PRINTED: 03/20/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DE AND PLAN OF CORP		(X1) PRDVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRU			TE SURVEY MPLETED
		495226	B. WING _			03	/09/2018
NAME OF PROVID		HABILITATION CENTER		730 LUNENE	RESS, CITY, STATE, ZIP CODI BURG HIGHW E, VA 23947	E	
(X4) ID PREFIX (TAG R	FACH DEFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	·	ROVIDER'S PLAN OF CORRECTIVE ACTION SHOWS AND WAY AND	IDULD BE	(X5] COMPLETION DATE
Surve Corre CFR Care E 018 Processer CFR (b) F deve policiplan asserand to this service minimaddre (2) A and service facilication of the foliocation of the foliocati	inannounced Eay was conducted was conducted and the communication. The power and updated a	ocedures. The [facilities] must ment emergency preparedness dures, based on the emergency ragraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of olicies and procedures must be ted at least annually.] At a ies and procedures must mg:] ok the location of on-duty staff ints in the [facility's] care during in-duty staff and sheltered and the specific name and iving facility or other location. 11.184(b), LTC at §483.73(b), 75(b), PACE at §460.84(b):] dures. (2) A system to track the staff and sheltered residents in CF/IID or PACE] care during ency. If on-duty staff and are relocated during the		18:	Rehabilitation center acknowledges receipt Statement of Deficier proposes this Plan of Correction to the externation to the externation of the summary of finding factually correct and it to maintain compliant the applicable rules as provisions of quality or residents. This Plan of Correction is submitted written allegation of compliance. Wayland Nursing and Rehabilitation Center' response to this State Deficiencies does not agreement with the Statement of Deficient does it constitute an admission that any deris accurate. Wayland and Rehabilitation Cerreserves the right to reany of the deficiencies Statement of Deficiencies Statement	t of the ncies and ent that ngs is in order ce with nd of care of fed as a second denote cies nor ficiency Nursing nter efute son this cies ute	RECEIVED APR 24 2018
must	document the	RTF's, LTC, ICF/IID or PACE] specific name and location of or other location.			procedure and/or any administrative or legal proceeding.	other	, 0
ABORATORY DIREC	TOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	N	TIFLE ((X6) OATE

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

FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION		E SURVEY MPLETED
		495226	B. WING			03/	09/2018
	SUMMARY STA	HABILITATION CENTER TEMENT OF DEFICIENCIES WINDOWS BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG	730 KE	EET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW YSVILLE, VA 23947 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	[X5] COMPLETION DATE
E 018	*[For Inpatient Hose Policies and proced (ii) Safe evacuation includes consideral needs of evacuees transportation; ident location(s) and princommunication with assistance. (v) A system to trace employees' on-duty hospice's care during on-duty employees relocated during the must document the the receiving facility. *[For CMHCs at §4 procedures. (2) Saft which includes constreatment needs of responsibilities; tracevacuation location means of communication assistance. *[For OPOs at § 48 procedures. (2) A structures and maintal secures and maintal facility, which includes constreatment that donor information, potential and actual secures and maintal secures and maintal facility, which included the patient of the pati	dures. If the hospice, which the from the hospice staff responsibilities; tiffication of evacuation many and alternate means of the external sources of the kind the location of hospice and sheltered patients in the fing an emergency. If the find or sheltered patients are expectific name and location of the or other location. 85.920(b):] Policies and the evacuees; staff insportation; identification of (s); and primary and alternate cation with external sources of the find the cation of the cation with external sources of the cation information, and the availability of records. 4.62(b):] Policies and the evacuation from the dialysis les staff responsibilities, and	EC	018	E-018 The facility will develop and implement an emergency plathat includes a system to tract the location of on-duty staff and sheltered patients that are relocated during an emergency. The Emergency Policies and procedures will be reviewed to incorporate the necessary components of a satisfactory overall plan. The Emergency Preparedness Plan will be reviewed and updated annually by the facility Safety Committee. The reviews and updates will be reported to and monitore by the facility's QA Committee on an annual basis.	ck / / ss	4/21/18

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

Event ID: IPQ811

Facility ID: VA0050

If continuation sheet Page 2 of 208

APR 24 2018
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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION		TE SURVEY MPLETED
		495226	B. WING		03,	/09/2018
	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 MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPOLICIENCY)	D BE	(X5) COMPLETION OATE
SS=C	Based on staff intereview it was deterralled to have a compreparedness plan. The facility staff fail system to document staff. The findings include On 3/9/18 at 9:45 at the facility's emergency evidence a tracking locations of patients that the facility did racking locations of patients that the facility did racking locations of patients that the facility did racking. No further information. No further information. No further information. No further information. Vision of patients that the facility did racking locations of patients that the facility did racking. No further information. No further information of patients that the facility did racking locations and procedures of the policies and procedures of the policies and procedures and the communication of the poreviewed and update minimum, the policies in the policies and procedures of the poreviewed and update minimum, the policies and procedures of the poreviewed and update minimum, the policies and procedures of	rview and facility document mined that the facility staff applete emergency ed to develop a tracking at locations of patients and locations of the preparedness plan failed to system to document and staff. ASM # 1 stated location of the findings at that location location location locations of the findings at that location location location location location of this section, risk location locati	E 018			
	address the following (5) A system of med	lical documentation that				

NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) E 023 Continued From page 3 preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. (3),(4),(6)] A system of medical documentation that preserves patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947 PROVIDER S LAN OF CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CO	STATEMENT (AND PLAN OF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		TE SURVEY MPLETED
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) E 023 Continued From page 3 preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. (3),(4),(6)] A system of medical documentation that preserves patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947 PROVIDER S LAN OF CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CO			495226	B, WING			03	/09/2018
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) E 023 Continued From page 3 preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCls at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information.		,	HABILITATION CENTER		7	30 LUNENBURG HIGHW		
preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCls at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	(X5) COMPLETION DATE
(iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures of how the facility preserves patient information, and secures and maintains availability of records. The findings include: On 3/9/18 at 9:45 a.m. a review and interview of		eserves patient in infidentiality of pad dimaintains avail (4),(6)] A system at preserves patientidentiality of pad dimaintains avail for RNHCIs at §2 ocedures. (5) A set does the follow Preserves patien Protects confidences and maintains avail (5) A set does the follow Preserves patien Protects confidences and maintains avail (5) A secures and maintains avail (5) A secures and maintains are appropriately as a comparedness planting and secures of how or a comparedness of how or a comparednes	information, protects attent information, and secures lability of records. [(5) or not medical documentation ent information, protects attent information, and secures lability of records. 403.748(b):] Policies and system of care documentation ving: not information. entiality of patient information. aintains the availability of entiality of patient information. aintains the availability of laborates confidentiality of laborates confidentiality of laborates confidentiality of laborates confidentiality of records. Note that the facility document mined that the facility staff inplete emergency led to develop policies and the facility preserves patient the cures and maintains ds. e:)23	The facility will develop and implement an emergency path that will include policies an procedures that will indicate how the patient information will be protected, preserve kept confidential, and maintained to provide availability of records. The Emergency policy and procedures will be reviewe to ensure that components a satisfactory plan are incorporated. The Emergency Prepared in Plan will be reviewed and updated annually by the facility Safety Committee. The reviews and updates where the facility's QA Committee in the facility's QA Committee in the facility's QA Committee.	olan d de n d, d s of ess	4/21/18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495226	B. WING	·	03/09/2018
	PROVIDER OR SUPPLIER D NURSING AND RE	HABILITATION CENTER	7	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	
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E 023 E 025 SS=C	conducted with ASI member) # 1, the a facility's emergency evidence policies a facility preserves pronfidentiality of pa and maintains avaistated that the resistent but that it had facility plan yet. AS findings at that time No further informat Arrangement with CFR(s): 483.73(b)([(b) Policies and proceed plan set forth in parassessment at para and the communication this section. The poreviewed and updaminimum, the policies at §441.184,(b) Hosp Facilities at §483.7 (7) [or (5)] The devother [facilities] [an patients in the ever	ency preparedness plan was M (administrative staff administrator. Review of the preparedness plan failed to a procedures for how the atient information, protects atient information, and secures lability of records. ASM # 1 dent's charts would go with I not been included into the M #1 was made aware of the ency of the		E-025 The facility will develop and implement contracts and Memorandums of Understanding with other entities to receive patients the event the facility is una	in ble sess e. be d by

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
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	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 MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
E 025	§483.475(b), CAHs §485.920(b) and ES Policies and proceed development of arra [facilities] [or] other in the event of limits operations to maint to facility patients. *[For RNHCIs at §4 procedures. (7) The arrangements with providers to receive limitations or cessar the continuity of nor patients. This REQUIREMEN by: Based on staff intereview it was determ failed to have a compreparedness plan. The facility staff failed of the arrangements facility has with other in the event the facility has with other in the event the facility is emergency evidence document and/or any agreement and/or a	at §486.625(b), CMHCs at SRD Facilities at §494.62(b):] dures. (7) [or (6), (8)] The angements with other providers to receive patients ations or cessation of ain the continuity of services 03.748(b):] Policies and development of other RNHCIs and other apatients in the event of tion of operations to maintain numedical services to RNHCI. It is not met as evidenced rview and facility document nined that the facility staff inplete emergency.	EC	025			

NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER (PA) D SUMMARY STATEMENT OF DEFICIENCIES (PA) D REGULATORY OR LSC IDENTIFYING INFORMATION) E 025 Is not able to care for them during an emergency. OSM # 1 stated that the facility did not have it. ASM #1 was made aware of the findings at that time. No further information was obtained prior to exit. ASM #1 was made aware of the findings at that time. No further information was obtained prior to exit. Names and Contact Information of CFR(s): 483.73(c)(1) (Ic) The [facility, except RNHCls, hospices, transplant centers, and HHAs] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following: (I) Names and contact information for the following: (I) Patients' physicians (IV) Other [facilities]. (V) Volunteers. *[For RNHCls at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (1) Staff. (3) Entities providing services under arrangement. (4) Deficiency preparedness plan will be reviewed and updated annually by the facility's Safety Committee.		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	IPLE CONSTRUCTION		TE SURVEY MPLETED
Table Tabl			495226	B. WING_		03	/09/2018
E 025 Continued From page 6 is not able to care for them during an emergency. OSM #1 stated that the facility did not have it. ASM #1 was made aware of the findings at that time. No further information was obtained prior to exit. Same and Contact Information CFR(s): 483.73(c)(1) [(c) The [facility, except RNHCls, hospices, transplant centers, and HHAs] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For RNHCls at \$403.748(c):] The communication plan must include all of the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Othere [facilities]. (v) Volunteers. *[For RNHCls at \$403.748(c):] The communication plan must include all of the following: (ii) Staff. (iii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Othere [facilities]. (v) Volunteers. *[For RNHCls at \$403.748(c):] The communication plan must include all of the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Entities providing services under arrangement. (iii) Entities providing services under arrangement. (iii) Entities providing services under arrangement.			HABILITATION CENTER		730 LUNENBURG HIGHW		
is not able to care for them during an emergency. OSM # 1 stated that the facility did not have it. ASM #1 was made aware of the findings at that time. No further information was obtained prior to exit. Names and Contact Information CFR(s): 483.73(c)(1) [(c) The [facility, except RNHCIs, hospices, transplant centers, and HHAs] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following: (i) Names and contact information for the following: (ii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *TFOR RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (1) Staff. (1) Emergency preparedness Plan will be reviewed and updated annually by the following: (1) Staff. (1) Emergency preparedness Plan will be reviewed and updated annually by the facility's Safety Committee.	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	
(iii) Next of kin, guardian, or custodian. (iv) Other RNHCls. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: Reviews and updates will be reported to and monitored by the Facility's QA Committee.	E 030	is not able to care for OSM # 1 stated that ASM #1 was made time. No further information Names and Contact CFR(s): 483.73(c)(c) [(c) The [facility, externsplant centers, maintain an emerge communication plans State and local laws updated at least an plan must include at (1) Names and confollowing: (i) Staff. (ii) Entities providing (iii) Patients' physic (iv) Other [facilities] (v) Volunteers. *[For RNHCIs at §4 communication plans following: (1) Names and confollowing: (1) Names and confollowing: (i) Staff. (ii) Entities providing (ii) Staff. (iii) Next of kin, gua (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416]	or them during an emergency. It the facility did not have it. aware of the findings at that on was obtained prior to exit. Information (1) cept RNHCls, hospices, and HHAs] must develop and ency preparedness in that complies with Federal, is and must be reviewed and mustly. The communication (1) of the following: I tact information for the complies under arrangement. It is an an an arrangement of the communication (1) of the following: I tact information for the communication (2) arrangement. It is a service of the communication (3) arrangement. It is a service of the communication (4) are communication (4) are communication (4) are communication (4).		The facility will develop and implement a procedure for sharing medical documentation for patients under the facility's care. The procedure will outline the means to ensure the continuity of care with other health care providers and the means to release necessary patient information. The Emergency Preparedness Plan will be reviewed and updated to ensure that the components of a satisfactory plan are incorporated. The Emergency preparedness Plan will be reviewed and updated annually by the Facility's Safety Committee. Reviews and updates will be reported to and monitored in	s s	4/31/18

PRINTED: 03/20/2018 FORM APPROVED OMB NO. 0938-0391

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E 030	(1) Names and confollowing: (i) Staff. (ii) Entities providin (iii) Patients' physic (iv) Volunteers. *[For Hospices at § communication plan following: (1) Names and confollowing: (i) Hospice employe (ii) Entities providin (iii) Patients' physic (iv) Other hospices *[For OPOs at §486 plan must include at (1) Names and confollowing: (i) Staff. (ii) Entities providin (iii) Volunteers. (iv) Other OPOs. (v) Transplant and of Donation Service A This REQUIREMEN by: Based on staff intereview it was determated to have a conpreparedness plan. The facility staff fail documentation that includes a method in medical documentation that includes a method in medical documentation.	g services under arrangement. ians. 418.113(c):] The n must include all of the tact information for the ees. g services under arrangement. ians. 6.360(c):] The communication ill of the following: tact information for the g services under arrangement. conor hospitals in the OPO's rea (DSA). NT is not met as evidenced rview and facility document mined that the facility staff inplete emergency	E	030			

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

Event ID; IPQ811

Facility ID: VA0050

If continuation sheet Page 8 of 208

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E 030	providers to maintal reviewing the commodocumentation that policies and proceed the facility will use the facility's encryonal the facility's emergency provide evidence of communication plans that in the continuity of car communication plans facility has developed that address the mere release patient information and locatic communication plans facility did not have	in the continuity of care by nunication plan and the facility has developed dures that address the means to release patient information ral condition and location of the communication plan. I	E	030				
E 036 SS≃C		on was obtained prior to exit. sting	Ε¢	36				
	develop and mainta preparedness traini based on the emerg	ting. The [facility] must in an emergency ng and testing program that is gency plan set forth in s section, risk assessment at						

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
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E 036	paragraph (a)(1) of procedures at paragraph the communication section. The training be reviewed and up *[For ICF/IIDs at §4 testing. The ICF/IID an emergency preparagraph that is bas forth in paragraph (assessment at paragolicies and proced section, and the comparagraph (c) of this testing program muleast annually. The requirements for ev §483.470(h). *[For ESRD Facilities testing, and orientation program emergency plan set section, risk assess this section, policies (b) of this section, aparagraph (c) of this and orientation program emergency plan set section, aparagraph (c) of this and orientation program that the section is section, aparagraph (c) of this section, aparagraph (c) of this and orientation program that the section is section, aparagraph (c) of this section, aparagraph (c) of this and orientation program that the section is section, aparagraph (c) of this section, aparagraph (c) of this and orientation program that is section, aparagraph (c) of this and orientation program that is section, aparagraph (c) of this and orientation program that is section, aparagraph (c) of this and orientation program that is section, aparagraph (c) of this section, aparagraph (c) of this and orientation program that is section, aparagraph (c) of this and orientation program that is section.	this section, policies and graph (b) of this section, and plan at paragraph (c) of this ag and testing program must odated at least annually. 83.475(d):] Training and must develop and maintain aredness training and testing ed on the emergency plan set a) of this section, risk agraph (a)(1) of this section, lures at paragraph (b) of this munication plan at a section. The training and lest be reviewed and updated at ICF/IID must meet the recuation drills and training at the set §494.62(d):] Training, the set on the at forth in paragraph (a) of this ment at paragraph (b) of this ment at paragraph (a) of this ment at paragraph (b) of this ment at paragraph (c) of this ment at paragraph (b) of this ment at paragraph (c) of this munication plan at the training testing the paragraph (c) of this munication plan at the paragraph (c) of this munication plan		036	E-036 The facility will adopt a written training and testing program that meets the requirements of the regulation and will document that the training and testing program has been reviewed and updated on an annual basis. The emergency preparedness Plan will be updated and reviewed by the administrate and facility consultant to ensure that the components of a satisfactory plan are incorporated. The Emergency preparedness Plan will be reviewed and updated annually by the facility's safety Committee. Reviews, updates and change will be reported to and monitored by the Facility's QA Committee.	s or s	Halle

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			C	<u>MB NO</u>	<u>. 0938-0391</u>
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	documentation that training and testing requirements of the documentation that program has been releast an annual bas documentation of the any updates made. The findings include On 3/9/18 at 9:45 a. the facility's emerge conducted with ASM member) # 1, the act facility's emergency provide evidence the and testing program of the regulation and training and testing and updated on, at I asking for document well as any updates	the facility has a written program that meets the regulation and the training and testing reviewed and updated on, at its by asking for the annual review as well as the annual review of the reparedness plan was the annual review of the reparedness plan failed to be facility has a written training that meets the requirements and documentation that the program has been reviewed least an annual basis by that its an annual review as the made. ASM # 1 stated that	ΕO	36			
E 037	EP Training Progran	on was obtained prior to exit.	E 0	37			
	ASCs, PACE organiz	n. The [facility, except CAHs, izations, PRTFs, Hospices, s] must do all of the following:		:			
	policies and procedu staff, individuals pro-	emergency preparedness ures to all new and existing viding services under olunteers, consistent with their					

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

Event ID: IPQ811

Facility ID: VA0050

If continuation sheet Page 11 of 208

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E 037	expected role. (ii) Provide emerge least annually. (iii) Maintain docum (iv) Demonstrate st procedures. *[For Hospitals at § at §491.12:] (1) Tra or RHC/FQHC] must (i) Initial training in expected roles and proced staff, individuals proarrangement, and expected roles. (ii) Provide emerge least annually. (iii) Maintain docum (iv) Demonstrate st procedures. *[For Hospices at § hospice must do all (i) Initial training in expected roles. (ii) Initial training in expected roles. (ii) Demonstrate staprocedures. (iii) Demonstrate staprocedures. (iii) Provide emerge least annually. (iv) Periodically reviemergency prepare employees (includir special emphasis p	ncy preparedness training at lentation of the training. aff knowledge of emergency 482.15(d) and RHCs/FQHCs ining program. The [Hospital st do all of the following: emergency preparedness lures to all new and existing oviding on-site services under volunteers, consistent with their ncy preparedness training at lentation of the training. aff knowledge of emergency 418.113(d):] (1) Training. The	EC	037	E-037 The facility will conduct inservice training for employee on the Emergency preparedness Plan. In service training and education will be conducted annually thereafter. The Emergency preparedness plan will be reviewed and updated to ensure that that the components of a satisfactory plan are incorporated. The Emergency preparedness Plan will be reviewed and updated annually by the Facility's Safety Committee. Reviews and updates will be reported to and monitored in the Facility's QA Committee.	e e s s by	4/21/18

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495226 B.. WING 03/09/2018 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] COMPLETION OATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) E 037 Continued From page 12 E 037 *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency

least annually.

with their expected roles.

preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent

(ii) Provide emergency preparedness training at

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 495226 B. WING 03/09/2018 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 ΙD (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX OATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) E 037 Continued From page 13 E 037 (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients. personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services

under arrangement, and volunteers, consistent

documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least

with their expected roles, and maintain

FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES DF CORRECTION	I (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING			(X3) DATE SURVEY COMPLETED	
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E 039 SS=C	annually. This REQUIREMENT by: Based on staff intereview it was detern failed to have a compreparedness plan. The facility staff failed documentation of the preparedness training preparedness training documentation that initial & annual emergency annual emergency provide evidence of initial emer	rview and facility document nined that the facility staff uplete emergency ed to provide evidence of the facility's initial emergency and annual emergency and facility staff have received regency preparedness training. E. m. a review and interview of ncy preparedness plan was diaministrator. Review of the preparedness plan failed to documentation of the facility's eparedness training and preparedness training and preparedness training mentation that facility staff & annual emergency and and staff had that not all staff had on was obtained prior to exit.		037			7/3/18

PRINTED: 03/20/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ B WING 495226 03/09/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) E-039 E 039 Continued From page 15 E 039 test the emergency plan at least annually. The The facility will conduct a [facility, except for RNHCIs and OPOs] must do tabletop exercise on an all of the following: annual basis to review, update *[For LTC Facilities at §483.73(d):] (2) Testing. and individualize the The LTC facility must conduct exercises to test Emergency preparedness the emergency plan at least annually, including plan. unannounced staff drills using the emergency procedures. The LTC facility must do all of the The Emergency preparedness following:] Plan will be reviewed and (i) Participate in a full-scale exercise that is updated to ensure that the community-based or when a community-based components of a satisfactory exercise is not accessible, an individual, plan are incorporated. facility-based. If the [facility] experiences an actual natural or man-made emergency that The Emergency Preparedness requires activation of the emergency plan, the Plan will be reviewed and [facility] is exempt from engaging in a community-based or individual, facility-based updated at least annually by full-scale exercise for 1 year following the onset of the actual event. the Facility's Safety (ii) Conduct an additional exercise that may Committee. Any interim include, but is not limited to the followina: revisions, reviews and (A) A second full-scale exercise that is community-based or individual, facility-based. updates will be reported to (B) A tabletop exercise that includes a group and monitored by the facility's discussion led by a facilitator, using a narrated, QA Committee. clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and

maintain documentation of all drills, tabletop exercises, and emergency events, and revise the

[facility's] emergency plan, as needed.

*[For RNHCIs at §403.748 and OPOs at

§486.360] (d)(2) Testing. The [RNHCl and OPO]

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STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		PLE CONSTRUCTION G	(X3) DA). 0938-0391 TE SURVEY MPLETED
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	must conduct exerce plan. The [RNHCl as following: (i) Conduct a paper least annually. A tat discussion led by a clinically relevant error problem stateme prepared questions emergency plan. (ii) Analyze the [RN to and maintain doce exercises, and eme [RNHCl's and OPO needed. This REQUIREMENT by: Based on staff interreview it was determated to have a compreparedness plan. The facility staff failed documentation of the and response evides its emergency progranalysis. The findings included On 3/8/18 at 9:45 a. the facility's emerge conducted with ASN administrator. Review preparedness plan for documentation, of the and response and evidated its emerger	cises to test the emergency and OPO] must do the er-based, tabletop exercise at bletop exercise is a group facilitator, using a narrated, mergency scenario, and a set ents, directed messages, or a designed to challenge an NHCI's and OPO's] response cumentation of all tabletop ergency events, and revise the ers] emergency plan, as NT is not met as evidenced erview and facility document mined that the facility staff inplete emergency ed to provide evidence of the facility's exercise analysis encing how the facility updated fram based on the exercise	E	039	9		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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E 039	did not have it. No further informa	tion was obtained prior to exit.	E 039				
F 580 SS=D	conducted from 3/Corrections are refollowing 42 CFR in Term Care requires survey/report will for the census at this at the time of the seconsisted of 25 cm 41, 34, 35, 44, 30, 42, 37, 23, 8, 9, 5, three closed recorn Notify of Changes CFR(s): 483.10(g) §483.10(g)(14) Notify and the consistent with his representative(s) Notify and the consistent with his representative (s) Notify and the consistent with his representative (s) Notify and the consistent with his representative (s) Notify and the consistent with the reconsistent with his representative (s) Notify and the consistent with his representative (s) Notify and the consistent with the reconsistent with his representative (s) Notify and the consistent with the reconsistent with his representative (s) Notify and the consistent with the reconsistent w	Medicare/Medicaid survey was 06/18 through 3/09/18. quired for compliance with the Part 483 of the Federal Long ments. The life safety code ollow. 90 certified bed facility was 53 survey. The survey sample urrent residents Residents # 10, 18, 36, 39, 12, 14, 43, 13, 40, 24, 20, 25, 27, and 45 and ds, Residents # 51, 52, and 53. (Injury/Decline/Room, etc.) (14)(i)-(iv)(15) diffication of Changes. In the resident when there isvolving the resident which d has the potential for requiring tion; nange in the resident's physical, social status (that is, a alth, mental, or psychosocial threatening conditions or ons); treatment significantly (that is, nue an existing form of	F 000	F-580 The facility notified the Physician regarding the Bloc Sugar levels for Resident #4 The facility notified the Physician and responsible representative that Residen #14 had refused the ordered protein supplement. The facility notified the Physician and responsible representative that resident #25 did not receive the ordered Symetrel for 3 and one half days. A review of resident charts that had orders for blood sugars, refusals of protein supplements and missed meds was conducted by the nursing staff and there was found to be no other affects residents.	t d n		
	treatment due to a	dverse consequences, or to form of treatment); or		· et			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION		E SURVEY PLETED
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F 580	resident from the fa §483.15(c)(1)(ii). (ii) When making not (14)(i) of this sectionall pertinent information is available and prophysician. (iii) The facility must resident and the section (iv) The facility must update the address phone number of the representative(s). §483.10(g)(15) Admission to a community and must specified and must specified in \$483.5) must disclosite physical configurations that composite \$483.5) must disclosite physical configurations that composite \$483.15(c)(9) This REQUIREMENT by: Based on staff inte and facility docume that the facility staff (medical doctor) and facility achange in conditions and change in	ensfer or discharge the scility as specified in obtification under paragraph (g) in, the facility must ensure that ation specified in §483.15(c)(2) wided upon request to the sident representative, if any, im or roommate assignment 8.10(e)(6); or ident rights under Federal or ions as specified in paragraph on. It record and periodically (mailing and email) and e resident in the second and periodically (mailing and email) and e resident in the second in the seco		580	An in-service was conducted with licensed personnel to reducate them on the proper procedures for notifications physicians and responsible representatives. Procedures for abnormal blood sugars, refusals of meds, and missed medications were also included. The DON or her designee will conduct an audit weekly for weeks then monthly of selected resident charts to determine that proper notifications are being provided to physicians and responsible representatives. To maintain continued compliance the DON will share the results of the audit with the Quality Assurance Performance Improvement (QAPI) Committee on a quarterly basis. If additional issues are noted those issues will be addressed immediate and corrective action taken.	e- of	A A A A A A A A A A A A A A A A A A A

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 495226 03/09/2018 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 IX5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 580 Continued From page 19 F 580 1. The facility staff failed to notify the medical doctor when the Resident #43's blood sugar

levels [1] were over 400 on three occasions in

2. The facility staff failed to notify the physician and responsible representative that Resident #14 refused the physician ordered protein supplement

 The facility staff failed to notify the physician and responsible representative that Resident #25 did not receive the physician ordered Symetrel for three and a-half days in February 2018.

1. The facility staff failed to notify the medical doctor when the Resident #43's blood sugar levels [1] were over 400 on three occasions in

Resident #43 was admitted to the facility on 1/31/18 with diagnoses that included but were not

limited to unspecified psychosis, type two diabetes, dementia, hypothyroidism and high blood pressure. Resident #43's most recent MDS (minimum data set) assessment was a 14-day

scheduled assessment, with an ARD (assessment reference date) of 2/14/18. Resident #43 was coded as being cognitively intact in the ability to make daily decisions scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #43 was coded as requiring extensive assistance from two or more staff with transfers, locomotion and toileting; extensive assistance from one staff member with

to promote wound healing 18 out of 34

opportunities in February 2018.

The findings include:

March of 2018.

March of 2018.

FORM APPROVED OMB 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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F 580	dressing and person totally dependent or Review of Resident (physician order surdocumented the following Insulin [2] BS (blood sugar): BS 201-250= 4 unit BS 251-300= 6 unit BS 301-350= 8 unit BS 351-400= 10 un BS 401 or greater = Review of Resident (Medication Adminis Resident #43 had B following dates and 3/3/18 at 5:00 p.m., at 9:00 p.m., blood sugar w Further review of the March nursing notes physician was notific sugars. On 3/8/18 at 8:37 a. conducted with LPN a nurse who frequer When asked what the for insulin meant, LF administer the 12 urif the resident's blood asked why the docto LPN #3 stated the dadditional units of in	nal hygiene, and as being in staff with bathing. #43's most recent POS immary) dated 2/2018 lowing order: "Accucheck AC and hours of sleep) with s is its its its its March 2018 MAR is stration Record) revealed S readings over 400 on the times: blood sugar was 560; 3/3/18 is sugar was 423; 3/4/18 at 5:00		580			

FORM APPROVED OMB NO. 0938-0391

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F 580	would be document record, LPN #3 stat a nursing note. Wh notify the physician reading was over 40 wouldn't necessarily the orders say to not physician has said unless it's over 500 RN (registered nursorder clarification. In current physician or there is no evidence LPN #3 stated, "Not did have a communication that documented in the was a chance the Market by the was a chance the Market by the was no documentated usually someone instated that Residen always within normal Con 3/8/18 at 3:28 physician could not recall beir instances where Rewere elevated. ASM expect nursing staff ASM #4 stated he withings are out of correcall telling staff to are over 500.	ted anywhere in the clinical ted it should be documented in the asked if nurses would every time a blood sugar 200, LPN #3 stated, "They y." LPN #3 stated, "Most of offity if 400 or over, but the in the past to not call them ." LPN #3 then consulted with the le) #2 and asked about an LPN #3 was asked if the off physician notification. "LPN #3 stated that nurses it ication book with the mented any concerns. LPN book for review and the blood or Resident #43 were not book. LPN #3 stated there and (medical doctor)/NP (nurse hade aware verbally but there is thouse quite a bit." LPN #3 tated that were not book. LPN #3 stated, "There is thouse quite a bit." LPN #3 tated that had a ware were were list." LPN #3 tated, "There is thouse quite a bit." LPN #3 tated that had a ware were list." LPN #3 tated that had a ware were list." LPN #3 tated that had a ware were list." LPN #3 tated that had a ware were list." LPN #3 tated that had a ware were list. "LPN #3 tated that had a ware were list." LPN #3 tated that had a ware were list. "LPN #3 tated that had a ware were list." LPN #3 tated that had a ware were list. "LPN #3 tated that had a ware were list." LPN #3 tated that had a ware were list. "LPN #3 tated that had a ware were list." LPN #3 tated that had a ware were list. "LPN #3 tated that had a ware were list." LPN #3 tated that had a ware were list. "LPN #3 tated that had a ware were list." LPN #3 tated that had a ware were list. "LPN #3 tated that had a ware were list." LPN #3 tated that had a ware were list." LPN #3 tated that had a ware were list." LPN #3 tated that had a ware were list." LPN #3 tated that had a ware were list." LPN #3 tated that had a ware were list." LPN #3 tated that had a ware were list." LPN #3 tated that had a ware were list." LPN #3 tated that had a ware were list." LPN #3 tated that had a ware were list." LPN #3 tated that had a ware were list." LPN #3 tated that had a ware were list." LPN #3 tated that had a ware were list."	F 5	80		

FORM APPROVED OMB NO. 0938-0391

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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 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 APPRODEFICIENCY)	D BE	(X5) COMPLETION OATE
F 580	member) #1, the ac DON (Director of N The facility policy tit for Change in Cond following: "It is the physician when a siresident's condition contained within the No further information. The last Nursing, Election (Potter and I was a reference so notification. Failure condition appropriation information to the provider are causes way to avoid being I follow standards of care, and to communications. The physician condition is the providers. The physician condition is the provider are causes way to avoid being I follow standards of care, and to communications. The physician condition is the providers. The physician condition is the providers.	th ASM (administrative staff dministrator and ASM #2, the ursing). Ited, Notification of "Physician lition" documented the policy of the facility to notify the ignificant change in a poccurs with documentation	F	580			
	and the body's main body's blood sugar meal, the pancreas enters the blood stra sugars into the body transformed into en blood sugar levels to not functioning propone or two diabetes	els are the sugars in the blood in source of energy. When the rises, for instance after a secretes insulin. Insulin eam and transports these y's cells where it is ergy. This then causes the or fall. When the pancreas is erly, like a person with type, blood sugar levels continue stream. This is also known as					

CENTE	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES				<u>)MB NO.</u>	<u> 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	MULTIPLE CONSTRUCTION UILDING			E SURVEY IPLETED
		495226	B. WING	;		03/	09/2018
NAME OF	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
WAYLAN	ID NURSING AND REI	HABILITATION CENTER		1	730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	DBE	(X5) COMPLETION DATE
	Hyperglycemia. Meneeded to control binformation was obtinstitutes of Health. https://medlineplus. Normal blood sugar have diabetes are 7 than 180 2 hours af was obtained from Health. https://www.ncbi.nlmT0024698/ [2] Humalog insulin helps turn sugar ing we eat into energy uniformation was obtinstitutes of Health. https://www.ncbi.nlmT0010736/?report=c2. The facility staff fa and responsible reprefused the physicia to promote wound hopportunities in February 19 with the most recent Mc quarterly assessment reference date) of 12 coded as having a the state of the state of the state of the most recent Mc quarterly assessment reference date) of 12 coded as having a the state of the state	dications (insulin) may be lood sugar levels. This tained from The National gov/hyperglycemia.html. I levels for people who do not 70-130 before meals and less fer meals. This information The National Institutes of m.nih.gov/pubmedhealth/PMH is a fast acting insulin that gested from the food and drink used by the body. This rained from The National m.nih.gov/pubmedhealth/PMH details ailed to notify the physician presentative that Resident #14 an ordered protein supplement lealing for 18 out of 34 ruary 2018. dmitted to the facility on ses that included but were not anemia, chronic pain, it is and elevated cholesterol. DS (minimum data set), a not, with an ARD (assessment 2/29/17. The resident was heree out of 15 on the BIMS	F	580			
		nental status) indicating the					

resident was severely impaired cognitively. The

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

FORM APPROVED OMB NO. 0938-0391

+	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		E CONSTRUCTION		E SURVEY IPLETED
		495226	B. WING		· · · · · · · · · · · · · · · · · · ·	03/	09/2018
	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 DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION OATE
F 580	resident was coded staff for all activities was not coded as he Review of the quart documented that the wound. Review of the dietition documented in part (medications) include (three times a day). In It is lower buttocks. Resident 123.4# (pounds) on of ~ (approximately). Review of the resident 1/30/17 and revised "Focus At Risk for some Cognitive impairme Supplements as oron Review of the physical 2017 through March "Beneprotein (a proof ID (three times a continuous of the Februal Coop) TID (three thealing." On 18 occurred circled indicating given on those occasion.	as requiring assistance from a of daily living. The resident aving a wound. erly MDS dated 10/27/17 e resident did not have a an's note dated 3/30/17, "Pertinent med's debeneprotein 1 scoop TID Resident with wound to right sident with a new wt (weight) of 3/22(2017) indicating wt loss) 8# past month." ent's care plan initiated on 1 on 8/11/17 documented, kin breakdown related to: nt, immobility. Interventions. dered by the physician. cian's orders from November of 2018 documented, tein supplement) 1 (scoop) day) for wound healing." uary 2018 MAR (medication red) documented, "Beneprotein et times a day) for wound asions, the nurse's initials ng the supplement was not asions. On the backside of the cumentation on three		580			
		uary 2018 nurse's notes did					

		AND HUMAN SERVICES & MEDICAID SERVICES			0		APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		495226	B. WING			03/	09/2018
	PROVIDER OR SUPPLIER ID NURSING AND REI	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 PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE ·	(X5) COMPLETION DATE
F 580	responsible represe the resident did not ordered. An interview was cop.m. with LPN (licer When asked when notified, LPN #2 state have a high heart rachange in the reside why the physician will be a second or followed." When ask would be notified if the ordered medication stated, "Yes. We would be document ma'am, under the properties of the policy of the facility "NOTIFICATION OF IN RESIDENT'S COtthe policy of the facility when a significant of the facility when	entative (RR) were notified that receive the beneprotein as and an active the beneprotein as and active the physician or RR was ted, "If they're short of breath, ate, low blood pressure, any ent's condition." When asked as notified, LPN #2 stated, to follow the physician's active are written to be ked if the physician and RR the resident refused an or a supplement, LPN #2 build call the MD (medical can get another supplement give it)." When asked if this ed, "LPN #2 stated, "Yes, rogresses notes for that m. ASM (administrative staff ministrator and ASM #2, the were made aware of the y's policy titled, FPHYSICIAN FOR CHANGE ENDITION" documented, "It is lity to notify the physician thange in a resident's the documentation contained	F	580			

No further information was provided prior to exit.

3. The facility staff failed to notify the physician

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '		E CONSTRUCTION		E SURVEY PLETED
		495226	B. WING			03/	09/2018
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		73	REET ADDRESS, CITY, STATE, ZIP CODE 10 LUNENBURG HIGHW EYSVILLE, VA 23947	·	,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	IX5) COMPLETION OATE
F 580	did not receive the pathree and a-half day Resident #25 was a 7/17/15 and readmidiagnoses that incluse Parkinson's disease psychotic disorders (2), anoxic brain injustic parkinson's disease psychotic disorders (2), anoxic brain injustic properties of the most recent concesses ment, with an resident as having a sthe BIMS indicating impaired cognitively requiring the assisted daily living with the cresident could perform Review of the care prevised on 4/3/17 diregarding medication. Review of the physic documented, "Symetrometric properties of the physic documented, "Symetrometric properties of the physic documented, "Symetrometric parking the physic documented," Symetrometric parking the physic documented of the physic documented, "Symetrometric parking the properties of the physic documented," Symetrometric parking the physic documented, "Symetrometric parking the physic parking the physic parking the physic parking the physical parking the physic parking the physical parking the ph	presentative that Resident #25 physician ordered Symetrel for ys in February 2018. Idmitted to the facility on ted on 12/19/17 with orded but were not limited to: e (1), heart failure, diabetes, depression, schizophrenia dry (3) and seizures. Implete MDS, a 30-day of ARD of 1/17/18 coded the scored a (six) 6 out of 15 on the resident was severely of the resident was coded as ance of staff for all activities of exception of eating which the firm with supervision. In all a color of the resident was coded as ance of staff for all activities of exception of eating which the firm with supervision. In all a color of the was coded as ance of staff for all activities of exception of eating which the firm with supervision. In all a color of the was coded as ance of staff for all activities of exception of eating which the firm with supervision. In all a color of the was coded as ance of staff for all activities of exception of eating which the firm with supervision. In all a color of the was coded as ance of staff for all activities of exception of eating which the firm with supervision. In all a color of the was coded as ance of staff for all activities of exception of eating which the firm with supervision. In all a color of the was coded as ance of staff for all activities of exception of eating which the firm with supervision. In all a color of the was coded as ance of staff for all activities of exception of eating which the firm with supervision.	F	580			
		given at 9:00 a.m. on 2/6/18 nurse's circled initials					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i ' '		PLE CONSTRUCTION 3		TE SURVEY MPLETED
		495226	B. WING	.		03	/09/2018
	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 PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION OATE
F 580	Review of the back for each of these damg PO (by mouth). Review of the Februe vidence document responsible represe Symetrel had not be 2/5 and 2/6/18. An interview was cop.m. with LPN (licer regarding how staff residents'. LPN #2 the pharmacy and sthe (name of local pharmacy." When a medication was not for four days, LPN # pharmacy and the canother medication (responsible party) stated yes. When a the family was alwa the resident's condiphysician would be because we have to Physician orders are When asked if this was alwa for that specific reast The nurses' who did medications were not facility and could not On 3/8/18 at 5:15 p. member) #1, the ad	side of the MAR documented ays and times, "Symetrel 100 out of stock." Juary nurse's notes did not ration that the physician or the entative were notified that the en administered on 2/3, 2/4, and to the entative were notified that the en administered on 2/3, 2/4, and to the entative were notified that the en administered on 2/3, 2/4, and to the entative were notified that the entative were notified nurse) #2, obtain medications for stated, "I would have to call see if they can call it over to the entation, my backup asked what staff would do if a available to for administration to see if we could get." When asked if the RP would be notified, LPN #2 stated that ays notified of any change in the entition. When asked if the notified, LPN #2 stated, "Yes to follow physician orders. It would be documented, LPN am under the progress notes son." I not administer the to longer employed by the	F	580			

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILD			(X3) DATE SURVEY COMPLETED			
		495226	B. WING			03/09			
	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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION OATE		
F 580	findings. No further information of provider are causes way to avoid being follow standards of care, and to community responsible for diof a patient. 1. Parkinson's diseas movement disorder in the brain don't prochemical called dop genetic, but most cafamilies. This informations. They may think other they may think other they talk. The disorder they talk. The disorder they talk.	ge 28 on was provided prior to exit. ssential for Practice, 6th Perry, 2007, pages 56-59), urce for physician's orders and to monitor the patient's tely and communicate that hysician or health care of negligent acts. The best liable for negligence is to care, to give competent health unicate with other health care sician or health care provider recting the medical treatment ase (PD) is a type of It happens when nerve cells beduce enough of a brain manine. Sometimes it is ases do not seem to run in mation was obtained from: gov/parkinsonsdisease.html as serious brain illness. People ar voices that aren't there, er people are trying to hurt mey don't make sense when der makes it hard for them to are of themselves. This	FS	580					
·	3. Cerebral hypoxia there is a decrease even though there is	ained from: gov/schizophrenia.html refers to a condition in which of oxygen supply to the brain a adequate blood flow.							

