADM and SW were

concerns that were noted from

immediately notified of any

audit.

that were not addressed was completed by the Corporate

	MENT OF HEALTH	AND H AN SERVICES & MEDICAID SERVICES				FORM	: 03/15/2016 APPROVED : 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		E CONSTRUCTION	CON	E SURVEY MPLETED
		495226	B. WING			1	C / 03/2016
	PROVIDER OR SUPPLIER D NURSING AND RE	HABILITATION CENTER		73	REET ADDRESS, CITY, STATE, ZIP CODI 80 LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 319	resident was coded depressed, or hope (indicating the resident Symptom Frequench had these feelings days)." In Section I resident was coded depression (bipolar An observation was of Resident #4. The was awake and ale wound care. The reconversation during An observation was of the resident. The a chair in his room An observation was of the resident. The wheelchair sitting quality A review of the nurse 2/11/16 at 4:54 p.m. staff reported to this 4:25 (p.m.) resident writer spoke to resident to her, DON (directed)	under "B. Feeling down, less. Symptom Presence, 1 lent felt these feelings). Under by 2 (indicating the resident 7-11 days (half or more of the Active Diagnoses, the as having depression, manic disease) and schizophrenia. It made on 3/2/16 at 11:00 a.m. by resident was lying in bed and rt. The resident was receiving sident did not engage in	F:	319	and the social worker were is serviced by the Administrate and/or SDC which was initis 3/16/16 on initiating interver when residents verbalize the of suicide or harming one's. They will notify the charge is SW/ADM and DON immed notify the RP, placing with the resident a one on one constate observation sitter, ensuring it is safety by removing any objet the resident can use to harm oneself, schedule a psychiatic consultation if appropriate a sending resident to ER if near All newly hired licensed nur CNA's will be in-serviced of initiating interventions when residents verbalize thoughts suicide or harming one's self include notifying the charge SW/ADM and DON immed notifying the RP, placing with resident a one on one constate observation sitter, ensuring it safety by removing any objet the resident can use to harm	in- interest and on entions oughts self. nurse, liately, the ent resident ects that eded. rice and eded. rices and on entions of lift to enurse, liately, eth the ent resident ects that extend entires e	

response from Md."

(medical doctor) paged as well, writer to request

(by mouth) @ hs (hour of sleep), writer awaiting

A review of the clinical record documented a

physician group). 2/11/16, (name of resident),

titled, "goDocs (the name of the facility's

something for resident (sic) depression and

anxiety, resident currently on Seroquel (an antipsychotic medication*^) 50 mg (milligrams) po

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Facility ID: VA0050

oneself, schedule a psychiatric

consultation if appropriate and

the SDC during orientation.

4) The Social Worker and/or Administrator will review all

sending resident to ER if needed by

resident's progress notes to include

resident #4 weekly x 8 weeks then

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

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495226			IFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED C 03/03/2016	
		495226					
5.55	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STA 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVI CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 319	DOB (date of birth) Chief Complaint, Rikill himself. Resider PO @ HS for anxie something else pleadepressed. MD gave pointing up) Seroque Further review of the timed, 2/11/16 doct call, verbal order gis Seroquel 50 mg poneeded) and start SPRN, RP (name of new order, RP state psychiatrist (sic) in (a.m.) and make the on, note to be left for Review of Resident 10/21/15 and revised documentation of the suicidal threat. Review of the resident 11/2/15 and revised "Use of psychotropiof: bipolar disorder, schizophreniaIntermental status function Monitor resident's in physician of any significant of the nurse suicidal ideation. Review of the nurse review of the	A. Facility (name of facility), esident stated he is going to not currently on Seroquel 50 mg ty. May we have an order for ase as resident is extremely we verbal order to (arrow usel to 100 mg PO @ HS PRN." He nurse's notes dated and amented, "Md returned writers wen to d/c (discontinue) Q (every) hs PRN (as Seroquel 100 mg po Q hs RP) called and made aware of ed she wants facility to call his (name of town) in the amem aware of whats (sic) going or DON." #44's care plan initiated on ed on 2/26/16 did not evidence he resident's depression or ent's care plan initiated on a control of co	F3	monthly x 1 mont resident with voca suicidal ideations with interventions psychiatric consul suicidal ideation (intervention will the MD contacted audit for any identical contacts.	alizations or s/s of were addressed s to include It utilizing a QI tool. An be initiated and I at the time of the tified areas of N will review and I Ideation QI tool then monthly x I ance to ensure oncern have been ursing will Its of the Suicidal and present to the athly for 3 ent plans of eloped by the QI equired. any potential It to determine the d/or frequency of		

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

Event ID: KMLK11

Facility ID: VA0050

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	ENT OF HEALTH				FO	ED: 03/15/2016 RM APPROVED	
	F DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) I	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		495226	B. WING	·····		C 03/03/2016	
	OVIDER OR SUPPLIER NURSING AND REI	HABILITATION CENTER		STREET ADDRESS, CITY, STATE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
sb Rithnth Riawrup AAdTLOttw Renb Rids A	review of the physicom 7/15 to 3/16 dinat the resident was ote of 8/15 did not ne resident was suffered by the social series of the series of	cian's and psychiatrist's notes d not evidence documentation is suicidal. The psychiatrist's evidence documentation that icidal. If worker's note for 2/23/16 at ted, "During the residents (sic) asked (name of resident) if he or depressed. (Name of ic) depressed. He has an pointment) with the re of town)." Isidents (sic) Weekly ruary 22, - February 26, 2016." 1. 2/23/16, (name of resident), ointment) 1:15 p.m., TIME 1/ 12:00 p.m., SPECIAL 1/ 12:00 p.m., SPECIAL 1/ 12:00 p.m., SPECIAL 1/ 12:00 p.m., Time	F 319				



Event ID: KMLK11

Facility ID: VA0050

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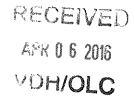
	MENT OF HEALTH	AND HOAN SERVICES				FORM	: 03/15/2016 APPROVED : 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		E CONSTRUCTION	(X3) DAT COM	TE SURVEY MPLETED
		495226	B. WING			C 03/03/2016	
	PROVIDER OR SUPPLIER D NURSING AND RE	HABILITATION CENTER		73	TREET ADDRESS, CITY, STATE, ZIP COL 10 LUNENBURG HIGHW EYSVILLE, VA 23947	E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	Addurán II. Andrán é ró Andrá (A Addurán e Andrá	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 319	the nurse's notes, of the doctor know and the doctor know and An interview was cop.m. with OSM (oth social worker. Whe aware of Resident a stated, "I never heat have someone sit with When asked what president threatens a sure the resident is call the MD." When would be document the nurse's notes." On 3/3/16 at 8:00 at this writer document called (name of docresident) an appoint depression and ver die the earliest availed 23rd at 1:15 p.m." If OSM #6, the appoint	emselves. LPN #4 stated, "In document follow up on it. Let d make the family aware." Inducted on 3/2/16 at 5:35 per staff member) #1, the en asked if she had been made #4's threat of suicide, OSM #1 and of it. If that was me I would with him and get the nurse." Inducted, OSM #1 stated, "Make safe at that moment and then a asked if this information ted, OSM #1 stated, "Yes, in e.m. a typed note was left for niting, "On February 12th I ctor) office to make (name of the they had was February they was signed and dated by intment coordinator. Inducted on 3/3/16 at 8:50	F3	19			
	a.m. with ASM (adn	ninistrative staff member) #2, ing. ASM #2 was made aware at 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.

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		AND H AN SERVICES & MEDICAID SERVICES			FORM): 03/15/2016 APPROVED): 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495226	B. WING		03	C / 03/2016
San A	PROVIDER OR SUPPLIER D NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 319	ASM #2 stated ther On 3/3/16 at 10:30 documented, "I (na call on 2/22/2016 fr stating that she cou on 2/23/2016. I als know that we did no of resident)." This v member) #4, unit so An interview was co a.m. with RN (regis coordinator. When resident threatened stated, "We would of statement, to have closer and make su (psychiatrist). Make	a.m. a typed note me of employee) received a om (name of physician) ald not see (name of resident) o called transport to let them of need them to pick up (name was signed by OSM (other staff ecretary. Inducted on 3/3/16 at 9:50 tered nurse) #1, the MDS asked what she would if a to commit suicide, RN #1 care plan him for suicidal him watched by staff little are he gets seen by somebody e sure staff knows he's made s already in a room in a busy	F3	119		
	On 3/3/16 at 3:10 p was made aware or	.m. ASM #1, the administrator f				TARY LA LIBRARIO ANTERNATA

Review of the facility's policy titled,

According to Mosby's Basic Skills and

and/or until resolved."

"DOCUMENTATION" documented in part, "6) Acute episodes chart every shift for 24 hours

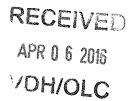
No further information was provided prior to exit.

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

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Facility ID: VA0050

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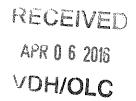
		AND H AN SERVICES & MEDICAID SERVICES				F	NTED: 03/15/2016 FORM APPROVED <u>3 NO.</u> 0938-0391	
STATEMEN ⁻	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495226	B. WING_				C 03/03/2016	
	PROVIDER OR SUPPLIER ND NURSING AND RE	HABILITATION CENTER		730 LUNEN	DRESS, CITY, STATE, ZIF IBURG HIGHW .E, VA 23947	2 CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(E <i>l</i>	PROVIDER'S PLAN OF C ACH CORRECTIVE ACTION SS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIA		
	**Seroquel is an arfor the treatment of Information Handboredition, Turkoski, L. Corp Hudson Ohio *Schizophrenia is a who have it may he They may think oth them. Sometimes to they talk. The disor keep a job or take of a job or	e nurse collaborate with disciplines so that the client's e met actipsychotic medication used schizophrenia. Drug pok for Nursing 2007 8th ance, Bonfiglio- Lexi-Comp page 1055-1056). I serious brain illness. People for voices that aren't there, er people are trying to hurt they don't make sense when der makes it hard for them to care of themselves. In.nih.gov/vivisimo/cgi-bin/quer ct=medlineplus&v%3Asources le&query=schizophrenia> Is a serious mental illness. Igo through unusual mood from very happy, "up," and and hopeless, "down," and back again. They often have etween. The up feeling is down feeling is depression ih.gov/medlineplus/depression. DENTS FREE OF DERRORS	F 3:	F333	esident #14 is no long	ger a resident	April 15, 2016	

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PRINTED: 03/15/2016



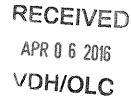
PRINTED:	03/15/2016
FORM	APPROVED
OMB NO.	0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495226	B. WING	_		03/0) 3/2016
NAME OF PROVIDER OR SUPPLIER NAYLAND NURSING AND REHABILITATION CENTER				73	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ix	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 333	Based on staff interclinical record revier complaint investigate ensure one of 21 reference in the resident # 14, was medication error. Resident # 14 had class of medication Klonopin (clonazep medication was ore dispensed by the proposed by the proposed in the findings included in the findings in this segment in the findings in the fin	erview, facility policy review, ew, and in the course of a ation the facility staff failed to esidents in the survey sample, a free from a significant a documented allergy to a as, benzodiazepines* to which earn) ** belongs. This dered by the physician and was harmacy and administered by e: admitted to the facility on oses that included but not lemia, aortic aneurysm, etes, hypothyroidism, eillure, hypertension, and ease. At the time of the transport of the transport of the etropy of 1/27/15 coded ing understood and able to The Resident had a BIMS Mental Status) of 15 out of 15 was cognitively intact. transport of the etropy of the etropy of the error of t	F	333	2. A 100% audit will be completed or resident's current MARs by RN/SDC on March 11, 2016 to ensure medica are not being administered that resid allergic to. All areas of concern will addressed by the RN/SDC during the with MD notification, order clarifica and completion of an incident report 3. All licensed nurses to include LPN LPN #2 will be in-serviced by RN/S regarding notifying the physician and clarifying physician orders if the resiallergic to a medication prior to the administration of the medication and completing an incident report for me errors by April 15, 2016. All newly license nurses will be in-serviced remotifying the physician and clarifying physician orders if the resident is allea a medication prior to the administration the medication and completing an increport for medication errors during orientation. 4. The Administrative Nurses (DON/ADON/SDC/MDS Coordinated Treatment Nurse) will review all new written physician orders for all residence to the resident's allergies and Medication Administration records to the resident's allergies and Medication are not being administed residents are allergic to utilizing and Clarification QI Tool. The Administ Nurse will immediately contact the	C nurse tions ents are be e audit tion, #1 and DC d ident is dication nired tarding gergic to ion of cident or or wly ents and nd weekly x ensure red that Order	