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 495226 B. WING 03/09/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ΙD (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) OATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 580 Continued From page 29 F 580 cardiac arrest, head trauma, carbon monoxide poisoning, and complications of general anesthesia can create conditions that can lead to cerebral hypoxia. Symptoms of mild cerebral hypoxia include inattentiveness, poor judgment. memory loss, and a decrease in motor coordination. Brain cells are extremely sensitive to oxygen deprivation and can begin to die within five minutes after oxygen supply has been cut off. This information was obtained from: https://www.ninds.nih.gov/Disorders/All-Disorders /Cerebral-Hypoxia-Information-Page 4. Amantadine is an antiviral that is used in the prophylactic or symptomatic treatment of influenza A. It is also used as an antiparkinsonian agent, to treat extrapyramidal reactions, and for postherpetic neuralgia. The mechanisms of its effects in movement disorders are not well understood but probably reflect an increase in synthesis and release of dopamine, with perhaps

some inhibition of dopamine uptake. This

https://pubchem.ncbi.nlm.nih.gov/compound/ama

§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility

§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events

information was obtained from:

Reporting of Alleged Violations

ntadine#section=Top

CFR(s): 483.12(c)(1)(4)

F 609

SS=D

must:

F 609

PRINTED: 03/20/2018 FORM APPROVED OMB 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			
		495226	B. WING			03/	0 9/ 2018		
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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION OATE		
F 609	that cause the alle serious bodily injur the events that cause and do not in the administrator officials (including adult protective se for Jurisdiction in loaccordance with Sprocedures. §483.12(c)(4) Reprinvestigations to the designated repressaccordance with Survey Agency, with incident, and if the appropriate correct This REQUIREME by: Based on staff intereview, and clinicate determined that far allegation of abuse survey sample, Refered to the facility staff allegation of sexual state agencies in a state agency of a for Resident #41. The findings included the Resident #41.	gation involve abuse or result in y, or not later than 24 hours if use the allegation do not involve result in serious bodily injury, to if the facility and to other to the State Survey Agency and rvices where state law provides ang-term care facilities) in tate law through established ort the results of all the administrator or his or her entative and to other officials in tate law, including to the State thin 5 working days of the alleged violation is verified tive action must be taken. NT is not met as evidenced erview, facility document are for two of 28 residents in the sident #9 and #41. failed to report Resident #9's all abuse to the appropriate at timely manner. failed to notify the appropriate in the propriate of the properties of the properties.		609	The facility did fail to timely report the allegations of abuse for resident #9 and #41. The investigations were completed and reviewed at the time of the survey. 100 % audit of notification of reportable events was completed by the administrator on 3/12. There were no other instances found of failure to report or reporting late. An in-service and reeducation was conducted by the SDC with facility personnel regarding the abuse policy, and reporting requirements. Facility Reported Incidents was be reviewed monthly by the facility administrator for compliance with reporting requirements and adherence to abuse policy.	n vill	4/21/20		

diagnoses that included but were not limited to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495226	B. WING			03/	09/2018	
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)			ıx	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CRDSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 609	disorder, type two of disorder, high blood heart disease, COP pulmonary disease most recent MDS (quarterly assessme reference date) of coded as being several function scoring 03 BIMS (Brief Interview Resident #9 was consistence with one (activities of daily like Review of Resident the following social and 12/20/17: 12/19/18 at 1:57 p. It assistant) reported outing with resident Administrator, and and this writer interverbalize any areas shopping and going son treats he well as a history of confusing at one point during people on the plant shopping to buy precontinue to monitor regarding visits."	ehavioral disturbance, anxiety diabetes, major depressive dispressure, chronic ischemic PD (chronic obstructive), and stroke. Resident #9's minimum data set) was a ent with an ARD (assessment 12/13/17. Resident #9 was rerely impaired in cognitive out of possible 15 on the ew for Mental Status) examoded as requiring extensive estaff member for most ADLS ving). #9's clinical record revealed worker notes dated 12/19/17 m.: "CNA (certified nursing some concerns regarding the est son (Name of son), DON (Director of Nursing), viewed resident who did not is of concerns. Talked about gout to eat. Stated that her and is kind to her. Resident has on and hallucinations, she said interview, she was waiting for eato get here and that she went estent for her mother. Will and follow up with resident	F	609	Results of the reviews will be reported by the Administrator to the facility's QA Committee on a monthly basis for three months then quarterly thereafter. If additional issues are noted those issues will be addressed immediately and corrective action taken.			
	(Director of Nursing Services) and spok services) worker, (N	.m.: "This writer and DON g) called (Name of Social e with APS (adult protective Name of social worker). social worker) of the report						

		AND HUMAN SERVICES			,		APPROVED	
LAND DUAN OF CODDECTION INDENTIFICATION NUMBER.					LE CONSTRUCTION	(X3) DAT	MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		495226	B. WING			03/	09/2018	
	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 MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)) BE	(X5) COMPLETION DATE	
	given by CNA regar statement made by worker) was given a she would be speak (Facility nurse pract 12/20/17 at 14:58 (2 DON and called resaccusations resider outing with son, Sor "he did not have ser "this was stupid." (If that he could not en investigation has be stated do what you that he will not get to mother" 12/21/17 at 2:47 p.m spoke with (Name of responsible party) a investigation was ur return to (Name of for son) stated that he Saturday at 4 p.m. to event and to ask nutray for when she re of above." A facility reported incommend to the app 12/20/17 (two days a abuse allegation to the speak of the submitted to the app 12/20/17 (two days a abuse allegation to the speak of the submitted to the app 12/20/17 (two days a abuse allegation to the speak of the submitted to the app 12/20/17 (two days a abuse allegation to the speak of the submitted to the app 12/20/17 (two days a abuse allegation to the speak of the submitted to the app 12/20/17 (two days a abuse allegation to the submitted to the submitted to the app 12/20/17 (two days a abuse allegation to the submitted to the submitted to the app 12/20/17 (two days a abuse allegation to the submitted to the submitted to the app 12/20/17 (two days a abuse allegation to the submitted to the submitted to the app 12/20/17 (two days a abuse allegation to the submitted to the	reding outing with son and the resident. (Name of social all information and stated that king with the teamFNP titioner) aware of above." 2:58 p.m.): "This writer called sident's son advise of a made against son during and that was with his mother" and that was with his mother" and that wame of son) was informed after (Name of facility) until teen completed. (Name of son) got to do. (Son) concerned to spend Christmas with an: "This writer called and of Son), resident's RP and advised that the afounded and that he could acility) to see mother. (Name to would pick up resident on to attend Christmas family resing to save resident's dinner furns. Nursing made aware coident (FRI) was not propriate state agency until after the resident reported the	F6	09				

2017 C.N.A. (certified nursing assistant) ask resident if she had a good time while out with her son over the weekend. Resident replied yes and began to discuss what they had done including that, he didn't use a rubber. When resident asked

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	COMPLETED		
	495226 B. WING					_{0:}	3/09/2018	
	PROVIDER OR SUPPLIER	HABILITATION CENTER	:	7	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULDBE	(X5) COMPLETION DATE	
F 609	what the rubber was She then admitted to The investigation are was completed and state agency on 12/2 On 3/7/18 at 1:44 p. conducted with LPN When asked about resident were to repfrom a family or state would first ensure the allegation immerand possibly the postated the administrathere and initiate and On 3/8/18 at 10:28 a conducted with OSN social worker. When an abuse allegation stated she was always reported an allegation stated she was always are ported an investigation allegation were repointed in initiate an investigation allegation were repointed in initiate an investigation allegation were responsibility protective services immediately. OSM # with creating the FR (Director of Nursing) the FRI. On 3/8/18 at 12:10 p. conducted with ASM	that she has sex with her son." Ind follow up to the initial FRI of submitted to the appropriate //21/17. Ind., an interview was of licensed practical nurse) #1. The process staff follows if a port an allegation of abuse off member, LPN #1 stated she the resident's safety, and report ediately to the administrator of lice department. LPN #1 rator would take over from		609				

		AND HUMAN SERVICES					APPROVED . 0938-0391		
AND DUAN OF CODDECTION INDENTIFICATION NUMBER.			l ' '		PLE CONSTRUCTION G	(X3) DAT	(X3) DATE SURVEY COMPLETED		
	•	495226	B. WING	i		03/	/ 09/201 8		
NAME OF PROVI	DER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
MANAGE AND ME	IDONIO AND DE	HABILITATION CENTED			730 LUNENBURG HIGHW				
WAYLAND NO	JRSING AND RE	HABILITATION CENTER			KEYSVILLE, VA 23947				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE		
DOI the and stat alle wou ASM adm imm hou ther alle app max wou app soon Res ASM Dec she cert state may On 3 cond #3, t aske state Res with had use she state	process staff for allegation of able ed the staff mer gation to the nurself report. The allegation to the allegation to the allegation to the process and the state again and the state again and the state again. ASM #1 state and the state again and the state again and the state again and the state again of the date state again of the date state again of the date state again and the state again again and the state again and the state again again and the state again agai	ge 34 ursing). When asked about flows when a resident reports ouse to the staff, ASM #2 mber would report the rese manager and the manager regation right to her (the DON). would then report to the diately. When asked what ASM #2 stated within 24 ed the administrator would. ASM #1 then stated that rewould be reported to the gencies within 2 hours stated the investigation of the would follow up with the gencies within 5 days or red when the allegation adde to the CNA had occurred, it was reported to the CNA on December 20th was when und out. ASM #2 was not she had found out. ASM #2 re what happened, the CNA the incident late." I.m., an interview was a (certified nursing assistant) involved in the FRI. When rents of 12/18/17, CNA #3 r 18th, she was caring for ked the resident how her visit CNA #3 stated the resident supset that her son did not they had sex. CNA #3 stated ident #9 to clarify that Resident #9 had severe stated the Resident had	F	609	9				

repeated herself and confirmed she has had sex with her son. CNA #3 stated she reported this

STATEMENT OF DE AND PLAN OF COF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPL	E CONSTRUCTION		E SURVEY		
		i e	A. BUILL	DING		(X3) DATE COMP			
		495226	B. WING	·		03/09/2018			
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER				7	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW (EYSVILLE; VA 23947				
	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
allegathes administrates and states and to the back work allegation of the back work a	cocial worker. In instrator at the sat the facility of say anything, this was one of the DON was the social work of DON the next to work. CNA er did not feel of ation. In asked if she eregarding Reference of the anion of the part of the the thing to be a soon of the social when the could "mess up ated, "This is not an asked when the DON as soon of asked when the the could of the addition of the could of	o the administrator as well as CNA#3 stated the time and who no longer, told her and the social worker the resident has dementia her behaviors. CNA#3 so out of work that day so she er had reported this allegation to day or when the DON came #3 stated she and the social comfortable not reporting this comfortable not reporting this p.m., further interview was M#1, the social worker. could recall the allegation of exident #9, OSM #1 stated she he CNA had reported this dithe Administrator, they were site and that an allegation like this man's (son's) life". OSM not the same administrator that #1 stated she reported to this has the DON came back. The DON arrived back to the ted it was the next day. When contact anyone else for ministrator was not willing to of abuse, OSM #1 stated she mbudsman and she did man. OSM #1 could not stacted the long-term care	F	609					

The facility policy titled "Abuse, Neglect, and

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION		MPLETED
		495226	B. WING	;		03	/09/2018
	PROVIDER OR SUPPLIER	HABILITATION CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5] COMPLETION DATE
	Misappropriation" d following: "It is ever immediately report: or suspected abuse supervisor and/or e immediately to the A supervisor is the all to be made to the a Nursing, or as need Vice President of O fails to immediately mistreatment, abuse unknown sources, r misappropriation of disciplinary action u of employmentRe Any alleged or susp reported to the adm Immediate reporting that abuse investiga authorities, and that further abuse." 2. The facility staff fis state agency of a 7/ for Resident #41. Resident #41 was a 6/21/16 with diagnor limited to Parkinson pressure and fractur Review of the most set) assessment da assessment, with ar date) of 1/17/18 cod scored a six out of 1 for mental status) in	documents in part, the ry employees responsibility an incident of resident abuse to his or her supervisor. The employee must then report Administrator. If the immediate deged perpetrator, the report is administrator or Director of ded to the facility's Regional operations. Any employee who report suspected is including injuries of neglect, and/or for property of a resident will face up to and including termination exporting to the administrator: pected abuse is immediately ninistrator or designee. If the resident is free from failed to notify the appropriate of the resident is free from the facility on the session that included but were not only disease, high blood ared hip. The recent MDS (minimum data ared 1/17/18, a 30 day on ARD (assessment reference ded the resident as having 15 on the BIMS (brief interview andicating the resident was		609			
		ognitively. The resident was assistance for all activities of					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING			E SURVEY (PLETED
		495226	B. WING	<u> </u>		03/	/09/2018
	PROVIDER OR SUPPLIER ND NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, Z 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	IP CODE		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD THE APPROPI) BE	(X5) COMPLETION DATE
	daily living except for could perform after A request was madentrance conference reported investigating green folder labeled was received. The fabout a facial bruise occurred on 7/15/17 were conducted from There was a notation documented, "No eefficied occurred on 7/15/17 facial bruise (administrative staff administrative staff administrator. At 3:3 stated they could not be contact the previous where the report was compared in the found it (the FR). An interview was computed in the director of nursing process followed to origin, ASM #2 states the staff member the it to the administrator asked if a FRI would situation, ASM #2 states asked if a FRI would situation, ASM #2 states asked if a FRI would situation, ASM #2 states asked if a FRI would situation, When asked ASM #2 stated, "The ASM #2 sta	or eating which the resident the tray was set up. le on 3/6/18 during the ce at 7:00 a.m. for all facility ons since the last survey. A d with Resident #41's name folder contained information e of unknown origin that 7. Multiple staff interviews m 7/15/17 through 7/17/17. On in the folder that evidence of abuse found." .m. a request for a copy of the dent (FRI) for Resident #41's e was made to ASM f member) #1, the 30 p.m., ASM #1 returned and of locate the FRI but would try ous administrator to ask as. .m. ASM #1 stated, "We have	F6	609			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY PLETED
		495226	B. WING	_		03/	09/2018
-	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		7	STREET 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION OATE
F 609	"On abuse we submaximum. After we investigation has to suspected staff, queresidents, and fami." On 3/8/18 at 1:07 p stated, "I just talked said if it's in a greer investigation, and wan unknown (injury) reports now." When ASM #1 stated it shas ASM #1 stated, "I receive of the nurse p.m. documented, "writer that resident in Upon assessment I noted to resident Loappears slightly swo Resident states that there, that it did not fall or hit on anythin RP (responsible pair Review of the inciderevised on 7/28/17 reported to writer the face. Upon assessment I have face. Upon assessment I noted to resident states that there, that it did not fall or hit on anythin RP (responsible pair Review of the inciderevised on 7/28/17 reported to writer the her face. Upon asset	sk on me." ASM # 1 stated, nit the report in 2 hours is submit the FRI, then the start. We send home the estion the resident, other lies." .m., ASM #1 returned and it to the last administrator. She in folder it was an internal we determined that it was not in lim looking at the incident in asked if that was acceptable, ould have been reported. Export everything." et's notes dated 7/15/17 at 1:59 Housekeeping reported to had a bruise on her face. Earge purplish colored bruise ower (sic) (R) jaw. R jaw collen compared to L (left). It she did not know it was hurt. States that she did not gMD (medical doctor) and ofty) made aware." ent report dated 7/15/17 and documented, "Housekeeping at resident had a bruise on essment, large purplish (sic)	Fé	609			
	did not know it was fall or hit it on anyth responsible represe completed, resident does have a long hy assistance. There is) lower jaw. States that she there. States that she did not ing. People Notified (name of entative). Investigation denies any accidents. She (history) of getting up without is no evidence of any foul play. standing, loss balance and hit					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l , ,		LE CONSTRUCTION		E SURVEY PLETED
		495226	B. WING		····	03/	09/2018
	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 / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION OATE
F 609	face on sink." An interview was cop.m. with LPN (licer	nge 39 onducted on 3/9/18 at 11:15 nsed practical nurse) #2, the r the resident on 7/15/17.	F 6	309	F-622 The record for Resident #25 was updated by the physician regarding transfer. The record		
F 622	When asked the president had an injure notify me. I notify me investigation we have the bruise found on LPN #2 stated, "I rebut she denied it."	ocess staff followed when a arry, LPN #2 stated, "They by supervisor and there's an eve to do." When asked about Resident #41 on 7/15/17, amember I asked her if she fell on was provided prior to exit.	F€	322	for resident #39 was updated by the physician regarding the transfer to the hospital. The record for Resident #53 was updated by the physician regarding the reason for a facility initiated transfer. The record for Resident#5 was		
	CFR(s): 483.15(c)(1) §483.15(c) Transfer §483.15(c)(1) Facili (i) The facility must remain in the facility discharge the reside (A) The transfer or resident's welfare a cannot be met in the (B) The transfer or because the resider sufficiently so the re services provided by (C) The safety of ince endangered due to status of the resider (D) The health of incotherwise be endan	r and discharge- ty requirements- permit each resident to y, and not transfer or ent from the facility unless- discharge is necessary for the nd the resident's needs e facility; discharge is appropriate nt's health has improved esident no longer needs the y the facility; dividuals in the facility is the clinical or behavioral nt; dividuals in the facility would			updated by the physician regarding transfer to the hospital. A review of resident transfers for the last 30 days was conducted by the IDT for compliance with regulations and updates were done as needed.		
	under Medicare or M	to pay for (or to have paid Medicaid) a stay at the facility. s if the resident does not					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495226	B. WING			03/	09/2018	
	PROVIDER OR SUPPLIER ND 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION OATE	
F 622	submit the necessary payment or after the Medicare or Medicare sident refuses to resident who become admission to a facility resident only allows or (F) The facility cease (ii) The facility may resident while the a § 431.230 of this chexercises his or her discharge notice from 431.220(a)(3) of this discharge or transferor safety of the resident years or safety of the resident under any in paragraphs (c)(1) section, the facility that failure to transferor discharge is documedical record and communicated to the institution or provide (i) Documentation in must include: (A) The basis for the (i) of this section. (B) In the case of pasection, the specific be met, facility attention of the specific be met, facility attention or must include:	ary paperwork for third party at third party, including aid, denies the claim and the pay for his or her stay. For a mes eligible for Medicaid after ity, the facility may charge a able charges under Medicaid; ses to operate. In transfer or discharge the papeal is pending, pursuant to papeal a transfer or on the facility pursuant to se chapter, unless the failure to be would endanger the health dent or other individuals in the must document the danger er or discharge would pose. In the circumstances specified of the circu	F	322	A review of resident discharge charts will be conducted by the IDT during its morning meetings to ensure compliance by the physician i documenting reasons for transfer. The Administrator will share with the Medical Director the results of the review weekly for 4 weeks then monthly thereafter. Results of the reviews will be reported by the Administrato to the facility's QA Committee on a monthly basis for three months then quarterly thereafter. If additional issues are noted those issues will be addressed immediately and corrective action taken.	n r e	2/3/8	

		AND HUMAN SERVICES & MEDICAID SERVICES					APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	LTIPL	.E CONSTRUCTION	(X3) DAT	. 0938-0391 E SURVEY
AND LANC	or connection	IDENTIFICATION NOMBER.	A. BUILI)ING		CON	MPLETED
		495226	B. WING	<u>'—</u>		03/	09/2018
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WAYLAN	ID NURSING AND REI	HABILITATION CENTER		l	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 OATE
	(ii) The documentat (2)(i) of this section (A) The resident's p discharge is necess (A) or (B) of this sec (B) A physician whe necessary under pathis section. (iii) Information proving the section. (A) Contact information (C) Advance Direction (C) Advance Direction (C) Advance Direction (C) Advance Direction (C) All special instruongoing care, as ap (E) Comprehensive (F) All other necess copy of the residentic consistent with §483 any other document a safe and effective This REQUIREMENT by: Based on staff internand clinical record rethe facility staff failed the physician in the two four of 28 residentics.	ion required by paragraph (c) must be made by- hysician when transfer or cary under paragraph (c) (1) ction; and en transfer or discharge is tragraph (c)(1)(i)(C) or (D) of ctided to the receiving provider mum of the following: tion of the practitioner care of the resident. entative information including entative information including over information including a care plan goals; cary information, including a serior discharge summary, 8.21(c)(2) as applicable, and ation, as applicable, to ensure	F	622			
	physician, for a facili	ailed to ensure, a note by the ty initiated transfer for hospital on 12/14/17.				:	

2. The facility staff failed to ensure, a note by the physician, for a facility initiated transfer for

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) OATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IOENTIFICATION NUMBER: COMPLETEO A. BUILOING 495226 B. WING 03/09/2018 STREET AOORESS, CITY, STATE, ZIP COOE NAME OF PROVIOER OR SUPPLIER 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF OFFICIENCIES 10 (X4) IO (EACH OEFICIENCY MUST BE PRECEOEO BY FULL (EACH CORRECTIVE ACTION SHOULO BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCEO TO THE APPROPRIATE TAG TAG OEFICIENCY) F 622 | Continued From page 42 F 622 Resident #39 to the hospital on 1/29/19. 3. Resident #53 was transferred to the hospital on 12/20/17. There were no physician notes documented in the clinical record regarding the reason for the facility-initiated transfer. 4. The facility staff failed to ensure the physician documented a note in the clinical record for Resident #5's facility initiated transfer to the hospital on 2/21/18. The findings include: 1. Resident #25 was admitted to the facility on 7/17/15 and readmitted on 12/19/17 with diagnoses that included but were not limited to: Parkinson's disease (1), heart failure, diabetes,

psychotic disorders, depression, schizophrenia (2), anoxic brain injury (3) and seizures.

assessment, with an ARD (assessment reference date) of 1/17/18, coded the resident as having scored a 6 out of 15 on the BIMS indicating the resident was severely impaired cognitively. The resident was coded as requiring the assistance of

The most recent complete MDS, a 30-day

staff for all activities of daily living with the exception of eating, which the resident could

Review of the physician's orders dated 12/14/17 documented, "Give one dose Albuterol 0.083% (4) via neb (nebulizer)/lf no improvement send to

Review of the nurse's note on 12/14/17 at 6:05 a.m. documented, "At 04:30 (4:30 a.m.) CNA (certified nursing assistant) called to nurse's

perform with supervision.

ER (emergency room)."

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION DING			E SURVEY PLETED
	•	495226	B. WING		<u>.</u>	03/	09/2018
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, S 730 LUNENBURG HIGHV KEYSVILLE, VA 2394	v		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	(EACH CORRECT CROSS-REFERENCE	LAN OF CORRECTION TIVE ACTION SHOULD SED TO THE APPROP FICIENCY)	BE	(X5) COMPLETION DATE
F 622	station C to state rebreathing Called (order to administer ineffective send to the Review of the nurse a.m. documented, breathing treatment auditory inspiration without the use of a (sic) [emergency modern of the physical of the physical of the physical of the emergency modern of the physical of the emergency modern of the emergency of the emergency modern of the emergency modern of the emergency modern of the emergency room, A we assess the residence of the emergency room, A we assess the residence in the emergency room, A we assess the residence in the emergency room, A we assess the residence in the emergency room, A we assess the residence in the emergency room, A we assess the residence in the emergency room, A we assess the residence in the emergency room, A we assess the residence in the emergency room, A we assess the residence in the emergency room, A we assess the residence in the emergency room, A we assess the residence in the emergency room, A we assess the residence in the emergency room, A we assess the residence in the emergency room, A we assess the residence in the emergency room in t	resident was having difficulty (name of physician) received albuterol via nebulizer if the ER." Pe's note on 12/14/17 at 4:45 PAdministered resident the company of the expiration wheezing and expiration wheezing as stethoscopeCalled Emstedical services] to transport at the (name of emergency room)." Cian's notes for December of the reason the resident could be facility and required a	F	622	FICIENCY)		
	what we have found to the ER or give us this was documented progress notes. One the ER or hospital was representative), we get the papers toget report and 911 for the physician wrote a not the resident required transfer, ASM #2, "I	I and they tell us to send them orders." When asked where ed, ASM #2 stated, "In the ce we decide they are going to be call the RR (resident talk to the resident and we ther and call the ER with ansport." When asked if the ote documenting the reason d an emergency room don't know. I'd have to check at ASM #2 were made aware		·			

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	!	TIPLE CONSTRUCTION			E SURVEY PLETEO
		495226	B. WING		_	03/	09/2018
	PROVIOER OR SUPPLIER ID NURSING AND REI	HABILITATION CENTER		STREET AOORESS, CITY, STA 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	TE, ZIP COOE		
(X4) IO PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDEO BY FULL SC IDENTIFYING INFORMATION)	IO PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED		BE	(X5) COMPLETION DATE
	An interview was cop.m. with ASM #4, to asked what role he to the hospital, ASM to the hospital oppositate I'm to be called circumstances and hospital or is there is care of it in the facility note regarding why transferred to the hodon't normally do the the nursing staff are he was aware of the transfers, ASM #3 is new regulations. I'm specific to the transfer or disched and of the survey of the resident of transfer or disched facility unless: a) The necessary for the reresident's needs care the transfer or disched the resident no long provided by the facility dividuals of the facility dividuals of the facility individuals of the facility dividuals di	at time. Inducted on 3/08/18 at 3:06 The resident's physician. When had in transferring a resident of the second of the patient's decide if they go to the something I can order to take sty." When asked if he wrote a caresident would be ospital, ASM #4 stated, "No. I at, as I am not there. I expect to doing that." When asked if enew regulations regarding tated, "I am not aware of the fer to the hospital." It's policy titled "TRANSFER revised on 3/9/18 (the last ocumented, "The facility will to remain in the facility, and arge the resident from the etransfer or discharge is sident's welfare and the not be met in the facility; b) harge is appropriate because has improved sufficiently so er needs the services ityd) The health of sility would otherwise be	F 6	22			

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	TIPLE CONSTRI			TE SURVEY MPLETED
		495226	B. WING			03	/09/2018
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		730 LUNEN	DRESS, CITY, STATE, ZIP CODE BURG HIGHW .E, VA 23947	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EA	PROVIDER'S PLAN OF CORRE ACH' CORRECTIVE ACTION SH SS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION OATE
F 622	that situations disconcurred. Before a a resident, the facilif known, a family nof the transfer or dithe move in writing manner they under No further informat 1. Parkinson's dise movement disorder in the brain don't prochemical called dorgenetic, but most of families. This information. This information was don't be they talk. The disorkeep a job or take of information was obto https://medlineplus. 3. Cerebral hypoxiathere is a decrease even though there is a decrease even though there in Drowning, stranglin cardiac arrest, head poisoning, and comanesthesia can createrebral hypoxia. Shypoxia include in a memory loss, and a coordination. Brain	Jussed in "a" or "b" have facility transfers or discharges ity will: Notify the resident and, nember or legal representative scharge and the reasons for and in a language and stand." Jone was provided prior to exit. Jone was provided prior to exit. Jone (PD) is a type of the transpens when nerve cells enduce enough of a brain pamine. Sometimes it is asses do not seem to run in mation was obtained from: Jone Jone Jone Jone Jone Jone Jone Jone	F	22			

CENTE	RS FOR MEDICARE	<u> </u>				<u>OMR NO</u>	<u>, 0938-0391</u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		LE CONSTRUCTION		TE SURVEY MPLETED
		495226	B. WING	_		03,	/09/2018
	PROVIDER OR SUPPLIER ND NURSING AND RE	HABILITATION CENTER		7	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 PREF TAG	ΊΧ	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	[X5] COMPLETION DATE
F 622	five minutes after on This information was https://www.ninds.ni/Cerebral-Hypoxia-la. Albuterol sulfate for the relief of brond of age and older with airway disease and bronchospasm. This from: https://dailymed.nlm	oxygen supply has been cut off. as obtained from: nih.gov/Disorders/All-Disorders Information-Page inhalation solution is indicated achospasm in patients 2 years th reversible obstructive	F	622			
	physician, for a facil Resident #39 to the Resident #39 was a 11/17/15 and readm that included but we chronic lung disease. The most recent colassessment, with an date) of 2/13/18 coolscored a four out of the resident was set The resident was cofrom staff for all actil Review of the nurse a.m. documented, "	implete MDS, a quarterly in ARD (assessment reference ded the resident as having fen on the BIMS indicating everely impaired cognitively. Ended as requiring assistance ivities of daily living. E's note dated 1/29/19 at 11:41 Patient noted with increased					
	difficulty communicate of breath) and some	spoke to the patient who had ating due to SOB (shortness e increased confusion) called (sic) agreed to send				,	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCT			(X3) DATE SURVEY COMPLETED	
		495226	B. WING			03/	/09/2018	
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		STREET ADDRES 730 LUNENBUR KEYSVILLE, \		<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOL REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION OATE	
	Review of the physical documented, "Send evaluation." Review of the January physician notes did regarding the reason emergency room transfer, As an interview was considered about when a resident was emergency room, A we assess the residency room, A we assess the residency room, and to the ER or give us this was documented progress notes. One the ER or hospital was representative), we get the papers toger report and 911 for transfer, ASM #2, "I on that." ASM #1 and of the findings at the asked what role he is to the hospital, ASM #4, the reseasked what role he is to the hospital, ASM	cian's orders dated 1/29/18 It to ER (emergency room) for ary and February 2018 not evidence documentation in the resident required an ansfer. Inducted on 3/8/18 12:01 p.m. rative staff member) #1, the SM #2, the director of nursing. the process staff followed is transferred to the SM#2 stated, "What we do is lent, and call the doctor or the iractitioner). We tell them If and they tell us to send them If orders." When asked where If and they stated, "In the If we decide they are going to If ye call the RR (resident talk to the resident and we ther and call the ER with ansport." When asked if the one when documenting the required an emergency room don't know. I'd have to check and ASM #2 were made aware	F 6	22				
	that I'm to be called							

FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION DING		ATE SURVEY DMPLETED
		495226	B. WING		0:	3/09/2018
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, Z 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		0.00,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION OATE
	circumstances and hospital or is there care of it in the facil note regarding why ASM #4 stated, "No am not there. I expethat." When asked i regulations regarding am not aware of the aware of the one that hospital." No further informati 3. Resident #53 was 12/20/17. There we documented in the creason for the facility Resident #53 was a 7/22/16 and readmit diagnoses that including cholesterol, and depressive disorder obstructive pulmona most recent assess assessment with AF date) of 12/6/18. Rebeing cognitively interview for Mental was coded as requir from one staff memoral facility on 1 from the facility on 1 from the facility on 1	decide if they go to the something I can order to take lity." When asked if he wrote a the resident was transferred, b. I don't normally do that, as I ect the nursing staff are doing if he was aware of the new ng transfers, ASM #3 stated, "I e new regulations. I'm not at is specific to the transfer to on was provided prior to exit. Is transferred to the hospital on ere no physician notes clinical record regarding the sy-initiated transfer. I dmitted to the facility on ted on 8/30/17 with reded but were not limited to exiety disorder, epilepsy, major, and COPD (chronic ary disease). Resident #53's ment was a quarterly RD (assessment reference esident #53 was coded as act in the ability to make daily 8 out of 15 on the BIMS (Brief Status) exam. Resident #53 ring extensive assistance ber with most ADLS (activities dent #53 was discharged	F 6	522		
	a.m.: "Went to give i resident was verball	note dated 12/20/17 at 5:35 resident his medication, y unresponsive. Skin hot and cough noted. When resident				

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

Event ID: IPQ811

Facility ID: VA0050

If continuation sheet Page 49 of 208

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APR 2 4 2018
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FORM APPROVED

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		E CONSTRUCTION	COMPLETED		
		495226	B. WING			03/09/2018	
	PROVIDER OR SUPPLIER ND 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 622	name called, he triesigns: 100.8 (temper (respirations), 110/6 (oxygen saturation blood]) 95 percent of the next note dated documented the following practitioner) notified Order give to send (emergency room) for the review of the following: 12/20/17 at 1:47 p.m hospital) ER (emergency room) for the following: 12/20/17 at 2:16 p.m (responsible party) is resident's condition room 332 with diagrical residents belonging (sic) assisted RP with the following season for the facility discharge summary clinical record. On 3/8/18 at 3:28 p. conducted with ASM member) #4, the mestated that he does facility-initiated transwas not aware of the stated that he writes was not aware of the stated that he writes	d to open his eyes. Vital erature), 93 (pulse), 28 60 (blood pressure), 02 sat [amount of oxygen in the on room air." d 12/20/17 at 5:41 a.m. lowing: "(Name of NP (nurse of or resident's condition. the resident to the ER for an evaluation." e nursing notes revealed the on. "Telephoned (Name of gency room) to follow up on Resident being admitted to	F				

CENTE	E & MEDICAID SERVICES			(OMB NO. 0938-0391			
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495226	B. WING	∍ <u> </u>	·	03/	/09/2018	
	PROVIDER OR SUPPLIER ND NURSING AND RE	HABILITATION CENTER		7	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	-ix	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETION DATE	
F 622	member) #1, the ac DON (Director of N the above concerns No further informati	B at that moment. D.m., ASM (administrative staff dministrator and ASM #2, the lursing were made aware of s. ion was presented prior to exit.	F	622				
	documented a note Resident #5's facilit hospital on 2/21/18. Resident #5 was ad	failed to ensure the physician in the clinical record for ty initiated transfer to the . dmitted to the facility on the readmission on 2/25/18,						
	with diagnoses that to: cancer of the left abuse, Alzheimer's peripheral vascular condition affecting b	included but were not limited to		!				
	assessment, an anr assessment referen the resident as scor interview for mental was severely impair	DS (minimum data set) nual assessment, with an nce date of 12/19/18, coded ring a zero on the BIMS (brief I status) score, indicating he red to make daily cognitive ant change assessment was me of survey.				,		
	nurse's note dated, NP (nurse practition resident to ER (eme (due to) resident bei	al record documented a 2/21/18 at 9:49 a.m., "Called ner), order received to send ergency room) - Farmville d/t ing in chair and lend (sic) to regain body control in				•		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '		DNSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495226	B. WING			03	3/09/2018	
	PROVIDER OR SUPPLIER	HABILITATION CENTER		730 L	et address, city, state, zip cdd .u nenburg highw SVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT DF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN DF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	JOULD BE	(X5) COMPLETION OATE	
F 622	chair. Nurse and Cassistant) laid reside vital signs." The nur 10:25 a.m. docume will answer simple of that he was weak a signs) 86/40 (blood 93 (pulse) 16 (respisaturation)." The nual a.m. documented, "transport resident to distress noted." The physician order "Transport to ER - (treat and eval (eval notified." Review of the clinic documentation by the reason for Resident to the hospital on 2 documentation regard not meet the reside. An interview was concerned to the "Usually we gather to get an order. A long practitioner) is in the order; we transfer it it to the pharmacy." writes when a resident transfer to the hospiaware of that."	CNA (certified nursing dent back in bed and obtained rse's note dated, 2/21/18 at ented, "Resident lethargic but questions. Resident voiced and didn't feel well. VS (vital pressure), 99.6 (temperature) irations) 97% (oxygen urse's note on 2/21/18 at 10:25 "(Name of county) squad in to o (name of hospital) no r dated, 2/21/18 documented, (name of hospital and town) to uate), RP (responsible party) all record did not reveal the physician regarding the t #5's facility initiated transfer /21/18. There was no arding how the facility could		322				

PRINTED: 03/20/2018 FORM APPROVED OMB NO. 0938-0391

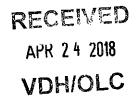
	ATEMENT OF DEFICIENCIES (Xt) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	· ·	(X3) DATE SURVEY COMPLETED	
		495226	B. WING		03/0	9/2018
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	· · · · · · · · · · · · · · · · · · ·	BE	(X5) COMPLETION DATE
F 622	staff member (ASM ASM #2, the director 12:01 p.m., regarding for facility initiated to hospital. ASM #2 swith you on that." An interview was comedical director, or asked what his role the hospital, ASM # be called and advisted decide whether we room) or give an orasked if he wrote a transfers to the ER, in the building where writes a note when #4 stated, "No, I do!" The administrator as	ember (ASM) #1, the administrator and 2, the director of nursing, on 3/8/18 at 0.m., regarding physician documentation lity initiated transfers of residents to the al. ASM #2 stated, "I'll have to get back u on that." rview was conducted with ASM #4, the al director, on 3/8/18 at 3:15 p.m. When what his role in transferring a resident to spital, ASM #4 stated, "I am supposed to ed and advised of the circumstances and I whether we transfer to the ER (emergency or give an order to treat here." When if he wrote a note for facility initiated rs to the ER, ASM #4 stated, "Only if I am building when it occurs." When asked if he a note when he is not in the building, ASM ed, "No, I don't usually."				
	5:10 p.m. No further informati	above findings on 3/8/18 at on was provided prior to exit. ts Before Transfer/Discharge 3)-(6)(8)	F 6	623 F-623		
	resident, the facility (i) Notify the resident representative(s) of the reasons for the language and mann	resfers or discharges a must- int and the resident's the transfer or discharge and move in writing and in a iter they understand. The copy of the notice to a e Office of the State		Written Notification to the to the resident representative and to the long term care ombudsman was provided for		

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

Event ID: IPQ811

Facility ID: VA0050

If continuation sheet Page 53 of 208



PRINTED: 03/20/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ B. WING 495226 03/09/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 623 | Continued From page 53 F 623 resident#34,#20,#53,#25,#39 (ii) Record the reasons for the transfer or discharge in the resident's medical record in and #5. accordance with paragraph (c)(2) of this section; A review by the Social Worker (iii) Include in the notice the items described in of transfers for last 30 days paragraph (c)(5) of this section. found no other incidents of non-compliance. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and An in-service will be (c)(8) of this section, the notice of transfer or discharge required under this section must be conducted with the Social made by the facility at least 30 days before the Worker by the Administrator resident is transferred or discharged. to update her on the rules (ii) Notice must be made as soon as practicable regarding notification of before transfer or discharge when-(A) The safety of individuals in the facility would Resident representatives and

must include the following:

transferred or discharged;

this section:

this section:

davs.

be endangered under paragraph (c)(1)(i)(C) of

(B) The health of individuals in the facility would

be endangered, under paragraph (c)(1)(i)(D) of

(C) The resident's health improves sufficiently to

required by the resident's urgent medical needs,

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section

(i) The reason for transfer or discharge:

(iii) The location to which the resident is

(ii) The effective date of transfer or discharge;

(iv) A statement of the resident's appeal rights,

under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30

allow a more immediate transfer or discharge,

under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is the Ombudsman. The IDT will

review discharges for proper

Results of the reviews will be

reported by the Social Worker

to the facility's QA Committee

thereafter. If additional issues

are noted those issues will be

addressed immediately and

corrective action taken.

on a monthly basis for three months then quarterly

notifications at its morning

meetings to ensure

compliance with the

regulations.