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Facility ID: VA0050

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

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		495226	B. WING		li li	C /03/2016	
	PROVIDER OR SUPPLIE	R EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 333	handwritten physic (Administrative Stadministrator, as physician]. This of the physician on documented: "1/2 (milligrams) PO (I reduce to 0.5 mg X 14 days then Documedical doctor) in exacerbates upon the physician of the physic	the clinical record was a cian order [identified by ASM taff Member) # 1, the being handwritten by the order was signed and dated by 1/20/15. This order 10/15 Clonazepam 0.5 mg by mouth) X (times) 7 days then PO q HS (every hour of sleep) //C (discontinue). Report to MD of insomnia or anxiety in discontinuation." The won 3/3/16 at 11:30 a.m. with sician that wrote the above was reviewed. ASM # 4 stated, "I age of that, it may have beed upon it and took action and medication." When asked if he dose of the medication was stated, "No, the nurse caught it	F3	physician for an order clarific complete and incident report during the audit for any iden concern. The DON will reviet the Order Clarification QI Toweeks the monthly x 1 mont compliance and to ensure the concern have been addressed. The Director of Nursing will results of the Order Clarification and present to the Quality In Committee Meeting monthly Subsequent plans of action we developed by the Committee Identification of any potential used to determine the need of frequency of continued months.	t as needed tified areas of ew and initial ool-weekly x 8 h for at all areas of d. I compile the ation QI Tool inprovement y x 3 months. will be e when required. al trends will be for action and/or		

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Event ID: KMLK11

Facility ID: VA0050

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		AND H AN SERVICES & MEDICAID SERVICES				FORM	03/15/2016 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		495226	B. WING			03/0) 03/2016
NAME OF PROVIDER OR SUPPLIER VAYLAND NURSING AND REHABILITATION CENTER				73	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 333	allergic to this medi she did and that she 4, to relay this informated her to do. It told her (LPN # 1) to and monitor the Re LPN # 1 was then a conversation and si had. At this time the with LPN # 1, and L wrote a note but do LPN # 1 was asked pharmacy calling at	cation. LPN # 1 stated that e called the Physician, ASM # mation to him and ask what he .PN # 1 stated that ASM # 4 o administer the medication sident for any side effects. asked if she documented this he (LPN # 1) stated that she e nurses notes were reviewed .PN # 1 stated, "I thought I	F 3	33			

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

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

further doses were administered.

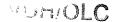
Event ID: KMLK11

Facility ID: VA0050

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APX 0 6 2016



	MENT OF HEALTH	AND H AN SERVICES & MEDICAID SERVICES				FORM): 03/15/2016 1APPROVED): 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED	
		495226	B. WING				C / 03/2016	
	PROVIDER OR SUPPLIER D NURSING AND RE	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 333	doctor, document a call the RP (responincident report. The "Risk Management" information would the During an interview (Registered Nurse) process for sending # 2 stated that the othe POS by one nurbehind and checks Allergies and diagn POS is faxed to the comes he reads an If he writes an orde Resident is allergic doctor and let him keepident for any adthe RP. One would and also do an incident the computer system paper form. During an interview ASM # 1 it was revenedication error repasked what she (ASASM # 1 stated that report and documents)	ge 84 a set of vitals, then call the my vitals and any new orders, sible party), and fill out an e incident report is under the "tab on the computer. All this hen go to the administrator. on 3/3/16 at 8:05 a.m. RN # 2 was asked to explain the gorders to the pharmacy. RN doctors order are written on rse then another nurse comes both nurses sign the POS. oses are also checked. This pharmacy. When the doctor d signs the copy of the POS. r for a medication that a to the nurse would call the know. If a Resident receives a y are allergic to then one notify the doctor, monitor the liverse reaction and also notify I document in the nurses notes dent report. This report is in m - there is a tab for it, but no on 3/3/16 at 9:45 a.m. with ealed that there was no port for this incident. When SM # 1) would have expected, t she would have expected, t she would have expected a ntation of monitoring the actions also would have	F3	333				

date (1/22/15).
FORM CMS-2567(02-99) Previous Versions Obsolete

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

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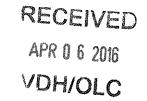
		AND H AN SERVICES & MEDICAID SERVICES					FORM.	03/15/2016 APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			ТТ	(X3) DATI COM	0938-0391 SURVEY PLETED
		495226	B. WING	~~~~	C 03/03/2016			
	PROVIDER OR SUPPLIER D NURSING AND RE	HABILITATION CENTER		7:	STREET ADDRESS, CITY, STATE, ZIP CODE 230 LUNENBURG HIGHW KEYSVILLE, VA 23947	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD E	BE	(X5) COMPLETION DATE
F 333	Continued From pa	ge 85	F:	333				
	ADMINISTRATION "G. All medication of detail on a Medicatifiled with the Direct physician shall be risignificant medicatifrom the following predication error: 1. Administration of the right dose; 4. By the method; 6. At the rideviations from the reported to the Sup Supervisor shall initial.	ty policy: "MEDICATION " documented the following: errors shall be described in ion Error Report which shall be or of Nursing. The attending notified immediately of all on errors." "N. Any deviation orinciples shall be considered a . To the right resident; 2. ie right medication; 3. In the e right method; 5. By the right ght time. All recognized above principles shall be iervisor, immediately. The tiate a Medication Error Report mitted to the Director of						
inem#	# 1 and ASM # 2, the concern was review	n 3/3/16 at 3:10 p.m. with ASM ne director of nurses, this ved. ASM # 1 stated that report was reviewed there was nedication error.		NORAL AND STREET AND				
	provided. * Benzodiazepines sedation, induce sle muscle spasms, an www.dea.gov/drugi azepines.pdf ** ClonazepamKl used alone or in comedications to contitof extreme fear	are depressants that produce eep, relieve anxiety and deprevent seizures. Info/drug_data_sheets/Benzodi onopin®Clonazepam is mbination with other trol certain types of seizures. and worry about these am is in a class of medications		A ANNA DA ANNA AL PARA ANNA ANNA ANNA ANNA ANNA ANNA ANNA				

called benzodiazepines.

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Facility ID: VA0050

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		AND HOAN SERVICES & MEDICAID SERVICES			PRINTED: 03 FORM AP OMB NO. 09	PROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SU COMPLE	URVEY
		495226	B. WING		03/03/	2016
NAME OF I	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
WAYLAN	D NURSING AND RE	HABILITATION CENTER		30 LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.DBE C	(X5) OMPLETION DATE
F 333		ge 86 .gov/medlineplus/druginfo/me	F 333			
	Edition, 2009: by Por "Medication Administread: "Professional American Nurses A and Standards of Note the activity of medication administremedication administration admini			1		
	COMPLAINT DEF 483.60(a),(b) PHAF ACCURATE PROC	RMACEUTICAL SVC -	F 425	F425	March	h 31, 2016
	drugs and biologica them under an agre §483.75(h) of this p unlicensed personr law permits, but on supervision of a lice	ovide routine and emergency als to its residents, or obtain ement described in art. The facility may permit all to administer drugs if State by under the general ensed nurse.		Resident #14 is no longer a resident facility. A 100% audit was completed of all resident's current MARs by RN/SDO on March 11, 2016 to ensure medica are not being administered that resid allergic to. All areas of concern note the audit will be addressed by the nu RN/SDC with MD notification, order clarification, and completion of an in	C nurse ations lents are d from larse,	

the needs of each resident.