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	S	COMPLETED				
		495226	B. WING		03/09/2018			
	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	PREFIX (EACH CORRECTIVE ACTION SHOU		IX5I COMPLETION OATE		
F 623	including the name, and telephone number courses such request to obtain an appeal completing the form hearing request; (v) The name, address telephone number of Long-Term Care On (vi) For nursing faciliand developmental disabilities, the mail telephone number of the protection and a developmental disabilities, the mail telephone number of the protection and a developmental disabilities of the Developmental disa	address (mailing and email), ber of the entity which ests; and information on how form and assistance in and submitting the appeal ess (mailing and email) and of the Office of the State inbudsman; lity residents with intellectual disabilities or related ing and email address and of the agency responsible for idvocacy of individuals with bilities established under Part ental Disabilities Assistance of 2000 (Pub. L. 106-402, c. 15001 et seq.); and lity residents with a mental lisabilities, the mailing and elephone number of the for the protection and rals with a mental disorder ne Protection and Advocacy duals Act.	F 623					

NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM-	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		CONSTRUCTION		COMPLETED		
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947 ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMB. TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			495226	B. WING	I		03/09/2018		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COME TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COME TO THE APPROPRIATE DEFICIENCY)			HABILITATION CENTER		730	LUNENBURG HIGHW			
F 623 Continued From page 55 F 623	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE		PREF		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE	(X5) COMPLETION DATE	
State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that facility staff failed to provide written notification to the resident representative and the long term care ombudsman of a facility initiated transfer to the hospital for six of 28 residents in the survey sample, Resident #34, #20, #53, #25, #39, and #5. 1. The facility staff failed to provide written notification to Resident #34, the resident representative and ombudsman for Resident #34's transfer to the hospital on 12/17/17. 2. The facility staff failed to provide written notification to Resident #20, the resident representative and ombudsman for Resident #20's transfer to the hospital on 12/17/17. 3. The facility staff failed to provide written notification to Resident #35, the resident representative and ombudsman for Resident #20's transfer to the hospital on 12/17/17. 4. The facility staff failed to provide written notification to Resident #35, the resident representative and ombudsman for Resident #53's transfer to the hospital on 12/10/17. 4. The facility staff failed to provide written documentation to Resident #25's responsible representative and notify the ombudsman when the resident was transferred to the emergency room on 12/14/17. 5. The facility staff failed to provide written documentation to Resident #39's responsible		State Long-Term C the facility, and the well as the plan for relocation of the re 483.70(I). This REQUIREMED by: Based on staff intereview, it was deter to provide written no representative and ombudsman of a factorial for six of 2 sample, Resident ##5. 1. The facility staff in notification to Resident representative and #34's transfer to the 2. The facility staff in notification to Resident representative and #20's transfer to the 3. The facility staff in notification to Resident representative and #53's transfer to the 4. The facility staff in documentation to Representative and the resident was transfer to the staff for the staff in the staff	resident representatives, as the transfer and adequate sidents, as required at § NT is not met as evidenced erview and clinical record rmined that facility staff failed otification to the resident the long term care acility initiated transfer to the 8 residents in the survey 434, #20, #53, #25, #39, and failed to provide written dent #34, the resident ombudsman for Resident et hospital on 12/17/17. If alled to provide written dent #20, the resident ombudsman for Resident et hospital on 12/17/17. If alled to provide written dent #53, the resident ombudsman for Resident et hospital on 12/20/17. If alled to provide written dent #53, the resident ombudsman for Resident et hospital on 12/20/17. If alled to provide written dent #25's responsible notify the ombudsman when ansferred to the emergency failed to provide written	F	623				

NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	
(XALID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPANY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PREFIX (EACH DE
F 623 Continued From page 56 representative and notify the ombudsman when the resident was transferred to the emergency room on 1/29/18. 6. The facility staff failed to provide written documentation to Resident #5, the resident's representative and the ombudsman, when Resident #5 was transferred to the hospital on 2/21/18. The findings include: 1. Resident #34 was admitted to the facility on 6/19/15 and readmitted on 12/20/17 with diagnoses that included but were not limited to morbid obesity, unspecified dementia without behavioral disturbance, major depressive disorder, Alzheimer's disease, high blood pressure, chronic heart failure and muscle atrophy and wasting. Resident #34's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 2/2/18. Resident #34 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #34's nursing notes revealed that Resident #34 was sent out to the hospital on 12/17/17. The following note was documented: "Resident #34 was sent out to the hospital on 12/17/17. The following note was documented: "Resident has vomited large amount of brown emesis. Smells like stool. VS (Vital signs: elevated). MD (medical doctor) made aware and order received to send to ER (emergency room) for evaluation and tx (treatment), 911 was called and RP (representative) and ER made aware. The next note dated 12/17/17 at 1:12 a.m., documented the following: "Resident has left the	representative the resident room on 1/2 6. The facility documentative representative Resident #5 2/21/18. The findings 1. Resident 6/19/15 and diagnoses the morbid obestoe behavioral diagnoses the morbid obestoe diagnoses the morbid obestoe behavioral diagnoses the morbid obestoe diagnoses the morbid ob

WAYLAND NURSING AND REHABILITATION CENTER (X4) ID PREFIX TAG (X4) ID PREFIX TAG (X4) ID PREFIX TAG (X5) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG (X6) ID PREFIX TAG (X7) ID REGULATORY OR LSC IDENTIFYING INFORMATION) F 623 Continued From page 57 facility on stretcher with (Name of ambulance) being transported to (Name of ER). She is alert and oriented and able to make needs known." Review of the clinical record revealed that Resident #34 was admitted to the hospital with a diagnosis of a bowel obstruction. Further review of Resident #34's clinical record failed to evidence that the RP (responsible party) was notified in writing of the reason for Resident #34's transfer, and that the ombudsman received a copy of this written notification. On 3/8/18 at 10:04 a.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked about the process followed when a resident is sent to the hospital, LPN #1 stated she would gather all information from her assessment such as vital signs etc, notify the physician and then she would get the verbal order to send the resident out to the emergency room if the physician agreed with her findings. When asked	_	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1, ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
WAYLAND NURSING AND REHABILITATION CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 623 Continued From page 57 facility on stretcher with (Name of ambulance) being transported to (Name of ER). She is alert and oriented and able to make needs known." Review of the clinical record revealed that Resident #34 was admitted to the hospital with a diagnosis of a bowel obstruction. Further review of Resident #34's clinical record failed to evidence that the RP (responsible party) was notified in writing of the reason for Resident #34's transfer, and that the ombudsman received a copy of this written notification. On 3/8/18 at 10:04 a.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked about the process followed when a resident to the hospital, LPN #1 stated she would gather all information from her assessment such as vital signs etc, notify the physician and then she would get the verbal order to send the resident out to the emergency room if the physician agreed with her findings. When asked			495226	B. WING				03/09/2018	
F 623 Continued From page 57 facility on stretcher with (Name of ambulance) being transported to (Name of ER). She is alert and oriented and able to make needs known." Review of the clinical record revealed that Resident #34 was admitted to the hospital with a diagnosis of a bowel obstruction. Further review of Resident #34's clinical record failed to evidence that the RP (responsible party) was notified in writing of the reason for Resident #34's transfer, and that the ombudsman received a copy of this written notification. On 3/8/18 at 10:04 a.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked about the process followed when a resident is sent to the hospital, LPN #1 stated she would gather all information from her assessment such as vital signs etc, notify the physician and then she would get the verbal order to send the resident out to the emergency room if the physician agreed with her findings. When asked			HABILITATION CENTER		730	LUNENBURG HIGHW			
facility on stretcher with (Name of ambulance) being transported to (Name of ER). She is alert and oriented and able to make needs known." Review of the clinical record revealed that Resident #34 was admitted to the hospital with a diagnosis of a bowel obstruction. Further review of Resident #34's clinical record failed to evidence that the RP (responsible party) was notified in writing of the reason for Resident #34's transfer, and that the ombudsman received a copy of this written notification. On 3/8/18 at 10:04 a.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked about the process followed when a resident is sent to the hospital, LPN #1 stated she would gather all information from her assessment such as vital signs etc, notify the physician and then she would get the verbal order to send the resident out to the emergency room if the physician agreed with her findings. When asked	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	(X5] COMPLETION DATE	
what she and other nurses would document about a facility-initiated transfer, LPN #1 stated she would document the timeframe of everything that had occurred such as the time the family and physician were notified. When asked if she would give the resident or family member anything in writing about their transfer, LPN #1 stated, "No, not generally." When asked if she would notify the ombudsman for every facility-initiated transfer to the hospital, LPN #1 stated, "No." On 3/8/18 at 10:20 a.m., an interview was conducted with OSM #1, the social worker. When asked her role with facility- initiated transfers to the hospital; OSM #1 stated that most of the time the nurses handled the transfers,	F 623	facility on stretcher being transported to and oriented and all Review of the clinic Resident #34 was a diagnosis of a bower Further review of R failed to evidence the was notified in writin #34's transfer, and a copy of this writte. On 3/8/18 at 10:04 conducted with LPN When asked about resident is sent to the would gather all information as vital signs of them she would get resident out to the ephysician agreed where would document that had occurred sphysician were noting give the resident or writing about their to the ombudsman for to the hospital, LPN On 3/8/18 at 10:20 conducted with OSI When asked her rottransfers to the hos	with (Name of ambulance) or (Name of ER). She is alert to le to make needs known." Fall record revealed that admitted to the hospital with a sel obstruction. Resident #34's clinical record that the RP (responsible party) and of the reason for Resident that the ombudsman received in notification. Ra.m., an interview was N (licensed practical nurse) #1. The process followed when a the hospital, LPN #1 stated she ormation from her assessment etc, notify the physician and the verbal order to send the emergency room if the emergency room if the ith her findings. When asked nurses would document ated transfer, LPN #1 stated and the timeframe of everything uch as the time the family and fied. When asked if she would family member anything in ransfer, LPN #1 stated, "No, an asked if she would notify revery facility-initiated transfer I #1 stated, "No." Ra.m., an interview was M #1, the social worker. It with facility- initiated pital; OSM #1 stated that most		123				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			[' '	ULTIPLE CONSTRUCTION LDING			OATE SURVEY COMPLETED	
		495226	B. WING			03/09/2018		
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		730	REET ADDRESS, CITY, STATE, ZIP CODI LUNENBURG HIGHW YSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG			PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 623	notifications and all nurses spoke to far #1 stated that she could with every facility-in On 3/8/18 at 5:12 pmember) #1 and ASmember) #2, the Domade aware of the Facility policy titled, documents in part, transfers or dischar Notify the resident amember or legal redischarge and the r	that. OSM #1 stated that the mily members verbally. OSM did not notify the ombudsman itiated transfer to the hospital. .m., ASM (administrative staff SM (administrative staff ON (Director of Nursing) were	F	523				
	notification to Resider representative and #20's transfer to the Resident #20 was a 11/2/15 with diagnost limited to compress vertebra, difficulty in type two diabetes, of disturbance, Alzheir altered mental statu Resident #20's mos set) assessment was an ARD (assessment was an ARD (assessment #20 was compaired in cognitive the Staff Assessment Resident #20 was compaired was compaired was compaired was compaired to the Staff Assessment Resident #20 was compaired was compair	ailed to provide written ent #20, the resident ombudsman for Resident e hospital on 12/17/17. Idmitted to the facility on ses that included but were not ion fracture of the first lumbar in walking, muscle weakness, lementia without behavioral mer's disease, heart failure, is, and difficulty swallowing. It recent MDS (minimum data is an annual assessment with int reference date) of 1/2/18. oded as being severely the function scoring a three on int for Mental Status exam. oded as being totally for most ADLS (activities of						

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495226	B. WING			03/	09/2018
_	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 623	daily living). Review of Resident that Resident #20 v 12/17/17. The follow "12/17/17 at 6:55 a projectile vomited to States her stomach Will send to (name tx (treatment and et a treatment and et a transfer to (Name of the next note dated documented the follow representative) has transfer to (Name of the next note dated documented the follow representative) has transfer to (Name of the next note dated documented the follow representative) has transfer to (Name of the next note	t #20's nursing notes revealed vent out to the hospital on wing was documented: .m., Resident has just brown coffee grounds-emesis. In hurts. ABD (abdomen) firm. of ER [emergency room]) for valuation)." d 12/17/17 at 7:13 a.m., lowing: "RR (resident been made aware of need for of ER)." need back to the facility on m. with no further episodes of y diagnosis from the ER	F 6				
	assessment such a physician and then to send the resident the physician agree asked what she and document about a f	s vital signs etc, notify the she would get the verbal order tout to the emergency room if d with her findings. When dother nurses would acility-initiated transfer, LPN would document the timeframe.					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		495226	B. WING			03/	09/2018
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		7	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION OATE
F 623	the family and physical asked if she would member anything in LPN #1 stated, "No if she would notify the facility-initiated transtated, "No." On 3/8/18 at 10:20 conducted with OSI When asked her rotransfers to the hose of the time the nurse notifications and all nurses spoke to family stated that she with every facility-in On 3/8/18 at 5:12 pmember) #1 and ASI	ad occurred such as the time ician were notified. When give the resident or family nowiting about their transfer, not generally." When asked he ombudsman for every sfer to the hospital, LPN #1 a.m., an interview was M #1, the social worker. We with facility- initiated pital; OSM #1 stated that most es handled the transfers, that. OSM #1 stated that the nily members verbally. OSM lid not notify the ombudsman itiated transfer to the hospital. m., ASM (administrative staff on (Director of Nursing) were	F6	623			
	notification to Resid representative and a #53's transfer to the Resident #53 was a 7/22/16 and readmit diagnoses that inclu- high cholesterol, and depressive disorder obstructive pulmonal most recent assess assessment with AF	ailed to provide written ent #53, the resident ombudsman for Resident chospital on 12/20/17. dmitted to the facility on tted on 8/30/17 with ded but were not limited to xiety disorder, epilepsy, major , and COPD (chronic ary disease). Resident #53's ment was a quarterly RD (assessment reference esident #53 was coded as					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	i	495226	B. WING			03/09/2018	
	PROVIDER OR SUPPLIER ID NURSING AND REI	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	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	DBE	IX5I COMPLETION OATE
F 623	being cognitively int decisions scoring 1. Interview for Mental was coded as requifrom one staff mem of daily living). Review of Resident the following nursing a.m.: "Went to give resident was verbal dry to touch. Loose named called he triesigns: 100.8 (temper (respirations), 110/6 (oxygen saturation [blood]) 95 percent of the next note dated documented the following notes: The next note dated documented the following notes: 12/20/17 at 1:47 p.m. hospital) ER to following notes: 12/22/17 at 2:16 p.m. (responsible party) in residents belonging (sic) assisted RP with to questions nor control of the control of th	act in the ability to make daily 3 out of 15 on the BIMS (Brief Status) exam. Resident #53 ring extensive assistance ber with most ADLS (activities #53's clinical record revealed g note dated 12/20/17 at 5:35 resident his medication, ly unresponsive. Skin hot and cough noted. When resident ed to open his eyes. Vital erature), 93 (pulse), 28 to (blood pressure), 02 sat famount of oxygen in the fon room air." I 12/20/17 at 5:41 a.m. owing: "(Name of NP) notified on. Order give to send the emergency room) for an enursing notes revealed the m. "Telephoned (Name of w up on resident's condition, itted to room 332 with	F	323			

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495226		l ` '	JLTIPLE CONSTRUCTION DING			(X3) DATE SURVEY COMPLETED		
			B. WING		03/09/2018				
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER				730	EET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW YSVILLE, VA 23947				
(X4) ID PREFIX TAG				x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
	reason for her reasombudsman receive notification. On 3/8/18 at 10:04 conducted with LPN When asked about resident is sent to the send the resident the physician and then to send the resident the physician agree asked what she and document about a full stated that she wo feverything that has the family and physician and the family and physician asked if she would generated, "No, if she would notify the facility-initiated transstated, "No." On 3/8/18 at 10:20 a conducted with OSN When asked her roll transfers to the hosy of the time the nurse notifications and all nurses spoke to fam #1 stated that she d with every facility-initiation. On 3/8/18 at 5:12 p.	_	F6	623					

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

Event ID: IPQ811

Facility ID: VA0050

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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION NG		COMPLETED		
495226			B. WING			03/	/09/2018	
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, C 730 LUNENBURG H KEYSVILLE, VA				
(X4) ID PREFIX TAG			ID PREFI TAG	(EACH COR	ER'S PLAN OF CORRECTIVE ACTION SHOUL RECTIVE ACTION SHOUL RENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 623	member) #2, the Demade aware of the 4. The facility staff is documentation to Be representative and the resident was trace on 12/14/17. Resident #25 was a 7/17/15 and readmidiagnoses that incluparkinson's disease psychotic disorders (2), anoxic brain injuments of 1/17/18 considered as 6 out of 18 resident was severed as 6 out of 18 resident was severed (4) via neb (nebulized ER." Review of the physical documented, "Give (4) via neb (nebulized ER." Review of the nurse a.m. documented, "Give (10 order to administer ineffective send to the Review of the nurse a.m. documented, "Give (11 order to administer ineffective send to the Review of the nurse a.m. documented, "breathing treatment auditory inspiration and the resident was presented to the nurse a.m. documented, "breathing treatment auditory inspiration"	ON (Director of Nursing) were	F	23				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILD		COMPLETED				
	495226			;		03.	03/09/2018		
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER				7	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947				
(X4) ID PREFIX TAG			ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE		
F 623	(sic) [emergency m 05:00 (5:00 a.m.) to Review of the clinic documentation that (RR) and the ombu about the resident's An interview was cowith LPN (licensed asked about the proresident to the hosp we gather all our intand get an order." Was notified of the to "Through the telephoresident or family was notified of the to "Through the telephoresident or family was not transfer, I generally." An interview was comproximately 10:15 member) #1, the some about the process some transferred to to the family was transferred to the family was an interview was not transferred to the homotounless there was an issue was, OSM transferred and the support. We notify the control of the composition of the support. We notify the control of the composition of the support. We notify the control of the composition of the support. We notify the control of the composition of the support. We notify the control of the composition of the	edical services] to transport at a (name of emergency room)." al record did not evidence the resident representative dsman were notified in writing emergency room transfer. anducted on 3/8/18 09:59 a.m. practical nurse) #1. When pocess staff follow for sending a bital, LPN #1 stated, "Usually formation, notify the doctor, when asked how the family transfer, LPN #1 stated, none." When asked if the pere given anything in writing LPN #1 stated, "No not asked worker. When asked staff follows when the resident the hospital, OSM #1 stated, "I know but usually the nurses asked if the resident or entative were given anything in ansfer, OSM #1 stated, "I'm or not." When asked if the obtified when a resident was ospital, OSM #1 stated, "I'm or not." When asked if the obtified when a resident was ospital, OSM #1 stated, "No, is an issue." When asked what #1 stated, "If they were family wasn't providing the ombudsman for that."		623					
	transferred and the support. We notify t An interview was co	family wasn't providing he ombudsman for that."							

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ' '	TIPLE CONSTRUCTION ING		COMPLETED		
		495226	B. WING		03	/09/2018		
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP 730 LUNENBURG HIGHW KEYSVILLE, VA 23947				
(X4) ID PREFIX TAG			ID PREFIX TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION OATE		
F 623	the administrator an nursing. When asked follows when a residemergency room, A we assess the residemergency room, A we assess the residence of the ER or give us this was documented progress notes. On the ER or hospital was documented progress notes. On the ER or hospital was get the papers togereport and 911 for the family or RR was get documentation about notified the omman of the family meet them a who notified the omman of the family of the susually meet them a who notified the omman of the family of the family meet them and the family meet them and the family meet them and the family of the survey of the family of the survey of the family of the survey of the family unless: a) The resident's needs can the transfer or discontinuous family unless: a) The transfer or discontinuous family unless fam	and ASM #2, the director of sed about the process staff dent was transferred to the ASM#2 stated, "What we do is dent, and call the doctor or the practitioner). We tell them do and they tell us to send them do asked where do and the RR (resident talk to the resident and we ther and call the ER with the ransport." When asked if the ven any written ut the transfer, ASM #2 stated, the resident's family over the doubt and the hospital." When asked budsman of the transfer and stated, "I'm not sure about do, "I do know under the new budsman should be notified that they have been doing an employment at the facility and ASM #2 were made	F6	23				

PRINTED: 03/20/2018 FORM APPROVED OMB NO. 0938-0391

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER: 495226		1	TIPLE CONSTRUCTION ING	COMPLETED		
			B. WING			03/09/2018	
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY 730 LUNENBURG HIG KEYSVILLE, VA 239	HW	,	
(X4) ID PREFIX TAG			ID PREFI TAG	X (EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD NCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION OATE
	provided by the factindividuals of the face individuals of the face endangered The documentation in that the above situation in "d" has attending physician that situations disconccurred. Before a a resident, the facilities known, a family most the transfer or disting manner they understock document anything to the ombudsman and discharges. No further information. Parkinson's disease movement disorder in the brain don't prochemical called dop genetic, but most cafamilies. This informations://medlineplus. 2. Schizophrenia is who have it may head they may think other they may think other they talk. The disord keep a job or take of information was obto https://medlineplus.endanger.	ilityd) The health of acility would otherwise be facility will have the resident's medical record ations discussed in "a" or "b" physician may document the occurred. The resident's will provide documentation used in "a" or "b" have facility transfers or discharges the will: Notify the resident and the member or legal representative scharge and the reasons for and in a language and stand." The policy did not regarding written notification for facility initiated transfers on was provided prior to exit. The policy did not regarding written notification for facility initiated transfers on was provided prior to exit. The policy did not regarding written notification for facility initiated transfers on was provided prior to exit. The policy did not regarding written notification for facility initiated transfers on was provided prior to exit. The policy did not regarding written notification for facility initiated transfers on was provided prior to exit. The policy did not regarding written nerve cells of the provided prior to exit. The policy did not regarding written nerve cells of the provided prior to exit. The policy did not regarding written notification for facility initiated transfers on was provided prior to exit. The policy did not regarding written notification for facility initiated transfers on was provided prior to exit. The policy did not regarding written notification for facility initiated transfers on was provided prior to exit. The policy did not regarding written notification for facility initiated transfers on was provided prior to exit.	F	23			

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

Event ID: IPQ811

Facility ID: VA0050

If continuation sheet Page 67 of 208



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

495226

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

(X3) DATE SURVEY COMPLETED

Description	NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
there is a decrease of oxygen supply to the brain even though there is adequate blood flow. Drowning, strangling, choking, suffocation, cardiac arrest, head trauma, carbon monoxide poisoning, and complications of general anesthesia can create conditions that can lead to cerebral hypoxia. Symptoms of mild cerebral hypoxia include inattentiveness, poor judgment, memory loss, and a decrease in motor coordination. Brain cells are extremely sensitive to oxygen deprivation and can begin to die within five minutes after oxygen supply has been cut off. This information was obtained from: https://www.ninds.nih.gov/Disorders/All-Disorders //Cerebral-Hypoxia-Information-Page 4. Albuterol sulfate inhalation solution is indicated for the relief of bronchospasm in patients 2 years of age and older with reversible obstructive airway disease and acute attacks of bronchospasm. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cf m?setid=5329614f-ae0b-4854-bb8f-ea0b7dae87c 0 5. The facility staff failed to provide written documentation to Resident #39's responsible representative (RR) and the ombudsman when the resident was transferred to the emergency room on 1/29/18. Resident #39 was admitted to the facility on 11/17/15 and readmitted on 2/6/18 with diagnoses that included but were not limited to: heart failure, chronic lung diseases and weakness.	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		<	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
that included but were not limited to: heart failure, chronic lung diseases and weakness.	F 623	there is a decrease of oxygen supply to the brain even though there is adequate blood flow. Drowning, strangling, choking, suffocation, cardiac arrest, head trauma, carbon monoxide poisoning, and complications of general anesthesia can create conditions that can lead to cerebral hypoxia. Symptoms of mild cerebral hypoxia include inattentiveness, poor judgment, memory loss, and a decrease in motor coordination. Brain cells are extremely sensitive to oxygen deprivation and can begin to die within five minutes after oxygen supply has been cut off. This information was obtained from: https://www.ninds.nih.gov/Disorders/All-Disorders/Cerebral-Hypoxia-Information-Page 4. Albuterol sulfate inhalation solution is indicated for the relief of bronchospasm in patients 2 years of age and older with reversible obstructive airway disease and acute attacks of bronchospasm. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cf m?setid=5329614f-ae0b-4854-bb6f-ea0b7dae87c 0 5. The facility staff failed to provide written documentation to Resident #39's responsible representative (RR) and the ombudsman when the resident was transferred to the emergency room on 1/29/18. Resident #39 was admitted to the facility on	F 6	23		
The most recent complete MDS, a quarterly		that included but were not limited to: heart failure,				
		The most recent complete MDS, a quarterly				

PRINTED: 03/20/2018 FORM APPROVED OMB NO. 0938-0391

F 623 Continued From page 68 assessment, with an ARD of 2/13/18 coded the resident as having scored a four out of ten on the BIMS indicating the resident was severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living. Review of the nurse's note dated 1/29/19 at 11:41 a.m. documented, "Patient noted with increased confusion by staff. I spoke to the patient who had difficulty communicating due to SOB (shortness of breath) and some increased confusion (Name of physician) called (sic) agreed to send out. 911 called and squad arrive at 11:42 (a.m.)." Review of the physician's orders dated 1/29/18 documented, "Send to ER (emergency room) for evaluation." Review of the clinical record did not evidence written documentation about the transfer had been provided to the RR (responsible	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1 ' '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
WAYLAND NURSING AND REHABILITATION CENTER (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG CEACH DEFICIENCY MUST BE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 623 Continued From page 68 assessment, with an ARD of 2/13/18 coded the resident as having scored a four out of ten on the BIMS indicating the resident was severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living. Review of the nurse's note dated 1/29/19 at 11:41 a.m. documented, "Patient noted with increased confusion by staff. I spoke to the patient who had difficulty communicating due to SOB (shortness of breath) and some increased confusion (Name of physician) called (sic) agreed to send out. 911 called and squad arrive at 11:42 (a.m.)." Review of the physician's orders dated 1/29/18 documented, "Send to ER (emergency room) for evaluation." Review of the clinical record did not evidence written documentation about the transfer had been provided to the RR (responsible	495226			B. WING			03/	03/09/2018	
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representative) and the ombudsman. An interview was conducted on 3/8/18 09:59 a.m. with LPN (licensed practical nurse) #1. When asked about the process staff follow for sending a resident to the hospital, LPN #1 stated, "Usually we gather all our information, notify the doctor, and get an order." When asked how the family was notified of the transfer, LPN #1 stated, "Through the telephone." When asked if the resident or family were given anything in writing about the transfer, LPN #1 stated, "No not generally." An interview was conducted on 3/8/18 at approximately 10:15 a.m. with OSM (other staff member) #1, the social worker. When asked	F 623	assessment, with a resident as having so BIMS indicating the impaired cognitively requiring assistance daily living. Review of the nurse a.m. documented, "confusion by staff. I difficulty communicated of breath) and some (Name of physician out. 911 called and Review of the physician documented, "Send evaluation." Review of the clinical written documentation been provided to the representative) and An interview was cowith LPN (licensed pasked about the progresident to the hosp we gather all our infland get an order." Was notified of the till "Through the teleph resident or family we about the transfer, Ligenerally." An interview was coapproximately 10:15	n ARD of 2/13/18 coded the scored a four out of ten on the resident was severely. The resident was coded as a from staff for all activities of the spoke to the patient who had ating due to SOB (shortness increased confusion) called (sic) agreed to send squad arrive at 11:42 (a.m.)." cian's orders dated 1/29/18 to ER (emergency room) for all record did not evidence on about the transfer had the RR (responsible the ombudsman. Inducted on 3/8/18 09:59 a.m. oractical nurse) #1. When locess staff follow for sending a ital, LPN #1 stated, "Usually ormation, notify the doctor, When asked how the family ransfer, LPN #1 stated, one." When asked if the lere given anything in writing LPN #1 stated, "No not inducted on 3/8/18 at 5 a.m. with OSM (other staff	· F	323				

FRINILL, USIAUIAUIU DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ 495226 B. WING 03/09/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 623 Continued From page 69 F 623 about the process staff follows when the resident was transferred to the hospital, OSM #1 stated, "I try to let the family know but usually the nurses handle that." When asked if the resident or responsible representative were given anything in writing about the transfer, OSM #1 stated, "I'm not sure if they do or not." When asked if the ombudsman was notified when a resident was transferred to the hospital, OSM #1 stated, "No, not unless there was an issue." When asked what an issue was, OSM #1 stated, "If they were transferred and the family wasn't providing support. We notify the ombudsman for that." An interview was conducted on 3/08/18 12:01 p.m. with ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing. When asked about the process staff follows when a resident was transferred to the emergency room, ASM#2 stated, "What we do is we assess the resident, and call the doctor or the FNP (family nurse practitioner). We tell them what we have found and they tell us to send them to the ER or give us orders." When asked where this was documented, ASM #2 stated, "In the progress notes. Once we decide they are going to the ER or hospital we call the RR (resident

representative), we talk to the resident and we get the papers together and call the ER with report and 911 for transport." When asked if the

documentation about the transfer, ASM #2 stated, "No, we just talk to the resident's family over the phone, because they usually don't come in. They usually meet them at the hospital." When asked who notified the ombudsman of the transfer and discharge, ASM #2 stated, "I'm not sure about that." ASM #1 stated, "I do know under the new regulations the ombudsman should be notified

family or RR was given any written

TRANSMISSION OK

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ST. TIME TIME USE

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ME USE 34'20 GES SENT 82

PAGES SENT 8: RESULT OK

Part 2 of 3

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730 Lunenburg Dr.

P.O. Box 719

Keysville, Va. 23947 Phone: 434-736-8406

Administration Fax: 434-736-0236

Nursing Fax Long Term Care unit- 434-736-2228 Nursing Fax Skilled Care Wing- 434-736-2269

FAX

TO: Dept of Hearth / Va.	FROM: Wayland Nursing
FAX: 804/527-4502	PAGES: 213
PHONE:	DATE: 3/30/2018
RE:	CC:
Comments (Occo) #11:00	S / MENAUSA

comments (POC) Office of Licensures
of Confication

This document may include protected Quality Assurance information which is privileged pursuant to Commonwealth code Section 8. 01-581.17: and other applicable Federal and State Laws.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495226		1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/09/2018			
		495226	B. WING					
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER				73	REET ADDRESS, CITY, STATE, ZIP CODE 80 LUNENBURG HIGHW EYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			Κ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5] COMPLETION OATE	
F 623	but I do not know w here." ASM #1 beg	hat they have been doing an employment at the facility and ASM #2 were made	F 6	23		·		
	6. The facility staff to documentation to F representative and	ion was provided prior to exit. failed to provide written Resident #5, the resident's the ombudsman, when ansferred to the hospital on						
	5/21/15 with a rece with diagnoses that to: cancer of the lef abuse, Alzheimer's peripheral vascular condition affecting by	dmitted to the facility on nt readmission on 2/25/18, included but were not limited t lung, dementia, alcohol disease, high blood pressure, disease (any abnormal blood vessels outside the of toes on left foot due to			r			
	assessment, an ani assessment referer the resident as scor interview for mental was severely impair	DS (minimum data set) nual assessment, with an nce date of 12/19/18, coded ring a zero on the BIMS (brief I status) score, indicating he red to make daily cognitive eant change assessment was me of survey.						
	nurse's note dated, NP (nurse practition resident to ER (eme (due to) resident be forward and unable	al record documented a 2/21/18 at 9:49 a.m., "Called ner), order received to send ergency room) - Farmville d/t ing in chair and lend (sic) to regain body control in NA (certified nursing			•			

PRINTED: U3/2U/2U18 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	[' '		CONSTRUCTION		ATE SURVEY OMPLETEO
		495226	B. WING			0	3/09/2018
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F 623	assistant) laid residuital signs." The nur 10:25 a.m. docume will answer simple of that he was weak a signs) 86/40 (blood 93 (pulse) 16 (respisaturation)." The nua.m. documented, "transport resident to distress noted." The physician order "Transport to ER - (treat and eval (evalunotified." Further review of the #5, failed to evidence resident or their repwith written notificate to the hospital on 2/evidencing the omb transfer to the hospital on 2/evidencing the omb transf	ent back in bed and obtained rse's note dated, 2/21/18 at inted, "Resident lethargic but questions. Resident voiced and didn't feel well. VS (vital pressure), 99.6 (temperature) trations) 97% (oxygen prese's note on 2/21/18 at 10:25 (Name of county) squad in to o (name of hospital) no or dated, 2/21/18 documented, name of hospital and town) to present a fee documentation that the resentative were provided ion of Resident #5's transfer 21/18, and no documentation udsman was notified of the	F	523			

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

Event IO: IPQ811

Facility IO: VA0050

If continuation sheet Page 72 of 208

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	} ` <i>'</i>		E CONSTRUCTION		E SURVEY PLETED
		495226	B. WING			03/	09/2018
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		73	REET ADDRESS, CITY, STATE, ZIP CODE 10 LUNENBURG HIGHW EYSVILLE, VA 23947	<u></u>	
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F 623	writing regarding the #1 stated, "No, we jet the nurse notifies the stated, "No." An interview was comember (OSM) #1, worker/admission/d 3/8/18 at 10:20 a.m when a resident is to OSM #1 stated, "If the would let the family transfers." When as family, OSM #1 stated, "A note in the spoke with the famility gives the resident of anything in writing restated, "I don't know they do." When ask ombudsman of transtated, "I email her stated, "I email her saked if she notifies resident is transferrestated, "No, only if the family."	e transfer to the hospital, LPN ust call them." When asked if the ombudsman, LPN #1 onducted with other staff the social ischarge coordinator, on . When asked about her role ransferred to the hospital, they haven't left the building I know. The nurses handle the sked how the staff notify the ed, "I think they call them." that is documented, OSM #1 to e nurse's notes that they ly." When asked if the facility resident representative elated to the transfer, OSM #1 or about that. I don't believe ed how she notifies the sfers to the hospital, OSM #1 with the discharges." When the ombudsman when a ed to the hospital, OSM #1 here has been a problem with	F€	3623			
	staff member (ASM ASM #2, the directo 12:01 p.m. When as followed for transfer ASM #2 stated, "The and call the doctor of them what we've for to the ER or give us When asked where	nducted with administrative) #1, the administrator, and r of nursing, on 3/8/18 at sked about the process ring a resident to the hospital, e nurses assess the resident or nurse practitioner. We tell und and they decide to send orders to treat in house." that is documented, ASM #2 ess note. Once the doctor or					

PRINTED: U3/2U/2U18 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		LE CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER ID NURSING AND REI	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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETION DATE
F 623	nurse practitioner he the resident, we not and resident. We tat together; we call the report." When aske representative is given transfer, ASM resident' family on the Many times they (the resident at the ER." ombudsman of the ASM #2 stated, "I'm stated, "I know under to be notified. I know what happens ASM #1 and ASM # above findings on 3.	as given the order to transfer ify the resident representative lk to the resident, get papers a family and call the ER with diff the resident or resident or any written documentation #2 stated, "No, we talk to the the phone and explain why. If the efamily will meet the When asked who notifies the transfers and discharges, not sure of that." ASM #1 or the new regulations they just came 2/1/18 and I don't here at this facility." 2 were made aware of the /8/18 at 5:10 p.m.	F	623			
	Non-Medical Reade Chapman, page 447 PASARR Screening CFR(s): 483.20(k)(1 §483.20(k) Preadmi individuals with a me with intellectual disa §483.20(k)(1) A nurs or after January 1, 1 (i) Mental disorder a (i) of this section, un authority has determindependent physical	for MD & ID)-(3) ssion Screening for ental disorder and individuals bility. sing facility must not admit, on 989, any new residents with: s defined in paragraph (k)(3) less the State mental health	F€	645			

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

Event ID: IPQ811

Facility ID: VA0050

If continuation sheet Page 74 of 208

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PRINTED: 03/20/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495226 B. WING 03/09/2018 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 IX51 COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 645 Continued From page 74 F 645 State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility: and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section-(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the

the hospital, and

hospital,

preadmission screening program under

to a nursing facility of an individual-

paragraph (k)(1) of this section to the admission

(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the

(B) Who requires nursing facility services for the condition for which the individual received care in

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	ING		IPLETED
	t	495226	B. WING		03/	09/2018
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F 645	(C) Whose attending before admission to is likely to require lefacility services. §483.20(k)(3) Definisection- (i) An individual is edisorder if the individual is intellectual disability intellectual disability or is a person with described in 435.10. This REQUIREME by: Based on staff interview, it was detected a Preadmission staff interview, it was detected and the sum of the sum	ing physician has certified, of the facility that the individual less than 30 days of nursing shiftion. For purposes of this considered to have a mental ridual has a serious mental 483.102(b)(1). considered to have an yif the individual has an y as defined in §483.102(b)(3) a related condition as 210 of this chapter. Note in the facility staff failed to his in Screening and PASARR) for four of 28 revey sample, Residents # 5, # failed to complete a Level I beening and resident review for sure each resident in a nursing I for a mental disorder (MD) or y (ID) prior to admission and evaluated and receive care most integrated setting	F6	PASARRs will be obtained residents #5, #10, #8, since they should have obtained prior to adm. The Social Worker and admissions personnel trained by the Adminion the need for a PAS prior to admission? New admits and refer be screened by the Screened by the Screened by the Screened by the father to admission to the father to admission to the father will be reviewed by the IDT at morning meeting to ecompliance with the I regulations. Results of the morning meeting reviews will submitted to the Administrator	and #25 e been ission. d were strator SARR rals will ocial r cion prior cility. e at its ensure PASARR	Town of the state

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		LE CONSTRUCTION		TE SURVEY MPLETED
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F 645	admission and that receive care and se setting appropriate 3. The facility staff f pre-admission scre Resident #8, to ens facility, is screened intellectual disability that individuals are and services in the appropriate to their 4. The facility staff f pre-admission screened intellectual disability are so (MD) or intellectual admission; and to ewith MD or ID, are exand services setting. The findings includes 1. The facility staff f pre-admission screened intellectual disability that individuals are and services in the appropriate to their	individuals are evaluated and ervices in the most integrated to their needs. failed to complete the ening and resident review for ure each resident in a nursing for a mental disorder (MD) or (ID) prior to admission and evaluated and receive care most integrated setting needs. failed to complete the ening and resident review for sure each resident in a screened for a mental disorder disability (ID) prior to insure individuals identified evaluated and receive care grappropriate to their needs. failed to complete a Level I ening and resident review for ure each resident in a nursing for a mental disorder (MD) or (ID) prior to admission and evaluated and receive care most integrated setting needs.	F	645			
	5/21/15 with a recer	mitted to the facility on nt readmission on 2/25/18, included but were not limited					

F 645 Continued From page 77 to cancer of the left lung, dementia, alcohol abuse, Alzheimer's disease, high blood pressure, peripheral vascular disease (any abnormal condition affecting blood vessels outside the heart) (1), absence of toes on left foot due to amputation. The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 12/19/18, coded the resident as scoring a zero on the BIMS (brief interview for mental status) score, indicating he was severely impaired to make daily cognitive decisions. In Section A1500 - Preadmission Screening and Resident Review, it coded the resident as not currently being considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. A significant change assessment was in progress at the time of survey. Review of the clinical record failed to evidence a Level I Preadmission Screening and Resident Review as having been completed. An interview was conducted with other staff member (OSM) #1, the social worker/admission/discharge coordinator, on 3/8/18 at 10:20 a.m., regarding the PASARR assessments. OSM #1 stated, "I know it's for people who have mental retardation. I recently met with someone at the local hospital to ask about it and they said they'd get back with me."		FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION		MPLETED
MAYLAND NURSING AND REHABILITATION CENTER (X4.1) I SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST SE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) F 645 Continued From page 77 to cancer of the left lung, dementia, alcohol abuse, Alzheimer's disease, injch blood pressure, peripheral vascular disease (any abnormal condition affecting blood vessels outside the heart) (1), absence of toes on left foot due to amputation. The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 12/19/18, coded the resident as scoring a zero on the BIMS (brief interview for mental status) score, indicating he was severely impaired to make daily cognitive decisions. In Section A1500 - Preadmission Screening and Resident Review, it coded the resident as not currently being considered by the state level II PASRR process to have a serious mental illness and/or Intellectual disability or a related condition. A significant change assessment was in progress at the time of survey. Review of the clinical record failed to evidence a Level I Preadmission Screening and Resident Review as having been completed. An interview was conducted with other staff member (OSM) #1, the social worker/admission/discharge coordinator, on 3/8/18 at 10:20 a.m., regarding the PASARR assessments. OSM #1 stated, 'I know it's for people who have mental retardation. I recently met with someone at the local hospital to ask about it and they said they dig et back with me."			495226	B. WING	·		03	3/09/2018
FREER TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 645 Continued From page 77 to cancer of the left lung, dementia, alcohol abuse, Alzheimer's disease, high blood pressure, peripheral vascular disease, high blood pressure, peripheral vascular disease, ligh blood pressure, peripheral vascular disease (any abnormal condition affecting blood vessels outside the heart) (1), absence of toes on left foot due to amputation. The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 12/19/18, coded the resident as scoring a zero on the BIMS (brief interview for mental status) score, indicating he was severely impaired to make daily cognitive decisions. In Section A1500 - Preadmission Screening and Resident Review, it coded the resident as not currently being considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. A significant change assessment was in progress at the time of survey. Review of the clinical record failed to evidence a Level I Preadmission Screening and Resident Review as having been completed. An interview was conducted with other staff member (OSM) #1, the social worker/admission/discharge coordinator, on 3/8/18 at 10:20 a.m., regarding the PASARR assessments. OSM #1 stated, "I know it's for people who have mental retardation. I recently met with someone at the local hospital to ask about it and they said they'd get back with me."			HABILITATION CENTER	•	7	730 LUNENBURG HIGHW		
to cancer of the left lung, dementia, alcohol abuse, Alzheimer's disease, high blood pressure, peripheral vascular disease (any abnormal condition affecting blood vessels outside the heart) (1), absence of toes on left foot due to amputation. The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 12/19/18, coded the resident as scoring a zero on the BIMS (brief interview for mental status) score, indicating he was severely impaired to make daily cognitive decisions. In Section A1500 - Preadmission Screening and Resident Review, it coded the resident as not currently being considered by the state level il PASRR process to have a serious mental illness and/or Intellectual disability or a related condition. A significant change assessment was in progress at the time of survey. Review of the clinical record failed to evidence a Level I Preadmission Screening and Resident Review as having been completed. An interview was conducted with other staff member (OSM) #1, the social worker/admission/discharge coordinator, on 3/8/18 at 10:20 a.m., regarding the PASARR assessments. OSM #1 stated, "I know it's for people who have mental retardation. I recently met with someone at the local hospital to ask about it and they said they'd get back with me."	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETION
When asked when this conversation occurred, OSM #1 stated, "Last month, maybe." When asked if she was familiar with the regulations related to PASARR, OSM #1 stated, "No."	F 645	to cancer of the left abuse, Alzheimer's peripheral vascular condition affecting theart) (1), absence amputation. The most recent MI assessment, an ani assessment referenthe resident as scorinterview for mental was severely impair decisions. In Section Screening and Resiresident as not curristate level II PASRE mental illness and/or related condition. A assessment was in survey. Review of the clinical Level I Preadmission Review as having be An interview was comember (OSM) #1, worker/admission/d 3/8/18 at 10:20 a.m assessments. OSM people who have met with someone about it and they sa When asked when the OSM #1 stated, "La asked if she was far	lung, dementia, alcohol disease, high blood pressure, disease (any abnormal blood vessels outside the of toes on left foot due to DS (minimum data set) hual assessment, with an ace date of 12/19/18, coded ring a zero on the BIMS (brief status) score, indicating he red to make daily cognitive in A1500 - Preadmission ident Review, it coded the ently being considered by the R process to have a serious or intellectual disability or a significant change progress at the time of all record failed to evidence a in Screening and Resident een completed. Inducted with other staff the social ischarge coordinator, on a regarding the PASARR 1 #1 stated, "I know it's for ental retardation. I recently at the local hospital to ask id they'd get back with me." this conversation occurred, st month, maybe." When miliar with the regulations	F	645			

	TOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		TE SURVEY MPLETED
		495226	B. WING			03	/09/2018
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		730	REET ADDRESS, CITY, STATE, ZIP CODE D LUNENBURG HIGHW YSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION OATE
F 645	An interview was constaff member (ASM ASM #2, the director 12:01 p.m. When a #1 stated, "It's a presental capabilities on every that comedoes the PASARR is stated, "I'm not away has to be. ASM #1 sending them either The administrator and the above finding.	onducted with administrative (1) #1, the administrator and or of nursing, on 3/8/18 at sked what a PASARR is, ASM eadmission screening for of the resident. We need one in here." When asked who in this building, ASM #1 are of anyone doing it, but it stated, "The hospital is not r." and ASM #2 were made aware as on 3/8/18 at 5:10 p.m. sing informed this surveyor on the facility did not have a	F	345			
	pre-admission scree Resident #10, to en nursing facility, is so (MD) or intellectual admission and that receive care and se setting appropriate to Resident #10 was a with diagnoses that to: Huntington's cho condition characteric rapid, jerky motions leading to dementia inflammation of the	dmitted to the facility 12/3/13 included but were not limited area (abnormal hereditary zed by progressive involuntary and mental deterioration, (1), depression, liver, lack of coordination, ecified mental disorder due to					

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		ATE SURVEY OMPLETED
		495226	B. WING			0	3/09/2018
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		730	REET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW YSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 645	The most recent MI assessment, a quarassessment referenthe resident as hav memory difficulties to make daily cogni was coded as being staff members for a living. Review of the clinic Level I Preadmission Review as having being the compact of the clinic Level I Preadmission Review as having being the compact of the clinic Level I Preadmission Review as having being the compact of the clinic Level I Preadmission of the compact of the clinic Level I Preadmission of the compact of the clinic Level I Preadmission of the compact of the compact of the clinic Level I Preadmission of the compact of the compact of the clinic Level I Preadmission of the compact of the clinic Level I Preadmission of the compact of the clinic Level I Preadmission of the compact of the clinic Level I Preadmission of the compact of the clinic Level I Preadmission of the clin	DS (minimum data set) rterly assessment, with an ance date of 12/21/17, coded ing both short and long-term and being severely impaired tive decisions. The resident g dependent upon one or more all of his activities of dally al record failed to evidence a on Screening and Resident teen completed. #10's PASARR was requested imately 9:00 a.m., ASM member) #2, the director of anducted with other staff	Fé	645			

	FOF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		ONSTRUCTION		E SURVEY IPLETED
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	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		730 L	ET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW SVILLE, VA 23947		
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F 645	does the PASARR stated, "I'm not awa has to be. ASM #1 sending them either On 3/8/18 at 12:25 member (ASM) #1 for Resident #10. His should be able to confus to the above finding. The director of nursial surveyor on 3/9/18 not have a policy for No further information. Non-Medical Reads Chapman, page 24 3. The facility staff of pre-admission screen Resident #8, to ensure facility, is screened intellectual disability that individuals are and services in the appropriate to their Resident #8 was activated in the services with diagnoses that to: Alzheimer's dised disorder, diabetes, and services in the appropriate to their Resident #8 was activated in the services in the appropriate to their Resident #8 was activated in the services in the appropriate to their Resident #8 was activated in the services in the appropriate to their Resident #8 was activated in the services in the appropriate to their Resident #8 was activated in the services in the appropriate to their Resident #8 was activated in the services in the appropriate to their Resident #8 was activated in the services in the appropriate to their Resident #8 was activated in the services in the appropriate to their Resident #8 was activated in the services in the appropriate to their Resident #8 was activated in the services in the appropriate to their Resident #8 was activated in the services in the appropriate to their Resident #8 was activated in the services in the appropriate to their Resident #8 was activated in the services in the appropriate to their Resident #8 was activated in the services in the appropriate to their Resident #8 was activated in the services in the appropriate to their Resident #8 was activated in the services in the appropriate to the services in the service	in this building, ASM #1 are of anyone doing it, but it stated, "The hospital is not r." p.m., administrative staff stated there was no PASARR le stated the social worker complete these. and ASM #2 were made aware as on 3/8/18 at 5:10 p.m. sing, ASM #2 informed this at 10:01 a.m., the facility did r PASARR completion. son was provided prior to exit. ary of Medical Terms for the er, 5th edition, Rothenberg and 7. failed to complete the ening and resident review for ure each resident in a nursing for a mental disorder (MD) or (ID) prior to admission and evaluated and receive care most integrated setting	F6	45			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
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F 645	of blood beneath do The most recent M assessment, a qua assessment referencesident as having memory difficulties, being severely impa decisions. Resident dependent upon on all of her activities of Swallowing/Nutrition coded as receiving feeding tube. Review of the clinic Preadmission Scree having been comple On 3/8/18 at 8:44 a member (ASM) #2, informed this surve for Resident #8. An interview was comember (OSM) #1, worker/admission/d 3/8/18 at 10:20 a.m assessments. OSM people who have m met with someone about it and they sa When asked when OSM #1 stated, "La asked if she was fa related to PASARR. An interview was comended the sale of the sal	DS (minimum data set) rterly assessment, with an accedate of 12/7/17, coded the both short and long-term The resident was coded as aired to make daily cognitive at #8 was coded as being e or more staff members for of daily living. In Section Kanal Status, the resident was all of her nutrition through a all record failed to evidence a sening and Resident Review as seted. Impact of the director of nursing, yor that there was no PASARR and conducted with other staff.	F 6	345		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l · ·	TIPLE CONSTRUCTION	P	COMPLETED
		495226	B. WING			03/09/2018
***	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, Z 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	IP CODE	
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F 645	ASM #2, the director 12:01 p.m. When a #1 stated, "It's a premental capabililies on every that comedoes the PASARR is tated, "I'm not awahas to be. ASM #1 sending them either The administrator a of the above finding The director of nurs 3/9/18 at 10:01 a.m policy for PASARR No further informati (1) Barron's Diction: Non-Medical Reade Chapman, page 26:4. The facility staff f pre-admission screen Resident #25, to en nursing facility are so (MD) or intellectual admission; and to ewith MD or ID, are eand services setting Resident #25 was a 7/17/15 and readmidiagnoses that included Parkinson's disease psychotic disorders.	or of nursing, on 3/8/18 at sked what a PASARR is, ASM sadmission screening for of the resident. We need one in here." When asked who in this building, ASM #1 are of anyone doing it, but it stated, "The hospital is not ." and ASM #2 were made aware is on 3/8/18 at 5:10 p.m. ing informed this surveyor on, the facility did not have a completion. on was provided prior to exit. ary of Medical Terms for the er, 5th edition, Rothenberg and	F6	545		

	TOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION NG	N 		E SURVEY PLETED
		495226	B, WING			03/	09/2018
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F 645	The most recent coassessment, with a resident as having a BIMS indicating the impaired cognitively requiring the assist daily living with the resident could perform the could perform the resident could perform the resident could perform the resident could perform the resident review on 3/7/18 at 4:47 pthe PASARR was most aff member) #2, the PASARR was most aff member) #2, the company the resident consultation on the resident consultation of the same as the company of the assistent complete consultation of the resident consultation of the residen	implete MDS, a 30-day in ARD of 1/17/18 coded the scored a 6 out of 15 on the resident was severely in The resident was coded as ance of staff for all activities of exception of eating which the form with supervision. all record did not evidence the pre-admission screening in (PASARR) was completed. Image: The complete comp	F6	45			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495226	B. WING			03/	09/2018	
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		7	STREET 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION OATE	
F 645	asked if anyone wa ASM #1 stated, "No for one from the ho nursing, stated, "I d what they are or who doing." On 3/8/18 at 5:15 p member) #1, the addirector of nursing with findings. A request PASARR was made On 3/9/18 at 8:37 a not have a PASARR	s completing the PASARR's, of to my knowledge. We asked spital." ASM #2, the director of on't think the hospital realizes not they are supposed to be .m. ASM (administrative staff diministrator and ASM #2, the were made aware of the for the facility's policy for eat that time to ASM #2. .m., ASM #2 stated they did	F	345	-			
	in the brain don't prochemical called dop genetic, but most cal families. This inform https://medlineplus. 2. Schizophrenia is who have it may hear they may think other them. Sometimes the them. Sometimes they talk. The disord keep a job or take conformation was obth https://medlineplus.	. It happens when nerve cells oduce enough of a brain namine. Sometimes it is asses do not seem to run in nation was obtained from: gov/parkinsonsdisease.html a serious brain illness. People ar voices that aren't there. For people are trying to hurt ney don't make sense when the der makes it hard for them to are of themselves. This						
		refers to a condition in which						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495226	B. WING		03/09/2	2018
	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)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE CO	(X5) MPLETION OATE
	even though there Drowning, stranglir cardiac arrest, hear poisoning, and comanesthesia can crecerebral hypoxia. Shypoxia include inamemory loss, and a coordination. Brain to oxygen deprivatifive minutes after of This information was https://www.ninds.r/Cerebral-Hypoxia-Develop/Implement CFR(s): 483.21(b)(1) The implement a compresident rights set of §483.21(b)(1) The implement a compresident rights set of §483.10(c)(3), that objectives and time medical, nursing, a needs that are identification assessment. The condescribe the following (i) The services that or maintain the resist physical, mental, arrequired under §48 (ii) Any services that under §483.24, §48 provided due to the under §483.10, inclutereatment under §4	s adequate blood flow. g, choking, suffocation, d trauma, carbon monoxide aplications of general ate conditions that can lead to ymptoms of mild cerebral attentiveness, poor judgment, d decrease in motor cells are extremely sensitive on and can begin to die within xygen supply has been cut off. as obtained from: aih.gov/Disorders/All-Disorders information-Page Comprehensive Care Plan 1) chensive Care Plans facility must develop and ehensive person-centered resident, consistent with the orth at §483.10(c)(2) and includes measurable frames to meet a resident's and mental and psychosocial tified in the comprehensive comprehensive care plan must and dent's highest practicable and psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights uding the right to refuse	F 65	F-656 The care plan was revised resident #37's pain. The caplan was revised for resident #18's dental concerns. The	for es. for ent	2/6

PRINTED: 03/20/2018 FORM APPROVED OMB 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		
		495226	B. WING			03/09	/2018
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD E	BE C	(X5) COMPLETION DATE
F 656	provide as a result recommendations. findings of the PAS rationale in the resi (iv)In consultation vesident's represent (A) The resident's gesired outcomes. (B) The resident's gesired outcomes. (B) The resident's getture discharge. For the resident community was associated contact agency entities, for this pur (C) Discharge plant plant, as appropriate requirements set for section. This REQUIREMED by: Based on observation document review, a was determined the and implement the five of 28 residents Resident #37, #18, 1. The facility staff address Resident #37 address Resident #37 address Resident #37.	es the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record. with the resident and the tative(s)-goals for admission and preference and potential for acilities must document nt's desire to return to the sessed and any referrals to cies and/or other appropriate pose. In accordance with the orth in paragraph (c) of this NT is not met as evidenced ation, staff interview, facility and clinical record review, it at facility staff failed to develop comprehensive care plan for in the survey sample, #5, #41 and #13. If alled to develop a care plan to the staff of the services are plan for hospice services are plan for hospice services are plan to address Resident	F6	The IDT will review can at its morning meeting ensure that care plans updated timely and reproper changes in conthe residents. Change made during the meet the MDS Nurse as need. The QI nurse will perform audit of care plans monthly for 3 months conclude continuous and revisions of care The results of the audit submitted to the DON maintain continued compliance the DON share the results of the with the Quality Assure Performance Improve (QAPI) Committee on quarterly basis. If addissues are noted thos will be addressed immand corrective action	gs to s are effect ndition or es will be ting by cessary. orm a ns s to updates plans. dit will be N. To will he audits urance ement n a ditional se issues mediatel	e	

3. The facility staff failed to implement Resident

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ B. WING 495226 03/09/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 656 Continued From page 87 F 656 #5's comprehensive care plan for wound care. 4. The facility staff failed to develop a comprehensive care plan to address Resident #41's dental issues. 5a. The facility staff failed to implement Resident #13's comprehensive care plan to maintain the bed in the low position and to apply non-skid strips on the floor by the bed. 5b. The facility staff failed to implement Resident #13's comprehensive care plan and physician's order not to take blood pressures in the residents left arm. The findings include: 1. Resident #37 was admitted to the facility on 3/31/17 and readmitted on 8/1/17 with diagnoses that included but were not limited to heart failure, high blood pressure, diabetes, high cholesterol, Alzheimer's disease, and dementia. Resident #37's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 2/8/18. Resident #37 was coded as being severely cognitively impaired scoring three out of possible 15 on the BIMS (Brief Interview for Mental Status)

exam. Resident #37.was coded as requiring extensive assistance from one staff member with most ADLS (activities of daily living). Resident #37 was coded in Section J (pain) as not having any pain. Further review of his MDS revealed that he was receiving hospice services.

Review of Resident #37's clinical record revealed he was receiving pain medications. Resident #37's most recent POS (physician order sheet)

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 495226 03/09/2018 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 ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 656 | Continued From page 88 F 656 dated 2/28/18, documented the following orders: "1) Morphine [1] Sul (sublingual) sol (solution) 100/5 ml (milliliters) under tongue every four hours as needed for pain/shortness of breath." This order was initiated on 9/21/17. 2) Tylenol [2] 650 mg sup (suppository) 1 per rectum every four hours as needed for pain." This order was initiated on 9/21/17." Review of Resident #37's February and March 2018 MAR revealed Resident #37 had received Morphine 0.25 ML on 2/8/18, 2/11/18 and 3/5/18. Review of Resident #37's clinical record revealed an order for Hospice Services on 8/11/17. The following order was documented: "Admit to (Name of Hospice company) - hospice services. palliative care...Code status DNR (do not resuscitate) - Activity as tolerated.' On 8/20/17, a significant change MDS (minimum data set) assessment was completed documenting that Resident #37 was receiving Hospice Services,

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

Review of Resident #37's comprehensive care plan dated 4/18/17, failed to evidence a care plan to address Resident #37's Pain or hospice care,

conducted with LPN (licensed practical nurse) #3. When asked what the care plan was used for, LPN #3 stated the care plan was used to

determine the level of care of the patient. LPN #3 stated that if the resident has issues, such as falls, interventions would be updated on the care plan. LPN #3 stated the care plan had to reflect

On 3/8/18 at 8:37 a.m., an interview was

Event ID: IPQ811

Facility ID: VA0050

MANUE OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER (X4) ID REPORT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 656 Continued From page 89 the resident. When asked if it was important that the care plan was accurate, LPN #3 stated it was. When asked if a resident is receiving pain medication and is on hospice services should the resident have a care plan addressing pain, LPN #3 stated that nursing staff have direct communication with hospice care and services if it is not on the resident's care plan, LPN #3 stated that nursing staff have direct communication with hospice are or orders, a hospice RN (registered nurse) would be really difficult." LPN #3 stated that nursing staff have direct communication with hospice care plan in place, LPN #3 stated that it staff needed clarification on hospice care plan in place. LPN #3 stated that it staff needed clarification on hospice care plan, LPN #3 stated that flor nurses do not develop or make changes to the care plans in place, LPN #3 stated that flor nurses do not develop or make changes to the care plans have to be put into place by the supervisors. On 3/8/18 at 9:03 a.m., an interview was conducted with RN (registered nurse) #1, the MDS nurse. When asked who was responsible for developing care plans, RN #1 stated care plans members can also develop different sections, RN #1 stated it should be a collaborative effort.		F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
WAYLAND NURSING AND REHABILITATION CENTER X(1) D			495226	B. WING	i		03/	09/2018
FREFIX TAS (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 656 Continued From page 89 the resident. When asked if it was important that the care plan was accurate, LPN #3 stated it was. When asked if a resident is receiving pain medication and is on hospice services should the resident have a care plan addressing pain, LPN #3 stated the resident should have a pain care plan in place. When asked how nursing would know how to coordinate hospice care and services if it is not on the resident's care plan, LPN #3 stated that nursing staff have direct communication with hospice and the hospice nurses themselves. LPN #3 stated that if staff needed clarification on hospice care or orders, a hospice RN (registered nurse) would be readily available. When asked if a resident receiving hospice services should have a hospice care plan in place, LPN #3 stated, "That seems like a good idea." LPN #3 stated that floor nurses do not develop or make changes to the care plan. LPN #3 stated changes to the care plan but into place by the supervisors. On 3/8/18 at 9:03 a.m., an interview was conducted with RN (registered nurse) #1, the MDS nurse. When asked who was responsible for developing care plans, RN #1 stated she was ultimately responsible but that other staff members can also develop different sections. RN #1 stated it should be a collaborative effort.			HABILITATION CENTER		7:	30 LUNENBURG HIGHW		
the resident. When asked if it was important that the care plan was accurate, LPN #3 stated it was. When asked if a resident is receiving pain medication and is on hospice services should the resident have a care plan addressing pain, LPN #3 stated the resident should have a pain care plan in place. When asked how nursing would know how to coordinate hospice care and services if it is not on the resident's care plan, LPN #3 stated, "That would be really difficult." LPN #3 stated that nursing staff have direct communication with hospice and the hospice nurses themselves. LPN #3 stated that if staff needed clarification on hospice care or orders, a hospice RN (registered nurse) would be readily available. When asked if a resident receiving hospice services should have a hospice care plan in place, LPN #3 stated that floor nurses do not develop or make changes to the care plan. LPN #3 stated changes to the care plan. LPN #3 stated changes to the care plan. LPN #3 stated changes to the care plans have to be put into place by the supervisors. On 3/8/18 at 9:03 a.m., an interview was conducted with RN (registered nurse) #1, the MDS nurse. When asked who was responsible for developing care plans, RN #1 stated she was ultimately responsible but that other staff members can also develop different sections. RN #1 stated it should be a collaborative effort.	PREFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
quarterly assessments or for any significant change. RN #1 stated she would expect to see pain and hospice care plans for a resident receiving pain medications and on hospice. RN #1 also stated that pain is always an area addressed on the care plan for any resident. RN #1 confirmed that Resident #37 did not have pain or hospice care plans in place.	F 656	the resident. When the care plan was a When asked if a re medication and is oresident have a car #3 stated the reside plan in place. When know how to coordiservices if it is not of LPN #3 stated, "The LPN #3 stated that communication with nurses themselves, needed clarification hospice RN (registe available. When as hospice services shin place, LPN #3 stated evelop or make ch #3 stated changes put into place by the On 3/8/18 at 9:03 a conducted with RN MDS nurse. When for developing care ultimately responsible members can also RN #1 stated care placed with the pain and hospice careceiving pain medi #1 also stated that paddressed on the care #1 confirmed that RN #1 confirme	n asked if it was important that accurate, LPN #3 stated it was sident is receiving pain on hospice services should the e plan addressing pain, LPN ent should have a pain care asked how nursing would nate hospice care and on the resident's care plan, at would be really difficult." nursing staff have direct a hospice and the hospice LPN #3 stated that if staff on hospice care or orders, a gred nurse) would be readily sked if a resident receiving hould have a hospice care plan ated, "That seems like a good ed that floor nurses do not hanges to the care plan. LPN to the care plans have to be a supervisors. Im., an interview was (registered nurse) #1, the asked who was responsible plans, RN #1 stated she was ble but that other staff develop different sections. Uld be a collaborative effort. Dians were also updated with ints or for any significant ted she would expect to see are plans for a resident cations and on hospice. RN drain is always an area are plan for any resident. RN desident #37 did not have pain		656			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILD	DING			(X3) DATE SURVEY COMPLETED		
		495226	B. WING			03/	/09/2018	
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		73	REET ADDRESS, CITY, STATE, ZIP CODE 0 LUNENBURG HIGHW EYSVILLE, VA 23947	O3/09/20 TO CORRECTION CTION SHOULD BE OTHE APPROPRIATE COMPLETE COMPLETE		
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F 656	Continued From pa	ge 90	F6	56				
	member) #1, the ac	o.m., ASM (administrative staff dministrator and ASM #2, the ursing) were made aware of s.			;			
	documents in part, of the facility to prove resident-centered or physician's orders, needs and preferent screening and residimplementation of the cocur by participating facility at a team coof the RN coordinate care plan) team's cobe limited to: the respensibility for the attending physician, responsibility for the the responsibility of food and nutrition of staff or professional resident's need or a Development of the with occur within 7 comprehensive ass Review of Modificate each assessment, in and quarterly review direction of the RN of the staff or professional resident's need or a Development of the with occur within 7 comprehensive ass Review of Modificate each assessment, in and quarterly review direction of the RN of the staff or professional resident's need or a Development of the with occur within 7 comprehensive ass Review of Modificate each assessment, in and quarterly review direction of the RN of the staff of the RN of the staff of the RN of the staff of the RN of the RN of the staff of the RN of	tled, "Resident Care Plan" the following: "It is the policy vide a written are plan based upon assessments of the resident's nces, and pre-admissions dent review. Development and the resident's care plan will ng disciplines available in the inference under the direction for. The ICP (interdisciplinary composition will include but not sident and the resident's e extent practicable, the a registered nurse with the resident, a nurse aide with the resident, a member of taff, and other appropriate as determined by the as requested by the resident. The comprehensive care plan days after the completion of a essment by each discipline. ion of the plan will occur after including the comprehensive or assessments, under the coordinator. The resident ongoing process and will						
	from a complete ass and Care Area Asse resident's response	plems and/or needs identified sessment including the MDS essments relevant to the to aging, illness, and his/her						
	deneral health statu	s. Any new problem or need	1	1			1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495226	B. WING			03/	09/2018
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F 656	of the resident which scheduled care plan the care plan by the line care plan by the lin	cated for the management of cated for which alternative and for which alternative lequate. This information was National Institutes of Health. In.nih.gov/dailymed/drugInfo.cf f325-475b-8453-fe3d1bb8f54. The second of the management of cated for the management of cated for which alternative lequate. This information was National Institutes of Health. In.nih.gov/dailymed/drugInfo.cf f325-475b-8453-fe3d1bb8f54. The second of the management of cated the cated factor of the second of the se	F	356			
	concerns.	5,					

		AND HUMAN SERVICES					ORM APPROV E D NO. 0938-0391
STATEMEN	CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495226 NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 656 Continued From page 92 An interview was conducted with Resident #18 3/6/18 at 9:13 a.m. Resident stated, "Somethin happened I never got my dentures. They pulled all of my teeth with a promise to get me dentures."		} ` ´		LE CDNSTRUCTION) DATE SURVEY COMPLETED
		495226	B. WING				03/09/2018
		HABILITATION CENTER		7	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
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F 656	Continued From pa	ge 92	Fθ	356			
·	3/6/18 at 9:13 a.m. happened I never g all of my teeth with	Resident stated, "Something ot my dentures. They pulled					·
	updated on 4/28/17	omprehensive care plan , failed to evidence any care sident #18's dental care and					
		from the Mobile Dental Unit imented in part, "TX: Exam, ins."					
	dated 6/28/17, docu	from the Mobile Dental Unit Imented in part, "TX: Op (operative) Possible Il set of dentures)."					
	practical nurse) #1 c asked why resident stated, "It so you kn and cannot do and h asked who uses the	onducted with LPN (licensed on 3/8/18 at 9:58 a.m. When have care plans, LPN #1 ow what they (residents) can now to care for them." When a care plan, LPN #1 stated, guide for the CNAs and the plan."					
	3/8/18 at 3:00 p.m. In the care plan, LPN # the resident." When care plan, LPN #2 s When asked why is	nducted with LPN #2 on When asked the purpose of #2 stated, "It's how to care for asked who has access to the tated, "CNAs, everyone." would not be followed, LPN always be followed."					

An interview was conducted with registered nurse

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			(MB NO.	0938-0391
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		495226	B. WING			03/	09/2018
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		7	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
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F 656	When asked if a reconcerns, should the stated, "Yes." RN# Resident #18's care Unit notes. When a care plan, RN #1 st dental on 3/7/18." Voncerns should be stated, "If the reside eating, chewing or saddressed on the compact of the administrator as were made aware of at 5:10 p.m. No further informations.	nurse, on 3/8/18 at 3:25 p.m. sident is having dental at be care planned, RN #2 1 was asked to review plan and the Mobile Dental sked if she saw dental on the ated, "I added a care plan for When asked why dental on the care plan, RN #1 ent is having difficulty with swallowing, these need to be	F	356			
	5/21/15 with a receivith diagnoses that to: cancer of the lefabuse, Alzheimer's peripheral vascular condition affecting by	Imitted to the facility on not readmission on 2/25/18, included but were not limited tlung, dementia, alcohol disease, high blood pressure, disease (any abnormal blood vessels outside the of toes on left foot due to					
	assessment, an ann assessment referer	OS (minimum data set) hual assessment, with an hoe date of 12/19/18, coded hing a zero on the BIMS (brief					

interview for mental status) score, indicating he

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947 (X4) ID PROVIDER'S PLAN OF CORRECTION	09/2018 (X5) COMPLETION DATE
WAYLAND NURSING AND REHABILITATION CENTER 730 LUNENBURG HIGHW KEYSVILLE, VA 23947 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
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· ·	
Continued From page 94 was severely impaired to make daily cognitive decisions. In Section M - Skin Conditions, the resident was not coded as having a pressure ulcer. A significant change MDS assessment was in progress at the time of survey. The comprehensive care plan dated, 2/15/18, documented in part, "Focus: Ulceration or interference with structural integrity of layers of skin caused by prolonged pressure related to: nutritional deficit, non-compliant (left foot) and left buttock." The "Interventions" documented in part, "Treatment as ordered by physician." Observation was made on 3/7/18 at 2:04 p.m. of LPN (licensed practical nurse) #4 performing the wound care for Resident #5. LPN #4 proceeded to gather her supplies. She went to the resident's left foot. The dressing on the left foot was dated 3/5/18. The date of the dressing was verified with LPN #4 and she stated she was off yesterday and didn't know who was doing treatments for the day. The physician order dated 2/12/18, documented, "Clean wound L (left) foot with Hibiclens", apply Santyl ointment, cover wi (with) NAD (non-adhesive dressing) daily until healed." *Hibiclens is an antiseptic antibacterial agent used in cleansing of the skin (2). The TAR (treatment administration record for March 2018 documented, "Hibiclens Liq (liquid) clean wound left foot W. Hibiclens. Liquid (liquid) clean wound left foot W. Hibiclens. Liquid (liquid) clean wound left foot W. Hibiclens. Apply Santyl oint (ointment), cover w/ NAD daily until healed." The TAR documented the wound care was not signed off as completed on 3/2/18 and 3/2/18 and 3/6/18.	

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION ING	COMPLETED			
		495226	B. WING			03/	/09/2018
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, S 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	<i>'</i>	•	
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	3/8/18 at 3:00 p.m. the care plan, LPN the resident." When care plan, LPN #2 s When asked why is #2 stated, "It should The facility policy, "I documented in part of the resident, which her/her scheduled caddressed on the caddres	onducted with LPN #2 on When asked the purpose of #2 stated, "It's how to care for a asked who has access to the stated, "CNAs, everyone." would not be followed, LPN I always be followed." Resident Care Plan", "Any new problems or need ch is identified between care plan review, will be are plan by the appropriate ught to the next scheduled or inform the ICP re plan) team of it's addition." Ind the director of nursing of the above findings on 3/8/18 on was provided prior to exit. The ary of Medical Terms for the er, 5th edition, Rothenberg and The ary of Medical Terms for the er, 5th edition, Rothenberg and The ary of Medical Terms for the er, 5th edition, Rothenberg and The ary of Medical Terms for the er, 5th edition, Rothenberg and The ary of Medical Terms for the er, 5th edition, Rothenberg and The ary of Medical Terms for the er, 5th edition, Rothenberg and The ary of Medical Terms for the er, 5th edition, Rothenberg and The ary of Medical Terms for the er, 5th edition, Rothenberg and The ary of Medical Terms for the er, 5th edition, Rothenberg and The ary of Medical Terms for the er, 5th edition, Rothenberg and The ary of Medical Terms for the er, 5th edition, Rothenberg and The ary of Medical Terms for the er, 5th edition, Rothenberg and The ary of Medical Terms for the er, 5th edition, Rothenberg and The ary of Medical Terms for the er, 5th edition, Rothenberg and The ary of Medical Terms for the er, 5th edition, Rothenberg and The ary of Medical Terms for the er, 5th edition and The ary of Medical Terms for the er, 5th edition and The ary of Medical Terms for the er, 5th edition and The ary of Medical Terms for the er, 5th edition and The ary of Medical Terms for the er, 5th edition and The ary of Medical Terms for the er, 5th edition and The ary of Medical Terms for the er, 5th edition and The ary of Medical Terms for the er, 5th edition and The ary of Medical Terms for the er, 5th edition and The ary of Medical Terms for the er, 5th edition and The ary of Medical Terms for the er, 5th edition and T	F6				
		recent MDS (minimum data					

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

Event ID: IPQ811

Facility ID: VA0050

If continuation sheet Page 96 of 208

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495226	B. WING			03/0	09/2018
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD O THE APPROPI	BE	(X5) COMPLETION OATE
F 656	(assessment refere the resident as have the BIMS (brief inte indicating the reside cognitively. The result as for eating which the the tray was set up. During an interview a.m. with Resident "They ordered dent have not received the the difficulty eating sometimes the turk. Review of the reside initiated on 3/6/18, the documented, "Focut the teeth or oral cavoral mucous membroblems related to Coordinate arrange needed." The care address/document and or was in need. An interview was cop.m. with OSM (othe social worker. When dentures was handle stated, "We go throw company). They con When asked if the oresidents for dentur OSM #1 was asked dental company was aske	ince date) of 1/17/18 coded ing scored a six out of 15 on rview for mental status) ent was severely impaired ident was coded as requiring civities of daily living except resident could perform after conducted on 3/6/18 at 11:12 #41, Resident #41 stated, ures over a year ago and I nem yet." When asked if she Resident #41 stated, "Well ey's a little tough." ent's comprehensive care plan he day the survey begun s. Care deficit pertaining to rity characterized by; altered rane; problems with s or other oral dental health cedentulous. Interventions. ments for dental care as olan failed to the resident had been waiting	F	556			

PRINTED. USIZUIZUTU DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 495226 B. WING 03/09/2018 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 1D (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRFFIX OATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 656 | Continued From page 97 F 656 2017. They're coming on March 22, 2018. I just found out today that I am handling the dental part. I have not been handling that before. I have two residents that have told us that they removed teeth last year and nothing has been done to get them dentures." An interview was conducted on 3/7/18 at 1:01 p.m. with ASM #2, the director of nursing. When asked how dental concerns were managed, ASM #2 stated, "We have just signed a new contract with a new dental provider that comes to the facility, in their own mobile unit." When asked when was the last time the facility had dental services available to residents, ASM #2 stated, "I don't know, I would have to check to see when they were last here. With our last provider supposedly she bought this company out, they came with a mobile unit and saw some residents, supposedly there was some conflict, some dentures had been made and she was holding them hostage. We contacted our regional and they were contracted with a new provider. They are coming soon with some new dentures." ASM #2 was asked to provide any documentation that relates to the dentist coming to see Resident #41. On 3/7/18 at 1:53 p.m., a copy of dental progress note for Resident #41 was received. Review of the note documented, "6/28/17. Treatment Notes:

Notes: Deliver F/F."

Pt (patient) presents today for post op (operative)

dentures). Will deliver next visit, Treatment Plan

An interview was conducted on 3/8/18 at 1:45 p.m. with LPN (licensed practical nurse) #2. When asked why residents had care plans, LPN #2 stated, "It's based on individual care." When

exam and possible impressions F/F (full

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495226	B. WING			03/	09/2018
	PROVIDER OR SUPPLIER ND NURSING AND RE	HABILITATION CENTER		7	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW (EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION OATE
F 656	Continued From pa	e care plan, LPN #2 stated,	Fe	656			
	When asked if staff care plan, LPN #2 s						
	p.m. with RN (regist coordinator. When	onducted on 3/8/18 at 3:23 itered nurse) #1, the MDS asked why Resident #41's not care planned until 3/6/18,					:
	RN #1 stated, "Someone told me that there was something missing from her care plan." When asked who that was RN #1 did not reply. When asked why a care plan would be developed for a resident who did not have any teeth and was						
3	waiting for dentures	s, RN #1 stated, "If there were with their eating, chewing or					
	member) #1, the ad	o.m. ASM (administrative staff dministrator and ASM #2, the were made aware of the					
	No further informati	ion was provided prior to exit.					
	#13's comprehensiv	f failed to implement Resident ve care plan to maintain the ion and to apply non-skid y the bed.					
	11/27/14 and readm diagnoses that inclu	admitted to the facility on nitted on 5/18/16 with uded but were not limited to: fficulty swallowing, depression, ner's disease.					
		DS (minimum data set), a					

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

Event ID: IPQ811

Facility ID: VA0050

If continuation sheet Page 99 of 208

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		AND HUMAN SERVICES & MEDICAID SERVICES			C		APPROVED 0938-0391
TOTAL OF CORPORATION INTERIOR TOTAL NUMBER.				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495226	B. WING			03/	09/2018
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WAYLAN	D NURSING AND REI	HABILITATION CENTER			/30 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 656	having scored a threat (brief interview for more resident was severed resident was coded activities of daily living. Review of the resident 12/3/14 and revised. "Focus. (Name of refalls and (sic) at risk impaired mobility ar Interventions. Bed in strips on floor by bed. An observation was of Resident #13. The bed height was There were no non-bed. An observation was of Resident #13's willying in the bed. After completed, the bed was inches. There were floor by the bed. An observation was of Resident #13 with nurse) #2, the resid lying in the bed. The approximately 43 in strips on the floor by bed was in the lower "No ma'am it is not bed to the lowest possible to the strips on the floor by bed to the lowest possible to the l	2/20/17 coded the resident as ee out of 15 on the BIMS nental status) indicating the ely impaired cognitively. The as requiring assistance for all ing. ent's care plan initiated on an on 7/19/17 documented, esident) has hx (history) of a for further falls related to an od cognitive impairments. In lowest position. Non-skid ed." a made on 3/6/18 at 7:30 a.m. are resident was lying in bed; at approximately 43 inches. Eskid strips on the floor by the entity of the was lowered to approximately ere no non-skid strips on the entity of the bed was at ches. There were no non-skid ythe bed. When asked if the list position, LPN #2 stated, "LPN #12 then lowered the	Fe	856			

there were non-skid strips on the floor next to the

PRINTED: USIZUIZUTO DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 495226 03/09/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX OATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 656 | Continued From page 100 F 656 resident's bed. LPN #2 stated, "No. She had them in her old room. There's no excuse for the non-skid strips to not be on the floor." An interview was conducted on 3/8/18 at 1:45 p.m. with LPN #2. When asked why residents had care plans, LPN #2 stated, "It's based on individual care." When asked who used the care plan, LPN #2 stated, "MDS (minimum data set staff) all the nurses." When asked if staff were expected to implement/follow the care plan, LPN #2 stated, "Yes." When asked why Resident #13 had a care plan that directed staff to maintain the bed in the lowest position, LPN #2 stated, "To prevent her from hurting herself." An interview was conducted on 3/8/18 at 3:23 p.m. with RN (registered nurse) #1, the MDS coordinator. When asked who developed the care plans, RN #1 stated, "I do. Other people can add to it as well, the DON (director of nursing), ADON (assistant director of nursing, social worker, activities." When asked why residents had care plans, RN #1 stated, "So we can individualize care for the residents. To make sure they get the care they need. When asked who used the care plans, RN #1 stated, "I would imagine everyone here. All the nurses, all the staff." When asked what things were included on the care plan, RN #1 stated, "When they first come in I do a baseline (care plan) that has to do with their falls.

findings.

skin integrity, pain and any kind of diagnosis that triggers." When asked if staff were expected to follow the care plan RN #1 stated they were.

On 3/8/18 at 5:15 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495226	B. WING		03/09/2018		
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947				
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F 656	Continued From pa	ge 101 on was provided prior to exit.	F6	356			
	#13's comprehensiv	failed to implement Resident ve care plan and physician's bod pressures in the residents					
	on 11/28/14 docume	ent's care plan guide initiated ented, "No BP (blood ouncture) in LEFT arm.					
	Review of the Marc documented, "No B	h 2018 physician's orders /P in Left arm."					
	from September 20 documented that the	nts and vitals summary sheet 17 to March 2018 e resident's blood pressure her left arm on 30 occasions.					
	a.m. with LPN #1. V care guide was use	onducted on 3/8/18 at 9:57 When asked what the resident d for, LPN #1 stated, "It's for e, caring for the resident."					
	p.m. with LPN #2. V had care plans, LPN individual care." Wh plan, LPN #2 stated staff) all the nurses. expected to follow the "Yes." When asked physician's order and blood pressures in the	whole on 3/8/18 at 1:45 When asked why residents In #2 stated, "It's based on the asked who used the care In "MDS (minimum data set In When asked if staff were the care plan, LPN #2 stated, why Resident #13 had a and a care plan not to obtain the left arm, LPN #2 stated that had a left mastectomy.					

		(X1) PRDVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495226	B. WING			03/0	09/2018
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	CODE		
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	An interview was cop.m. with RN (regis coordinator. When plans, RN #1 stated to it as well, the DC (assistant director cactivities." When as plans, RN #1 stated care for the resider care they need." W plans, RN #1 stated here. All the nurses what things were in #1 stated, "When the baseline (care planskin integrity, pain a triggers." When ask follow the care planskin integrity, pain a triggers." When ask follow the care planskin integrity, pain a triggers." When ask follow the care planskin integrity, pain a triggers." When ask follow the care planskin integrity, pain a triggers." When ask follow the care planskin integrity, pain a triggers. "When ask follow the care planskin integrity, pain a triggers." When ask follow the care planskin integrity, pain a triggers." When ask follow the care planskin integrity, pain a triggers. "When ask follow the care planskin integrity, pain a triggers." When ask follow the care planskin integrity, pain a triggers." When ask follow the care planskin integrity, pain a triggers." When ask follow the care planskin integrity, pain a triggers." When ask follow the care planskin integrity, pain a triggers." When ask follow the care planskin integrity, pain a triggers." When ask follow the care planskin integrity, pain a triggers." When ask follow the care planskin integrity, pain a triggers." When the care planskin integrity, pain a triggers. The care planskin integrity integrity integrity integrity.	tered nurse) #1, the MDS asked who developed the care d, "I do. Other people can add bN (director of nursing), ADON of nursing), social worker, sked why residents had care d, "So we can individualize ats. To make sure they get the hen asked who used the care d, "I would imagine everyone e, all the staff." When asked cluded on the care plan, RN ney first come in I do a b) that has to do with their falls, and any kind of diagnosis that ked if staff were expected to a RN #1 stated they were. I.m. ASM (administrative staff diministrator and ASM #2, the were made aware of the son was provided prior to exit. and Revision 2)(i)-(iii) behensive Care Plans imprehensive care plan must a 7 days after completion of assessment. interdisciplinary team, that imited to	F6	F-657 The fall care plan for #41 was revised to current interventio A review of resident plans with incident past 30 -45 days was completed by the I	include ns. nt's Care s in the as	nt	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495226		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	DING			MPLETED
		B. WING			03/09/2018		
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)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION OATE
F 657	(C) A nurse aide wiresident. (D) A member of for (E) To the extent prother resident and the An explanation murmedical record if the and their resident resident's care plan (F) Other appropriated disciplines as deter or as requested by (iii) Reviewed and reteam after each as comprehensive and assessments. This REQUIREMED by: Based on staff intereview and clinical determined the factorevise the care plan survey sample, Resident #41 was a 6/21/16 with diagnoral limited to: Parkinso pressure and fractures (assessment reference).	od and nutrition services staff. racticable, the participation of e resident's representative(s). It is included in a resident's representative is determined the development of the resident representative is determined the development of the resident resident resident. The staff or professionals in rained by the resident's needs the resident. The resident revised by the interdisciplinary resesment, including both the display review record review, it was record review, it was record review, it was resident #41. The determined revise the resident record review and revise the record review and revise the record review and revise the resident record review and revise the resident record review and revise the record review and rec		557	Plans were updated as necessary. The IDT will review any resident with a fall at its morning meeting and the ca Plan will be updated during the meeting. Fall interventions and referrals to the therapy will be documented. The QI nurse will perform a 10% audit of care plans monthly for 3 months to conclude continuous update and revisions of care plans. The results of the audit will submitted to the DON. To maintain continued compliance the DON will share the results of the audit with the Quality Assurance Performance Improvement (QAPI) Committee on a quarterly basis. If additional issues are noted those issue will be addressed immediat and corrective action taken	o es be its	4/21/8

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING __ B. WING 495226 03/09/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC | DENTIFY ING | INFORMATION) TAG DEFICIENCY) F 657 Continued From page 104 F 657 (brief interview for mental status) indicating the resident was severely impaired cognitively. The resident was coded as requiring assistance for all activities of daily living except for eating which the resident could perform after the tray was set up. Review of the nurse's notes documented that the resident had frequent falls. On 3/7/18 at 9:00 a.m. a request for all of Resident #41's fall investigations from ASM (administrative staff member) #2, the director of nursing. A review of the fall investigations documented, "10/26/18. CNA (certified nursing assistant) reported to nurse that (name of resident) was found sitting on the floor next to her bed." There was no documentation regarding the care plan review or revision. Review of the care plan initiated on 10/1/16 and revised on 8/28/17 did not evidence documentation that the care plan had been reviewed or revised regarding the resident's fall on 10/26/17. An interview was conducted on 3/8/18 at 3:23

p.m. with RN (registered nurse) #1, the MDS coordinator. When asked who developed the care plans, RN #1 stated, "I do. Other people can add to it as well, the DON (director of nursing), ADON (assistant director of nursing), social worker, activities." When asked why residents had care plans, RN #1 stated, "So we can individualize care for the residents. To make sure they get the care they need." When asked who used the care plans, RN #1 stated, "I would imagine everyone here. All the nurses, all the staff." When asked

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	WW 11	TIDLE CONCEDITORION	OVEN DATE OUR VEV	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	· ·	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
	495226	B. WING		03/09/2018	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WAYLAND NURSING AND RE	ABILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947		_
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#1 stated, "When the baseline (care plan) skin integrity, pain a triggers." When ask was reviewed and re "Quarterly unless so asked if the care planevised following a few the SDC (staff dereviews things and plane asked if she continued to stated, "Um, not all the something." When asked if she continued to stated, "Um, not all the something." When a would be updated at would. On 3/8/18 at 5:15 p. and ASM #2, the direct aware of the findings. Review of the facility CARE PLAN" docume facility to provide a well-asked upon physically to provide a very plane based upon physical physi	cluded on the care plan, RN ey first come in I do a that has to do with their falls, and any kind of diagnosis that ed how often the care plan evised, RN #1 stated, an would be reviewed and all, RN #1 stated, "That would evelopment coordinator). She outs interventions into place." Inducted on 3/8/18 3:37 p.m. If development coordinator. Idid care plan updates, RN #2 the time. I do if I see asked if the care planned fiter a fall, RN #2 stated it Im. ASM #1, the administrator ector of nursing were made s. Is policy titled, "RESIDENT mented, "It is the policy of the viritten resident-centered care ysician's orders, the esident needs and esident's care plan will be (sic)	F	957		

No further information was obtained prior to exit.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

FORM APPROVED OMB NO. 0938-0391

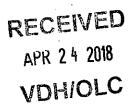
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION . (X'		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING				COMPLETED	
		495226	B. WING			03/	09/2018	
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE; VA 23947					
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F 657	Williams and Wilkin documented, "A wr communication too members that help careThe nursing information about the and goals. It contant achieving the goals and is used to direct revise and update the	amentals of Nursing Lippincott ins 2007 pages 65-77 litten care plan serves as a if among health care team is ensure continuity of care plan is a vital source of the patient's problems, needs, ins detailed instructions for the established for the patient of careexpect to review, the care plan regularly, when in condition, treatments, and	F6	557	F-658 The care plan regarding was updated for residen The physician was conta and an order clarifying the proper pain medication the resident's level of pawas obtained.	t #37. cted ne for		
F 658 SS=D	& Wilkins 2007 Lip pages 65-77. Services Provided CFR(s): 483.21(b)(§483.21(b)(3) Com	prehensive Care Plans	F€	558	The Care plans for any of Resident who had trigger for Pain were reviewed a updated as necessary. MDSs will be reviewed at morning meeting to ensure	red nd : the		
	as outlined by the omust- (i) Meet profession. This REQUIREMED by: Based on staff into and clinical record the facility staff faile standards of praction the survey sample. The facility staff faile standards of practions are survey sample.	led to clarify two prn (as cation orders for Resident #37.			that any resident that has triggered for pain has the proper non-pharmacolog interventions noted and the care plan has been updated. The QI nurse will perform 10% audit of care plans monthly for 3 months to conclude continuous updated and revisions of care plans. The results of the audit wis submitted to the DON.	ical ichat n a		

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

Event ID: IPQ811

Facility ID: VA0050

If continuation sheet Page 107 of 208



PRINTED: 03/20/2018 FORM APPROVED OMB NO. 0938-0391

MAYLAND NURSING AND REHABILITATION CENTER WAYLAND NURSING AND REHABILITATION CENTER TO SUMMARY STATEMENT OF DEPRECIABLES (PROCESS OF THE APPROPRIATE OF THE APPROPR		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION		MPLETED
WAYLAND NURSING AND REHABILITATION CENTER WAYLAND NURSING AND REHABILITATION CENTER (ACH) DEFICIENCY (REGULATORY OR LSC IDENTIFYING INFORMATION) F 658 Continued From page 107 Resident #37 was admitted to the facility on 3/31/17 and readmitted on 8/1/17 with diagnoses that included but were not limited to heart failure, high blood pressure, diabetes, high cholesterol, Alzheimer's Disease, and dementia Resident #37's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 2/9/16. Resident #37 was coded as being severely cognitively impaired scoring three out of possible 15 on the BIMS (Brief interview for Mental Status) exam. Resident #37's clinical record revealed that he was placed on Hospice Services on 8/11/17. Review of Resident #37's clinical record revealed that he was placed on Hospice Services on 8/11/17. Review of Resident #37's most recent POS (physician order sheet) dated 2/26/18, documented the following orders: 1) "Morphine [1] Sul (sublingual) sol (solution) 100/5 ml (milliliters) under tongue every four hours as needed for pain/shortness of breath." This order was initiated on 9/21/17. Review of Resident #37's February and March 2018 MARS (Medication Administration Records) revealed that Resident #37's February and March 2018 MARS (Medication Administration Records) revealed that Resident #37's February and March 2018 MARS (Medication Administration Records) revealed that Resident #37's February and March 2018 MARS (Medication Administration Records) revealed that Resident #37's February and March 2018 MARS (Medication Administration Records) revealed that Resident #37's February and March 2018 MARS (Medication Administration Records) revealed that Resident #37's received Morphine on the following dates and times:			495226	B. WING			03	/09/2018
FREENT TAG REGULATORY OR ISC IDENTIFYING INFORMATION) F 658 Continued From page 107 Resident #37 was admitted to the facility on 3/31/17 and readmitted on 8/1/17 with diagnoses that included but were not limited to heart failure, high blood pressure, diabetes, high cholesterol, Alzheimer's Diseases, and dementia Resident #37's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 2/8/18. Resident #37 was coded as being severely cognitively impaired scoring three out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #37's clinical record revealed that he was placed on Hospice Services on 8/11/17. Review of Resident #37's clinical record revealed that he was placed on Hospice Services on 8/11/17. Review of Resident #37's most recent POS (physician order sheet) dated 2/28/18, documented the following orders: 1) "Morphine [1] Sul (sublingual) sol (solution) 100/5 ml (millilliters) under tongue every four hours as needed for pain/shortness of breath." This order was initiated on 9/21/17. 2) Tylenol [2] 650 mg sup (suppository) 1 per rectum every four hours as needed for pain/shortness of breath." This order was initiated on 9/21/17. Review of Resident #37's February and March 2018 MARS (Medication Administration Records) revealed that Resident #37 received Morphine on the following dates and times:	Í		HABILITATION CENTER		73	0 LUNENBURG HIGHW		
Resident #37 was admitted to the facility on 3/31/17 and readmitted on 8/1/17 with diagnoses that included but were not limited to heart failure, high blood pressure, diabetes, high cholesterol, Alzheimer's Disease, and dementia Resident #37's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 2/8/18. Resident #37 was coded as being severely cognitively impaired scoring three out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #37 was coded as requiring extensive assistance from one staff member with most ADLS. Review of Resident #37's most recent POS (physician order sheet) dated 2/28/18, documented the following orders: 1) "Morphine [1] Sul (sublingual) sol (solution) 100/5 ml (millilliters) under tongue every four hours as needed for pain/shortness of breath." This order was initiated on 9/21/17. 2) Tylenol [2] 650 mg sup (suppository) 1 per rectum every four hours as needed for pain/shortness of breath." This order was initiated on 9/21/17. Review of Resident #37's February and March 2018 MARS (Medication Administration Records) revealed that Resident #37 received Morphine on the following dates and times:	PREFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETION DATE
identified. The following was documented on the	F 658	Resident #37 was 3/31/17 and readm that included but we high blood pressure Alzheimer's Diseas #37's most recent in assessment was a ARD (assessment Resident #37 was a cognitively impaired 15 on the BIMS (Brexam. Resident #3 extensive assistant most ADLS. Review of Resident that he was placed 8/11/17. Review of Resident (physician order sh documented the following as needed for This order was initiated Review of Resident 2018 MARS (Medic revealed that Resident 2018 MARS (Medic re	admitted to the facility on itted on 8/1/17 with diagnoses ere not limited to heart failure, a, diabetes, high cholesterol, e, and dementia Resident MDS (minimum data set) quarterly assessment with an reference date) of 2/8/18. Coded as being severely discoring three out of possible itel Interview for Mental Status) are from one staff member with the three services on the services of breath. It is also to service of breath and the service of bre		658	compliance the DON will share the results of the audits with the Quality Assurance Performance Improvement (QAPI) Committee on a quarterly basis. If additional issues are noted those issues will be addressed immediatel and corrective action taken.		4/24/18

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495226 B. WING 03/09/2018 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 ΙD (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 658 Continued From page 108 F 658 back of the MAR: "Morphine 0.25 ml; Reason: restlessness and discomfort." A pain level was not documented. 2/11/18 at 06:00. AM or PM could not be identified. The following was documented on the back of the MAR: "Morphine 0.25 ml; Reason: Pain/Anxiety." A pain level was not documented. 2/11/18 at 2:30. AM or PM could not be identified. The following was documented on the back of the MAR. "Morphine 0.25 ml; Reason: Back pain." A pain level was not documented. 3/5/18 at 7:00 p.m. No reason was documented on the back of the MAR to indicate why Morphine was administered. The back of the MAR was blank. There were no nursing notes regarding the administration of Morphine on the above dates. Review of Resident #37's comprehensive care plan dated 4/18/17, failed to evidence a care plan for Pain or Hospice. On 3/6/18 at 2 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 asked about the process followed if a resident

had two prn (as needed) pain medication orders

indication on when to use each medication. LPN #1 stated she would try Tylenol and alternate methods of pain relief first, and then try the stronger medication if the Tylenol or alternate method (non-pharmacological interventions) were ineffective. LPN #1 stated it would also depend on her assessment. LPN #1 stated she wasn't going to administer Tylenol first to a resident who

(Tylenol and Morphine), but there was no

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING _ B. WING 495226 03/09/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION OATE SUMMARY STATEMENT OF DEFICIENCIES 1D (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 658 Continued From page 109 F 658 has a pain of 10. When asked at what point (on a scale from 1-10) would she administer the Morphine over the Tylenol, LPN #1 stated, "That is a tough call." LPN #1 stated pain tolerance was different from person to person. When asked if nurses can administer pain medication at their discretion, LPN #1 stated she would probably have to call the physician to clarify the order. On 3/8/18 at 8:37 a.m., an interview was conducted with LPN (licensed practical nurse) #3, Resident #37's nurse. LPN #3 was asked about the process followed if a resident had two prn (as needed) pain medication orders (Tylenol and Morphine), but there was no indication on when to use each medication. LPN #3 stated she would usually give the Tylenol first and then go to the Morphine if the Tylenol was not effective. When asked if nurses were able to determine what medication to administer at their discretion, LPN #3 stated that she would think so.

03/8/18 at 12:35 p.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). ASM #2 stated nursing was able to make a nursing judgment based on their pain assessment and determine which pain medication to use for relief. ASM #2 stated her staff have never had to clarify pain medication orders before.

On 3/8/18 at 5:12 p.m., ASM (administrative staff member) #1, the administrator and ASM #2 the DON (Director of Nursing) were made aware of the above concerns. ASM #2 stated that they use Lippincott as a professional standard of practice.

[1] Morphine is indicated for the management of

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STATEMENT OF DEF AND PLAN OF CORR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION		MPLETED
		495226	B. WING		· · · -	03	3/09/2018
NAME OF PROVIDE		HABILITATION CENTER		730 L	ET ADDRESS, CITY, STATE, ZIP CODE .UNENBURG HIGHW SVILLE, VA 23947		
	EACH DEFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
acute an optreatm obtain https: m?se [2] Ty Treat fever. Natio https: T000; F 659 SS=D CFR(§483. The s as ou must-(ii) Be accor care. This f by: Base docur was conly cone oo Resid	ploid analgesic ments are inact med from The cl/dailymed.nlr ctid=3f3a870e- denol Tablet 3: s minor aches . This informational Institutes of cl/www.ncbi.nlr 8785/?report= fied Persons s): 483.21(b)(.21(b)(3) Compartices provided tilined by the of cervices provided by of dance with earlier and the exprovided by of dance with earlier and the qualified staff of f 28 residents lent #8.	cain severe enough to require and for which alternative dequate. This information was National Institutes of Health. In. nih.gov/dailymed/drugInfo.cf-f325-475b-8453-fe3d1bb8f54. 25 mg (Acetaminophen)-and pains and also reduces ation was obtained from The of Health. In. nih.gov/pubmedhealth/PMH details. 3)(ii) prehensive Care Plans ded or arranged by the facility, comprehensive care plan, and resident's written plan of NT is not met as evidenced tion, staff interview, facility and clinical record review, it a facility staff failed to ensure administered tube feedings for in the survey sample, and the feeding from the feeding 8.	F	559	F-659 The C.N.A who removed resident #8's feeding tube of the CNA responsibilities related to residents with a feeding tube. No other residents were found to be affected by this deficient practice.	oe.	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		495226	B. WING		. <u>-</u>	03/	09/2018
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		730	REET ADDRESS, CITY, STATE, ZIP CODE D LUNENBURG HIGHW CYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 659	Resident #8 was and 12/11/12 with a recumith diagnoses that to: Alzheimer's disedisorder, diabetes, and history of subdisorder diabetes, and history of subdisorder diabetes, and history of subdisorder diabetes. The most recent M assessment, a quassessment references as having memory difficulties, being severely imported decisions. Resident dependent upon on all of her activities of Swallowing/Nutrition coded as receiving feeding tube. The physician orde "Diabetisource (nut specific for diabetic (milliliters per hour) inserted through the Observation was many 1/8/18 at 8:45 a.m. room. The tube feed on the pole next to tubing, the tip that is was not visible to the An interview was conursing assistant) # When asked where stated she had just	dmitted to the facility on ent readmission on 11/6/17, included but were not limited ease, mood disorder, anxiety stroke, high blood pressure, ural hematoma (a collection of mater in the brain) (1). DS (minimum data set) rterly assessment, with an noce date of 12/7/17, coded the both short and long-term. The resident was coded as eared to make daily cognitive it #8 was coded as being the or more staff members for of daily living. In Section Kinal Status, the resident was all of her nutrition through a residents) (2) @ (at) 40 ml/hr via Peg tube (a feeding tube e abdominal wall). ade of Resident #8's room on The resident was not in the eding was observed hanging the bed. The end of the sconnected to the resident,	Fé	559	Nursing staff were RE-educated regarding the proper procedure for the removal and insertion of feeding tubes and the proper scope of their practice — including responsibilities of licensed vs. non-licensed personnel. Residents who have feeding tubes will be monitored on a 5 days for 1 week then weekly for 4 weeks by the DON or her designee to determine proper placement and removal of feeding tubes. The results of the monitoring will be documented and submitted to the DON. To maintain continued compliance the DON will share the results of the audits with the Quality Assurance Performance Improvement (QAPI) Committee on a quarterly basis. If additional issues are noted those issues will be addressed immediately and corrective action taken.		The state of the s

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
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feeding from the resc CNA#3 stated, "The it." When asked if s to take care of a fee "No, Ma'am." CNA# of the tubing with the pulled the tubing out when asked why it uncovered in the beinfection control issued in the practical nurse) #2 casked if a CNA is alfeeding, LPN #2 stated to touch a tube feed was shared with LP change the entire seed was shared with LP change the entire seed and revised on 12/1 "Focus: At risk for seed body requirement of intake, decreased a therapeutic diets, condepression." The "Ir part, "Diet as ordere hour via peg tube." An interview was constaff member (ASM) on 3/8/18 at 12:35 ped disconnect a resider #2 stated, "No."	sident, CNA #3 stated, "I did." e nurses show us how to do he had been trained in school eding tube, CNA #3 stated, #3 was asked where the end e tip was located; CNA #3 t from under the covers. is not good to have the tubing ed, CNA #3 stated, "It's an ue." Inducted with LPN (licensed on 3/8/18 at 8:52 a.m. When lowed to disconnect a tube sted, "Never. They are never ling." The above observation N #2, who then proceeded to et up of tube feeding. It care plan dated, 10/30/16 9/17, documented in part, tate of nourishment: less than haracterized by inadequate ppetite related to: being on a lognitive impairment enterventions" documented in ed (Diabetisource) @ 40cc per linducted with administrative of the director of nursing, e.m. When asked if a CNA can enter from a tube feeding, ASM escription for a CNA did not	F	659			
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa feeding from the res CNA#3 stated, "The it." When asked if s to take care of a fee "No, Ma'am." CNA# of the tubing with th pulled the tubing ou When asked why it uncovered in the be infection control isse An interview was co practical nurse) #2 a sked if a CNA is al feeding, LPN #2 state to touch a tube feed was shared with LP change the entire se The comprehensive and revised on 12/1 "Focus: At risk for s body requirement of intake, decreased a therapeutic diets, co depression." The "In part, "Diet as ordere hour via peg tube." An interview was co staff member (ASM on 3/8/18 at 12:35 p disconnect a resider #2 stated, "No."	PROVIDER OR SUPPLIER ID NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 112 feeding from the resident, CNA #3 stated, "I did." CNA #3 stated, "The nurses show us how to do it." When asked if she had been trained in school to take care of a feeding tube, CNA #3 stated, "No, Ma'am." CNA #3 was asked where the end of the tubing with the tip was located; CNA #3 pulled the tubing out from under the covers. When asked why it is not good to have the tubing uncovered in the bed, CNA #3 stated, "It's an infection control issue." An interview was conducted with LPN (licensed practical nurse) #2 on 3/8/18 at 8:52 a.m. When asked if a CNA is allowed to disconnect a tube feeding, LPN #2 stated, "Never. They are never to touch a tube feeding." The above observation was shared with LPN #2, who then proceeded to change the entire set up of tube feeding. The comprehensive care plan dated, 10/30/16 and revised on 12/19/17, documented in part, "Focus: At risk for state of nourishment: less than body requirement characterized by inadequate intake, decreased appetite related to: being on a therapeutic diets, cognitive impairment depression." The "Interventions" documented in part, "Diet as ordered (Diabetisource) @ 40cc per hour via peg tube." An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 3/8/18 at 12:35 p.m. When asked if a CNA can disconnect a resident from a tube feeding, ASM	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 112 feeding from the resident, CNA#3 stated, "I did." CNA#3 stated, "The nurses show us how to do it." When asked if she had been trained in school to take care of a feeding tube, CNA#3 stated, "No, Ma'am." CNA#3 was asked where the end of the tubing with the tip was located; CNA#3 pulled the tubing out from under the covers. When asked why it is not good to have the tubing uncovered in the bed, CNA#3 stated, "It's an infection control issue." 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WING STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) WISE BE PRECEIVED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 112 feeding from the resident, CNA #3 stated, "I did." CNA #3 stated, "The nurses show us how to do it." When asked if she had been trained in school to take care of a feeding tube, CNA #3 stated, "No, Ma'am." CNA #3 was asked where the end of the tubing out from under the covers. When asked why it is not good to have the tubing uncovered in the bed, CNA #3 stated, "It's an infection control issue." An interview was conducted with LPN (licensed practical nurse) #2 on 3/8/18 at 8:52 a.m. When asked if a CNA is allowed to disconnect a tube feeding, LPN #2 stated, "Never. They are never to touch a tube feeding." The above observation was shared with LPN #2, who then proceeded to change the entire set up of tube feeding. 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F 659 F 684 SS=D	The administrator a were made aware of at 5:10 p.m. (1) Barron's Diction Non-Medical Reade Chapman, page 26 (2) This information following website: https://www.allegronts-c522/enteral-fee 2f688a20012f6abe: Quality of Care CFR(s): 483.25 § 483.25 Quality of Quality of Quality of care is a applies to all treatm facility residents. Bassessment of a rethat residents receivaccordance with propractice, the compression and the rational clinical record in the ensure residents services in accordas standards of practice care plan for three sample, Resident #	and the director of nursing of the above findings on 3/8/18 ary of Medical Terms for the er, 5th edition, Rothenberg and 5 and 549. It was obtained from the medical.com/dietary-suppleme eding-diabetisource-xff808181767b4d0c\$4050.html care fundamental principle that tent and care provided to eased on the comprehensive sident, the facility must ensure we treatment and care in ofessional standards of ehensive person-centered residents' choices. NT is not met as evidenced review, facility document review review, the facility staff failed received treatment and nce with professional ce and the comprehensive of 28 residents in the survey 43, #13 and #40. Failed to notify the MD (medical	F6	F-684 The physician was notifi	the the t#13. The n for nts agars, b d lab ays OT No und to		
		n's order when Resident evels [1] were over 400 on		practice.			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			TE SURVEY MPLETED
		495226	B. WING			03	/09/2018
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 684	three occasions in 2a. The facility staff order and compreh obtain Resident #1 arm. 2b. The facility staff #13's weight every physician. 3. The facility staff laboratory specime for Resident #40. The findings includ 1. The facility staff doctor when the Relevels [1] were over March of 2018. Resident #43 was a 1/31/18 with diagnoral limited to unspecified in the diagnoral limited to unspecified in the data set scheduled assessment refere Resident #43 was a intact in the ability the 13 out of 15 on the Mental Status) exa as requiring extensioner staff with transextensive assistant dressing and personal resident and personal re	March. If failed to follow the physician's ensive care plan to not to 3's blood pressure in the left If failed to obtain Resident two weeks as ordered by the failed to obtain weekly as ordered by the physician e: If ailed to notify the medical esident #43's blood sugar 400 on three occasions in the ded psychosis, type two hypothyroidism and high esident #43's most recent MDS assessment was a 14-day			Physician orders will be reviewed at the morning meetings by the IDT and charts will be updated at the time in PCC to ensure that orders are followed properlored order changes and Physicianotifications will be documented and all parties notified. Copies of updates and minutes of the meeting will be kept by the administrator. The results of the minutes a compliance will be submitted to the Facility's QA Commitmonthly for three months then quarterly for review and guidance.	y n s and ed tee	The Table

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER D NURSING AND RE	HABILITATION CENTER		730	REET ADDRESS, CITY, STATE, ZIP CODE D LUNENBURG HIGHW EYSVILLE, VA 23947		
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	(physician order sur documented the fol + HS (before meals Humalog Insulin [2] BS (blood sugar): BS 201-250= 4 unit BS 251-300= 6 unit BS 351-400= 10 un BS 401 or greater = Review of Resident (Medication Adminis Resident #43 had B following dates and 3/3/18 at 5:00 p.m., at 9:00 p.m., blood sugar w Further review of th March nursing note: physician was notificated with LPN a nurse who frequent When asked what the for insulin meant, LF administer the 12 unif the resident's blood asked why the docto LPN #3 stated the dadditional units of in checks. When asked would be document	t #43's most recent POS mmary) dated 2/2018 lowing order: "Accucheck AC s and hours of sleep) with s s s s s s s s s s s s s s s s s s s	F				
1	record, LPN #3 state	ed it should be documented in		İ			!

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ 495226 B. WING 03/09/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 684 Continued From page 116 F 684 a nursing note. When asked if nurses would notify the physician every time a blood sugar reading was over 400, LPN #3 stated, "They wouldn't necessarily." LPN #3 stated, "Most of the orders say to notify if 400 or over, but the physician has said in the past to not call them unless it's over 500." LPN #3 then consulted with RN (registered nurse) #2 and asked about an order clarification. LPN #3 was asked if the current physician order was being followed if there is no evidence of physician notification. LPN #3 stated, "No." LPN #3 stated that nurses did have a communication book with the physician that documented any concerns. LPN #3 presented this book for review and the blood sugars above 400 for Resident #43 were not documented in the book. LPN #3 stated there was a chance the MD (medical doctor)/NP (nurse practitioner) were made aware verbally but there was no documentation. LPN #3 stated, "There is usually someone in-house guite a bit." LPN #3 stated that Resident #43's blood sugars were always within normal limits for her. On 3/8/18 at 3:28 p.m., an interview was conducted with ASM (administrative staff member) #4, Resident #43's physician. ASM #4 could not recall being made aware of the above instances where Resident #43's blood sugars were elevated. ASM #4 stated that he would expect nursing staff to contact him or the NP.

are over 500.

ASM #4 stated he would want to know when "things are out of control." ASM #4 could not recall telling staff to call him only if blood sugars

On 3/08/18 at 5:12 p.m., the above concerns were addressed with ASM (administrative staff member) #1, the administrator and ASM #2, the

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		73	REET ADDRESS, CITY, STATE, ZIP CODE 0 LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	DON (Director of Notes of the facility policy disconcerns.) No further information in "Fundamentals of Patricia A. Potter articia A. Pott	on was presented prior to exit. If Nursing" 6th edition, 2005; and Anne Griffin Perry; Mosby, e physician is responsible for eatment. Nurses are 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." els are the sugars in the blood a source of energy. When the rises, for instance after a secretes insulin. Insulin eam and transports these	F	684			
	information was obt Institutes of Health. https://medlineplus. Normal blood sugar have diabetes are 7 than 180 2 hours af	gov/hyperglycemia.html. levels for people who do not 0-130 before meals and less ter meals. This information					

		AND HUMAN SERVICES & MEDICAID SERVICES					APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l '		E CONSTRUCTION		E SURVEY IPLETED
		495226	B. WING			03/	09/2018
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F 684	Health. https://www.ncbi.nlr T0024698/ [2] Humalog insulin helps turn sugar ing we eat into energy information was obt Institutes of Health. https://www.ncbi.nlr T0010736/?report= 2a. The facility staff order and comprehe obtain Resident #13 arm. Resident #41 was a 6/21/16 with diagno limited to: Parkinson pressure and fractu Review of the most set) dated 1/17/18, ARD (assessment r coded the resident a 15 on the BIMS (bri indicating the reside cognitively. The reside cognitively. The reside assistance for all ac for eating which the the tray was set up.	is a fast acting insulin that gested from the food and drink used by the body. This rained from The National m.nih.gov/pubmedhealth/PMH details failed to follow the physician's ensive care plan to not to b's blood pressure in the left admitted to the facility on ses that included but were not n's disease, high blood red hip. recent MDS (minimum data a 30 day assessment, with an reference date) of 1/17/18 as having scored a six out of the finterview for mental status) ent was severely impaired ident was coded as requiring civities of daily living except resident could perform after	F	684			

Review of the March 2018 physician's orders documented, "No B/P in Left arm."

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION		E SURVEY PLETED
		495226	B. WING	· <u> </u>		03/	09/2018
	PROVIDER OR SUPPLIER ID NURSING AND REI	HABILITATION CENTER		7	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	Continued From pa	ige 119	Ff	684			
	Review of the Marc administration reco BP in Left arm. FYI.	rd (MAR) documented, "No					
	from September 20 documented that th	hts and vitals summary sheet 017 to March 2018 he resident's blood pressure her left arm on 30 occasions.					
	p.m. with (licensed When asked why R order and a care plain the left arm, LPN resident had had a leviewed the weight and stated, "Oh." Wresident's vital signs my own." When ask	practical nurse) LPN #2. Resident #13 had a physician's an not to take blood pressures #2 stated because the left mastectomy. LPN #2 ts and vital summary sheet //hen asked who took the s, LPN #2 stated, "I always do ked if staff were following the LPN #2 stated they were not.					
	member) #1, the ad	.m. ASM (administrative staff dministrator and ASM #2, the were made aware of the					
	No further information	on was provided prior to exit.					
	2b. The facility staff #13's weight every t physician.	failed to obtain Resident two weeks as ordered by the					
		ent's care plan did not attaction addressing the weights.				•	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG			E SURVEY PLETED
		495226	B. WING_			03/0	09/2018
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP OF 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	ODE		
(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 (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD	BE	(X5) COMPLETION OATE
F 684	Review of the Septe 2018 physician's on EVERY 2 WEEKS.' date for the order down defended and inistration reconsists and the Review of the Weight from 9/25/17 to 2/1/documented on the Review of the weight from 9/25/17 to 2/1/documented that the taken on 9/25/17, 10 An interview was coa.m. with LPN #1. Vexpected to follow the stated, "Yes." When followed if they were physician's order, "It the MD (medical down review Resident #13 sheet for the resider "It doesn't look like weights]) every two obtained the weight aide." When asked #1 stated the nurses physician's order has stated it had not. On 3/8/18 at 5:15 p. member) #1, the addirector of nursing we findings.	ember 2017 through March ders documented, "WEIGHT 'There was no original start ocumented. h 2018 MAR (medication rd) documented, "WEIGHT 'There were no weights	F 68	84			

	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		CONSTRUCTION		E SURVEY MPLETED
		495226	B. WING			03/	/09/2018
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		730	EET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW YSVILLE, VA 23947		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION OATE
F 684	Continued From partial laboratory specime for Resident #40 was a 3/16/17 with diagnor limited to: leukemia dementia, irregular pressure. The most recent M with an ARD of 2/2 having scored a two indicating the reside impaired. The reside impaired. The reside assistance for all additional residence of the care laboratory specime. Review of the Marce documented, "LAB (complete blood concepted blood concepted blood concepted blood concepted." To (Nar HEMATOLOGY." To documented. On 3/8/18 at 3:00 pthe original dated COSM (other staff m staff.	age 121 and as ordered by the physician admitted to the facility on oses that included but were not a, Alzheimer's disease, heart beat and high blood DS, an annual assessment, 1/18 coded the resident as o out of 15 on the BIMS ent was severely cognitively dent was coded as requiring ctivities of daily living. plan did not address the ns. ch 2018 physician's orders (laboratory tests): CBC unt) [1] WKLY (weekly) & FAX		684	DEFICIENCY)		
	physician's orders of	ary 2018 and February 2018 documented, "LAB: CBC unt) [1] WKLY (weekly) & FAX ne of hospital)					

FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION		E SURVEY PLETED
		495226	B. WING			03/	09/2018
	PROVIDER OR SUPPLIER ID 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 MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION OATE
F 684	A request was made ASM #2, the directoresident's CBC laboratory repland 2/12/18 to this value laboratory speciment ASM #2 stated, "The ASM #2 was shown 2018 physician's one know about that." At the findings at that the findings at the find	e on 3/8/18 at 5:15 p.m. of or of nursing, for a copy of the oratory results. .m., ASM#2 provided three orts dated, 12/14/17, 1/15/18 writer. When asked why the ns were not collected weekly, ere wasn't an order for it." the order from the March ders. ASM #2 stated, "I didn't SM #2 was made aware of time. Inducted on 3/9/18 at 11:15 When asked about the process ain laboratory specimens, is a routine lab (laboratory it up on a lab slip." When aboratory specimens were eated, "We used to be able to er, but we can't do that now." Intered the laboratory orders stated, "At one point the rector of nursing) was doing by staff would know if a n had not been done as ated, "Hard to know." When sident #40's order for the 4 stated, she was getting was on an oral chemotherapy	F 6	684	DEFICIENCY)		
	1. CBC - Your blood (RBC), white blood	contains red blood cells cells (WBC), and platelets.					

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Event ID: IPQ811

Facility ID: VA0050

If continuation sheet Page 123 of 208

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l.' '	TIPLE CONSTRUCTION UNG		E SURVEY IPLETED
		495226	B. WING		03/	09/2018
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION OATE
F 686 SS=D	of cells in your blood on your overall head diagnose diseases anemia, infections, cancers, and immutypes include tests and types of RBC in numbers and types. Platelets - the num Hemoglobin - an irrocells that carries ox space red blood cells that carries ox space red blood cells are in your blood Mean corpuscular size of your red blocount (CBC) included CBC is one of their information was obhttps://medlineplus. Treatment/Svcs to CFR(s): 483.25(b) (1) Pres Based on the compresident, the facility (i) A resident receive professional standard pressure ulcers and ulcers unless the indemonstrates that (ii) A resident with professional standard pressure ulcers and ulcers unless the indemonstrates that (iii) A resident with professional standard pressure ulcers and ulcers unless the indemonstrates that (iii) A resident with professional standard pressure ulcers and ulcers unless the indemonstrates that (iii) A resident with professional standard pressure ulcers and ulcers unless the indemonstrates that (iii) A resident with professional standard pressure ulcers and ulcers unless the indemonstrates that (iii) A resident with professional standard pressure ulcers and ulcers from deling, promote healing, promote healing, promote healing, promote from deling pressure ulcers from de	d. This helps doctor's check lth. The tests can also help to and conditions such as clotting problems, blood ne system disorders. Specific for ·RBC - the numbers, size, in the blood ·WBC - the of WBC in the blood abers and size of the platelets on-rich protein in red blood aggen · Hematocrit - how much alls take up in your blood volume (MCV) - the average od cells. The complete blood es most or all of these. The most common blood tests. This tained from agov/bloodcounttests.html Prevent/Hea! Pressure Ulcer 1)(i)(ii) regrity sure ulcers. In the protein in red blood tests are care, consistent with ards of practice, to prevent does not develop pressure advidual's clinical condition they were unavoidable; and pressure ulcers receives and services, consistent trandards of practice, to revent infection and prevent		F-686 Residents with wo treatment orders potential to be aff alleged deficient particular and the DON to assess status of wounds, with negative find addressed immed corrective action. The nurses provide treatment were in proper bandage of infection control by the Director of the desired treatment were in the proper bandage of the desired treatment were in the proper bandage of the desired treatment were in the proper bandage of the desired treatment were in the desired treatment were in the proper bandage of the desired treatment were in t	have the fected by the practice. pleted by courrent any wounds lings were liately and was taken. ling n-serviced on change and procedures	

PRINTED: U3/2U/2U18 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION			COMPLETED			
		495226	B. WING		<u>-</u>	03/	/09/2018
	PROVIDER OR SUPPLIER	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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION OATE
F 686	by: Based on observator document review a was determined the wound care in a management of survey sample, Referenced by the physical streament for a presordered by the physical streament in factor of the provided in the stuffed into his coast of the practical nurse of the practical nu	ation, staff interview, facility and clinical record review, it e facility staff failed to provide anner to promote healing of a or three of 28 residents in the esidents #5, # 45 and #13. aff failed to change the issure wound every day as esician for Resident #5. aff failed to administer the essure ulcer in a manner to promote healing ion. ASM (administrative staff ADON (Assistant Director of erved touching gauze used for sing Resident #45's wound with dialso used gloves to perform the took from the glove box and at pocket. failed to administer a wound oner to promote healing and or Resident #13. LPN (licensed in failed to change gloves yound care to Resident #13 te items, the bed controls, side to resident with her gloved	F	386	The Director of Nursing or he designee will observe wound Care weekly for 4 weeks ther monthly thereafter on residents being provided care to ensure that proper procedures and infection control procedures are being followed. The results of the observations will be shared with the Administrator weekly. To maintain continued compliance the DON will share the results of the audit with the Quality Assurance Performance Improvement (QAPI) Committee on a quarterly basis. If additional issues are noted those issues will be addressed immediate and corrective action taken.	ts	2/1/2/2

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		OATE SURVEY OMPLETED
		495226	B. WING		· · · · · · · · · · · · · · · · · · ·		3/09/2018
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		73	REET ADDRESS, CITY, STATE, ZIP COD 0 LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION OATE
F 686	with diagnoses that to: cancer of the lef abuse, Alzheimer's peripheral vascular condition affecting I heart) (1), absence amputation. The most recent MI assessment, an anassessment referer the resident as scorinterview for mental was severely impaired decisions. In Section resident was not coulcer. A significant progress at the time. Observation was m LPN (licensed practivound care for Resto gather her supplieft foot. The dress observed dated 3/5,	included but were not limited to lung, dementia, alcohol disease, high blood pressure, disease (any abnormal blood vessels outside the of toes on left foot due to DS (minimum data set) mual assessment, with an nice date of 12/19/18, coded ring a zero on the BIMS (brief I status) score, indicating he red to make daily cognitive in M - Skin Conditions, the ded as having a pressure change assessment was in	F	586			
	The physician order "Clean wound L (lef Santyl ointment, cov	dated 2/12/18, documented, t) foot with Hibiclens*, apply ver w/ (with) NAD		-			
	*Hibiclens is an anti used in cleansing of The TAR (treatment	sing) daily until healed." septic antibacterial agent f the skin (2). administration record) for ented, "Hibiclens Liq (liquid) -				,	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ B. WING 495226 03/09/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION . (X5) COMPLETION iD (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 686 Continued From page 126 F 686 clean wound left foot w/ hibiclens. Apply Santyl oint (ointment), cover w/ NAD (non-adhesive dressing) daily until healed." The TAR documented the wound was not signed off as completed on 3/2/18 and 3/6/18. The "Norton Scale for Predicting Risk of Pressure Ulcer" dated 2/25/18; documented in part, based on the scale was deemed to be at "High Risk" for developing pressure ulcers. The comprehensive care plan dated, 2/15/18. documented in part, "Focus: Ulceration or interference with structural integrity of layers of skin caused by prolonged pressure related to: nutritional deficit, non-compliant (left foot) and left buttock." The "Interventions" documented in part, "Treatment as ordered by physician." The "Wound Ulcer Flowsheet" dated, 2/28/18, documented in part, "Left lateral foot. Length -1.5; width - 1.5; depth - 0.2." All measurements were in centimeters. The wound was staged at "Unstageable*."

*Unstageable Pressure Injury: Obscured

Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. (3)

An interview was conducted with LPN #4 on 3/7/18 at 2:28 p.m. When asked if a dressing is ordered every day, should it be done every day.

full-thickness skin and tissue loss

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		495226	B. WING			03/	09/2018
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		730	EET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW YSVILLE, VA 23947		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	LPN #1 stated, "At can happen to a w done as ordered, L	age 127 psplutely." When asked what pound if the treatments are not PN #4 stated, "It can become to it to breakdown faster."	F 6	86	•		
	3/8/18 at 9:58 a.m. treatments, LPN #' (Name of LPN #4), extra." When aske an order for daily d stated, "Change it can't get to it, then ADON (assistant d When asked if the the physician order asked about the pr	onducted with LPN #1, on When asked who does the 1 stated, "Recently it's been then it's the nurse who is d what staff do when there is ressing changes, LPN #1 daily." LPN #1 stated, "If I I should ask the next shift or irector of nursing) for help." nurses are supposed to follow rs, LPN #1 stated, "Yes." When ocess staff follow when they der, LPN #1 stated, "You notify					
	staff member (ASM nursing, on 3/8/18 does treatments, A nurse does them. It there is no treatments tated, "Then I show he was on the med shift, ASM #3 state staff do if they can't stated, "You should When asked if he they didn't complete the ASM #3 stated, "Not the nurse should do ASM #3 stated, "In	onducted with administrative (1) #3, the assistant director of at 1:38 p.m. When asked who SM #3 stated the treatment (1) When asked who does them if nt nurse available, ASM #3 and be doing it." When asked if the iteration cart on 3/6/18 for day (1) "Yes, I was." When asked if the treatments, ASM #3 and the next nurse know." (1) old the next shift nurse he resident treatments on 3/6/18, and the dressings as ordered, order to keep them as healthy not doing the dressing it can of deteriorate."					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING R WING 495226 03/09/2018 STREET ADDRESS, CITY, STATE, ZIP CDDE NAME OF PROVIDER OR SUPPLIER 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 PROVIDER'S PLAN DF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) 1D (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 686 F 686 | Continued From page 128 The facility policies, "Dressings - Clean" and "Wound/Ulcer Treatment" did not address following the physician orders for wound care. The administrator and the director of nursing were made aware of the above findings on 3/8/18 at 5:10 p.m. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 447. (2) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH T0009564/?report=details. (3) This information was obtained from the following website: http://www.npuap.org/resources/educational-andclinical-resources/npuap-pressure-injury-stages/ 1. b. The facility staff failed to administer the treatment for a pressure ulcer in a manner to promote healing for Resident #5. Observation was made of LPN #4 performing the wound care for Resident #5's left foot on 3/7/18 at

2:04 p.m. LPN #4 gathered her supplies. She pulled her scissors out of her pocket and put them on her clean field. She cut the bandage that was on Resident #5's left foot wound off with her scissors and removed the old dressing, which was dated 3/5/18. LPN #4 proceeded to wipe the wound with the Hibiclens liquid. She wiped from the inside out and then went down the sides of the wound and back to the center of the wound. The second time she wiped the wound she went from the center out and discarded her gauze pad.