(including procedures that assure the accurate

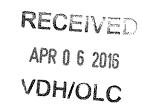
acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet

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report.

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All of the pharmacist' have been re-educated

on the monitoring of drug/allergy

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 '	PLE CONSTRUCTION G	COV	(X3) DATE SURVEY COMPLETED		
		495226	B. WING			C /03/2016	
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 425	The facility must end a licensed pharma on all aspects of the services in the facility and the facility document recomplaint investigate failed to clarify a reprior to dispensing Residents in the sure Resident # 14 had class of medication Klonopin (clonazer medication was ore dispensed by the part of the findings included Resident # 14 was 1/16/15 with diagnostic dispensed by the part of the findings included Resident # 14 was 1/16/15 with diagnostic dispensed by the part of the findings included Resident # 14 was 1/16/15 with diagnostic dispensed by the part of the findings included Resident # 14 was 1/16/15 with diagnostic dispensed by the part of the findings included Resident # 14 was 1/16/15 with diagnostic dispensed by the part of the findings included Resident # 14 was 1/16/15 with diagnostic dispensed by the part of the findings included Resident # 14 was 1/16/15 with diagnostic dispensed by the part of the findings included Resident # 14 was 1/16/15 with diagnostic dispensed by the part of the findings included Resident # 14 was 1/16/15 with diagnostic dispensed by the part of the findings included Resident # 14 was 1/16/15 with diagnostic dispensed by the part of the findings included Resident # 14 was 1/16/15 with diagnostic dispensed by the part of the findings included Resident # 14 was 1/16/15 with diagnostic dispensed by the part of the findings included Resident # 14 was 1/16/15 with diagnostic dispensed by the part of the findings included Resident # 14 was 1/16/15 with diagnostic dispensed by the part of the findings included Resident # 14 was 1/16/15 with diagnostic dispensed by the part of the findings included Resident # 14 was 1/16/15 with diagnostic dispensed by the part of the findings included Resident # 14 was 1/16/15 with diagnostic dispensed by the part of the findings included Resident # 14 was 1/16/15 with diagnostic dispensed by the part of the findings included Resident # 14 was 1/16/15 with diagnostic dispensed by the part of the findings included Resident # 14 was 1/16/15 with	mploy or obtain the services of cist who provides consultation are provision of pharmacy lity. INT is not met as evidenced erview, clinical record review, eview, and in the course of a ation the facility pharmacy esident's medication allergy medications for one of 21 urvey sample, Resident # 14. a documented allergy to a ms, benzodiazepines* to which pam) ** belongs. This dered by the physician and was pharmacy.	F 42	interactions by the Pharmacy Opera Manager by March 31, 2016. At the end of the business day twice for 4 weeks a Neil Medical Group pharmacist in Kinston will compare orders to be dispensed to Wayland of date vs. the allergies listed in the ph database. The pharmacist will sign report indicating that the review has completed. If a potential drug aller contraindication that has not been as upon is identified by the pharmacist end of the day, then that pharmacist create an internal incident report for by the Pharmacy Quality Assurance the Kinston pharmacy. The reviewing pharmacist will also act upon the post allergy contraindication by contacting member of the facility's nursing statistic take other actions as deemed appropring the reviewing pharmacist's profession judgment. The Pharmacy's Quality Assurance will review the findings of the audit determine the necessity for, manner frequency of continued audits.	the on that armacy the been rgy cted at the will review team at ng aff and/or oriate per onal		

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

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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F 425	Review of Resider a physician order signed by the physician order signed by the physician of this form allergies. In this s "Benzodiazepines to the pharmacy of this form was fa "3/3/2016 at 12:42" Also located in the handwritten physician on 1 documented: "1/20 (milligrams) PO (breduce to 0.5 mg in X 14 days then D/(medical doctor) if exacerbates upon Review of the pha 1/21/15 document was sent to the fact 14). During an interview OSM (Other Staff revealed that the public faxed copy he OSM # 8 was asked a physician orderer resident was document was document was document was stated that the most stated that the most stated that the most side of the physician orderer resident was document was docum	at # 14's clinical record revealed sheet (POS) dated 1/16/15 and sician on 1/20/15. Near the is a section to list the ection was documented:" This form (POS) was faxed in: "1/16/2015 at 16:32." A copy exed from the pharmacy on: PM". It clinical record was a clian order [identified by ASM aff Member) # 1, the being handwritten by the erder was signed and dated by 1/20/15. This order 20/15 Clonazepam 0.5 mg by mouth) X (times) 7 days then PO q HS (every hour of sleep) C (discontinue). Report to MD insomnia or anxiety	F 42	25				

		AND H AN SERVICES & MEDICAID SERVICES				FORM	: 03/15/2016 I APPROVED : 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION		E SURVEY IPLETED
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NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
-WAYLAN	D NURSING AND RE	HABILITATION CENTER			0 LUNENBURG HIGHW EYSVILLE, VA 23947		
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F 425	Continued From pa	ge 89	F4	25			Andersonalistics
	then contact the fac	cility and ask that the physician					
		the order. It would be					
		se's note be written and that a					
		e obtained and faxed to the 8 stated that when the order					Assessment
		ed to the pharmacy the records					
		because of the allergy. OSM					
	# 8 further stated th						
		ailing what the pharmacist that		<			
	received the order	did when the flag occurred.					
	LPN (Licensed Pracasked if she remen	on 3/3/16 at 12:55 p.m. with ctical Nurse) # 1, LPN # 1 was bered the pharmacy calling on and the Resident's allergy I that she did not.		maa ka maraa ka maraa ka k	•		
geologic and the second and the seco		n 3/3/16 at 3:10 p.m. with ASM ne director of nurses, this wed.		THE THE PROPERTY OF THE PROPER			
inner sure	Prìor to exit no addi provided.	itional information was		RAVA ACRESANTA LA COLONIA LA CARROLA ACADONA A			
	sedation, induce sle muscle spasms, an	are depressants that produce eep, relieve anxiety and d prevent seizures. nfo/drug_data_sheets/Benzodi		REIN UPPERVITERERATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFERRATIFE			
		onopin® Clonazepam is		THE PERSON A LAW STREET TO SERVICE THE SER			

benzodiazepines. ...

ds/a682279.html -

medications to control certain types of seizures. It ...of extreme fear and worry about these attacks) Clonazepam is in a class of medications called

https://www.nlm.nih.gov/medlineplus/druginfo/me

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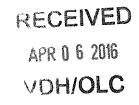
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION	CON	(X3) DATE SURVEY COMPLETED		
		495226	B. WING			C / 03/2016	
AME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		103/2010	
WAYLAN	ID NURSING AND RE	HABILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
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	COMPLAINT DEFI	_	F 4	*	Ap	ril 15, 2016	
	Infection Control Prisafe, sanitary and control to help prevent the of disease and infection Control The facility must esprogram under whice (1) Investigates, coin the facility; (2) Decides what pushould be applied to (3) Maintains a reconstructions related to in (b) Preventing Sprecent (1) When the Infective determines that a reprevent the spread isolate the resident (2) The facility must communicable disections after each display the facility must hands after each display the facility must hand washing is incorressional practice (c) Linens Personnel must hand the facility must hand the facility must hand washing is incorressional practice.	I Program tablish an Infection Control ch it - introls, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective infections. and of Infection cion Control Program esident needs isolation to of infection, the facility must it prohibit employees with a lase or infected skin lesions with residents or their food, if ansmit the disease. It require staff to wash their rect resident contact for which dicated by accepted		LPN #3 was in-serviced regard sanitizing hands after removing gloves and before applying clear gloves during dressing changes not taking multi dose treatment creams and solutions to include santyl in the resident's room dua dressing change; ointments at solutions must be placed in a creprior to going in the resident's room by RN/SDC on or before March 31, 2016. 100% observation will be completed with all license nurs include LPN # 3 to ensure prop sanitation of hands after remov gloves and applying clean gloveduring dressing changes, multitreatment creams and solutions include santyl are not taken interesident room during dressing changes to include resident # 4 ointments and/or solutions are placed in a cup prior to going resident's room on or before A 15, 2016 by Administrative N (DON/ADON/SDC/MDS Coordinator and/or Treatment Nurse). Retraining was conducted by Administrative Nurse during audit for any identified areas of concern.	es to er ing es dose to o and in the april arses		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
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F 441	Continued From pa	age 91	F 4	41		The state of the s	
	by: Based on observate determined that the infection control prin the survey samp. Facility staff failed removing gloves at gloves during a dreather tube of Santyl* treatment cart. The findings include Resident #4 was a 7/17/15 and readmediagnoses that include arthritis, anemia, dischizophrenia* and Resident #4's mosset), a 30 day asset (assessment reference resident's BIMS status) as a 15 out was cognitively into The resident was owith activities of da Conditions. M0100 Ulcer Risk. A. Resa a scar over bony pinon-removable dreather than the physical resident was a scar over bony pinon-removable dreather than the physical resident was a scar over bony pinon-removable dreather than the physical resident was a scar over bony pinon-removable dreather than the physical resident was a scar over bony pinon-removable dreather than the physical resident was a scar over bony pinon-removable dreather than the physical resident was a scar over bony pinon-removable dreather than the physical resident was a scar over bony pinon-removable dreather than the physical resident was a scar over bony pinon-removable dreather than the physical resident was a scar over bony pinon-removable dreather than the physical resident was a scar over bony pinon-removable dreather than the physical resident was a scar over bony pinon-removable dreather than the physical resident was a scar over bony pinon-removable dreather than the physical resident was a scar over bony pinon-removable dreather than the physical resident was a scar over bony pinon-removable dreather than the physical resident was a scar over bony pinon-removable dreather than the physical removable dreather than	to sanitize their hands after and before applying clean essing change and to sanitize the prior to returning it to the the decision and the sanitize that the sanitize that the sanitize that the sanitize that the sanitize the sanitize that the sanitize that the sanitize the sani		100% of license nurses to in LPN #3 and CNAs were inserviced on or before April 12016 by the RN/SDC regard proper sanitation of hands af removing gloves and applying clean gloves. 100% of licens nurses will also be inserviced not taking multi dose treatmed creams and solutions to inclusion and taking multi dose treatmed creams and solutions to inclusion and taking multi dose treatmed creams and/or solutions in placed in a cup prior to going resident's room. All newly have license nurses will be inserving gloves applying clean gloves, not take multi dose treatment creams solutions to include santyl in resident's room during a dreschange; ointments and/or solutions to include santyl in resident's room during a dreschange; ointments and/or solutions to include santyl in resident's room conducted in a cup prior going in the resident's room CNAs will also be inserviced regarding proper sanitation of hands after removing gloves applying clean gloves by the during orientation.	ing iter ing iter ing iter ing iter iter ited on iter ited of and king and the essing utions to and d f and		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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		493226	D. WING			03/	03/2016	
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947					
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F 441	and water, to apply 4 inch gauze, apply with a gauze wrap. An observation was of Resident #4's let (licensed practical resident's permissi wound care to the any pain. LPN #3 ptable and then place Santyl on the pape put on gloves and resident's foot. LPN and put on another hands. She then we soap and water; shand put on another her hands. LPN #3 went to the treatmed depressor and a me (from a tube alread into the cup. LPN adepressor to scoop spread it on the wowithout washing hed dressing. LPN #3 to disposed of the suptrash bag and the testing. LPN #3 to disposed of the suptrash bag and the testing. LPN #3 wand nose during the trash bag and washing and the trash bag and washing hed as question. LPN #3 wand nose during the trash bag and washing hed as question. LPN #3 wand nose during the trash bag and washing hed as question. LPN #3 wand nose during the trash bag and washing hed as question. LPN #3 wand nose during the trash bag and washing hed as question. LPN #3 wand nose during the trash bag and washing hed as question. LPN #3 wand nose during the trash bag and washing hed washi	Santyl***, cover with 4 inch by a bulky dressing and secure it is made on 3/2/16 at 11:00 a.m. It heel dressing change by LPN nurse) #3 after obtaining the on. LPN #3 explained the resident and asked if he was in blaced waxed paper on the red the gauzes and tube of r. LPN #3 washed her hands, removed the dressing from the N #3 then removed her gloves a pair without washing her ashed the resident's heel with the then removed the gloves and then to get a tongue edicine cup. Some Santyl ly in the room) was squeezed #3 then used the tongue of the Santyl out of the cup and and. LPN #3 put on gloves are hands and applied the new then took off the gloves, oplies in a trash bag, took the sube of Santyl out of the room. If Santyl back into the treatment the medication cart holding the taff member asked her a was observed to rub her eye is time. LPN #3 disposed of	F4	(DON/ADON/SE) Coordinator and/o Nurse) will obser during a resident to include resident sanitation of hanc gloves and applyi during dressing c treatment creams include santyl ar the resident's roo dressing changes t resident # 4 and o solutions are place to going in the res weekly x 8 weeks month utilizing a audit tool. Retrair immediately conc license nurse by t Nurse for any ide concern. The DO initial the Resider	or Treatment are 10% of nurses dressing change at # 4 to ensure ds after removing ing clean gloves changes, multi dose and solutions to be not taken into om prior to the to include of the include of th			

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

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495226	B. WING			C 03/03/2016		
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		73	REET ADDRESS, CITY, STATE, ZIP CODE 10 LUNENBURG HIGHW EYSVILLE, VA 23947		0012010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 441	and end." When as she removes glove hands between glo asked what proces tube of Santyl into returning it to the tr "I should have sque the cup instead of twhen asked why, I could have germs of the could have germs of the cup instead of twhen asked why, I could have germs of the cup instead of twhen gloves are returned to the director of nurs when gloves are returned to the countrol." An interview was cop.m. with ASM (address the director of nurs when gloves are returned to the countrol. "As the countrol." As the countrol of the countro	sked what she should do when s, LPN #3 stated, "Wash ve changes. LPN #3 was then s staff follow when taking a the resident's room and then eatment cart, LPN #3 stated, eezed some (of the Santyl) into taking the tube into the room." LPN #3 stated, "It (the tube) on it." conducted on 3/2/16 at 3:00 When asked what occurs moved during wound care, ash your hands." When asked LPN #4 stated, "For infection onducted on 3/2/16 at 3:15 ministrative staff member) #2, ing. When asked what occurs moved during wound care, nould wash your hands." ASM e it's a standard of care and aSM #2 was asked what ollows if they take a tube of ant's room. ASM #2 stated, "It d, again because of germs, ons**** and infection control." aware of the findings at that	F 4	441	The Director of Nursing will compileresults of the Resident Care Audit T present to the Quality Improvement Committee Meeting monthly x 3 months Subsequent plans of action will be developed by the Committee when Identification of any potential trendused to determine the need for action frequency of continued monitoring	onths. required. s will be		

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	1	(X3) DATE COM	SURVEY PLETED
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)	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		73	REET ADDRESS, CITY, STATE, ZIP CODE O LUNENBURG HIGHW EYSVILLE, VA 23947	-		
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F 441	washing and the ushands are conduits potential pathogens from a contaminate a staff member to the single most impinfectiontypically before coming on dindirect patient contadministering medihands with soap affusing hand sanitize alcohol-based hands. Rub hands product has dried (using hands it may he They may think other them. Sometimes they talk. The disorkeep a job or take of https://vsearch.nlm.meta?v%3Aprojectmedlineplus-bundle**Bipolar disorder is People who have it changes. They go factive to very sad a inactive, and then be normal moods in be called mania. The of https://www.nlm.nhtml>. ***Santyl ointment is ointment. It works be ****Nosocomial Hostings.	for almost every transfer of a from one patient to another, and object to the patient, or from the patient. Hand hygiene is cortant procedure in preventing hands are washed with soap tuty; before and after direct or tact;before preparing or cationsalways wash your ter removing gloveswhen r, apply a small amount of the trub to all surfaces of the together until the entire usually about 30 seconds)." serious brain illness. People are voices that aren't there, er people are trying to hurt they don't make sense when der makes it hard for them to	F	441				

provide challenge to clinicians. Measures of

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	495226		B. WING			C 03/03/2016	
	MAYLAND NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, Z 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCED TO TO THE PROVIDER TO THE PRO	TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 441	infection control inco of nosocomial infect hygiene, following stransmission" http://www.ncbi.nlm 3198/	clude identifying patients at risk ctions, observing hand standard precautions to reduce n.nih.gov/pmc/articles/PMC396	F 44				
SS=D	3198/ 502 483.75(j)(1) ADMINISTRATION				on 3/3/16 by ts of the De rded to the Don. Inpleted on or N/Corporate s to include r the last 90 of drawn time identified an tely correcturses with ph dit. was initiated as nurses to garding fol	btained y Vista epakote MD on before e Nurse resident days to ely per reas of ted by ysician d with	ril 15, 2016

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Event ID: KMLK11

Facility ID: VA0050

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		B. WING			С	
	495226	B. WING		03	03/2016	
WAYLAND NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE	
status) as 10 out of moderately impaire resident was coded staff for activities of Active Diagnoses, it having "Seizure Dis Review of the physisigned on 2/5/16 do (laboratory) orders, months, Depakote Review of the Febradministration reconceptation of the period of the director of nursing Depakote level had it had not. ASM #2 verbal order for the order into the laboratory staff) collaboratory staff) collaborator	S (brief interview for mental f 15 indicating the resident was ed to make daily decisions. The d as requiring assistance from f daily living. In Section I the resident was coded as sorder or Epilepsy." sician's orders dated and occumented, "Clarification of lab occumented, "Clarification of lab occumented, "Clarification of lab occumented, "Section of Italian and Italian	F	obtaining labs timely as process for obtaining a lab test ordered by the physicial before April 15, 2016 by the DON. All newly hired nurses will be in-serviced reg following physicians ord include obtaining labs time the process for obtain laboratory test ordered be physician by the Staff Facturing orientation. 4. All newly ordered labs for all residents to include resident to include Depakote level will reviewed by Administrative 1 (DON/ADON/SDC/MDS Coordinator) weekly x 8 weethen monthly x 1 month to enlabs have been drawn timely physician's order utilizing a Laboratory Monitoring QI to identified areas of concern will immediately be corrected by the Administrative Nurse with retraining with the license nur and physician notification dur the audit. The DON will revie and initial the Laboratory Monitoring QI Tool weekly x weeks the monthly x 1 month compliance and to ensure that areas of concern have been addressed.	oratory of on or SDC or license garding ers to ly and ong a ory the ilitator 15 and l be lurses oer ol. All ll he se ing w 8 for		

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Event ID: KMLK11

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CENTERS FOR MEDICARE & MEDICAID SE	RVICES

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495226	B. WING		l l	C 03/2016	
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		03/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
	was a process to f specimen had bee "The night shift do doctor's orders) is the MAR (medicat A review of the fact LABORATORY Design part, "In order the regularly monitore effectiveness and determinations she approval of the att residents to which (Depakote), valprothen q (every) 6 m On 3/3/16 at 3:10 member) #1, the additional member of the findings. No further information was a strength of the findings. No further information was a lab test blood. https://www.nlm.nids/a682412.html **A1C is a lab test blood sugar (glucomonths. It shows by your diabetes. https://www.nlm.nid03640.htm 483.75(j)(2)(i) LAB	follow up that the laboratory on obtained, LPN #1 stated, sees, the pink slip (from the the one we take out and put on ion administration record)." Sility's policy titled, "ROUTINE ETERMINATIONS" documented nat certain medications may be d for appropriateness of dose, possible toxicity, the following ould be done routinely with the ending physician, for those they apply. Valproic acid loic acid level within 1 month, nonths." p.m. ASM (administrative staff administrator was made aware at certain types of seizures. evels are lab tests to look for the amount of a drug in the lih.gov/medlineplus/druginfo/me that shows the average level of ose) over the previous 3 now well you are controlling lih.gov/medlineplus/ency/article/ B SVCS ONLY WHEN	F 50	The Director of Nursing will comresults of the Laboratory Monitor Tool and present to the Quality Improvement Committee Meeting 3 months. Subsequent plans of ac developed by the Committee whe Identification of any potential trerused to determine the need for act frequency of continued monitorin Director of Nursing is responsible overall compliance.	ing QI g monthly g tion will be n required, nds will be tion and/or g. The	e .	
			F 50	4			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i .	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER				73	TREET ADDRESS, CITY, STATE, ZIP CODE 80 LUNENBURG HIGHW EYSVILLE, VA 23947	03/	03/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 504	services only when physician. This REQUIREME by: Based on staff interclinical record reviet facility staff obtained physician's order for survey sample, Resolved and the survey sample, Reso	rovide or obtain laboratory a ordered by the attending NT is not met as evidenced erview, facility policy review and ew, it was determined the ed a laboratory test without a per one of 21 residents in the esident #10. facility staff failed to obtain a prior to obtaining a CBC* count) laboratory test. de: admitted to the facility on coses that included but were not ge renal disease requiring ons, diabetes, high blood nia. IDS (minimum data set), a ent, with an ARD (assessment 2/23/16 coded the resident's ew of mental status) as 15 out a resident was cognitively intact sions. The resident was coded sive assistance from staff for all ring except for eating which the after having the meal tray in I Active Diagnoses, the dias having anemia.		504	The MD was notified of obtaining the for resident #10 on March 24, 2016 by DON. A 100 % audit was conducted by Corn Nurse Consultant, on or before March 2016 to ensure that all laboratory tests including blood draws for CBCs, that collected within the past 30 days were obtained as ordered by the physician of facility protocol. The MD was notified Administrative Nurse for any identified areas of concern. All licensed nurses were in-serviced on need to ensure physician order in place to obtaining any lab work, including be draws for a CBC by Administrative N (DON/ADON/SDC/MDS Coordinator or before April 15, 2016. All newly his license nurses will be in-serviced regathe need to ensure physician order in prior to obtaining any lab work, included blood draws for a CBC by the Staff Facilitator during orientation.	c CBC y the porate 30. s, were cor per d by d n the e prior lood urses c) on red rding blace	il 15, 2016
TO THE O'VERNITY TO A COMMISSION		sician's orders dated 11/2/15		WAA WAYWA WEEK WATER			





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CENTERS FOR MEDICARE & MEDICAID SE	RVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
		495226	B. WING			03/0) 3/2016
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	ZIP CODE	03/0	13/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD THE APPROPR	BE	(X5) COMPLETION DATE
F 504	one week. A review of the labor CBC results on 11/ On 3/3/16 at 2:00 pronducted with ASI member) #2, the diabout the order for #2 stated, "I can't fisomeone confused to recheck in one with the distribution of the facility PHYSICIAN'S ORE documentation abors specimens without	repeat CBC was to be done in pratory results documented 7/15 and 11/9/15. I.m. an interview was W (administrative staff rector of nursing. When asked the 11/7/15 CBC result, ASM and an order for it, not sure if the numbers. The order was week, it (the CBC) should have 9/ (15)." Ty's policy titled, "RECEIPT OF DERS" did not evidence ut obtaining laboratory	F 50	(DON/ADON/SDC/MD conduct an audit of upcording the conduct an audit of upcording the collection of and or special laboratory work per facing all residents to includ weekly x 8 weeks then rusing a QI Lab Audit To Administrative Nurse widentified areas of concerders are written prior the during the audit. The DO initial the QI Lab Audit weeks then monthly x 1 compliance and to ensur concern have been addressed.	os Coordinator oming labs per hose for CBCs was written per men was obtain lity protocol of e resident # 10 monthly x 1 mool. The fill address any on the lab draw on will review Tool weekly x month for the that all areas essed.	r the s, to orior to ned for of 25% 0 onth y v and x 8 s of	
F 514 SS=D	was made aware of No further informate *A complete blood the following: The recount <./003644.htt blood cells (WBC of total amount of hem blood, the fraction of blood cells (hemate 483.75(I)(1) RES RECORDS-COMPLE		F 5	results of the QI Lab Au to the Quality Improvem Meeting monthly x 3 mo plans of action will be de Committee when require any potential trends will determine the need for a frequency of continued r	dit Tool and parent Committee on the Subsequeveloped by the d. Identificate be used to ction and/or	eresent e ent ne	

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CENTERS FOR MEDICARE & MEDICAID	SERVICES

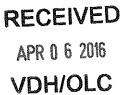
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alled like the second		495226	B. WING	-		C	
NAME OF I	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP COD		03/2016	
		REHABILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE	
F 514	standards and proaccurately docume systematically organized from the clinical recordinformation to idea resident's assess services provided preadmission scrand progress note. This REQUIREM by: Based on staff in review it was determined for one of sample, Resident. The facility staff from the	actices that are complete; nented; readily accessible; and ganized. d must contain sufficient entify the resident; a record of the ments; the plan of care and it; the results of any eening conducted by the State; es. ENT is not met as evidenced enterview and clinical record ermined that the facility staff a complete and accurate clinical 21 residents in the survey if 14. ailed to document the nurse's in the physician concerning nedication allergy. Resident # ented allergy to a class of zodiazepines* to which Klonopin pelongs. This medication was anysician and was dispensed by diadministered by nursing staff.		Resident # 14 Klonopin was dithe MD on 1/22/15 with a written physician's order. Resident #1 a resident of this facility. A 100% audit will be complete resident's physician orders witten days comparing to the resident allergies by the SDC/RN on N 2016 to ensure if a resident has a medication, the physician was with documentation of the notic clinical record. All areas of considered by the nurse during MD notification, order clarific completion of an incident report and documentation in the clinical record by Administrati (DON/ADON/SDC/MDS Cooregarding notifying the physicial clarifying physician orders if the allergic to a medication prior the administration of the medication documenting the physician not the clinical record on. All new license nurses will be in-serviced in the service of the service of the medication of the me	iscontinued by ten 14 is no longer 14 is no longer 15 distribution 16 distribution 17 distribution 18 an allergy to as notified 18 ification in the audit with ation, ort if needed, cal. LPN #1 will ve Nurses ordinator) 18 ian and the resident is o the to the on and tification in well hired	r	
	1/16/15 with diag limited to hyperlip osteoporosis, dial congestive heart coronary artery di complaint Reside	s admitted to the facility on noses that included but not idemia, aortic aneurysm, betes, hypothyroidism, failure, hypertension, and isease. At the time of the int # 14's MDS (minimum data essment, with an ARD		notifying the physician and cla physician orders if the resident a medication prior to the admit the medication and documenti physician notification in the cl during orientation.	arifying t is allergic to nistration of ng the		

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DEPARTMENT OF HEALTH	I AND HOAN	SERVICES
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	PRINTED: 03/15/201
4	FORM APPROVE
<i>A</i>	OMB NO. 0938-039

AND PLAN OF CORRECTION 495226 A95226 NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) 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 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. STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947 PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTION SHOULD BE (EACH CORRECTION SHOULD BE (EACH CORRECTION SHOULD BE (EACH	<u> </u>	(O) OI (III LOIO) (I (L	C MEDIONID OF LANDED	<u>, </u>		<u> </u>	IVID IVO.	0900-0091		
A S S S S S S S S S	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			1		COMPLETED				
MAYLAND NURSING AND REHABILITATION CENTER (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947 D PROVIDER'S PLAN OF CORRECTION OF CORRECTION OF CORRECTION OF CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 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.	Para Maria	495226		B. WING			· I			
Tag Summary Statement of Deficiencies (EACH Deficiency Must be preceded by Full Regulatory or LSC identifying information) 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. Tag PROVIDER'S PLAN OF CORRECTION (REACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE (EACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE (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.	LAME OF	BOOVIDED OF OURDINED	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			TOUT ADDITION OF A STATE TO CODE	0.5/	U3/2U16		
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. PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 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 residents'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 orders for an order clarification, document in the clinical record, and retrain the license nurse during the audit for any identified areas of concern.				730 LUNENBURG HIGHW						
(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. (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.	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			ICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD PREFIX (EACH CORRECTIVE ACTION SHOULD INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATION CRO			D BE COMPLÉTION		
handwritten physician order [identified by ASM (Administrative Staff Member) # 1, the administrative Staff Member) # 1, 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	(assessment reference the Resident as being understand others.) (Brief Interview for indicating that she will be resident as physician order signed by the physician order signed by the physician of this form allergies. In this see "Benzodiazepines to the pharmacy on this form was faxed 3/3/2016 at 12:42 F. Also, located in the handwritten physician (Administrative State administrator, as be physician). This order the physician on 1/3 documented: "1/20 (milligrams) PO (by reduce to 0.5 mg PX 14 days then D/C (medical doctor) if it exacerbates upon of the clinical documentation for #14 received a meto. During an interview LPN (Licensed Pranthat administered that admi	ence date) of 1/27/15 coded ing understood and able to The Resident had a BIMS Mental Status) of 15 out of 15 was cognitively intact. If # 14's clinical record revealed heet (POS) dated 1/16/15 and cian on 1/20/15. Near the is a section to list the ection was documented: If This form (POS) was faxed 1/16/2015 at 16:32. A copy of from the pharmacy on PM. Clinical record was a an order [identified by ASM ff Member) # 1, the eing handwritten by the der was signed and dated by 20/15. This order (15 Clonazepam 0.5 mg mouth) X (times) 7 days then O q HS (every hour of sleep) C (discontinue). Report to MD insomnia or anxiety discontinuation." Fall record revealed no nurse's 1/22/15 the date that Resident dication that she was allergic on 3/3/16 at 12:55 p.m. with ctical Nurse) # 1, the nurse he clonazepam, LPN # 1 was ad that the Resident was	F	514	(DON/ADON/SDC/MDS Coordinated review all newly written physician or all residents to include resident #14 at compare to the resident's allergies we 8 weeks then monthly x 1 month to et a resident has an allergy to a medicate physician was notified with document of the notification in the clinical reconstillation and of the notification in the clinical reconstillation and of the notification of the clinical reconstillation and of the notification in the clinical reconstillation and of the notification of the clinical reconstillation and of the notification of the clinical reconstillation of the notification of the clinical reconstillation of the notification of the clinical reconstillation of the clinical reconstillation of the clinical reconstillation of the clinical reconstillation of the notification of the compliance and ensure that all areas of concern have the addressed. The Director of Nursing will compile results of the Order Clarification of the Quality Improvement Committee Meeting monthly x 3 mon subsequent plans of action will be developed by the Committee when reconstillation of any potential trends we used to determine the need for action and present to the need for action and present to determine the need for action and present to determine the need for action and present to determine the need for action and present to the need for action and present to determine the need for action and present to the need for action and present to determine the need for action and present to the n	ders for and seekly x ansure if son, the tation and sol. The seem seem seem seem seem seem seem se			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				IPLE CONSTRUCTION NG	(X3) DAT COM	(X3) DATE SURVEY COMPLETED	
495226			B. WING _		03/03/2016		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI			
WAYLAN	D NURSING AND REI	HABILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 514	Continued From pa	ge 102	F 51	14			
	4, to relay this informated her to do. Let told her (LPN # 1) to and monitor the Research Her to the LPN # 1 was then a conversation and shad. At this time the with LPN # 1 and shade but do not see. During a meeting on # 1 and ASM # 2, the concern was review. No further information and further information page 477 reanything written or precord or proof for a Documentation with aspect of nursing precord or proof for a Documentation must and flexible enough maintain continuity and reflect current seedation, induce slemuscle spasms, an	n 3/3/16 at 3:10 p.m. with ASM se director of nurses, this red. on was provided prior to exit. mentals of Nursing, 6th eads: "Documentation is printed that is relied on as authorized persons. In a client record is a vital reactice. Nursing st be accurate, comprehensive to retrieve critical data, of care, track client outcomes, standards of nursing practice. are depressants that produce sep, relieve anxiety and					

called benzodiazepines.

** 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

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		AND H AN SERVICES				FORM.	03/15/2016 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
495226			B. WING			C 03/03/2016		
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	SHOULD BE COM		
F 514	,	ge 103 n.gov/medlineplus/druginfo/me	F	514				

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