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		E SURVEY (PLETED
		495226	B. WING			03/	09/2018
	PROVIDER OR SUPPLIER ND NURSING AND RE	HABILITATION CENTER		730	REET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW YSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 OATE
F 686	the wound. She the treatment to the rest taken off the dressi cleaned the wound #4 proceeded to me (centimeters). She stage 3 pressure ul a stage three LPN # slough in the wound hands, put on new which was clipped to scrubs, and wrote of #4 then proceeded prescribed dressing her hands and her so when asked the proceeded prescribed dressing her hands and her so when asked if she was transed, "I guess it reasked if she was transed another nurse assessments." *Stage 3 Pressure I Full-thickness loss of is visible in the ulce epibole (rolled wounds visible in the ulce epibole (rolled wounds of tissue damage vas areas of significant wounds. Underminity Fascia, muscle, tendand/or bone are not obscures the extent Unstageable Pressure.	to administer the treatment to en went on to administer the sident's left buttock. She had ng left buttock wound and per the physician order. LPN easure the wound, 1.0 x .7 cm stated that the wound was a cer*. When asked why it was 44 stated there was now 4. She then washed her gloves. She took the pen, of the neck opening of her lown the measurements. LPN to apply the physician and LPN #4 proceeded to wash ecissors with soap and water. Deferred method of cleaning dressing change, LPN #4 cally should be alcohol." When ained to be the treatment ed, "A while back, I oriented eatment nurse but then they but she's now doing MDS of skin, in which adipose (fat) or and granulation tissue and and edges) are often present. For any be visible. The depth aries by anatomical location; adiposity can develop deep ing and tunneling may occur. I gament, cartilage exposed. If slough or eschar of tissue loss this is an	F	586			

FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′		CONSTRUCTION	COMPLETED		
		495226	B. WING			03/0	09/2018	
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		73	REET ADDRESS, CITY, STATE, ZIP CODE 0 LUNENBURG HIGHW EYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTID (EACH CDRRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION OATE	
F 686	3/7/18 at 2:28 p.m. should clean a wou from the inside out, gauze." The above the wound was sha asked when scissos stated, "After we us was in her pocket, I paused and then st before the treatmer preferred, soap and stated, "It's probable." The facility policy, "documented in particleaning an area, or cleaning is needed 4 x 4 (gauze pad). I "When cleaning, be least-contaminated most-contaminated wound, such as an to bottom in one mowound and moving such as a pressure concentric circles, a wound and moving gauze pad each time Discard the gauze prepeat the procedurentire wound. Dry to pads, using the sam Discard the used gate (2)	When asked how a nurse nd, LPN #4 stated, "You start then you discard the dirty observation of her cleansing red with LPN #4. When rs should be cleaned, LPN #4 te them." When asked what LPN #4 stated, "Pens." She ated, "I should wash them nt." When asked what is divater versus alcohol, LPN #4 by be alcohol." DRESSINGS - CLEAN", "8. Cleanse wound. When lean from the inside out." If again, then use another clean NEVER reuse the same one."	F	886				
	Conference on Nos							

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

Event ID: IPQ811

Facility ID: VA0050

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	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION		OATE SURVEY COMPLETED
		495226	B. WING			03/09/2018
***	PROVIDER OR SUPPLIER	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 PREFII TAG		OTION SHOULD BE OTHE APPROPRIATE	IX5I COMPLETION OATE
F 686	showed that ordinar patients sick. In one study, a resenurses and physicia well as communal sand tables. Three-qmicroorganisms, indaureus, Groups A agram-negative bacil If health care worke alcohol after each uthe risk of transmiss study, contaminated disinfected after swalcohol. (3) The administrator amade aware of the state o	ry items can make your parcher gathered scissors that ans kept in their pockets, as acissors left on dressing carts uarters of the scissors carried cluding Staphylococcus and B streptococcus, and li. The solution is quite simple. Ars swab the scissors with se, they will virtually eliminate sion of microorganisms. In the discissors were effectively abbing the scissors with and director of nursing were above findings on 3/8/18 at on was provided prior to exit. was obtained from the ag/resources/educational-and- ouap-pressure-injury-stages/ f Nursing Made Incredibly lliams & Wilkins, 2007, page B, McLeod J, et al. Scissors a of nosocomial infection? a Decennial International	F 6	286		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY PLETED
		495226	B. WING			03/	09/2018
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 80 LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION OATE
F 686	#45's wound care in and prevent infection member) #3, the All Nursing) was obser cleaning and dress his bare hands and wound care that he stuffed into his coard Resident #45 was a 2/5/18 with diagnos limited to Stage 4 p blood pressure, mu of urine. Resident (minimum data set) scheduled assessman reference date) of 2 coded as being mo function scoring a SBIMS (Brief Intervier Resident #45 was a cassistance from two and bed mobility; extaff member with a cassistance from two and total dependent Resident #45 was a Conditions) of the Natage 4 pressure used mission. Review of Resident care orders docume 2/5/18: "Cleanse W daily with sterile salin the wound twice apply wet to dry dresser and dresser apply wet to dry dresser and dresser apply wet to dry dresser and dresser and total dresser and the wound twice apply wet to dry dresser and previous and the wound twice apply wet to dry dresser and previous and the wound twice apply wet to dry dresser and previous and previ	n a manner to promote healing on. ASM (administrative staff DON (Assistant Director of wed touching gauze used for ing Resident #45's wound with also used gloves to perform took from the glove box and	F	586			

	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUL A. BUILO	TIPLE CONSTRUCTION		(X3) OATE SURVEY COMPLETEO	
		495226	B. WING			03/09/2018	
	PROVIOER OR SUPPLIER	HABILITATION CENTER		STREET AOORESS, CITY, STATE, Z 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	IP COOE		
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG		TION SHOULO BE THE APPROPRIATE	(X5) COMPLETION OATE	
F 686	On 3/8/18 at 10:58 observation was co ADON (Assistant I first took a wad of stuffed them in his with his bare hands package, taking outhen placed the gadirectly on top of the administration reco ASM #3 carried the with his bare hands clean field in the result of the clean field. He began to remove the washed his hands part of his wad of gused the gauze that hands to clean the saline. ASM #3 the placed on gloves, santyl and rubbed ithe wound first; and the wound bed using them threw out the washed his hands, room to grab additionable to grab addition	a.m., a wound care onducted with ASM #3 the Director of Nursing). ASM #3 gloves from the glove box and coat pocket. ASM #3 then is, reached into the gauze at a stack of gauze. ASM #3 uze onto the medication cart be opened TAR (treatment ord). On 3/8/18 at 11:05 a.m., a stack of gauze and santyl is and placed them onto the isident's room. On 3/08/18 at 3 put on gloves (from his at 11:15 a.m., ASM #3 took his pocket and put them on then placed gloves on and the old dressing. ASM #3 then and put on gloves that were gloves. At 11:16 a.m., ASM #3 then and put on gloves that were gloves. At 11:16 a.m., ASM #3 then and put on gloves that were gloves. At 11:16 a.m., ASM #3 then and put on gloves that were gloves. At 11:16 a.m., ASM #3 then and put on gloves that were gloves. At 11:16 a.m., ASM #3 at the had touched with his bare wound along with normal and and secured his gloves, and went out of the resident's onal gloves. On 3/8/18 at 3 put on clean gloves and then 45's wound with the get. This gauze was part of the had touched with his bare an placed the ABD (abdominal and and secured the dressing.	F 6	586			

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING_ B. WING 495226 03/09/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 686 | Continued From page 134 F 686 On 3/8/18 at 1:33 p.m., an interview was conducted with ASM #3. When asked how to

gloves."

used to clean the wound.

the above concerns.

maintain infection control during wound care, ASM #3 stated that he would wash hands and remove gloves after he removed the old dressing and started to clean the wound. ASM #3 stated he would wash his hands again and put on new gloves before applying the clean (new) dressing. When asked if he currently has any items in his pocket, ASM #3 stated no. When asked if gloves he was going to use for a dressing change should ever be placed in his pocket; ASM #3 stated that his pocket was clean because he washed his coat the night before. ASM #3 then stated he was wearing a new jacket. ASM #3 did state he made a mistake grabbing the gauze from the package with his bare hands and putting it on the TAR. When asked if it was ok to apply santyl to the outside of the wound and then move into the wound bed using the same Q tip; ASM #3 stated it wouldn't matter because the santyl was not

On 3/8/18 at 5:12 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of

documented in part the following: "Equipment and Supplies: Clean dressing instruments, clean

[1] A pressure ulcer is an inflammation or sore on the skin over a bony prominence (e.g., shoulder blade, elbow, hip, buttocks, or heel), resulting from prolonged pressure on the area, usually

The facility policy titled "Dressing-Clean"

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 495226 B. WING 03/09/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX OATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 686 Continued From page 135 F 686 from being confined to bed. Most frequently seen in elderly and immobilized persons, decubitus ulcers may be prevented by frequently change of position, early ambulation, cleanliness, and use of skin lubricants and a water or air mattress. Also called bedsores. Pressure sores. Barron's Dictionary of Medical Terms for the Non Medical Reader 2006; Mikel A. Rothenberg, M.D. and Charles F. Chapman. Page 155. Stage IV Pressure Ulcer Full thickness tissue loss with exposed bone. tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. Further description: The depth of a stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear. occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable. This information was obtained from National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm.

[2] *SANTYL® Ointment is an FDA-approved active enzymatic therapy that continuously removes necrotic tissue from wounds at the microscopic level. This works to free the wound bed of microscopic cellular debris, allowing granulation to proceed and epithelialization to occur. (http://www.santyl.com/about)

3. The facility staff failed to administer a wound treatment in a manner to promote healing and prevent infection for Resident #13. LPN (licensed

FORM APPROVED OMB NO. 0938-0391

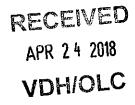
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;			LE CONSTRUCTION		E SURVEY PLETED
		495226	B. WING			03/	09/2018
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		7	TREET ADDRESS, CITY, STATE, ZIP CODE '30 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	before providing we after touch multiple rail, sheets and the hands. Resident #13 was a 11/27/14 and readmediagnoses that includeft mastectomy, difference and Alzhein. The most recent MI quarterly assessmenterence date) of 1 having scored a three (brief interview for most resident was severe resident was coded activities of daily livit. Review of the care documented, "Focu or development of form to: High risk for presil to coccyx) [1]." Review of the Marcid documented, "TX (to COCYX W/NS (with AQUACEL (2) AND (dressing) QD (ever Review of the Marcid administration reconsultation reconsultation). APP	failed to change gloves and care to Resident #13 items, the bed controls, side resident with her gloved admitted to the facility on nitted on 5/18/16 with oded but were not limited to: ficulty swallowing, depression, ner's disease. OS (minimum data set), a nt, with an ARD (assessment 2/20/17 coded the resident as see out of 15 on the BIMS nental status) indicating the ely impaired cognitively. The as requiring assistance for all ng. Olan initiated on 1/24/18 s. At Risk for skin breakdown urther pressure ulcers related soure ulcer immobility (Stage on 2018 physician's orders reatment): CLEANSE th normal saline). APPLY ALLEVYN FOAM (3) DRSG yday) and PRN (as needed)." In 2018 medication documented, "TX SE COCCYX W/NS (with LY AQUACEL (2) AND) DRSG (dressing) QD	Fé	386			

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

Event ID: IPQ811

Facility ID: VA0050

If continuation sheet Page 137 of 208



	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION		E SURVEY PLETED
		495226	B. WING	_		03/	09/2018
	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION OATE
F 686	A wound care obse 3/7/18 at 10:20 a.m nurse) #4, the treat protective cover on and placed the wouthe dressing and la hands. LPN #4 ther raised the height of resident's head usir lowered the bed raidown. She turned the removed the reside wound with normal took from her wound overbed table. LPN change gloves after controls, sheets and care to the pressure was 4.5 cm (centim partially covered with An interview was cop.m. with LPN #4. Vehanged gloves dur stated, "After you to above wound care of the pressure was 4.5 cm (centim partially covered with the press	ervation was conducted on in. with LPN (licensed practical ment nurse. LPN #4 put a in the resident's bedside table and care supplies on it, opened abeled it and then washed her in put on a pair of gloves. She if the bed and lowered the ing the bed controller. LPN #4 illing pulled the resident's sheet the resident onto her left side, ent's brief and washed the saline soaked gauzes that she ind supplies on the resident's left did not wash her hands or in touching the resident's bed in the resident prior to providing the ulcer. The pressure ulcer interest by 1.5 cm and was the slough (4). Sonducted on 3/7/18 at 2:32 When asked when staff ring wound care, LPN #4 ake the dirty dressing off." The observation was reviewed with		686	DEFICIENCY)		
	the gloves." When a be changed, LPN # all those things. Bed those little microorg On 3/8/18 at 5:15 p. member) #1, the ad	ated, "I should have changed asked why the gloves should 4 stated, "Because I touched cause they probably had all ganisms all over them." .m. ASM (administrative staff dministrator and ASM #2, the					
	findings.	were made aware of the					

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		495226	B. WING			03/09/	2018
	PROVIDER OR SUPPLIER	HABILITATION CENTER	-	STREET ADDRESS, CITY, ST 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		VE ACTION SHOULD BE ED TO THE APPROPRIAT		JX5J DMPLETION DATE	
F 686	CARE/ULCER TRI documentation reg wound care. No further informat 1. Stage 2 Pressur loss with exposed of skin with exposed of viable, pink or red, as an intact or rupt Adipose (fat) is not not visible. Granula are not present. The from adverse micro over the pelvis and should not be used associated skin da incontinence-associ intertriginous derm related skin injury ((skin tears, burns, was obtained from: http://www.npuap.oc clinical-resources/r 2. Aquacel - A texti sodium carboxyme wound-healing acti carboxymethylcellu wound site from ex pain, promote infect healing process. So is a non-toxic, non- water-soluble polyn Check for active cli This information wa https://www.cancer	EATMENT" did not evidence arding handwashing during tion was provided prior to exit. The Injury: Partial-thickness skindermis. Partial-thickness loss of dermis. The wound bed is moist, and may also present ured serum-filled blister. It is visible and deeper tissues are ation tissue, slough and escharatese injuries commonly result oclimate and shear in the skin shear in the heel. This stage I to describe moisture mage (MASD) including ciated dermatitis (IAD), atitis (ITD), medical adhesive MARSI), or traumatic wounds abrasions. This information org/resources/educational-and-apuap-pressure-injury-stages/le fiber dressing composed of thylcellulose with potential vity. Sodium allose dressing protects the ternal factors that may cause estion, or slow the natural wound ordium carboxymethylcellulose allergenic, anionic mer derived from cellulose. nical trials using this agent.					
ORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: IPQ81	1 F	acility ID: VA0050	If continuation she	et Page	1 3 9 of 208

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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	
	495226		B. WING		03/09/2018	
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	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
	assing 3. Allevyn - a hydro able to absorb 10 to providing a cost-eff exuding, granulating was obtained from: https://www.ncbi.nli 4. Slough -1. Necroseparating from via information was obhttp://medical-dictiough Tube Feeding Mgm CFR(s): 483.25(g)(formation was obenty://medical-dictiough Tube Feeding Mgm CFR(s): 483.25(g)(formation was obenty://medical-dictiough Tube Feeding Mgm CFR(s): 483.25(g)(formation was obenty://medical-dictiough S483.25(g)(formation) S483.25(g)(formation) S483.25(g)(formation) S483.25(g)(formation) S483.25(g)(formation) S483.25(g)(formation) S483.25(g)(formation) S483.25(g)(formation)	cellular foam dressing which is imes its weight in exudate, fective treatment option for g wounds. This information m.nih.gov/pubmed/7703644 bitic tissue in the process of able portions of the body. This tained from: mary.thefreedictionary.com/slo at/Restore Eating Skills 4)(5) Enteral Nutrition atric and gastrostomy tubes, endoscopic gastrostomy and ed on a resident's sessment, the facility must enteral who has been able to or with assistance is not fed by aless the resident's clinical rates that enteral feeding was and consented to by the	F 686	F-693 The C.N.A. who removed the feeding tube from Resident #8 was Reeducated by the Director of Nursing regarding the remove of the feeding tube on the doof survey. No other residents were found to be affected by this deficient practice. Nursing staff were in-service on the proper policy and procedure for care and removal of feeding tubes. Residents who have feeding tubes will be monitored by the Director of Nursing or he designee on a weekly basis the ensure compliance with policy, procedure, and proper scope of practice. Reports of these observation	d John Control of the	
	and to prevent com including but not lin	if possible, oral eating skills aplications of enteral feeding nited to aspiration pneumonia, dehydration, metabolic		will be submitted to the Facility's QA committee for guidance and review.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ 495226 B. WING 03/09/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION 1D (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 693 Continued From page 140 F 693 abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced bv: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide care and services for a tube feeding per the physician order for one of 28 residents in the survey sample, Resident #8. The facility staff failed to ensure Resident #8's tube feeding was administered, continuously, per the physician order. The findings include: Resident #8 was admitted to the facility on 12/11/12 with a recent readmission on 11/6/17, with diagnoses that included but were not limited to: Alzheimer's disease, mood disorder, anxiety disorder, diabetes, stroke, high blood pressure, and history of subdural hematoma (a collection of blood beneath dura mater in the brain) (1). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/7/17, coded the resident as having both short and long-term memory difficulties. The resident was coded as being severely impaired to make daily cognitive decisions. Resident #8 was coded as being dependent upon one or more staff members for

feeding tube.

all of her activities of daily living. In Section K -Swallowing/Nutritional Status, the resident was coded as receiving all of her nutrition through a

The physician order dated, 11/7/18, documented, "Diabetisource (nutritional replacement for food

		AND HUMAN SERVICES & MEDICAID SERVICES			Ol		APPROVED 0938-0391	
		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILOING		(X3) OATE SURVEY COMPLETEO			
		495226	B. WING			03/0	9/2018	
NAME OF	PROVIOER OR SUPPLIER		<u> </u>	STREET AOORESS, CITY, STATE, ZII	P COOE			
WAYLAND NURSING AND REHABILITATION CENTER				730 LUNENBURG HIGHW KEYSVILLE, VA 23947				
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES 'MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG		ON SHOULO	BE	(X5) COMPLETION DATE	
F 693	specific for diabetic (milliliters per hour) inserted through the Observation was ma 3/8/18 at 8:45 a.m. room. The tube fee next to the bed. An interview was conursing assistant) # When asked where stated she had just station. When asked feeding from the result when asked why she had been trained feeding tube, CNA # An interview was concertical nurse) #2 constant asked if a CNA is all feeding, LPN #2 stated to touch a tube feeding tube, considered in the comprehensive and interview was sproceeded to change feeding. The comprehensive and revised on 12/1 "Focus: At risk for subody requirement of intake, decreased a therapeutic diets, condepression." The "Ir electrons was subody requirement of intake, decreased a therapeutic diets, condepression." The "Ir electrons was subody requirement of intake, decreased a therapeutic diets, condepression." The "Ir electrons was subody requirement of intake, decreased a therapeutic diets, condepression." The "Ir electrons was subody as the results of the results was subody as the	residents) (2) @ (at) 40 ml/hr via Peg tube (a feeding tube a abdominal wall). ade of Resident #8's room on The resident was not in the eding was hanging on the pole onducted with CNA (certified 3 on 3/8/18 at 8:49 a.m. Resident #8 was, CNA #3 put her up by the nurse's d who disconnected the tube sident, CNA #3 stated, "I did." he did this, CNA #3 stated, is how to do it." When asked if at in school to take care of a #3 stated, "No, Ma'am." Inducted with LPN (licensed on 3/8/18 at 8:52 a.m. When lowed to disconnect a tube ted, "Never. They are never ling." The above observation hared with LPN #2 who then ge the entire set up of tube In care plan dated, 10/30/16 9/17, documented in part, tate of nourishment: less than haracterized by inadequate ppetite related to: being on a	F 6	593				

hour via peg tube."

DEPARTMENT OF HEALTH AND HUMAN 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		03/	03/09/2018	
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 PREFI) TAG	<	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	(X5) COMPLETION DATE	
F 693	An interview was co staff member (ASM on 3/8/18 at 12:35 p disconnect a reside #2 stated, "No." The facility policy, " in part, "Licensed p nurses or designate	ge 142 conducted with administrative b) #2, the director of nursing, c.m. When asked if a CNA can ent from a tube feeding, ASM Enteral Feeding" documented ractical nurses, registered ed staff members technically ester the tube feedings as	F6	93			
	Patricia A. Potter ar Inc; Page 419. "The directing medical tre obligated to follow p believe the orders a clients."	of Nursing" 6th edition, 2005; and Anne Griffin Perry; Mosby, e physician is responsible for eatment. Nurses are oblysician's orders unless they are in error or would harm and the director of nursing of the above findings on 3/8/18					
	Non-Medical Reade Chapman, page 26 (2) This information following website: https://www.allegror nts-c522/enteral-fee 2f688a20012f6abe7 Respiratory/Tracher CFR(s): 483.25(i) § 483.25(i) Respirat	was obtained from the medical.com/dietary-suppleme eding-diabetisource-xff808181/67b4d0c\$4050.html ostomy Care and Suctioning	F 6	95			
		sure that a resident who					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		495226	B. WING			03/	09/2018
	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 MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFINED DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 695	care and tracheal scare, consistent with practice, the compresent plan, the reside and 483.65 of this scare plan, the reside and 483.65 of this scare plan, the reside and 483.65 of this scare plan, the residents Resident review, a was determined the provide appropriate two of 28 residents Residents #9 and #1. The facility staff #9's oxygen equipm 2. The facility staff #12's a nebulizer in The findings includ 1. Resident #9 was 6/14/17 and readm diagnoses that includementia without be disorder, type two of disorder, high blook heart disease, COF pulmonary disease most recent MDS (quarterly assessmereference date) of coded as being set function scoring 03 BIMS (Brief Intervier Resident #9 was considered with the considered plans the con	are, including tracheostomy uctioning, is provided such the professional standards of rehensive person-centered ents' goals and preferences, subpart. NT is not met as evidenced tion, staff interview, facility and clinical record review, it at the facility staff failed to e respiratory care services for in the survey sample; the facility staff to maintain Resident ment in a sanitary manner.	F	695	F-695 The Oxygen tubing for Resident #8s equipment was discarded and new tubing secured immediately on 3/6/18. The nebulizer mask for Resident #12 was discarded and replaced immediately on 3/6/18 with mask in a plastic bag for storage purposes. A 100% observation audit we completed on 3/9/2018 by the DON of residents with orders for oxygen therapy an ebulizer treatments. No other residents were found be affected by this alleged deficient practice. Nursing staff were in-service on proper changing of Oxygen tubing and nebulizers and Infection Control proceduring required for proper storage the SDC	a a vas and to ced gen the es	The state of the s

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		TE SURVEY MPLETED
		495226	B. WING			03	3/09/2018
	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 DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	JX5J COMPLETION OATE
F 695	(activities of daily live Review of Resident (physician order shape the following order: (liters)/min (minute continuous." On 3/6/18 at 7:23 at of Resident #9's roconcentrator was stoom. Her oxygen from the concentratouching the floor. (CNA) #2 was comstated she was put Resident #9's room bring the concentratesident #9 was sit CNA into the dining sitting. The aide pluther resident, placed the resident, placed the resident and turnoxygen went to up on 3/7/18 at 3:13 pconducted with CN process followed if oxygen tubing on the could ask central sicould get a wipe and she could recall Rethe floor on 3/6/18, aware of that." When change oxygen tub CNA #2 stated she because of the general seconds of the gener	wing). #9's most recent POS eet) dated 2/28/18 revealed "02 (oxygen) @ 3 L via N/C (nasal cannula) .m., an observation was made om. Resident #9's 02 itting in the doorway of her tubing dated 3-5, was hanging tor. Most of the tubing was At 7:24 a.m., a nursing aide ing down the hallway. CNA #2 ting soiled linen away from and was coming back to tor to the dining room where tting. This writer followed the room where the resident was aced the concentrator next to d the nasal cannula back on red the oxygen on. The to 3 liters automatically. .m., an interview was A #2. When asked about the she were to see a resident's ne floor, CNA #2 stated she upply for a new tubing or she ad wipe it off. When asked if sident #9's oxygen tubing on CNA #2 stated, "I was not en asked why she would ing if it had touched the floor, would change the tubing	F	695	The Director of Nursing or he designee will perform observation audits to verify proper placement and storator of Oxygen equipment, tubin and nebulizers on a weekly basis for 4 weeks then monthly thereafter. The results of the observation audits will be communicate to the IDT during am meetings. To maintain continued compliance the DON will share the results of the audit with the Quality Assurance Performance Improvement (QAPI) Committee on a quarterly basis. If additional issues are noted those issue will be addressed immediat and corrective action taken.	ge g d its	

		AND HUMAN SERVICES & MEDICAID SERVICES					APPROVED 0938-0391
STATEMEN	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		495226	B. WING			03/	09/2018
	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 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 695	member) #1, the add DON (Director of Nithe above concerns). The facility policy tit documents in part, cannulas, and tubin residents, or whene soiled." No further information of the facility staff of the facility decision of the staff of the facility of the f	Iministrator and ASM #2 the ursing) were made aware of led "Oxygen therapy" the following: "Discard masks, g, if disposable, between ver it has become visibly on was presented prior to exit.		695			

Review of Resident #12's most recent POS

(physician order sheet) revealed the following order: "Pulmicort [1] 0.5 mg/2 ml; premixed unit via nebulizer every night at bedtime for COPD. (Chronic Obstructive Pulmonary Disease)."

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		E CONSTRUCTION		E SURVEY PLETED
		495226	B. WING			03/	09/2018
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 80 LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 695	On 3/6/18 at 9:08 a observations of Reconducted. His net observed lying on towas not contained in On 3/6/18 at approxinterview was conditively	m., 11:56 a.m., and 2:11 p.m., sident #12's nebulizer were bulizer mask dated 3/5, was op of the nebulizer machine. It in a plastic bag. kimately 2:11 p.m., an aucted with Resident #12. and take the mask off himself bedside table, Resident #12 elp with everything and could Resident #12 stated the staff it night when the treatment is a.m., an observation of a ulizer was conducted. The stated that morning. The mask	F	695			
	a plastic bag. On 3/7/18 at 8:53 a conducted with LPN Resident #12's nurs nebulizer mask sho LPN #1 stated a ne in a plastic bag to m#1 followed this writ When asked what s#12's nebulizer, LPI plastic bag. LPN #1 in the plastic bag ne if Resident #12 take himself, LPN #1 sta	f the nebulizer machine not in .m., an interview was I (licensed practical nurse) #1, se. When asked how a uld be stored when not in use, bulizer mask should be stored naintain infection control. LPN er to Resident #12's room. The observed about Resident N #1 stated it was not in a I took the mask and placed it ext to the mask. When asked as off his nebulizer mask ted that he could not do that. m., ASM (administrative staff ministrator and ASM #2 the					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION			E SURVEY PLETED
		495226	B. WING				03/0	09/2018
7.7	PROVIDER OR SUPPLIER D NURSING AND RE	HABILITATION CENTER		730	REET ADDRESS, CITY, STATE, ZIP COL LUNENBURG HIGHW YSVILLE, VA 23947	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	Χ	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TD THE AF DEFICIENCY)	HOULD	BE	(X5) COMPLETION DATE
F 695	DON (Director of N the above concerns	ursing) were made aware of S.	F€	595	F-697 A pain assessment was completed immediately		,	
F 697 SS=D	used for the manag information was ob Institutes of Health Pain Management	zer is an inhaled corticosteroid gement of asthma. This tained from The National	F (597	Resident #37 for pain the included non-pharmacon interventions and the effectiveness of the promedication by the ADO	ologica	al	
	provided to resident consistent with profite comprehensive and the residents' of This REQUIREMED by: Based on staff intereview, and clinical failed to ensure pair to residents consists standards of practic centered care plants urvey sample, Residents	Insure that pain management is ats who require such services, fessional standards of practice, a person-centered care plan, goals and preferences. No is not met as evidenced erview, facility document record review, facility staff in management was provided tent with professional ce and the comprehensive for one of 28 residents in the sident #37.			An audit was completed 100% of residents with Morphine ordered for prelief by the DON to est that non-pharmacologic interventions are availated and effectiveness of medication is documen No other resident was to be affected by this dipractice. Residents who trigger for the sidents was to be affected by the sidents who trigger for the s	d for prn pain tablish cal able able found eficie	nt	
	Resident #37's pail non-pharmacologic administration of pi facility staff also fai	led to accurately assess in and failed to attempt cal interventions, prior to the rn (as needed) Morphine. The led to monitor the in (as needed) Morphine after			and who are on pain medication will be mor weekly by the IDT in its morning meeting to en that proper non-pharmacological interv	nitore s sure rentio	d	
	The findings includ Resident #37 was a	e: admitted to the facility on		- - - - -	are documented and the effectiveness of the medication noted.	he		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY IPLETED
•		495226	B. WING			03/	09/2018
	PROVIDER OR SUPPLIER ID NURSING AND RI	EHABILITATION CENTER		730	REET ADDRESS, CITY, STATE, ZIP CODE D LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 697	3/31/17 and reading that included but with high blood pressur. Alzheimer's Disea #37's most recent assessment was a ARD (assessment Resident #37 was cognitively impaired 15 on the BIMS (Elexam. Resident #extensive assistant most ADLS (activity). Review of Resident that he was placed 8/11/17. Review of Resident for "Morphine [1] Sulm (milliliters) under the following dates the following dates the following dates the following dates of the MAR: restlessness and not documented. non-pharmacologicattempted prior to	nitted on 8/1/17 with diagnoses were not limited to heart failure, re, diabetes, high cholesterol, se, and dementia Resident MDS (minimum data set) a quarterly assessment with an a reference date) of 2/8/18. coded as being severely ed scoring three out of possible Brief Interview for Mental Status) etc. From one staff member with ties of daily living). Int #37's clinical record revealed don Hospice Services on the task of		897	To maintain continued compliance the DON will share the results of the audit with the Quality Assurance Performance Improvement (QAPI) Committee on a quarterly basis. If additional issues are noted those issue will be addressed immediate and corrective action taken.	s ely	Par

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	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	١	(X3) DATE COMP	PLETED
		495226	B. WING		•	03/0	9/2018
	PROVIDER OR SUPPLIER ND NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STAT 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	CROSS-REFERENCED	ACTION SHOULD	BE	(X5) COMPLETION OATE
F 697	identified. The follow back of the MAR: "I Pain/Anxiety." A pain There was no evide interventions were a administering Morp assessment was comply assessment was a comply assessment was a comply assessment was a comply assessment was a conducted with LPN when asked about administering a print and a conducted with LPN when asked about administering a print and a conducted with LPN when asked about administering a print a conducted with LPN when asked about administering a print a conducted with LPN when asked about administering a print a conducted with LPN when asked about administering a print a conducted with LPN when asked about administering a print a conducted with LPN when asked about a conducted with LPN when a conducted wit	was administered. AM or PM could not be wing was documented on the Morphine 0.25 ml; Reason: in level was not documented. Ince that non-pharmacological attempted prior to hine. A follow up pain inducted and documented the defective." AM or PM could not be wing was documented on the Morphine 0.25 ml; Reason: level was not documented. Ince that non-pharmacological attempted prior to hine. There was no evidence assessment after the nistered. M. No reason could be found MAR indicating why Morphine The back of the MAR was ing notes regarding the orphine on the above dates. #37's comprehensive care failed to evidence a care plan	F6	697			

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	OF CORRECTION	IDENTIFICATION NUMBER:	I ' '		UNSTRUCTION		PLETED
		. 495226	B. WING			03/	09/2018
	PROVIDER OR SUPPLIER	HABILITATION CENTER		730 L	ET ADDRESS, CITY, STATE, ZIP CODE .UNENBURG HIGHW SVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT 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 APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 697	the resident or try of interventions. LPN she would administ pain assessment. assessment would would look for non-well as verbal, would location and the levafter she administe then do a follow up asked if the initial a should be documented on the asked where the pain a documented on the asked where the pain and the levafter she administe then do a follow up asked if the initial a should be documented on the asked where the pain adocumented if it is in nursing notes, LPN was done if there is asked where non-pinterventions were adoesn't usually documented, LP should be documented, LP should be documented, LP should be documented, LP should be documented would know if nursing non-pharmacological they are not documented are not documented are not documented by wouldn't know if nursing non-pharmacological they are not documented by wouldn't know if nursing non-pharmacological they are not documented by wouldn't know if nursing non-pharmacological they are not documented if they are n	other non-pharmacological #3 stated if that didn't work, were the pain medication after a When asked what the pain include, LPN #3 stated she verbal indications of pain as ld assess to determine the rel of pain. LPN #3 stated rs the medication, she would pain assessment. When and follow up pain assessment and follow up pain assessment assessment is usually back of the MAR. When ain assessment would be not in the MAR or in the #3 stated, "I wouldn't think it no documentation." When harmacological pain relief written, LPN #3 stated that she ument what all interventions were d. When asked if they should the with the word when asked how she and staff were offering all pain relief interventions if ented, LPN #3 stated that she now. Im., ASM (administrative staff liministrator and ASM #2, the cursing) were made aware of	F6	97			

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING _ B. WING 495226 03/09/2018 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 [X5] COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 697 Continued From page 151 F 697 degree of pain relief on the pain management log, reassess the resident and document the degree of pain relief 30 minutes after parenteral analgesic and 60 minutes after oral analgesic administration." The facility policy did not address the additional concerns addressed above. Fundamentals of Nursing, 6th Edition, Potter and Perry, 2005, pages 1239-1287, "Nurses need to approach pain management systematically to understand a client's pain and to provide appropriate intervention....it is necessary to monitor pain on a consistent basis....Assessment of common characteristics of pain helps the nurse form an understanding of the type of pain, its pattern, and types of interventions that may bring relief....Onset and duration....Location....Intensity....Quality....Pain Pattern....Relief Measures....Contributing Symptoms....Pain therapy requires an individualized approach....Nurses administer and monitor interventions ordered by physicians for pain relief and independently use pain-relief

management.

centralize the information about pain

measures that complement those prescribed by a physician....Effective communication of a client's assessment of pain and his or her response to intervention is facilitated by accurate and thorough documentation. This communication needs to transpire from nurse to nurse, shift to shift, and nurse to other health care providers. It is the professional responsibility of the nurse caring for the client to report what has been effective for managing the client's pain. The client is not responsible for ensuring that this information is accurately transmitted. A variety of tools such as a pain flow sheet or diary will help

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•	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495226	B, WING _	<u> </u>	03/09/2018
	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)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	D BE COMPLETION
F 745 SS=D	acute and chronic pan opioid analgesic treatments are inactobtained from The https://dailymed.nlnm?setid=3f3a870e-Provision of Medica CFR(s): 483.40(d) §483.40(d) The factor medically-related somaintain the highest and psychosocial with This REQUIREMENT by: Based on staff interclinical record revies taff failed to provid services for three or sample, Residents 1. The facility staff for medically related so regards to the preaderesident review (PA) 2. The facility staff for related social services for three or sample, Residents 3. The facility staff for related social services for three or sample, Residents 3. The facility staff for related social services for three or sample, Residents 3. The facility staff for related social services for three or sample, Residents 3. The facility staff for related social services for three or sample, Residents 3. The facility staff for related social services for three or sample, Residents 3. The facility staff for related social services for three or sample, Residents 3. The facility staff for related social services for three or sample, Residents 3. The facility staff for related social services for three or sample, Residents 3. The facility staff for related social services for three or sample, Residents 3. The facility staff for related social services for three or sample, Residents 3. The facility staff for related social services for three or sample, Residents 4. The facility staff for related social services for three or sample, Residents 4. The facility staff for related social services for three or sample, Residents 5. The facility staff for related social services for three or sample, Residents 6. The facility staff for related social services for three or sample, Residents 7. The facility staff for related social services for three or sample, Residents 8. The facility staff for related social services for three or sample, Residents 9. The facility staff for related social services for three or sample, Residents 9. The facility staff for related	cated for the management of pain severe enough to require and for which alternative lequate. This information was National Institutes of Health. In.nih.gov/dailymed/druglnfo.cf f325-475b-8453-fe3d1bb8f54. The service state of the provide ocial services to attain or of practicable physical, mental rell-being of each resident. The service of the services to attain or of the practicable physical, mental rell-being of each resident. The services was evidenced or resident and well-being of each resident of the survey facility policy review and well-being of each resident facility emedically related social facility and facility related social facility the services were provided in dission screening and SAAR) for Resident #25. The services were provided in the survey resident facility the services were provided in dission screening and SAAR) for Resident #25. The services were provided in the survey resident #25. The services were provided in the services	F 69	F-745 The PASSARR will be obtained for resident #25. The Dentures for Resident #18	al with of the control of the contro

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,		CONSTRUCTION		E SURVEY PLETED
		495226	B. WING_		313 A.T. 1	03/	09/2018
	PROVIDER OR SUPPLIER D NURSING AND RE	HABILITATION CENTER		73	REET ADDRESS, CITY, STATE, ZIP CODE 0 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION OATE
F 745	1. Resident #25 wa 7/17/15 and readmidiagnoses that incluse Parkinson's disease psychotic disorders (2), anoxic brain injute. The most recent coassessment, with a resident as having a BIMS indicating the impaired cognitively requiring the assisted aily living with the resident could perform Review of the clinic documentation that and resident review. On 3/7/18 at 4:47 pthe PASARR was mataff member) #2, the Con 3/8/18 at 8:30 at no PASARR for Resident review. An interview was coally a more and the passion of the passion has mental one. I met with some about it. They said to When asked when stated, "It's probable in the passion in	s admitted to the facility on litted on 12/19/17 with uded but were not limited to: e (1), heart failure, diabetes, depression, schizophrenia ury (3) and seizures. Implete MDS, a 30-day in ARD of 1/17/18 coded the scored a 6 out of 15 on the resident was severely in The resident was coded as ance of staff for all activities of exception of eating which the form with supervision. In record did not evidence the pre-admission screening in (PASARR) was completed. Im., a request for a copy of made to ASM (administrative the director of nursing. Im., ASM #2 stated there was sident #25. Inducted on 3/8/18 at 10:15 for staff member) #1, the in asked if she knew what a maked if she knew what	F 7	45	Admissions will be reviewed by the IDT to determine PASARR compliance. Dental Services will be provided as contracted and notations made in Social progress notes. A list of Dental consults will be maintained by the Social worker. The medical records staff member or QI nurse will complete an audit of 10 % admissions each month for 3 months then quarterly thereafter to determine procurement of the PASARR and availability of the PASARR in the medical records. The results of the audit will be shared with the administrator		
,	An interview was co	inducted on 3/8/18 at 12:01	1				1

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION		OMPLETED
		495226	B. WING	,			03/09/2018
	PROVIDER OR SUPPLIEF	EHABILITATION CENTER		7 30	EET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW YSVILLE, VA 23947	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	- 1	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 745	p.m. with ASM #1, the director of numerical passage if the SNF (sk placement." When PASARR complete one for everyone wasked if anyone wasked i	the administrator and ASM #2, sing. When asked what a M #1 stated, "It's preadmission ssessment of the resident to illed nursing facility) is a proper n asked which residents had a ed, ASM #1 stated, "We need who comes in here" When as completing the PASARR's, lot to my knowledge. We asked ospital." ASM #2, the director of don't think the hospital realizes that they are supposed to be go were reviewed at that time. Ity's job description titled, ocumented, "PURPOSE OF TION: The primary purpose of a to plan, develop, organize, ate and direct the Social Work cordance with current existing local standards, as well as our s and procedures, to assure related emotional and social ents are met/maintained on an the responsibilities my include a missions, documentation, and attes. MAJOR DUTIES AND ES: Listed below is an outline of ponsibilities that you will be m. AS SOCIAL WORKER, you authority, responsibility, and arry out your assigned duties. organize, implement, evaluate, ital service programs of this and maintain a good working epartmental personnel and y health, welfare, and social et that social service programs		745	To maintain continued compliance the Medical Records staff member or Quarter will share the results the audits with the Quality Assurance Performance Improvement (QAPI) Committee on a quarterly basis. If additional issues a noted those issues will be addressed immediately an corrective action taken.	of re	

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUI			TE SURVEY MPLETED
		495226	B. WING			03	/09/2018
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER	•		RESS, CITY, STATE, ZIP CO BURG HIGHW E, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EAC	ROVIDER'S PLAN OF COR CH CORRECTIVE ACTION S S-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION OATE
F 745	can be properly may the residents 4) Ke and state regulation standards and make changes in policy a corporate consultant service activities who formulation of resident interdisciplinary resident facility's consulting lement recommodular to the facility's consulting lement recommodular to the facility stafform obtaining dentures. Resident #18 was a 9/29/14 with diagnoral limited to: stroke, concluded the resident as soon interview for mentant capable of making resident was coded limited assistance for section K - Swall resident was coded concerns. An interview was coded to the resident was coded concerns. An interview was coded concerns.	aintained to meet the needs of sep abreast of current federal as as well as professional are recommendations on and procedures to the art 21) Coordinate social aith other departments in the lent's individual aident care plan. 22) Work with tants as necessary and rended change as required."	F	45			

FORM APPROVED OMB NO. 0938-0391

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION	(X3) DATE S COMPLI	
		495226	B, WING			03/	09/2018
	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 DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)) BE	(X5) COMPLETION DATE
F 745	The documentation dated 4/21/17, docu (treatment): Exam. The documentation dated 6/28/17, docu (treatment) Post - C impressions F/F (further review of the coupdated on 4/28/17 plan addressing derobtaining dentures of the coupdated on 4/28/17 plan addressing derobtaining dentures of the coupdated on 4/28/17 plan addressing derobtaining dentures of the commentation of the facility, through (name of mocome out and see the facility, through (name of mocome out and see the facility of the residents stated, "Yes." When dental unit was at the came the end of Mascheduled to come today that I am hand not been handling the facility of the provided the facility of the residents stated, "Yes." When dental unit was at the came the end of Mascheduled to come today that I am hand not been handling the facility of the provided the facility of the fa	from the Mobile Dental Unit umented in part, "TX Full mouth extractions." from the Mobile Dental Unit umented in part, "TX: "TX: "Op (operative) Possible II set of dentures)." comprehensive care plan and a failed to evidence any care notal care or the need for for Resident #18. conducted with other staff the social worker/ are planner, on 3/7/18 at 12:53 are residents obtain dentures OSM #1 stated, "We go obile dental company). They he residents." When asked if so for dentures, OSM #1 asked the last time the me facility, OSM #1 stated, "I asked the last time the me facility, OSM #1 stated, "I asked the dental part. I have not along the dental part. I have not before." Inducted with administrative of the facility, ASM #2 st signed a new contract with the er that comes to the facility."	F	745			
	were provided at the	the last time dental services e facility, ASM #2 stated, "I have to check to see when					i P I

FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		495226	B. WING			03	/09/2018
	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 PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE	(X5) COMPLETION DATE
F 745	bought out the comsaw some resident's de hostage." An interview was comember (OSM) #2 member, on 3/8/18 she had any invoice	Our last provider supposedly pany and came out and they s. There was a conflict and ntures are being held onducted with other staff at 1:38 p.m. When asked if es for Resident #18 to receive stated she had no invoices for	F 7	'45			
	The administrator a were made aware of at 5:10 p.m.	and the director of nursing of the above findings on 3/8/18 on was provided prior to exit.			.t		
	related social service obtaining dentures. Resident #30 was a 3/28/12 with diagnolimited to: demential peripheral vascular condition affecting theart) (1), anxiety depend to the service of the service	admitted to the facility on ses that included but were not i, high blood pressure, disease (any abnormal blood vessels outside the isorder, and dysphasia (a wallowing is difficult or painful)					
	assessment, an ani	OS (minimum data set) nual assessment, with an nce date of 1/31/18, coded the					

		AND HUMAN SERVICES & MEDICAID SERVICES					APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l · ·		E CONSTRUCTION		E SURVEY IPLETED
		495226	B. WING			03/	09/2018
NAME OF F	ROVIDER OR SUPPLIER				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 PREFI TAG	×	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO' CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION OATE
F 745	was capable of main The documentation dated 6/28/17, documentation of teeth a pt (Patient) is a candentures)." The comprehensive documented in part broken and missing (mouth) hygiene. Dottime." The "Interver" "Monitor and notify and symptoms) of confor evaluation when the came last year and supposed to come for dentures. I wan they never came be An interview was comember (OSM) #1, admission/discharg p.m. When asked he while at the facility, through (name of mome out and see they fit the residents stated, "Yes." When dental unit was at the came the end of Mainterview and the same the same the same the same the end of Mainterview and the same t	I status) score, indicating he king daily cognitive decisions. I from the Mobile Dental Unit, umented in part, "Needs as charted. After extractions, indidate for F/P (fitting for partial e care plan dated, 6/5/17; "Focus: (Resident #30) has greeth related to poor PO enies any dental pain at this intions" documented in part, physician or any s/sx (signs dental pain. Refer to dentist in resident feels able." Inducted with Resident #30 on the resident stated, "They cleaned my teeth but were back and pull teeth and fit me to eat pork chops and corn. ack." Inducted with other staff the social worker/ the planner, on 3/7/18 at 12:53 now residents obtain dentures OSM #1 stated, "We go nobile dental company). They he residents." When asked if so for dentures, OSM #1 stated, "I asked the last time the ne facility, OSM #1 stated, "I ay 2017 and they are	F 7	745			
	scheduled to come	on 3/22/18. I just found out dling the dental part. I have					

not been handling that before. "

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495226	B. WING			03/09/2018	
	PROVIDER OR SUPPLIER D NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, Z 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD THE APPROPE	BE COMPLETION	
F 777 SS=D	An interview was comember (OSM) #2, member, on 3/8/18 she had any invoice dentures, OSM #2. Resident #30 to har The administrator awere made aware of at 5:10 p.m. No further information. Non-Medical Reade Chapman, page 44 (2) Barron's Diction Non-Medical Reade Chapman, 178. Radiology/Diag Srv CFR(s): 483.50(b)(2) The fill (i) Provide or obtain diagnostic services physician; physician or clinical nurse specialist of reclinical reference rafacility policies and practitioner or per fill This REQUIREMENT.	enducted with other staff the account receivable staff at 1:38 p.m. When asked if es for Resident #30 to receive stated she had no invoices for we dentures. and the director of nursing of the above findings on 3/8/18 fon was provided prior to exit. ary of Medical Terms for the er, 5th edition, Rothenberg and 7. ary of Medical Terms for the er, 5th edition, Rothenberg and cs Ordered/Notify Results 2)(i)(ii)	F 7	F-777 The ordered CBC woobtained for Reside The Physician was recorded the results and new	ent #40. notified of v orders completed nel for ordered nes were	48/18	

PRINTED: 03/20/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		495226	B. WING	i	<u>.</u>	03/0	09/2018
	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 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 OATE
F 777	obtain physician or for one of 28 resider for one of 28 resider Resident #40. The facility staff fail specimens as order Resident #40. The Findings Included Resident #40 was a 3/16/17 with diagnoral limited to: leukemia dementia, irregular pressure. The most recent M with an ARD of 2/2 having scored a two indicating the residing impaired. The residing assistance for all and Review of the Carellaboratory specime Review of the Marcellaboratory specime Review of the Marcellaboratory specime Results To (Nar HEMATOLOGY." To documented. On 3/8/18 at 3:00 put the original dated of the original dated of the carellaboratory specime Resident Resident Results To (Nar HEMATOLOGY." To documented.	mined the facility staff failed to dered laboratory specimens ents in the survey sample, led to obtain weekly laboratory red by the physician for de: admitted to the facility on oses that included but were not a, Alzheimer's disease, heartbeat and high blood DS, an annual assessment, 1/18 coded the resident as o out of 15 on the BIMS ent was severely cognitively dent was coded as requiring ctivities of daily living. plan did not address the ens. ch 2018 physician's orders (laboratory tests): CBC sount) [1] WKLY (weekly) & FAX	F	7777	Any new orders will be noted and the documentation will be placed in the residents chart. Follow-up will be completed and documented in the afternoon meeting to ensure that specimens and cultures are obtained timely. Documentation of follow-up to lab orders will be kept in the IDT meeting minutes and reviewed by the director of Nursing or her designee. The ADON/QI nurse will perform weekly audits for 4 weeks then monthly thereafter for obtaining lab results. The results of the audit will be reviewed by the DON. To maintain continued compliance the DON will share the results of the audi with the Quality Assurance Performance Improvement (QAPI) Committee on a quarterly basis. If additional issues are noted those issue will be addressed immediate and corrective action taken.	ts ts	
	otan,				and corrective action taken.	ı	

FORM APPROVED OMB NO. 0938-0391

F 777 Continued From page 161 On 3/8/18 at 3:33 p.m., OSM #5 returned and stated she could not locate the original order. Review of the January 2018 and February 2018 physician's orders documented, "LAB: CBC (complete blood count) [1] WKLY (weekly) & FAX RESULTS TO (Name of hospital) HEMATOLOGY." A request was made on 3/8/18 at 5:15 p.m. of ASM #2, the director of nursing, for a copy of the resident's CBC laboratory reports dated, 12/14/17, 1/15/18 and 2/12/18 to this writer. When asked why the laboratory specimens were not collected weekly, ASM #2 stated, "There wasn't an order for it." ASM #2 was shown the order from the March 2018 physician's orders. ASM #2 stated, "I didn't know about that." ASM #2 was made aware of the findings at that time. An interview was conducted on 3/9/18 at 11:15 a.m. with LPN #4. When asked about the process staff followed to obtain laboratory specimens, LPN #4 stated, "If it's a routine lab (laboratory)			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
WAYLAND NURSING AND REHABILITATION CENTER X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG F777 Continued From page 161 On 3/8/18 at 3:33 p.m., OSM #5 returned and stated she could not locate the original order. Review of the January 2018 and February 2018 physician's orders documented, "LAB: CBC (complete blood count) [1] WKLY (weekly) & FAX RESULTS TO (Name of hospital) HEMATOLOGY." A request was made on 3/8/18 at 5:15 p.m. of ASM #2, the director of nursing, for a copy of the resident's CBC laboratory results. On 3/9/18 at 8:50 a.m., ASM#2 provided three CBC laboratory reports dated, 12/14/17, 1/15/18 and 2/12/18 to this writer. When asked why the laboratory specimens were not collected weekly, ASM #2 stated, "There wasn't an order for it." ASM #2 was shown the order from the March 2018 physician's orders. ASM #2 stated, "I didn't know about that." ASM #2 was made aware of the findings at that time. An interview was conducted on 3/9/18 at 11:15 a.m. with LPN #4. When asked about the process staff followed to obtain laboratory specimens, LPN #4 stated, "If it's a routine lab (laboratory)			495226	B. WING			03/	09/2018
FREFIX TAG (EACH DERICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 777 Continued From page 161 On 3/8/18 at 3:33 p.m., OSM #5 returned and stated she could not locate the original order. Review of the January 2018 and February 2018 physician's orders documented, "LAB: CBC (complete blood count) [1] WKLY (weekly) & FAX RESULTS TO (Name of hospital) HEMATOLOGY." A request was made on 3/8/18 at 5:15 p.m. of ASM #2, the director of nursing, for a copy of the resident's CBC laboratory results. On 3/9/18 at 8:50 a.m., ASM#2 provided three CBC laboratory reports dated, 12/14/17, 1/15/18 and 2/12/18 to this writer. When asked why the laboratory specimens were not collected weekly, ASM #2 stated, "There wasn't an order for it." ASM #2 was shown the order from the March 2018 physician's orders. ASM #2 stated, "I didn't know about that." ASM #2 was made aware of the findings at that time. An interview was conducted on 3/9/18 at 11:15 a.m. with LPN #4. When asked about the process staff followed to obtain laboratory specimens, LPN #4 stated, "If it's a routine lab (laboratory)			HABILITATION CENTER		730 LUNENBURG HIGHW	ZIP CODE		
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specimen) we write it up on a lab slip." When asked how weekly laboratory specimens were obtained, LPN #4 stated, "We used to be able to do it on the computer, but we can't do that now." When asked who entered the laboratory orders since then, LPN #4 stated, "At one point the ADON (assistant director of nursing) was doing it." When asked how staff would know if a laboratory specimen had not been done as ordered, LPN #4 stated, "Hard to know." When asked to review Resident #40's order for the	F 777	On 3/8/18 at 3:33 p stated she could not Review of the Janu physician's orders of (complete blood con RESULTS TO (Nan HEMATOLOGY." A request was mad ASM #2, the director resident's CBC laboratory repand 2/12/18 to this value laboratory specimen ASM #2 stated, "The ASM #2 was shown 2018 physician's order know about that." At the findings at that the findings at that the findings at that the findings at the specimen) we write asked how weekly lobtained, LPN #4 stated, "If it specimen) we write asked how weekly lobtained, LPN #4 stated who elsince then, LPN #4 ADON (assistant direction)." When asked who elsince then, LPN #4 ADON (assistant direction) was asked how laboratory specimen ordered, LPN #4 stated, LPN #4 stated how laboratory specimen ordered, LPN #4 stated how laboratory specimen ordered how laboratory	ary 2018 and February 2018 documented, "LAB: CBC unt) [1] WKLY (weekly) & FAX ne of hospital) e on 3/8/18 at 5:15 p.m. of or of nursing, for a copy of the oratory results. .m., ASM#2 provided three orts dated, 12/14/17, 1/15/18 writer. When asked why the ns were not collected weekly, here wasn't an order for it." In the order from the March ders. ASM #2 stated, "I didn't SM #2 was made aware of time. Inducted on 3/9/18 at 11:15 When asked about the process ain laboratory specimens, is a routine lab (laboratory it up on a lab slip." When aboratory specimens were stated, "We used to be able to ear, but we can't do that now." Intered the laboratory orders stated, "At one point the rector of nursing) was doing w staff would know if a n had not been done as ated, "Hard to know." When	F 7	777			

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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DPLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495226	B. WING		03/0	09/2018
	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)	TEMENT OF DEFICIENCIES Y 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 OATE
F 777 F 791 S S =D	those because she medication. No further informat 1. CBC - Your blood (RBC), white blood Blood count tests n of cells in your blood your overall health. diagnose diseases anemia, infections, cancers, and immutypes include tests and types of RBC in numbers and types Platelets - the num Hemoglobin - an irrecells that carries ox space red blood ce Reticulocyte count cells are in your blood (MCV) - the average The complete blood or all of these. The common blood test obtained from: https://medlineplus Routine/Emergency CFR(s): 483.55(b)(§483.55 Dental Set The facility must as	was on an oral chemotherapy ion was provided prior to exit. d contains red blood cells cells (WBC), and platelets. neasure the number and types od. This helps doctors check on The tests can also help to and conditions such as clotting problems, blood ane system disorders. Specific for · RBC - the numbers, size, an the blood · WBC - the of WBC in the blood · bers and size of the platelets · con-rich protein in red blood avgen · Hematocrit - how much alls take up in your blood · - how many young red blood od · Mean corpuscular volume are size of your red blood cells d count (CBC) includes most CBC is one of the most as. This information was .gov/bloodcounttests.html by Dental Srvcs in NFs 1)-(5) rvices asist residents in obtaining	F 777	F-791 The facility obtained Dental services for Resident #18, and #41. Other residents requiring Dental services were identified and services provided. A new Dental services Contract was negotiated a signed by the administrate Dental services were on sithe facility on March 22 a provided dentures and partials as needed. Referrals for Dental service will be scheduled by Social	#30, ind or. te at ind	Left of the state
	§483.55(b) Nursing The facility-	r emergency dental care. ı Facilities.				,

PRINTED: 03/20/2018 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495226	B. WING		· •	03/	09/2018	
	PROVIDER OR SUPPLIER	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 791	§483.55(b)(1) Must outside resource, ir of this part, the foliothe needs of each r (i) Routine dental sunder the State pla (ii) Emergency dental services local state of the making appoint (ii) By arranging for dental services local services. If a 3 days, the facility residents with lost of dental services. If a 3 days, the facility residents with lost of dental services and the experience and drink adequate services and the experience are sident for dental services whe dental services and the experience of the delay: §483.55(b)(4) Must circumstances whe dental services and the experience of the delay: §483.55(b)(5) Must deligible and wish to reimbursement of dental expense under the delay of the facility document resident resid	provide or obtain from an accordance with §483.70(g) owing dental services to meet resident: ervices (to the extent covered n); and tal services; if necessary or if requested, attention to and from the ations; promptly, within 3 days, refer or damaged dentures for a referral does not occur within must provide documentation of sure the resident could still eat ly while awaiting dental tenuating circumstances that have a policy identifying those in the loss or damage of ity's responsibility and may not or the loss or damage of din accordance with facility lity's responsibility; and assist residents who are participate to apply for ental services as an incurred	F	791	To maintain continued compliance Social Services will share the results of the dental compliance audits with the Quality Assurance Performance Improvement (QAPI) Committee on a quarterly basis. If additional issues are noted those issues will be addressed immediately and corrective action taken.			

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			03/0	09/2018
	PROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, 730 LUNENBURG HIGH KEYSVILLE, VA 2394	ıw		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD E ICED TO THE APPROPRI EFICIENCY)		(X5) COMPLETION DATE
F 791	the survey sample, 1. The facility staff dental services wer 2. The facility staff ensure dental serving with serving staff ensure dental serving serving staff ensure dental serving serving staff ensure dental serving serving serving serving ensure dental serving	ices for three of 28 residents in Residents #18, #30, and #41. failed to arrange and ensure re provided to Resident #18. failed to arrange for and ices were provided to Resident failed to arrange for and ices were provided to Resident failed to arrange for and ices were provided to Resident ices were provided to Resident	F7	791			

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

Event ID: IPQ811

Facility ID: VA0050

If continuation sheet Page 165 of 208

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APR 2 4 2018
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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO.	. 0938-0391
	TATEMENT OF DEFICIENCIES (X1) PROV	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''		PLE CONSTRUCTION		E SURVEY IPLETED
		495226	B. WING	;		03/	/09/2018
	PROVIDER OR SUPPLIER ND 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 Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ix	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 791	The documentation dated 4/21/17, docu (treatment): Exam, The documentation dated 6/28/17, docu (treatment) Post - C impressions F/F (fu The review of the coupdated on 4/28/17	from the Mobile Dental Unit umented in part, "TX Full mouth extractions." from the Mobile Dental Unit umented in part, "TX: Op (operative) Possible II set of dentures)." omprehensive care pland, failed to evidence any care intal care or the need for	F	791			
	member (OSM) #1, admission/discharg p.m., regarding how while at the facility, through (name of mome out and see they fit the residents stated, "Yes." When dental unit was at the came the end of Mascheduled to come	e planner, on 3/7/18 at 12:53 or residents obtain dentures OSM #1 stated, "We go public dental company). They he residents." When asked if s' for dentures, OSM #1 asked the last time the he facility, OSM #1 stated, "I say 2017 and they are on 3/22/18. I just found out dling the dental part. I have			•		
	staff member (ASM on 3/7/18 at 1:01 p.i concerns are handle stated, "We have just a new dental provide When asked when twere provided at the don't know, I would	enducted with administrative) #2, the director of nursing, m. When asked how dental ed in the facility, ASM #2 st signed a new contract with er that comes to the facility." the last time dental services e facility, ASM #2 stated, "I have to check to see when Our last provider supposedly					

FORM APPROVED

		AND HUMAN SERVICES & MEDICAID SERVICES			C		APPROVED 0938-0391
STATEMENT	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		495226	B. WING			03/6	09/2018
NAME OF	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·			TREET ADDRESS, CITY, STATE, ZIP CODE		
WAYLAN	ID NURSING AND RE	HABILITATION CENTER			30 LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 791	saw some residents some resident's der hostage." An interview was comember (OSM) #2, member, on 3/8/18 she had any invoice dentures, OSM #2 sResident #18 to have The facility policy, "lin part, "Arrangeme resident's personal routine and emerge resident does not have a greement is obby a dentist with who This dentist will probasis and a needed necessary, the Soci resident or his/her richere arrangements Worker will assist rewish to participate, dental services as a second resident or his/her richere arrangements worker will assist rewish to participate, dental services as a second resident or his/her richere arrangements worker will assist rewish to participate, dental services as a second resident or his/her richere arrangements worker will assist rewish to participate, and the services as a second resident re	pany and came out and they so. There was a conflict and natures are being held conducted with other staff the account receivable staff at 1:38 p.m. When asked if as for Resident #18 to receive stated she had no invoices for we dentures. Dental Services" documented into are made with the dentist for the provision of incy dental care. If the ave a personal dentist, then tained for care to be provided om the facility has a contract, wide dental care on a routine lIf financial assistance is all Worker will help the epresentative and to see if a can be made. The Social esident who are eligible and to apply for reimbursement of an incurred medical expense,	F 7	91	DEFICIENCY		
		nd the director of nursing of the above findings on 3/8/18					
	No further informati	on was provided prior to exit.					
	2. The facility staff f services for Reside	ailed to arrange for dental nt #30.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING __ 495226 B. WING 03/09/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** OATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 791 | Continued From page 167 F 791 Resident #30 was admitted to the facility on 3/28/12 with diagnoses that included but were not limited to: dementia, high blood pressure, peripheral vascular disease (any abnormal condition affecting blood vessels outside the heart) (1), anxiety disorder, and dysphasia (a condition in which swallowing is difficult or painful) (2).The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 1/31/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating he was capable of making daily cognitive decisions. The documentation from the Mobile Dental Unit, dated 6/28/17, documented in part, "Needs extraction of teeth as charted. After extractions, pt (Patient) is a candidate for F/P (fitting for partial dentures)." The comprehensive care plan dated, 6/5/17 documented in part. "Focus: (Resident #30) has broken and missing teeth related to poor PO (mouth) hygiene. Denies any dental pain at this time." The "Interventions" documented in part, "Monitor and notify physician or any s/sx (signs and symptoms) of dental pain. Refer to dentist for evaluation when resident feels able." An interview was conducted with Resident #30 on 3/6/18 at 10:20 a.m. The resident stated, "They

They never came back."

came last year and cleaned my teeth but were supposed to come back and pull teeth and fit me for dentures. I want to eat pork chops and corn.

An interview was conducted with other staff

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495226	B. WING			03/	09/2018
	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 Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETION OATE
F 791	member (OSM) #1, admission/discharg p.m. When asked h while at the facility, through (name of m come out and see they fit the resident stated, "Yes." When dental unit was at the came the end of Mascheduled to come today that I am han not been handling the An interview was comember (OSM) #2, member, on 3/8/18 she had any invoice dentures, OSM #2 Resident #30 to have No further information. When the companies of	the social worker/ the planner, on 3/7/18 at 12:53 how residents obtain dentures OSM #1 stated, "We go hobile dental company). They he residents." When asked if s' for dentures, OSM #1 he asked the last time the he facility, OSM #1 stated, "I hay 2017 and they are hay 2017 and they are hat before." Inducted with other staff the account receivable staff at 1:38 p.m. When asked if he for Resident #30 to receive hat before at 1:30 to receive hat dentures. In was provided prior to exit. In ary of Medical Terms for the her, 5th edition, Rothenberg and The car, 5th edition, Rothenberg and The car arise for and he didnitted to the facility on he disease, high blood	F	791			

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

Event ID: IPQ811

Facility ID: VA0050

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FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NG		COMPLETED		
		495226	B. WING _		0	3/09/2018	
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZII 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 791	set), a 30 day asse (assessment refere the resident as have the BIMS (brief interiodicating the reside cognitively. The resides assistance for all are for eating which the the tray was set up. During an interview a.m. with Resident "They ordered dent have not received thad difficulty eating sometimes the turk. Review of the reside initiated on 3/6/18, documented, "Focuthe teeth or oral cavoral mucous membed dentures/teeth/gumproblems related to Coordinate arrange needed." The care address/document and or was in need. An interview was cop.m. with OSM (oth social worker. Whe dentures was hand stated, "We go throcompany). They cowhen asked if the oresidents for dentur OSM #1 was asked.	ssment, with an ARD ence date) of 1/17/18 coded ing scored a six out of 15 on eview for mental status) ent was severely impaired ident was coded as requiring civities of daily living except e resident could perform after exconducted on 3/6/18 at 11:12 #41, Resident #41 stated, ures over a year ago and I hem yet." When asked if she Resident #41 stated, "Well ey's a little tough." ent's comprehensive care planthe day the survey begun is. Care deficit pertaining to vity characterized by; altered rane; problems with s or other oral dental health: edentulous. Interventions. Interventions. Interventions in the resident had been waiting of dentures. Inducted on 3/7/18 at 12:53 er staff member) #1, the in asked how obtaining led at the facility, OSM #1 ugh (name of dental me out to see the patients." Indental company fits the les, OSM #1 stated they did. In the date of the last time the	F 79				
	dental company wa	s at the facility. OSM #1					

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

Event ID: IPQ811

Facility ID: VA0050

If continuation sheet Page 170 of 208

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DEPAR	INENT OF REALTH	AND HUMAN SERVICES					APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			0	<u>MB NO.</u>	<u>0938-0391</u>
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495226	B. WING			03/	09/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WAYLAND NURSING AND REHABILITATION 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 PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION OATE
F 791	2017. They're comin found out today that I have not been har residents that have teeth last year and it them dentures." An interview was cop.m. with ASM #2, tasked how dental composed with a new dental properties available to don't know, I would they were last here. Supposedly she boucame with a mobile supposedly there will denture and been them hostage. We denture had been them hostage. We composed to the dentise to the dentise on 3/7/18 at 1:53 p. note for Resident #4 the note documente Pt (patient) presents exam and possible	me. I came in the end of Maying on March 22, 2018. I just at I am handling the dental part. I have two told us that they removed nothing has been done to get onducted on 3/7/18 at 1:01 he director of nursing. When oncerns were managed, ASM is just signed a new contract rovider that comes to the mobile unit." When asked me the facility had dental or residents, ASM #2 stated, "I have to check to see when With our last provider upth this company out, they unit and saw some residents, as some conflict, some made and she was holding contacted our regional and d with a new provider. They the some new dentures." ASM ovide any documentation that at coming to see Resident #41. m., a copy of dental progress the was received. Review of ad, "6/28/17. Treatment Notes: a today for post op (operative) impressions F/F (full er next visit. Treatment Plan	F	791			

On 3/8/18 at 5:15 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	COMPLETED	
		495226	B. WING		03/09/2018
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)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES OF THE	D BE COMPLÉTION
	findings.No further to exit. Food Procurement, CFR(s): 483.60(i)(1) §483.60(i) Food sa The facility must - §483.60(i)(1) - Procapproved or considistate or local author (i) This may include from local producer and local laws or refuil This provision of facilities from using gardens, subject to safe growing and for (iii) This provision of from consuming for §483.60(i)(2) - Stor serve food in accorstandards for food This REQUIREMED by: Based on observation of the facility staff failed to store one of one kitchens sanitary manner for 1. The facility staff pureed pot roast with the same consumer to the same consumer for the facility staff pureed pot roast with the same consumer for the same consumer for the facility staff pureed pot roast with the same consumer for the same consumer for the facility staff pureed pot roast with the same consumer for th	Store/Prepare/Serve-Sanitary)(2) fety requirements. sure food from sources ered satisfactory by federal, rities. food items obtained directly s, subject to applicable State gulations. foes not prohibit or prevent produce grown in facility compliance with applicable food-handling practices. floes not preclude residents fods not procured by the facility. e, prepare, distribute and dance with professional service safety. NT is not met as evidenced tion, staff interview, and facility t was determined the facility food in a sanitary manner for and failed to serve food in a two of three dining rooms. failed to discard leftover nen expired.	F 791	The out of date, leftover, pureed pot roast was throw away. C.N.A #1 was reeducated regarding the proper handling and deliver of food to residents in the dining room. C.N.A #2 was reducated regarding the proper and sanitary assisting of Resident #9's breakfast trand juice cup. An observation audit was completed by the FSM No other observations / instance of outdated food or inappropriate food delivery were Observed. Dietary staff were in-service by the Food Service Manager regarding the policy for data and discarding leftovers. Nursing personnel were inserviced by the SDC regard	y e- g ray es ed er cing
	sanitary manner in	failed to serve food in a the Peach Haven dining room. from the tray, to serve to		proper technique for delive of trays and liquids.	ry

PRINTED: U3/2U/2U18 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PRDVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495226	B. WING	B. WING			09/2018
	PROVIDER OR SUPPLIER D NURSING AND RE	HABILITATION CENTER		7	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW (EYSVILLE, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION OATE
F 812	residents' CNA (cerwas observed place top surface of the plate. 3. The facility staff with her breakfast idining observation CNA (certified nurs observed grabbing placing her bare fin CNA #2 then broug mouth, and Reside The findings includ 1. Observation was at 7:00 a.m. The return There was a bowly was ground puree a date of 2/27/18. A second observation was at 7:00 a.m. The return was a bowly was ground puree a date of 2/27/18.	rtified nursing assistant) #1 ing her thumb directly on the blate around the rim of the failed to assist Resident #9 in a sanitary manner during the in the Paradise dining room. ing assistant) #2 was Resident #9's cup of juice by igers along the top of the cup. In the cup to the resident's int #9 took a sip. e: is made of the kitchen on 3/6/18 frigerator was observed. with a label that documented it pot roast. The label contained on was made on 3/6/18 at	F	812	The Dietary manager or her designee will observe examine the kitchen for outdated food items and discard items properly. Administrative staff will observe meal service at least three times per week to ensure compliance with proper food delivery and sanitation practices. A record of observation will be kept in the Director of nurses Office and reviewed by the facility's QA Committee on a monthly basis.		
	(OSM) #6, the dieta puree pot roast dat "That should have what day it should i #6 stated, "It should 3/4/18." The facility policy, "documented in partime a food may be	nied by other staff member ary manager. When shown the ed 2/27/18, OSM #6 stated, been tossed." When asked have been disposed of, OSM d have been thrown away on Use and Storage of Leftovers" t, "The maximum length of kept is shown on the following ocumented, "Food Category:					
:	soups containing p	ny food containing vegetables, otentially hazardous foods - 5 at 41 degrees or below."					

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Event ID: IPQ811

Facility ID: VA0050

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				<u>OMB NO.</u>	0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY PLETED
		495226	B. WING			03/	09/2018
	PROVIDER OR SUPPLIER	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 PREFI TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION OATE
F 812	Continued From pa	ge 173	F8	12			, , , , , , , , , , , , , , , , , , ,
		nd the director of nursing of the above findings on3/7/18					
	No further information was obtained prior to exit.						
	sanitary manner in the White taking plates residents' CNA (cer was observed placing the sanitary manner in the waster of the was	ailed to serve food in a the Peach Haven dining room. from the tray, to serve to tified nursing assistant) #1 ng her thumb directly on the late around the rim of the					
	dining room on 3/6/ nursing assistant) # several residents th the plates off the tra the resident. While	ade of the Peach Haven 18 at 8:05 a.m. CNA (certified 1 was observed serving eir breakfast. CNA #1 took bys to place them in front of taking plates from the tray, thumb on the top surface of erim of the plate.					
	3/7/18 at 3:01 p.m. demonstrate how sha resident. CNA #1 with both of her thur plate. When asked it	inducted with CNA#1 on CNA#1 was asked to he holds a plate when serving demonstrated holding a plate habs on the top surface of the if she should be touching the where the resident's food is, bably not."					
		Food, Serving" does not I a plate when serving					

The administrator and the director of nursing were made aware of the above findings on 3/7/18

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

		AND HUMAN SERVICES					RM APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			1			OMB NO. 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495226	B. WING				03/09/2018	
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
MATANAL A NI	D MUDEING AND DE	HABILITATION CENTED		73	30 LUNENBURG HIGHW			
WAILAN	D NOKSING AND KE	HABILITATION CENTER		K	EYSVILLE, VA 23947			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	iD	\neg	PROVIDER'S PLAN OF CORRECT	CTION	(X5)	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	,	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION OATE	
F 812		ge 174 on was obtained prior to exit. ailed to assist Resident #9	F8	12				
	with her breakfast in dining observation i CNA (certified nursi observed grabbing placing her bare fing	n a sanitary manner during the n the Paradise dining room. ng assistant) #2 was Resident #9's cup of juice by gers along the top of the cup. nt the cup to the resident's						
	6/14/17 and readmidiagnoses that includementia without be disorder, type two disorder, high blood heart disease, COP pulmonary disease) most recent MDS (nquarterly assessme reference date) of 1 coded as being sever function scoring 03 BIMS (Brief Interview Resident #9 was continuous to the code of the cod	ded but were not limited to chavioral disturbance, anxiety liabetes, major depressive pressure, chronic ischemic D (chronic obstructive, and stroke. Resident #9's minimum data set) was a nt with an ARD (assessment 2/13/17. Resident #9 was erely impaired in cognitive out of possible 15 on the w for Mental Status) exam. ded as requiring extensive staff member for most ADLS						
	Paradise dining room was conducted. On (certified nursing as- assisting Resident # was observed grabb by placing her bare to cup. CNA #2 then b	m., observation of the m (feeding assistance dining) 3/6/18 at 8:25 a.m., CNA sistant) #2 was observed 9 with her breakfast. CNA #2 bing Resident #9's cup of juice fingers along the top of the rought the cup to the d Resident #9 took a sip.						

FORM APPROVED OMB NO. 0938-0391

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		495226	B. WING			03/0	09/2018
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER				730 1	EET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW /SVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	On 3/7/18 at 3:13 p conducted with CN #2 should grab a re feeding assistance wash her hands pri CNA #2 stated that bottom of the cup a cup up to her mout would not touch the stated, "That is ger informed of the abo by this writer, CNA sorry." On 3/7/18 at 4:58 p member) #1, the ac DON (Director of N the above concerns Facility Assessment CFR(s): 483.70(e)(§483.70(e) Facility The facility must co facility-wide assess resources are nece competently during and emergencies. update that assess least annually. The update this assess facility plans for, ar substantial modifica assessment. The fa address or include:	a.m., an interview was A #2. When asked how CNA esident's cup who needs CNA #2 stated that she would or to assisting the resident. she would hold around the and help the resident bring the h. When asked why she e top rim of the cup, CNA #2 ms." When CNA #2 was ove observation made in dining #2 stated, "Did, I do that? I'm a.m., ASM (administrative staff dministrator and ASM #2, the tursing) were made aware of s. at 1)-(3) assessment. assessment. assessment to determine what essary to care for its residents both day-to-day operations The facility must review and ment, as necessary, and at facility must also review and ment whenever there is, or the ay change that would require a ation to any part of this acility's resident population, facility's resident population,		338	F-838 The Facility Assessment will be updated to maintain compliance with the regulation. The IDT will collaborate on the facility Assessment to include all required facets of a comprehensive and acceptable plan and will conduct a review of the plan at least annually. After completion and adoption the Facility assessment will be reviewed with staff and current copies will be placed in different locations throughout the building. The facility assessment will be approved by the facility's QA Committee on an annual base.	pe A	The state of the s

CENTE	RS FOR MEDICARE	<u> & MEDICAID SERVICES</u>				<u>MR NO.</u>	<u>0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495226	B. WING	i		03/	09/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WAYLAND NURSING AND REHABILITATION CENTER				7:	30 LUNENBURG HIGHW		
WAYLAN	ID NURSING AND RE	HABILITATION CENTER		K	EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFED DEFICIENCY)	DBE	1X5) COMPLETION ĐATE
F 838	resident capacity; (ii) The care require considering the type physical and cognit and other pertinent that population; (iii) The staff compe provide the level and resident population; (iv) The physical enservices, and other that are necessary (v) Any ethnic, culturnay potentially affer facility, including, but food and nutrition services; (ii) Equipment (medically in Equipment (v) Contracts, memor other agreements services or equipments are in Equipment (medically in Equipment) in Equipment (v) Contracts, memor other agreements services or equipments are in Equipment (more in Equipment) in Equipment (in Equ	of residents and the facility's of dispersion of types of care needed for the dispersion of types of care needed for the dispersion of		338			
	such as systems for	r electronically managing electronically sharing					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

		I AND HUMAN SERVICES E & MEDICAID SERVICES				APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVI COMPLETED		
		495226	B. WING		03	/09/2018
	PROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 838	all-hazards approac	cility-based and risk assessment, utilizing an	F 838	3		
	by: Based on staff inte review, it was deter	erview and facility document mined that facility staff failed facility assessment.				
	assessment utilizing determine resource	ed to conduct a facility-wide g an "all hazards approach" to es necessary to care for its y-to day operations and				
	The findings include	e:				
	assessment was co assessment failed t facility's resident po ethnic, cultural, or re potentially affect the	p.m., review of the facility's onducted. The facility to address all elements of the opulation, more specifically any eligious factors that may be care provided by the facility nited to, activities and food and				
	of the facility's resord (medical and non-medical and non-medical and faile other agreements w	nent also failed to address all urces including all equipment nedical), all buildings and other of to address contracts, or with third parties to provide ent to the facility during both and emergencies.				
	conducted with ASM member) #1, the ad	p.m., an interview was // (administrative staff Iministrator. ASM #1 stated /hat the facility had before he				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/20/2018 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	PLE CONSTRUCTION IG	(X3) DATE S COMPL	
	٠	495226	B. WING_		03/09/2018	
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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	IX5) COMPLETION DATE
F 838 F 840 SS=D	Continued From parrived in the build that the facility ass ASM #1 stated that together to work of No further informatuse of Outside RecFR(s): 483.70(g) §483.70(g) Use of §483.70(g)(1) If the qualified profession service to be provimust have that serperson or agency carrangement desc Act or an agreeme (2) of this section. §483.70(g)(2) Arrangement agreeme (2) of this section. §483.70(g)(2) Arrangement agreeme (3) of this section. §483.70(g)(2) Arrangement agreement agr	age 178 ing in February. ASM #1 stated essment was not complete. It he needed to put a team in the facility assessment. Ition was presented prior to exit. sources (1)(2) outside resources. It is facility does not employ a nal person to furnish a specific ded by the facility, the facility vice furnished to residents by a putside the facility under an outside in paragraph (g) Ingements as described in the Act or agreements as described in the Act or agreements as the facility is that meet professional outside that apply to diding services in such a facility;	F 83	88	s	Jan
	Based on resident facility document review, it was determaintain a contract 28 residents in the	t interview, staff interview, eview and clinical record rmined the facility staff failed to t for dental services for three of survey sample. failed to maintain a contract to				

		& MEDICAID SERVICES					APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,		E CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
		495226	B. WING			03/	09/2018
NAME OF	PROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	-1	
WAYLAN	D NURSING AND RE	HABILITATION CENTER			'30 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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION OATE
F 840	ensure dental service Resident #18. Resident #18. Resident #18. Resident #2017 for 2. The facility staff from the ensure dental service Resident #30. Resident #30. Resident #30. Resident #30. The facility staff from the ensure dental service Resident #41. Resident #41. Resident #41.	ces were provided for dent #18 has been waiting this set of dentures. ailed to maintain a contract to be were provided for dent #30 has been waiting have his teeth removed and res. ailed to maintain a contract to be were provided for dent #41 has been waiting receive her dentures that and not delivered.	F8	40			
	ensure dental service Resident #18. Resident #18. Resident #18 was a 9/29/14 with diagnoral limited to: stroke, concluded the control of the most recent ME assessment, an annuassessment referent the resident as scorinterview for mental capable of making cresident was coded	ailed to maintain a contract to be were provided for dent #18 has been waiting his set of dentures. dmitted to the facility on sees that included but were not entractures, depression, and high blood pressure. DS (minimum data set) hala assessment, with an ce date of 12/28/17, coded ing a 15 on the BIMS (brief status) score, indicating he is laily cognitive decisions. The as requiring supervision to or his activities of daily living.					

In Section K - Swallowing/Nutritional Status the resident was coded as not having any dental

		AND HUMAN SERVICES & MEDICAID SERVICES					APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		LE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		495226	B. WING			03/	09/2018
	PROVIDER OR SUPPLIER D NURSING AND REI	HABILITATION CENTER		7	STREET ADDRESS, CITY, STATE, ZIP CODE 230 LUNENBURG HIGHW KEYSVILLE, 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 CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPED DEFICIENCY)) BE	X5) COMPLETION DATE
	dated 4/21/17, docu (treatment): Exam, The documentation dated 6/28/17, docu (treatment) Post - C impressions F/F (furity An interview was considered as 1/2/13 a.m., happened I never goall of his teeth with a dentures." 2. The facility staff for the	from the Mobile Dental Unit amented in part, "TX Full mouth extractions." from the Mobile Dental Unit amented in part, "TX: pp (operative) Possible ll set of dentures)." Inducted with Resident #18 on Resident stated, "Something of my dentures. They pulled a promise to get me alled to maintain a contract for Resident #30. Resident #30 nce June 2017 to have his measured for dentures. dmitted to the facility on ses that included but were not, high blood pressure, disease (any abnormal clood vessels outside the sorder, and dysphasia (a wallowing is difficult or painful)	F	340			
	assessment, an anr assessment referen resident as scoring a interview for mental	inual assessment, with an ce date of 1/31/18, coded the a 15 on the BIMS (brief status) score, indicating he ling daily cognitive decisions.					

The documentation from the Mobile Dental Unit,

		AND HUMAN SERVICES					APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY MPLETED
		495226	B. WING			03.	/09/2018
	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 DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	Χ.	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 840	extraction of teeth a pt (Patient) is a can dentures)."	ge 181 umented in part, "Needs as charted. After extractions, didate for F/P (fitting for partial anducted with Resident #30 on	F8	40			
	came last year and supposed to come	. The resident stated, "They cleaned my teeth but were back and pull teeth and fit me to eat pork chops and corn. ack."					
	Non-Medical Reade Chapman, page 44 (2) Barron's Diction Non-Medical Reade Chapman, 178.	ary of Medical Terms for the er, 5th edition, Rothenberg and 7. ary of Medical Terms for the er, 5th edition, Rothenberg and failed to maintain a contract for					
	dental services for I has been waiting si	Resident #41. Resident #41 nce June to receive her already made and not					
	6/21/16 with diagno	admitted to the facility on ses that included but were not n's disease, high blood red hip.					
	set) dated 1/17/18, ARD (assessment recoded the resident at the BIMS (brief inte- indicating the reside cognitively. The res- assistance for all ac-	recent MDS (minimum data a 30 day assessment, with an reference date) of 1/17/18 as having a six out of 15 on rview for mental status) ent was severely impaired ident was coded as requiring civities of daily living except resident could perform after					

the tray was set up.

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			C	MB NO.	0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495226	B. WING			03/0	09/2018
	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 CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPRIES (CROSS-REFERENCE)	D BE	(X5) COMPLETION OATE
F 840	,	-	F	340			C
		from the Mobile Dental Unit, umented, "TX (treatment):					
	dated, 6/28/18, doc	from the Mobile Dental Unit, umented, "TX: Post-Op e F/F (full set of dentures)					
	member (OSM) #1, admission/discharg p.m. When asked h dentures while at th go through (name of they come out and asked if they fit resistated, "Yes." When dental unit was at the came the end of Mascheduled to come	e planner, on 3/7/18 at 12:53 ow a resident obtains e facility, OSM #1 stated, "We of mobile dental company). see the residents." When dents' for dentures, OSM #1 asked the last time the ne facility, OSM #1 stated, "I ay 2017 and they are on 3/22/18. I just found out dling the dental part. I have					
	staff member (ASM on 3/7/18 at 1:01 p. concerns are handle stated, "We have jute a new dental provided When asked when were provided to restated, "I don't know see when they were supposedly bought out and they saw so	onducted with administrative) #2, the director of nursing, m. When asked how dental ed in the facility, ASM #2 st signed a new contract with er that comes to the facility." the last time dental services sidents at the facility, ASM #2 v, I would have to check to e last here. Our last provider out the company and came ome residents. There was a esident's dentures are being					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION ING	(X3)	COMPLETED
		495226	B. WING			03/09/2018
	PROVIDER OR SUPPLIER D NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIAT	(X5) COMPLETION E OATE
F 880 SS=F	accounts receivable asked how long the dental contract, OS want to say. The la 6/28/17. I'm not sue ended but services then and the new of the facility must estimate and the surrounder to this surrounder made aware at 5:10 p.m. No fur prior to exit. Infection Prevention CFR(s): 483.80(a)(s) §483.80 Infection of the facility must estimate the surrounder to the surrounder to the surrounder to provide comfortable environder to the surrounder to the surrounder to the surrounder to the surrounder to provide comfortable environder to the surrounder	onducted with OSM #2, the e, on 3/8/18 at 3:39 p.m. When e facility has been without a SM #2 stated, "I really don't ast visit they made was on are that's when the contract have not been provided since contract was signed 2/22/18." cy was made of ASM #2 on ately 10:00 a.m. ASM #2 veyor at 11:00 a.m. and stated a policy on obtaining outside s. and the director of nursing of the above findings on 3/8/18 ther information was provided a. Control (1)(2)(4)(e)(f) Control stablish and maintain an and control program e a safe, sanitary and nment and to help prevent the ransmission of communicable tions. In prevention and control stablish an infection prevention m (IPCP) that must include, at		F-880 The Facility's Infection policy and procedure been Reviewed and The program for Leg has been implement Residents #9, #12, # #5, #8, and #13 have assessed and have been to be unaffected by deficient practice. Every resident has to possibility of being a failure to follow the control policy and pas well as the legion Program.	e has Accepted. gionella ted. 20, #45, been been found the the affected by infection procedure	
	§483.80(a)(1) A sy	stem for preventing, identifying,				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION		PLETED
		495226	B. WING			03/	09/201 8
	PROVIDER OR SUPPLIER D NURSING AND RE	HABILITATION CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 80 LUNENBURG HIGHW EYSVILLE, VA 23947	,	
(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	tX5I COMPLETION DATE
F 880	and communicable staff, volunteers, vi providing services arrangement based conducted accordinaccepted national significant states of the but are not limited (i) A system of survice possible communications before the persons in the facili (ii) When and to who communicable discreported; (iii) Standard and to be followed to provide (ii) When and how resident; including (A) The type and depending upon the involved, and (B) A requirement to least restrictive posticumstances. (v) The circumstant must prohibit emploidisease or infected contact with reside contact will transmit	atting, and controlling infections of diseases for all residents, sitors, and other individuals under a contractual dupon the facility assessmenting to §483.70(e) and following standards; then standards, policies, and program, which must include, to reillance designed to identify cable diseases or ney can spread to other lity; nom possible incidents of ease or infections should be ransmission-based precautions revent spread of infections; isolation should be used for a but not limited to: uration of the isolation, e infectious agent or organism that the isolation should be the ssible for the resident under the ces under which the facility by each of their food, if direct		880	In-services for facility personnel have been conducted to re-inforce the tenets of the Infection Control program. Education on the legionella program will be conducted for staff. New employees will receive education on both programs as part of their orientation. The infection Control program will be monitored by the Infection Control Nurse. The Legionella Program will be monitored by the Maintenance Director. Reports of compliance and education will be submitted the and monitored by the Facility's QA Committee.		4 2 2
	§483.80(a)(4) A sys	direct resident contact. stem for recording incidents a facility's IPCP and the			i		

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 495226 B. WING 03/09/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES [X5) COMPLETION (X4) ID 1D (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 880 Continued From page 185 F 880 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to have a complete legionella program; and failed to follow infection control practices for seven of 28 residents in the survey sample, Resident #9, #12, #20, #45, #5, #8, and #13. 1. The facility failed to have a complete Legionella program. 2. The facility staff failed to maintain infection control practices and ensure Resident #9's oxygen tubing was not in contact with the floor. Resident #9's oxygen tubing dated 3-5, was observed hanging from the concentrator with most of the tubing touching the floor. At 7:24 a.m., a nursing aide (CNA [certified nursing assistant]) #2 was observed placing the nasal cannula and tubing that had been on the floor

back on the resident.

3. The facility staff failed to maintain infection control practices and store Resident #12's nebulizer mask in a plastic bag when not in use.

4. The facility staff failed to assist Resident #20

FORM APPROVED MB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ', '		E CONSTRUCTION		E SURVEY IPLETED
		495226	B. WING	;		03/	09/2018
_	PROVIDER OR SUPPLIER	HABILITATION CENTER		7:	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW (EYSVILLE, VA 23947		
(X4) ID PREFIX TA G	(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 APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 880	with meals in a san resident's room. 5. The facility staff to control practices du wound dressing chastaff member) #3, to f Nursing) was obsfor cleaning and drewith his bare hands perform wound care box and stuffed into 6. The facility staff the practices during the for Resident #5 7. The facility staff the practices in the admitted for Resident #8. 8. The facility staff the practices during the Resident #13. LPN failed to change glocare to Resident #1 the bed controls, sid with her gloved hand. The findings include 1. The facility failed program. On 3/7/18 at approximate the Legionella program (administrative staff)	failed to maintain infection uring Resident #45's stage four ange. ASM (administrative he ADON (Assistant Director served touching gauze used essing Resident #45's wound and also used gloves to e that he took from the glove on his coat pocket. failed to follow infection control administration of a treatment failed to follow infection control ininistration of a tube feeding failed to follow infection control in wound care observation on a (licensed practical nurse) #4, wes before providing wound 3 after touch multiple items, de rail, sheets and the resident ids. a: to have a complete Legionella kimately 11:00 a.m., review of ram was conducted with ASM		880			

		AND HUMAN SERVICES					APPROVED
		& MEDICAID SERVICES	l				0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION	COM	E SURVEY PLETED
		495226	B. WING		·	03/	09/2018
NAME OF F	PROVIDER OR SUPPLIER	, , , , , , , , , , , , , , , , , , , ,		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
WAYLAN	D NURSING AND REI	HABILITATION CENTER			0 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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION OATE
	presented documer the facility kitchen's side, temperature of tank, and chlorine let C were also tested numbers were not in On 3/7/18 at 11:14 a conducted with ASM he could find was sisheets. ASM #1 state program (for Legion On 3/7/18 at 5:12 pmember) #1, the add DON (Director of Not the above concerns 2. The facility staff ficontrol practices an oxygen tubing was a Resident #9's oxygen tubing was a Resident #9's oxygen tubing to a.m., a nursing aide assistant]) #2 was designed to the side of the tubing to a.m., a nursing aide assistant]) #2 was designed to the side of the si	1-3-18 and 2-12-18 were nting water temperatures of sinks on the cold and hot of the water heater, holding evel. Rooms on units A, B, and for water temperature. Rooms dentified. a.m., an interview was of the water temperature ted that all ome water temperature ted they did not have a nella) and that he will get on it. a.m., ASM (administrative staff deninistrator and ASM #2, the cursing) were made aware of the densure Resident #9's not in contact with the floor. See the concentrator with the cuching the floor. At 7:24 at (CNA [certified nursing observed placing the nasal that had been on the floor.	F8	80			
	6/14/17 and readmit diagnoses that inclu	mitted to the facility on tted on 8/19/17 with ded but were not limited to ehavioral disturbance, anxiety			•		

disorder, type two diabetes, major depressive disorder, high blood pressure, chronic ischemic heart disease, COPD (chronic obstructive pulmonary disease), and stroke. Resident #9's

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ B. WING 495226 03/09/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION 1D (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 880 Continued From page 188 F 880 most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/13/17. Resident #9 was coded as being severely impaired in cognitive function scoring 03 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #9 was coded as requiring extensive assistance with one staff member for most ADLS (activities of daily living). Review of Resident #9's most recent POS (physician order sheet) dated 2/28/18 revealed the following order: "02 (oxygen) @ 3 L (liters)/min (minute) via N/C (nasal cannula) continuous." On 3/6/18 at 7:23 a.m., an observation was made of Resident #9's room. Resident #9's 02 (oxygen) concentrator was sitting in the doorway of her room. Her oxygen tubing dated 3-5, was hanging from the concentrator. Most of the tubing was touching the floor. At 7:24 a.m., a nursing aide (CNA) #2 was coming down the hallway. CNA #2 stated she was putting soiled linen away from Resident #9's room and was coming back to bring the concentrator to the dining room where Resident #9 was sitting. This writer followed the CNA into the dining room

automatically.

where the resident was sitting. The aide placed the concentrator next to the resident, placed the nasal cannula back on the resident and turned the oxygen on. The oxygen went to up to 3 liters

conducted with CNA#2. When asked about the process followed if she were to see a resident's oxygen tubing on the floor, CNA#2 stated she could ask central supply for a new tubing or she

On 3/7/18 at 3:13 p.m., an interview was

FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION		MPLETED
-		495226	B. WING			03	3/09/2018
	PROVIDER OR SUPPLIER ND NURSING AND RE	HABILITATION CENTER		73	REET ADDRESS, CITY, STATE, ZIP CODE 10 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 880	could get a wipe an she could recall Re the floor on 3/6/18, aware of that." Wh change oxygen tubic CNA #2 stated she because of the gerron on 3/8/18 at 5:12 pmember) #1, the act DON (Director of N the above concerns The facility policy tit documents in part, cannulas, and tubin residents, or whene soiled." No further information of the facility staff frontrol practices an nebulizer mask in a Resident #12 was a 12/6/14 and readmidiagnoses that inclumajor depressive di COPD (chronic obs and urinary retentio MDS (minimum dat annual assessment reference date) of 1 coded as being cog make daily decision 15 on the BIMS (Bri	d wipe it off. When asked if sident #9's oxygen tubing on CNA #2 stated, "I was not en asked why she would ing if it had touched the floor, would change the tubing ms on the floor. .m., ASM (administrative staff Iministrator and ASM #2 the ursing) were made aware of		880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING B, WING 495226 03/09/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ťΩ (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX OATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 880 F880 Continued From page 190 extensive assistance from one staff member with bed mobility, and dressing, and total dependence on staff with toileting, personal hygiene, and bathing. Review of Resident #12's most recent POS (physician order sheet) revealed the following order: "Pulmicort [1] 0.5 mg/2 ml; premixed unit via nebulizer every night at bedtime for COPD. (Chronic Obstructive Pulmonary Disease)." On 3/6/18 at 9:08 a.m., 11:56 a.m., and 2:11 p.m., observations of Resident #12's nebulizer were conducted. His nebulizer mask dated 3/5, was observed lying on top of the nebulizer machine. It was not contained in a plastic bag. On 3/6/18 at approximately 2:11 p.m., an interview was conducted with Resident #12. When asked if he could take the mask off himself and place it on his bedside table. Resident #12 stated he needed help with everything and could not reach that far. Resident #12 stated the staff take off his mask at night when the treatment is finished.

a plastic bag.

On 3/7/18 at 8:47 a.m., an observation of Resident #12's nebulizer was conducted. The nebulizer mask was dated 3/7, indicating that it had just been changed that morning. The mask was sitting on top of the nebulizer machine not in

On 3/7/18 at 8:53 a.m., an interview was

Resident #12's nurse. When asked how a nebulizer mask should be stored when not in use, LPN #1 stated a nebulizer mask should be stored in a plastic bag to maintain infection control. LPN

conducted with LPN (licensed practical nurse) #1,

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		495226	B. WING			03/09/2018
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, ST 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	1	
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F 880	#1 followed this wri When asked what s #12's nebulizer, LP plastic bag. LPN # in the plastic bag no if Resident #12 take himself, LPN #1 sta On 3/8/18 at 5:12 p member) #1, the ac DON (Director of N the above concerns [1] Pulmicort nebuli used for the manag information was ob Institutes of Health. https://dailymed.nln	ter to Resident #12's room. she observed about Resident N #1 stated it was not in a 1 took the mask and placed it ext to the mask. When asked as off his nebulizer mask ated that he could not do that. a.m., ASM (administrative staff dministrator and ASM #2 the ursing) were made aware of s. zer is an inhaled corticosteroid gement of asthma. This tained from The National	F	380		
	with meals in a san resident's room. Resident #20 was a 11/2/15 with diagno limited to compress vertebra, difficulty in type two diabetes, of disturbance, Alzheir altered mental status Resident #20's mos set) assessment was an ARD (assessment Resident #20 was of Resident #20 was of the reside	o, facility staff failed to assist litary manner while in the admitted to the facility on ses that included but were not sion fracture of the first lumbar in walking, muscle weakness, dementia without behavioral mer's disease, heart failure, us, and difficulty swallowing, at recent MDS (minimum data as an annual assessment with ent reference date) of 1/2/18, coded as being severely e function scoring a three on				

FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING			SURVEY PLETED
		495226	B. WING			03/0	09/2018
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CI 730 LUNENBURG HI KEYSVILLE, VA 2	1GHW 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X EACH CORI	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULI RENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 880	the Staff Assessmer Resident #20 was of dependent on staff daily living). On 3/6/18 at 8:56 at conducted of Resid (certified nursing as assisting Resident #4 was observed he hands and feeding. On 3/7/18 at approxinterview was conducted of Resid (certified nursing as assisting Resident #4 was observed he hands and feeding. On 3/7/18 at approxinterview was conducted how she would first wash he with the meals. When all the with the meals with the meals with the pieces using a fork to the toast to the rewhat she did with Resident's food #4 stated she had rewhen asked why it touch resident's mouth on 3/7/18 at 4:58 pmember) #1, the according to the pieces using a fork to the toast to the rewhat she did with Resident's mouth for a sked why it touch resident's mouth on 3/7/18 at 4:58 pmember) #1, the according to the pieces using a fork to the toast to the rewhat she did with Resident's mouth for a sked why it touch resident's mouth on 3/7/18 at 4:58 pmember) #1, the according to the pieces using a fork to the toast to the rewhat she did with Resident she asked why it touch resident's mouth on 3/7/18 at 4:58 pmember) #1, the according to the pieces using a fork to the toast to the rewhat she did with Resident she according to the pieces using a fork to the toast to the rewhat she did with Resident she according to the pieces using a fork to the rewhat she did with Resident she according to the pieces using a fork to the rewhat she did with Resident she according to the pieces using a fork to the rewhat she did with Resident she according to the pieces using a fork to the rewhat she did with Resident she according to the pieces using a fork to the rewhat she did with Resident she according to the pieces using a fork to the rewhat she did with Resident she according to the pieces using a fork to the rewhat she according to the pieces using a fork to the piec	ant for Mental Status exam. coded as being totally for most ADLS (activities of .m., an observation was ent #20. A nursing aide (CNA esistant) #4 was observed #20 with her breakfast. CNA olding toast with her bare it to Resident #20. kimately 3:00 p.m., an ucted with CNA #4. When ald maintain infection control dent, CNA #4 stated she r hands before she assists hen asked how she would eeds to be fed to a resident, would break the toast into and then use the fork to give esident. When asked if this is tesident #20 on 3/6/18, CNA made a mistake that morning. was important for staff not to ad with their bare hands, CNA s from her hands would go to h. .m., ASM (administrative staff dministrator and ASM #2, the ursing) were made aware of	F	380			

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				<u>MB NO.</u>	0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED
		495226	B. WING			03/0	09/2018
	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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 880	5. The facility staff of control practices do wound dressing chastaff member) #3, to for Nursing) was obstor cleaning and drewith his bare hands perform wound care box and stuffed into Resident #45 was a 2/5/18 with diagnos limited to Stage 4 polood pressure, must of urine. Resident a coded as being more function scoring a 9 BIMS (Brief Interview Resident #45 was a assistance from two and bed mobility; extaff member with a care orders docume 2/5/18: "Cleanse W daily with sterile sal in the wound twice apply wet to dry dresident wound dresident was a considered with sterile sal in the wound twice apply wet to dry dresident wound twice	Failed to maintain infection oring Resident #45's stage four ange. ASM (administrative he ADON (Assistant Director served touching gauze used essing Resident #45's wound and also used gloves to e that he took from the glove		380			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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FORM APPROVED

PRINTED: USIZUIZUTO DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ B. WING 03/09/2018 495226 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 880 F 880 Continued From page 194 pads." On 3/8/18 at 10:58 a.m., a wound care observation was conducted with ASM #3 the ADON (Assistant Director of Nursing). ASM #3 first took a wad of gloves from the glove box and sluffed them in his coat pocket. ASM #3 then with his bare hands, reached into the gauze package, taking out a stack of gauze. ASM #3 then placed the gauze onto the medication cart directly on top of the opened TAR (treatment administration record). On 3/8/18 at 11:05 a.m., ASM #3 carried the stack of gauze and santyl with his bare hands and placed them onto the clean field in the resident's room. On 3/08/18 at 11:11 a.m., ASM #3 put on gloves (from his pocket) and cleaned his scissors with an alcohol swap. On 03/08/18 at 11:15 a.m., ASM #3 took all the gloves from his pocket and put them on the clean field. He then placed gloves on and began to remove the old dressing. ASM #3 then washed his hands and put on gloves that were part of his wad of gloves. At 11:16 a.m., ASM #3 used the gauze that he had touched with his bare hands to clean the wound along with normal saline. ASM #3 then washed his hands and placed on gloves. ASM #3 then took a Q-tip of santyl and rubbed it on an excoriated area around the wound first; and then moved into the center of the wound bed using the same Q-tip. ASM #3

then threw out the Q-tip and removed his gloves, washed his hands, and went out of the resident's room to grab additional gloves. On 3/8/18 at 11:20 a.m., ASM #3 put on clean gloves and then

saline-soaked gauze. This gauze was part of the stack that ASM #3 had touched with his bare hands. ASM #3 then placed the ABD (abdominal pad) over the wound and secured the dressing.

packed Resident #45's wound with the

FORM APPROVED OMB 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	
		495226	B. WING			03/	09/2018
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, Z 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	IP CODE		
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F 880	On 3/8/18 at 1:33 p conducted with ASI maintain infection of ASM #3 stated that remove gloves after and started to clear he would wash his gloves before apply When asked if he opocket, ASM #3 state he was going to use ever be placed in his pocket was clear coat the night beforewas wearing a new made a mistake grapackage with his battar. When asked the outside of the wouldn't matter be used to clean the wouldn't matter be used to clean the word (Director of N) the above concerns. The facility policy tit documented in part Supplies: Clean dregloves."	.m., an interview was M#3. When asked how to control during wound care, he would wash hands and representation in the removed the old dressing in the wound. ASM #3 stated hands again and put on new ring the clean (new) dressing. The work with the clean stated in his stated no. When asked if gloves a for a dressing change should its pocket; ASM #3 stated that in because he washed his re. ASM #3 then stated he jacket. ASM #3 did state he abbing the gauze from the lare hands and putting it on the lift it was ok to apply santyl to round and then move into the life same Q tip; ASM #3 stated recause the santyl was not round. I.m., ASM (administrative staff diministrator and ASM #2, the larsing) were made aware of	F	880			

	TEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3)	(X3) DATE SURVEY COMPLETED	
•		495226	B. WING			03/09/2018	
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, 2 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIAT	(X5) COMPLETION OATE	
F 880	from being confined in elderly and immodulcers may be previousition, early ambits kin lubricants and called bedsores. Projectionary of Medic Reader 2006; Mike Charles F. Chapma Stage IV Pressure Full thickness tissue tendon or muscle. Spresent on some painclude undermining Further description: The depth of a stage anatomical location occiput and malleol tissue and these uldulcers can extend in structures (e.g., fast making osteomyelit bone/tendon is visible information was obtuicer Advisory Panehttp://www.npuap.o. [2] *SANTYL® Oint active enzymatic the removes necrotic tismicroscopic level. bed of microscopic granulation to proceed occur. (<http: facility="" for="" of="" process="" staff="" td="" the="" the<="" www.6.=""><td>d to bed. Most frequently seen shilized persons, decubitus ented by frequently change of ulation, cleanliness, and use of a water or air mattress. Also essure sores. Barron's al Terms for the Non Medical A. Rothenberg, M.D. and In. Page 155. Ulcer e loss with exposed bone, Blough or eschar may be arts of the wound bed. Often g and tunneling. The bridge of the nose, ear, us do not have subcutaneous cers can be shallow. Stage IV into muscle and/or supporting cia, tendon or joint capsule) is possible. Exposed ble or directly palpable. This tained from National Pressure el website at</td><td>F 8</td><td>380</td><td></td><td></td></http:>	d to bed. Most frequently seen shilized persons, decubitus ented by frequently change of ulation, cleanliness, and use of a water or air mattress. Also essure sores. Barron's al Terms for the Non Medical A. Rothenberg, M.D. and In. Page 155. Ulcer e loss with exposed bone, Blough or eschar may be arts of the wound bed. Often g and tunneling. The bridge of the nose, ear, us do not have subcutaneous cers can be shallow. Stage IV into muscle and/or supporting cia, tendon or joint capsule) is possible. Exposed ble or directly palpable. This tained from National Pressure el website at	F 8	380			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	riple constr NG			COMPLETED
		495226	B. WING		·		03/09/2018
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		730 LUNEN	DRESS, CITY, STATE, ZIP (IBURG HIGHW .E, VA 23947	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(E/	PROVIDER'S PLAN OF CO ACH CORRECTIVE ACTION ISS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION OATE
F 880	5/21/15 with a receivith diagnoses that to: cancer of the lef abuse, Alzheimer's peripheral vascular condition affecting theart) (1), absence amputation. The most recent MI assessment, an ani assessment referenthe resident as scorinterview for mental was severely impair decisions. In Section resident was not coulcer. A significant progress at the time. Observation was mound care for Res 2:04 p.m. LPN #4 gpulled her scissors them on her clean for that was on Residenther scissors and relivated her scissors and relivated her scissors and relivated her scissors and the wound with the Hibit the inside out and the second time should form the center out LPN #4 proceeded the wound. She the	dmitted to the facility on not readmission on 2/25/18, included but were not limited to lung, dementia, alcohol disease, high blood pressure, disease (any abnormal blood vessels outside the of toes on left foot due to DS (minimum data set) nual assessment, with an note date of 12/19/18, coded ring a zero on the BIMS (brief I status) score, indicating he red to make daily cognitive on M - Skin Conditions, the ded as having a pressure change assessment was in	F8	80			
		ng left buttock wound and	1				

	FEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CONSTRUCTION	COMPLETED	
		495226	B. WING			03	/09/2018
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		730	EET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW YSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ION SHOULD BE COMPLE THE APPROPRIATE DATE	
F 880	#4 proceeded to me (centimeters). She stage 3 pressure uld a stage three LPN slough in the wound hands, put on new which was clipped a scrubs, and wrote of the fands and her when asked the prescribed dressing her hands and her when asked the prescribed treated, "I guess it reasked if she was tranurse, LPN #4 state with the previous treated."	per the physician order. LPN easure the wound, 1.0 x .7 cm stated that the wound was a cer*. When asked why it was #4 stated there was now d. She then washed her gloves. She took the pen, to the neck opening of her down the measurements. LPN to apply the physician g. LPN #4 proceeded to wash scissors with soap and water. eferred method of cleaning dressing change, LPN #4 eally should be alcohol." When ained to be the treatment ed, "A while back, I oriented eatment nurse but then they but she's now doing MDS	F	380			
-	Full-thickness loss is visible in the ulce epibole (rolled would Slough and/or eschoof tissue damage vareas of significant wounds. Undermin Fascia, muscle, ter and/or bone are no obscures the exten Unstageable Press An interview was compared to the control of	Injury: Full-thickness skin loss of skin, in which adipose (fat) or and granulation tissue and and edges) are often present. Har may be visible. The depth aries by anatomical location; adiposity can develop deep using and tunneling may occur. Hadon, ligament, cartilage to exposed. If slough or eschart of tissue loss, this is an ure Injury. (1) Inducted with LPN #4 on When asked how a nurse and, LPN #4 stated, "You start then you discard the dirty observation of her cleansing					

PRINTED: 03/20/2018 FORM APPROVED OMB NO. 0938-0391

•	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		TIPLE CONSTRUCTION NING		TE SURVEY MPLETEO
		495226	B. WING		00	3/09/2018
	PROVIOER OR SUPPLIER D NURSING AND RE	HABILITATION CENTER		STREET AOORESS, CITY, STATE, ZII 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	P COOE	·
(X4) IO PREFIX TAG	(EACH OFFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IDENTIFYING INFORMATION)	IO PREFI TAG	"	ION SHOULO BE HE APPROPRIATE	(X5) COMPLETION OATE
F 880	the wound was shat asked when scisson stated, "After we us was in her pocket, paused and then sibefore the treatment preferred, soap and stated, "It's probable. The facility policy, "documented in particle aning an area, or cleaning is needed 4 x 4 (gauze pad). "When cleaning, be least-contaminated most-contaminated wound, such as an to bottom in one mound and moving such as a pressure concentric circles, awound and moving gauze pad each time Discard the gauze repeat the procedurentire wound. Dry pads, using the same Discard the used greated Infections in showed that ordinal patients sick. In one study, a reservant in the study and study are study.	ared with LPN #4. When are should be cleaned, LPN #4 se them." When asked what LPN #4 stated, "Pens." She tated, "I should wash them at." When asked what is d water versus alcohol, LPN #4 by be alcohol." **DRESSINGS - CLEAN" t, "8. Cleanse wound. When alean from the inside out." If again, then use another clean NEVER reuse the same one."	F	380		

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

Event ID: IPQ811

Facility IO: VA0050

If continuation sheet Page 200 of 208

NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER WAYLAND NURSING AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		STRUCTION		E SURVEY IPLETED
WAYLAND NURSING AND REHABILITATION CENTER XOLIND SUMMARY STATEMENT OF DEFICIENCIES (PACH DEFICIENCY MAST BE PRECEDED BY FULL REGULATORY OR USE DENTIFYING INFORMATION) PREFIX TAG			495226			03/	09/2018	
FREENT TAG RESULATORY OR LSC IDENTIFYING INFORMATION) F 880 Continued From page 200 well as communal scissors left on dressing carts and tables. Three-quarters of the scissors carried microorganisms, including Staphylocoocus aureus, Groups A and B streptococcus, and gram-negative bacilli. The solution is quite simple. If health care workers swab the scissors with alcohol. (3) The administrator and director of nursing were made aware of the above findings on 3/8/18 at 5:10 p.m. No further information was provided prior to exit. (1) This information was obtained from the following website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ (2) Fundamentals of Nursing Made Incredibly Easy, Lippincott, Williams & Wilkins, 2007, page 428. (3) Embil JM, Dyck B, McLeod J, et al. Scissors as a potential source of nosocomial infection? Presented at the 4th Decennial International Conference on Nosocomial and Healthcare-Associated Infections. Atlanta; March 8, 2000.			HABILITATION CENTER		730 LUN	NENBURG HIGHW		
well as communal scissors left on dressing carts and tables. Three-quarters of the scissors carried microorganisms, including Staphylococcus aureus, Groups A and B streptococcus, and gram-negative bacilli. The solution is quite simple. If health care workers swab the scissors with alcohol after each use, they will virtually eliminate the risk of transmission of microorganisms. In the study, contaminated scissors were effectively districted after swabbing the scissors with alcohol. (3) The administrator and director of nursing were made aware of the above findings on 3/8/18 at 5:10 p.m. No further information was provided prior to exit. (1) This information was provided prior to exit. (1) This information was obtained from the following website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ (2) Fundamentals of Nursing Made Incredibly Easy, Lippincott, Williams & Wilkins, 2007, page 428. (3) Embil JM, Dyck B, McLeod J, et al. Scissors as a potential source of nosocomial infection? Presented at the 4th Decennial International Conference on Nosocomial and Healthcare-Associated Infections. Atlanta; March 8, 2000.	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	COMPLETION
TOT INCOMENTE ITO.	F 880	well as communal sand tables. Three-ormicroorganisms, incaureus, Groups A a gram-negative bacilf health care worke alcohol after each of the risk of transmissistudy, contaminated disinfected after swalcohol. (3) The administrator a made aware of the 5:10 p.m. No further information following website: http://www.npuap.orclinical-resources/n (2) Fundamentals of Easy, Lippincott, W 428. (3) Embil JM, Dyck as a potential source Presented at the 4th Conference on Nos Healthcare-Associa 8, 2000.	scissors left on dressing carts puarters of the scissors carried cluding Staphylococcus and B streptococcus, and Ili. The solution is quite simple. Early swab the scissors with use, they will virtually eliminate sion of microorganisms. In the discissors were effectively abbing the scissors with and director of nursing were above findings on 3/8/18 at on was provided prior to exit. If was obtained from the arg/resources/educational-and-puap-pressure-injury-stages/ If Nursing Made Incredibly illiams & Wilkins, 2007, page B, McLeod J, et al. Scissors are of nosocomial infection? In Decennial International ocomial and sted Infections. Atlanta; March failed to follow infection control failed to follow infection control		80			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		495226	B. WING			03/	09/2018
	PROVIDER OR SUPPLIER ND NURSING AND RE	HABILITATION CENTER		730	REET ADDRESS, CITY, STATE, ZIP CODE D LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PÑOVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION OATE
F 880	12/11/12 with a recumith diagnoses that to: Alzheimer's diserdisorder, diabetes, and history of subdiof blood beneath du. The most recent Milliansessment, a qual assessment references dent as having memory difficulties, being severely impadecisions. Resident dependent upon on all of her activities of Swallowing/Nutrition coded as receiving feeding tube. Observation was madial/3/8/18 at 8:45 a.m. room. The tube feeding tube. Observation was madial/3/8/18 at 8:45 a.m. room. The tube feeding tube. An interview was converse to the this surveyor. An interview was conversing assistant) #When asked where stated she had just station. When asked why slinurses show us how had been trained in feeding tube, CNA#	Indited to the facility on ent readmission on 11/6/17, included but were not limited ease, mood disorder, anxiety stroke, high blood pressure, ural hematoma (a collection ura mater in the brain) (1). DS (minimum data set) reterly assessment, with an ince date of 12/7/17, coded the both short and long term. The resident was coded as aired to make daily cognitive if #8 was coded as being e or more staff members for of daily living. In Section Kenal Status, the resident was all of her nutrition through a lade of Resident #8's room on The resident was not in the eding was hanging on the pole end of the tubing, the part eresident, was not visible to enducted with CNA (certified if 3 on 3/8/18 at 8:49 a.m. Resident #8 was, CNA #3 put her up by the nurse's did who disconnected the tube sident, CNA #3 stated, "I did." the did it, CNA #3 stated, "I did." the did it, CNA #3 stated, "The wood to take care of a #3 stated, "No, Ma'am." CNA et the end of the tubing was.	F	380			

NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING_			СОМ	PLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW			495226	B. WING				03/	09/2018
			HABILITATION CENTER		73	LUNENBURG HIGHW	IP CODE		
(EACH DESIGNERACY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COME	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TION SHOULD THE APPROPI	BE	(X5) COMPLETION OATE
F 880 Continued From page 202 CNA #3 pulled the tubing out from under the covers. When asked why it is not good to have the tubing uncovered in the bed, CNA #3 stated, "It's an infection control issue." There was an odor of a bowel movement in the room, when asked about the odor, CNA #3 stated, "I just cleaned up (Resident #8) from having a BM (bowel movement)." CNA #3 was asked why the tubing for the tube feeding being found in the covers was a concern; CNA #3 stated it was an infection control issue. An interview was conducted with LPN (licensed practical nurse) #2 on 3/8/18 at 8:52 a.m. When asked if a CNA is allowed to disconnect a tube feeding, LPN #2 stated, "Never. They are never to touch a tube feeding." The above observation was shared with LPN #2, who then proceeded to change the entire set up of tube feeding. The physician order dated, 11/7/18, documented, "Diabetisource (nutritional replacement for food specific for diabetic residents) (2) @ (at) 40 ml/hr (millilliters per hour) via Peg tube (a feeding tube inserted through the abdominal wall). The comprehensive care plan dated, 10/30/16 and revised on 12/19/17, documented in part, "Focus: At risk for state of nourishment: less than body requirement characterized by inadequate intake, decreased appetitie related to: being on a therapeutic diets, cognitive impairment depression." The "Interventions" documented in part, "Diet as ordered (Diabetisource @ 40cc per hour via peg tube." An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 3/8/18 at 12.35 p.m. When asked if a CNA can	Conthus of the contract of the	CNA #3 pulled the covers. When aske he tubing uncovered the an infection condor of a bowel more asked about the odeleaned up (Reside bowel movement), ubing for the tube covers was a concenfection control issent an interview was a concenfection control issent a CNA is a seeding, LPN #2 state of the couch a tube feed was shared with LF change the entire second condition of the comprehensive and revised on 12/2 Focus: At risk for second requirement of the comprehensive and revised on 12/2 Focus: At risk for second requirement of the comprehensive and revised on 12/2 Focus: At risk for second requirement of the comprehensive and revised on 12/2 Focus: At risk for second requirement of the comprehensive and revised on 12/2 Focus: At risk for second requirement of the comprehensive and revised on 12/2 Focus: At risk for second requirement of the comprehensive and revised on 12/2 Focus: At risk for second requirement of the comprehensive and revised on 12/2 Focus: At risk for second requirement of the comprehensive and revised on 12/2 Focus: At risk for second requirement of the comprehensive and revised on 12/2 Focus: At risk for second requirement of the comprehensive and revised on 12/2 Focus: At risk for second requirement of the comprehensive and revised on 12/2 Focus: At risk for second requirement of the comprehensive and revised on 12/2 Focus: At risk for second requirement of the comprehensive and revised on 12/2 Focus: At risk for second requirement of the comprehensive and revised on 12/2 Focus: At risk for second requirement of the comprehensive and revised on 12/2 Focus: At risk for second requirement of the comprehensive and revised on 12/2 Focus: At risk for second requirement of the comprehensive and revised on 12/2 Focus: At risk for second requirement of the comprehensive and revised on 12/2 Focus: At risk for second requirement of the comprehensive and revised on 12/2 Focus: At risk for second requirement of the comprehensive and revised requirement of the comprehensive and revised requirement of th	tubing out from under the ed why it is not good to have ed in the bed, CNA #3 stated, ntrol issue." There was an evement in the room, when lor, CNA #3 stated, "I just ent #8) from having a BM." CNA #3 was asked why the feeding being found in the ern; CNA #3 stated it was an sue. Inducted with LPN (licensed on 3/8/18 at 8:52 a.m. When allowed to disconnect a tube eated, "Never. They are never ding." The above observation PN #2, who then proceeded to set up of tube feeding. In dated, 11/7/18, documented, critional replacement for food eresidents) (2) @ (at) 40 ml/hr is via Peg tube (a feeding tube erabdominal wall). In care plan dated, 10/30/16 19/17, documented in part, estate of nourishment: less than characterized by inadequate appetite related to: being on a ognitive impairment interventions" documented in ed (Diabetisource @ 40cc per onducted with administrative 1) #2, the director of nursing,		380				

FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION		DATE SURVEY COMPLETED
		495226	B. WING				03/09/2018
	PROVIDER OR SUPPLIER	HABILITATION CENTER		73	REET ADDRESS, CITY, STATE, ZIP CODE 80 LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 880	disconnect a reside #2 stated, "No." The facility policy, "Enteral Nutrition Purcontrol practices and with the end of the state of the	Gastrostomy Tube Feeding - Imp" did not address infection ad did not document what to do tubing when it was not in use. Ind the director of nursing of the above findings on 3/8/18 ary of Medical Terms for the er, 5th edition, Rothenberg and 5 and 549. was obtained from the medical.com/dietary-suppleme eding-diabetisource-xff808181 767b4d0c\$4050.html 1.nih.gov/dailymed/drugInfo.cf 33be-44d1-bbae-e0579da12c failed to follow infection control wound care observation on (licensed practical nurse) #4, ves before providing wound 3 after touch multiple items, de rail, sheets and the resident		880			
	anemia and Alzhein The most recent MI	ner's disease. DS (minimum data set), a					

FORM APPROVED OMB NO. 0938-0391

	TEMENT OF DEFICIENCIES OPLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, .		E CONSTRUCTION	COMPLETED		
		495226	B. WING	i		03/	09/2018	
	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 DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION OATE	
F 880	quarterly assessment reference date) of thaving scored a threst (brief interview for resident was severe resident was coded activities of daily living Review of the care documented, "Focus or development of to: High risk for prell to coccyx) [1]." Review of the Marc documented, "TX (the Coccyx W/NS (was AQUACEL (2) AND (dressing) QD (even Review of the Marc administration reconsultation (treatment): CLEAN normal saline). APP ALLEVYN FOAM (3 (everyday) and PRIMALLEVYN FOAM (3 (everyday) and PRIMALLEVYN FOAM (4 (everyday) and PRIMALLEVYN FOAM (5 (everyday) and PRIMALLEVY	ent, with an ARD (assessment 12/20/17 coded the resident as ee out of 15 on the BIMS mental status) indicating the ely impaired cognitively. The las requiring assistance for all ing. plan initiated on 1/24/18 is. At Risk for skin breakdown further pressure ulcers related issure ulcer immobility (Stage h 2018 physician's orders reatment): CLEANSE ith normal saline). APPLY ALLEVYN FOAM (3) DRSG ryday) and PRN (as needed)." th 2018 medication and documented, "TX ISE COCCYX W/NS (with PLY AQUACEL (2) AND B) DRSG (dressing) QD		880				

FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	-		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495226	B-WING			03/09/2018		
	PROVIDER OR SUPPLIER ID NURSING AND RE	HABILITATION CENTER		730	EET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW /SVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 880	took from her wour over bed table. LPI change gloves after controls, sheets and care to the pressur was 4.5 cm (centime partially covered with the changed gloves dustated, "After you to above wound care LPN #4. LPN #4 stated gloves." When be changed, LPN #4 all those things. Be those little microorg. On 3/8/18 at 5:15 pmember) #1, the addirector of nursing findings. Review of the facility CARE/ULCER TRE documentation regarded care. No further informated. Stage 2 Pressure loss with exposed of skin with exposed of skin with exposed viable, pink or red, as an intact or ruptage.	saline soaked gauzes that she and supplies on the resident's N #4 did not wash her hands or r touching the resident's bed d resident prior to providing e ulcer. The pressure ulcer neters) by 1.5 cm and was	F	880				

FORM APPROVED OMB NO. 0938-0391

F 880 Continued From page 206 are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pekis and shear in the heal. This stage should not be used to describe moisture associated skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions. This information was obtained from: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ 2. Aquacel - A textile fiber dressing composed of sodium carboxymethylcellulose with potential wound-healing activity. Sodium carboxymethylcellulose dressing protects the wound site from external factors that may cause pain, promote infection, or slow the natural wound healing process. Sodium carboxymethylcellulose is a non-toxic, non-allergenic, anionic water-soluble polymer derived from cellulose. Check for active clinical trials using this agent. This information was obtained from: https://www.cancer.gov/publications/dictionaries/cancer-drug/def/sodium-carboxymethylcellulose-dressing 3. Allevyn - a hydrocellular foam dressing which is able to absorb 10 times its weight in exudate, providing a cost-effective treatment option for exuding, granulating wounds. This information was obtained from: https://www.ncbi.nlm.nih.gov/pubmed/7703644 4. Slough -1. Necrotic tissue in the process of separating from viable portions of the body. This information was obtained from:		OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:			CONSTRUCTION	COM	PLETED
MAYLAND NURSING AND REHABILITATION CENTER T30 LINENBURG HIGHW KETSVILLE, VA 23947			495226	B. WING			03/0	09/2018
PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 880 Continued From page 206 are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including inconfinence-associated dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions. This information was obtained from: http://www.npuap.org/resources/educational-and-clinical-resources/mpuap-pressure-injury-stages/ 2. Aquacel - A textile fiber dressing composed of sodium carboxymethylcellulose with potential wound-healing activity. Sodium carboxymethylcellulose with potential wound-healing process. Sodium carboxymethylcellulose dressing protects the wound site from external factors that may cause pain, promote infection, or slow the natural wound healing process. Sodium carboxymethylcellulose is a non-toxic, non-allergenic, anionic water-soluble polymer derived from cellulose. Check for active clinical trials using this agent. This information was obtained from: https://www.cancer.gov/publications/dictionaries/cancer-drug/def/sodium-carboxymethylcellulose-dressing 3. Allevyn - a hydrocellular foam dressing which is able to absorb 10 times its weight in exudate, providing a cost-effective treatment option for exuding, granulating wounds. This information was obtained from: https://www.ncbi.nlm.nih.gov/pubmed/7703644 4. Slough -1. Necrotic tissue in the process of separating from viable portions of the body. This information was obtained from:			HABILITATION CENTER		73	30 LUNENBURG HIGHW		
are not present. These injuries commonly result from adverse microcolimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence-associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions. This information was obtained from: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ 2. Aquacel - A textile fiber dressing composed of sodium carboxymethylcellulose with potential wound-healing activity. Sodium carboxymethylcellulose dressing protects the wound site from external factors that may cause pain, promote infection, or slow the natural wound healing process. Sodium carboxymethylcellulose is a non-toxic, non-allergenic, anionic water-soluble polymer derived from cellulose. Check for active clinical trials using this agent. This information was obtained from: https://www.cancer.gov/publications/dictionaries/c ancer-drug/def/sodium-carboxymethylcellulose-dressing 3. Allevyn - a hydrocellular foam dressing which is able to absorb 10 times its weight in exudate, providing a cost-effective treatment option for exuding, granulating wounds. This information was obtained from: https://www.ncbi.nlm.nih.gov/pubmed/7703644 4. Slough -1. Necrotic tissue in the process of separating from viable portions of the body. This information was obtained from:	PREFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
https://www.ncbi.nlm.nih.gov/pubmed/7703644 4. Slough -1. Necrotic tissue in the process of separating from viable portions of the body. This information was obtained from:	F 880	are not present. The from adverse micro over the pelvis and should not be used associated skin dai incontinence-associated skin injury ((skin tears, burns, awas obtained from http://www.npuap.oclinical-resources/n2. Aquacel - A textisodium carboxyme wound-healing acticarboxymethylcellu wound site from expain, promote infect healing process. So is a non-toxic, non-water-soluble polyn Check for active cli This information was https://www.cancerancer-drug/def/sodessing 3. Allevyn - a hydroable to absorb 10 tiproviding a cost-eff exuding, granulatin	ese injuries commonly result oclimate and shear in the skin shear in the heel. This stage to describe moisture mage (MASD) including stated dermatitis (IAD), actitis (ITD), medical adhesive MARSI), or traumatic wounds abrasions. This information rg/resources/educational-and-puap-pressure-injury-stages/ le fiber dressing composed of thylcellulose with potential vity. Sodium lose dressing protects the ternal factors that may cause tion, or slow the natural wound odium carboxymethylcellulose allergenic, anionic ner derived from cellulose. Inical trials using this agent. It is obtained from: I.gov/publications/dictionaries/cium-carboxymethylcellulose-dressing which is mes its weight in exudate, ective treatment option for gwounds. This information		380			
http://medical-dictionary.thefreedictionary.com/slo		https://www.ncbi.nli 4. Slough -1. Necro separating from via information was ob	m.nih.gov/pubmed/7703644 tic tissue in the process of ble portions of the body. This tained from:				·	

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

Event ID: IPQ811

Facility ID: VA0050

If continuation sheet Page 207 of 208

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CENTERS FOR MEDICARE & MEDICAID SERVICES OME							IB 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		
		495226	B. WING			03/0	/09/2018	
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 STA (EACH DEFICIENC) REGULATORY OR L	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
F 880	Continued From pa	ige 207	F	880				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED