PRINTED: 10/11/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED C		
		495255	B. WING		09/27/2018	
	PROVIDER OR SUPPLIER V SPRINGS REHAB A	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835		
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E 000			E 00	RECEI		
-	survey was conduc Corrections are req	mergency Preparedness ted 9/25/18 through 9/27/18. uired for compliance with 42 lequirement for Long-Term		NOV 0 6	2018 PLC	
E 001 SS=C	Establishment of th CFR(s): 483.73 The [facility, except comply with all applemergency prepare [facility] must estab comprehensive emprogram that meets section.* The emermust include, but nelements: *[For hospitals at §comply with all applocal emergency prhospital must development that meets are program that meets are comprehensive emprogram that meets.]	ergency preparedness the requirements of this gency preparedness program of be limited to, the following 482.15:] The hospital must licable Federal, State, and eparedness requirements. The	EOC	A Comprehensive Emergency Preparedness Plan and program was prepared 0n10/16/2018 that meets the requirements. All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this. The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensure substantial compliance Staff educated on 10/17/18 by ADON on the Comprehensive		
	*[For CAHs at §485 with all applicable Femergency prepare CAH must develop comprehensive emprogram, utilizing a This REQUIREMED by: Based on staff intereview it was determined to have a correct to the staff alled to have a correct to the staff all the st	6.625:] The CAH must comply federal, State, and local adness requirements. The and maintain a ergency preparedness in all-hazards approach. NT is not met as evidenced erview and facility document mined that the facility staff implete emergency		Emergency Preparedness Plan And will be given education monthly X 3 months then yearly. QAPI committee will review the plan Annually for completeness and educ Date Of Compliance: 10/30/2018	ation.	
	Y DIRECTOR'S OR PROVIDE La (100 P.	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	administrator	(X6) DATE	018

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

E. IEU IZE4044

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495255	B. WING		ng ng	C /27/2018		
	PROVIDER OR SUPPLIER W SPRINGS REHAB	AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835		12112010		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT TAG CROSS-REFERENCED TO THE APPRINCE DEFICIENCY)		JLD BE	(X5) COMPLETION DATE		
E 001	comprehensive em program that meets	=	ΕO	001				
E 004 SS=C	preparedness plan staff member) #11, OSM #7, the mainted the facility's emerged to evidence a comprequirements of the OSM #7 were made On 9/27/18 at 1:05 staff member), the aware of the above No further information Develop EP Plan, FCFR(s): 483.73(a) [The [facility] must of Federal, State and I preparedness requirements of this * [For hospitals at § 485.625(a):] The [I with all applicable Femergency preparedness requirements of this state and I prepared the state and I pre	a.m., the facility's emergency was reviewed with OSM (other the maintenance director, and enance assistant. Review of ency preparedness plan failed rehensive plan that meets the se regulations. OSM #11 and enaware of this concern. p.m., ASM, (administrative administrator, #1, was made findings. on was presented prior to exit. Review and Update Annually exemply with all applicable ocal emergency rements. The [facility] must and maintain a comprehensive dness program that meets the	Ε 0	A Comprehensive Emergency Preparedness Plan and program was prepared 0n10/16/2018 that meets the requirements that includes an all hazard approach. All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495255	B. WING			no	C /27/2018
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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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
E 004	comprehensive emprogram that meets section, utilizing an The emergency preinclude, but not be lelements:] (a) Emergency Plan and maintain an em that must be [review annually. * [For ESRD Facilities Plan. The ESRD facination an emerge must be [evaluated] annually. This REQUIREMENT by: Based on staff interreview it was determ failed to maintain a expreparedness plan. The facility staff failed complete emergency. The findings include On 9/27/18 at 8:30 apreparedness plan via staff member) #11, to OSM #7, the mainted the facility's emergency to evidence a complication of this complete aware of this compared the second aware of this compared aware of this compared the second aware of the	ergency preparedness the requirements of this all-hazards approach. paredness program must imited to, the following The [facility] must develop ergency preparedness plan red], and updated at least es at §494.62(a):] Emergency cility must develop and ency preparedness plan that and updated at least is not met as evidenced eview and facility document enined that the facility staff complete emergency ed to develop and maintain a ey preparedness plan. : a.m., the facility's emergency evas reviewed with OSM (other the maintenance director, and mance assistant. Review of mcy preparedness plan failed ete plan that contained all the OSM #11 and OSM #7 were	E 0	004	The Comprehensive Emergency Preparedness Plan and program wa completed per regulations to ensur substantial compliance. Staff educated on 10/17/18 by ADON on the Comprehensive Emergency Preparedness Plan And will be given education monthly X 3 months then yearly. QAPI committee assisted with the Development of the Comprehensive Emergency plan and will review months X 3 months then annually. Date of Compliance: 10/30/2018 RECEIN NOV 0 6 2 VDH/O	y enthly	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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•	PROVIDER OR SUPPLIER N SPRINGS REHAB A	AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835		72.72510	
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	staff member), the aware of the above No further information Plan Based on All FCFR(s): 483.73(a)() [(a) Emergency Plan and maintain an emithat must be review annually. The plan response of the pl	administrator, #1, was made findings. on was obtained prior to exit. lazards Risk Assessment	EO		vas vas ure		
7	this REQUIREMEN by:	IT is not met as evidenced.					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTR		(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER				PRESS, CITY, STATE, ZIP CODE	09/	/27/2018
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	Based on staff intereview, it was determined to develop an plan based on and it community-based riall-hazards approach. The facility staff failed and community-based. The findings included On 9/27/18 at 8:30 appreparedness plan with the facility's emergence to evidence a facility community-based riall-hazards approach were made aware of On 9/27/18 at 1:05 pataff member), the aware of the above of the abov	rview and facility document mined that the facility staff emergency preparedness including a facility-based and sk assessment, utilizing an h. ed to complete a facility-based ed risk assessment. e. a.m., the facility's emergency was reviewed with OSM (other the maintenance director, and mance assistant. Review of ncy preparedness plan failed y-based and sk assessment, utilizing an h. OSM #11 and OSM #7 f this concern. b.m., ASM, (administrative administrator, #1, was made findings. on was obtained prior to exit. Population	EO	A Comp Prepare was pre that add populat the type has abill emerge operation	committee assisted with the opment of the Comprehensive ency plan and will review monorths then annually. If Compliance: 10/30/2018 Orehensive Emergency edness Plan and program expared 0n10/16/2018 Exertise the requirements dresses resident/client effects in including persons at-risk, as of services the (facility) effects on including delegations of the end succession plans.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF	DOWNER OR OURDUIER	493233	D. WING			09/	27/2018
NAMEOF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
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E 007	an emergency; and including delegation plans.** *Note: ["Persons at hospice, PACE, HH FQHC, or ESRD fact This REQUIREMEN by: Based on staff intereview it was determated to have a compreparedness plan. The facility staff failed preparedness plan in patient population the strategies that the facthe needs of at-risk. The findings included On 9/27/18 at 8:30 apreparedness plan is staff member) #11, OSM #7, the mainted the facility's emerge to evidence the emericlipholes.	continuity of operations, as of authority and succession risk" does not apply to: ASC, A, CORF, CMCH, RHC, cilities.] IT is not met as evidenced rview and facility document nined that the facility staff applete emergency ed to develop the emergency that included the facility's nat would be at risk and acility put in place to address or vulnerable patients.	E	007		be ly.	
location and	place to address the	oneeds of at-risk or OSM #11 and OSM #7 were			REC	EIVE	D.
		o.m., ASM, (administrative administrator, #1, was made			NOV 0		l
	aware of the above				VDH		
	No further information	on was obtained prior to exit.			·	Riggs	

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	[(a) Emergency Pla and maintain an em that must be review annually. The plan responsible of the transfer of transfer of the tr	n. The [facility] must develop bergency preparedness plan ed, and updated at least must do the following:] It is for cooperation and cal, tribal, regional, State, and preparedness officials' efforts rated response during a bey situation, including e facility's efforts to contact when applicable, of its borative and cooperative Is only at §494.62(a)(4)]: (4) or cooperation and cal, tribal, regional, State, and preparedness officials' efforts rated response during a bey situation, including e dialysis facility's efforts to sand, when applicable, of its borative and cooperative edialysis facility must contact or preparedness agency at a firm that the agency is aware of the same and that the facility document and that the facility document and that the facility staff	E 00	Preparedness Plan and program was prepared 0n10/16/2018 that meets the requirements including a process for coopera and collaboration with local, tregional, state and federal empreparedness officials 'including or emergency situation and its to contact such officials when a participation in collaborative at corporative planning efforts. All residents have the potentiat to be affected by not having the plan in place, Preparing the plan will correct this. The Comprehensive Emergency Preparedness Plan and program completed per regulations to ensubstantial compliance. Staff educated on 10/17/18 by ADON on the Comprehensive Emergency Preparedness Plan, including a process for cooperat and collaboration with local, tri regional, state and federal eme preparedness officials' including documentation of its efforts to an integrated response during a	etion ribal, ergency g maintain a disaster efforts needed of its nd was nsure ion bal, rgency maintain		

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	(X3) DATE SURVEY COMPLETED	
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ina			iAu	DEFICIENCY)	
E 009	cooperation and col regional, State, and preparedness official integrated response emergency situation the facility's efforts the facility's efforts the facility's efforts the facility's emergency and collaborative and collaborative and collaborative and collaborative and collaborative and collaborative and collaboration with effort integration with long the facility's emergency to maintain an integration of the such officials and, we will regional to the such officials and, we will regionally state of the such officials and, we will regionally situation and the such officials and, we will regionally situation and the such officials and, we will regionally situation and the such officials and, we will regionally situation and the such officials and, we will regionally situation and the such officials and, we will regionally situation and the such situation and	llaboration with local, tribal, Federal emergency als' efforts to maintain an e during a disaster or n, including documentation of to contact such officials and, its participation in coperative planning efforts.	E 009	or emergency situation and its effort to contact such officials when neede participation in collaborative and corporative planning efforts. Educati will be given monthly X 3 months then yearly. QAPI committee assisted with the Development of the Comprehensive Emergency plan and will review mon X 3 months then annually. Date of Compliance: 10/30/2018	d of its on
	planning efforts. Os made aware of this	SM #11 and OSM #7 were			
,	staff member), the a aware of the above	administrator, #1, was made findings.		A Comprehensive Emergency	
		on was obtained prior to exit.		Preparedness Plan and program	*
E 013		Policies and Procedures	E 013		
SS=C	CFR(s): 483.73(b)			that meets the requirements that	
Annual Annua	develop and implem	cedures. [Facilities] must nent emergency preparedness ures, based on the emergency		policies and procedures are develope based on the facility-and- community based risk assessment and comminat plan, utilizing an all-hazards approach	tion

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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AIANSE OF	PROVIDER OR SUPPLIER	100200	1		TTOTAL ADDRESS OF COLUMN STATE TO CODE	09/	27/2018
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E 013	Continued From pa	ge 8	E	013	A16 41		
	plan set forth in par	agraph (a) of this section, risk			All residents have the potential	ļ	
		graph (a)(1) of this section,			to be affected by not having		
		ition plan at paragraph (c) of			the plan in place, Preparing the		
	this section. The policies and procedures must be reviewed and updated at least annually.				plan will correct this.		
	·	·			The Comprehensive Emergency	1	
		ments for PACE and ESRD			Preparedness Plan and program was		
	Facilities:	TO THE PARTY OF TH			completed per regulations to ensure		
	*IEar DACE at \$460	94/h\v1 Daliaina and			substantial compliance.	j	
		.84(b):] Policies and CE organization must			Staff educated on 10/17/18 by		ŀ
		nent emergency preparedness			ADON on the Comprehensive	ĺ	
		ures, based on the emergency			Emergency Preparedness Plan, on the]	ŀ
		agraph (a) of this section, risk			policies and procedures developed		
		graph (a)(1) of this section,			based on the facility-and- community	į	
		tion plan at paragraph (c) of			based risk assessment and comminati	ion	
		licies and procedures must			plan, utilizing an all-hazards approach		
		ent of medical and nonmedical ling, but not limited to: Fire;			Education will be given monthly X 3 m		
		or water failure; care-related			then yearly.	OHLIIS	
		atural disasters likely to			cherry carry.		
		or safety of the participants,			QAPI committee assisted with the		
		The policies and procedures			Development of the Comprehensive		
	must be reviewed a	nd updated at least annually.					
					Emergency plan and will review month	ily	
		es at §494.62(b):] Policies and			X 3 months then annually.		
		llysis facility must develop and			Data of Co. 11		
		on the emergency plan set			Date of Compliance: 10/30/2018		
		a) of this section, risk					
	assessment at para	graph (a)(1) of this section,			•	İ	1
		tion plan at paragraph (c) of				Ì	
	this section. The po	licies and procedures must be					
		ed at least annually. These				1	
		e, but are not limited to, fire,	٠			[
		failures, care-related					
		supply interruption, and					1
	natural disasters like	ely to occur in the facility's			•		
		1		- 1		1	1

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<u> </u>		495255	B. WING		09/27/2018		
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E 013	Continued From pa	ge 9	E 01:	3	ļ		
	geographic area.					ı	
		NT is not met as evidenced					
	by:	niou and facility document					
		rview and facility document nined that the facility staff					
	failed to have a con					- 1	
	preparedness plan.						
	ann 112 an a 14 a .				į	ı	
		o provide documentation that					
		cedures were developed /-and-community based risk					
		mmunication plan, utilizing an					
	all-hazards approac				Ì		
	The findings include	9:					
	On 9/27/18 at 8:30	a.m., the facility's emergency					
	preparedness plan	was reviewed with OSM (other					
		the maintenance director, and					
		enance assistant. Review of				1	
		ency preparedness plan failed entation that the policies and					
		eveloped based on a facility-			į		
		nity-based risk assessment					
		azards approach. OSM #11			1		
	and OSM #7 were r	made aware of this concern.			######################################		
	On 0/07/40 -24-05	n m ACM /administrative			· [
.		p.m., ASM, (administrative administrator, #1, was made					
***************************************	aware of the above						
Ī					AND		
	No further information	on was obtained prior to exit.					
		for Staff and Patients	E 015				
SS=C	CFR(s): 483.73(b)(1	1)		Preparedness Plan and program			
	(h) Policies and are	poduros (Facilitics) must		was prepared 0n10/16/2018]		
		ocedures. [Facilities] must nent emergency preparedness		that meets the requirements that			
		ures, based on the emergency		includes the provision of subsistence	*Primaries		
	Fairting of the brooking			needs for staff and residents' weather			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF	BOOMBED OF OHORMED	133233	L. MINO			09/	27/2018
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
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E 015	plan set forth in parassessment at para and the communicathis section. The poreviewed and update minimum, the policity address the following: (1) The provision of and patients whether place, include, but a control of a control of and patients whether place, include, but a control of a cont	agraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of dicies and procedures must be ted at least annually.] At a less and procedures must ages and procedures must ages and procedures must ages. Subsistence needs for staff for they evacuate or shelter in are not limited to the following: dical and pharmaceutical as of energy to maintain the sto protect patient health and afe and sanitary storage of aghting. The extinguishing, and alarm waste disposal. Sice at §418.113(b)(6)(iii):] ures. The additional requirements for additional requirements for patient care facilities only. In occurrence must address the subsistence needs for and patients, whether they in place, include, but are not	E	015	they evacuate or shelter in place include, but not limited to the followin food, water, medical and pharmaceutic supplies, alternate sources of energy to maintain temperature, emergency light fire detection, extinguishing and alarm systems, sewage and waste disposal. All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this. The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensure substantial compliance. Staff educated on 10/17/18 by ADON on the Comprehensive Emergency Preparedness Plan, includes the provision of subsistence needs for staff and residents' weather they evacuate or shelter in place include, but not limited to the followin food, water, medical and pharmaceutic supplies, alternate sources of energy to maintain temperature, emergency light fire detection, extinguishing and alarm systems, sewage and waste disposal. Education will be given monthly X 3 months then yearly.	g cal	

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	į	495255	B. WING			1	C /27/2018
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E 015	and safety and for to for provisions. (2) Emergency (3) Fire detectionsystems. (C) Sewage and This REQUIREMENT by: Based on staff interreview it was determed failed to have a compreparedness plan. The facility staff failed procedures for the procedures for the procedures for the procedures and waste of the findings included on 9/27/18 at 8:30 apreparedness plan wasteff member) #11, to SM #7, the maintententententententententententententen	r lighting. on, extinguishing, and alarm waste disposal. IT is not met as evidenced rview and facility document nined that the facility staff uplete emergency ed to develop policies and provision of subsistence not limited to food, water, disposal. e. a.m., the facility's emergency was reviewed with OSM (other the maintenance director, and mance assistant. Review of ncy preparedness plan failed entation of policies and provision of subsistence not limited to food, water, disposal. OSM #11 and OSM the of this concern. o.m., ASM, (administrative administrator, #1, was made	EO)15	QAPI committee assisted with the Development of the Comprehensive Emergency plan and will review mont X 3 months then annually. Date of Compliance: 10/30/2018	hly	
	No further information	on was obtained prior to exit. king of Staff and Patients	E 01	18	A Comprehensive Emergency Preparedness Plan and program	e e e e e e e e e e e e e e e e e e e	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		E CONSTRUCTION	COM	E SURVEY PLETED
		495255	B. WING	i		1	27/2018
•	PROVIDER OR SUPPLIER V SPRINGS REHAB A	ND NURSING CENTER		3(TREET ADDRESS, CITY, STATE, ZIP CODE 0 MONTVUE DRIVE URAY, VA 22835		
(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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 018	develop and impler policies and proced plan set forth in parassessment at para and the communicathis section. The poreviewed and upda minimum, the policies address the following (2) A system to trace and sheltered patients are relocated an emergency. If the patients are relocated an emergency. If the patients are relocated an emergency is patients at §483.47 Policies and proceducation of on-duty the [PRTF's, LTC, I and after an emergency, the I and after an emergency includes consideration and procedure includes consideration; ideal location(s) and printed and procedure includes and procedure include	ocedures. The [facilities] must ment emergency preparedness lures, based on the emergency agraph (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 les and procedures must ng:] ock the location of on-duty staff ints in the [facility's] care during in-duty staff and sheltered led during the emergency, the ment the specific name and living facility or other location. In 1.184(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 lency. If on-duty staff and are relocated during the external system and location of yor other location.		018	was prepared 0n10/16/2018 that meets the requirements that a system is to be in place to track the location of on-duty staff and sheltere residents in the (facility's) care during an emergency. If on-duty staff are sheltered and residents are relocated during an emergency, the (facility) must document the specific name and location of the receiving facility or other location. All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this. The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensure substantial compliance. Staff educated on 10/17/18 by ADON on the Comprehensive Emergency Preparedness Plan a system is to be in place to track the location of on-duty staff and shelterer residents in the (facility's) care during an emergency. If on-duty staff are sheltered and residents are relocated during an emergency, the (facility) must document the specific name and location of the receiving facility or other location. Education will be given monthly X 3 months then yearly.		

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION			E SURVEY IPLETED
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	495255	B. WING	····	_	09/	27/2018
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE		
SKYVIEW SPRINGS REHAB AND	NURSING CENTER		30 MONTVUE DRIVE			
ON TEN OF EMODILING AND	SHOROMA CENTER		LURAY, VA 22835			
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED		BE	(X5) COMPLETION DATE
hospice's care during a on-duty employees or relocated during the er must document the sp the receiving facility or *[For CMHCs at §485.9 procedures. (2) Safe e which includes conside treatment needs of evaresponsibilities; transpevacuation location(s); means of communication assistance. *[For OPOs at § 486.3 procedures. (2) A systed documentation that predonor information, protopotential and actual dosecures and maintains *[For ESRD at § 494.6 procedures. (2) Safe e facility, which includes needs of the patients. This REQUIREMENT by: Based on staff interviewer it was determined failed to have a complet preparedness plan.	the location of hospice and sheltered patients in the sheltered patients are mergency, the hospice pecific name and location of rother location. 1920(b):] Policies and evacuation from the CMHC, eration of care and acuees; staff portation; identification of; and primary and alternate tion with external sources of the serves potential and actual properties and estemption and estemption, and estemption and est	EO	QAPI committee assist Development of the Committee assist Developm	omprehensive will review mont ally.	:hly	

PRINTED: 10/11/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT AND PLAN C	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		PLETED
		495255	B. WING			09/2	7/2018
	PROVIDER OR SUPPLIER	AND NURSING CENTER		30	REET ADDRESS, CITY, STATE, ZIP CODE MONTVUE DRIVE JRAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT 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)	OBE	(X5) COMPLETION DATE
E 018	•		E	018		a. a	
E 020 SS=C	preparedness plan staff member) #11, OSM #7, the maint the facility's emerg to evidence policie tracking system for and OSM #7 were On 9/27/18 at 1:05 staff member), the aware of the above No further informa Policies for Evac. (CFR(s): 483.73(b) [(b) Policies and proce plan set forth in parasessment at para and the communication this section. The previewed and updated minimum, the policies the follow Safe evacuation for consideration of cevacuees; staff residentification of evacuees; staff residentification of evacuees.	a.m., the facility's emergency was reviewed with OSM (other the maintenance director, and tenance assistant. Review of ency preparedness plan failed and procedures to include a patients and staff. OSM #11 made aware of this concern. p.m., ASM, (administrative administrator, #1, was made indings. tion was obtained prior to exit. and Primary/Alt. Comm. (3) rocedures. The [facilities] must ment emergency preparedness dures, based on the emergency aragraph (a) of this section, risk ragraph (a) (1) of this section, cation plan at paragraph (c) of colicies and procedures must be ated at least annually. At a cies and procedures must be ated at least annually. At a cies and procedures must be ated at least annually. At a cies and treatment needs of sponsibilities; transportation; racuation location(s); and the means of communication	Transmission of the state of th	020	A Comprehensive Emergency Preparedness Plan and program was prepared 0n10/16/2018 that meets the requirements that safe evacuation from the (facility) which includes consideration of car and treatment needs of evacuees; responsibilities, transportation; identification of evacuation locatio and primary and alternate means o communication with external source assistance All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this.	staff on(s) of	

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

Facility ID: VA0166

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '		LE CONSTRUCTION	COM	E SURVEY IPLETED
		495255	B. WING		<u> </u>	1	C 27/2018
	PROVIDER OR SUPPLIER V SPRINGS REHAB	AND NURSING CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE O MONTVUE DRIVE LURAY, VA 22835	-	
(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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
E 020	§416.54(b)(2):] Safe evacuation frincludes the followi (i) Consideration of (ii) Staff responsibilitient (iii) Transportation. (iv) Identification of (v) Primary and altocommunication with assistance. * [For CORFs at §4 Rehabilitation Ager §485.727(b)(1), ans §494.62(b)(2):] Safe evacuation from Rehabilitation Ager Agencies as Proviot Therapy and Speed Services; and ESR staff responsibilitient (For RHCs/FQHC) evacuation from the appropriate placem responsibilities and This REQUIREME by: Based on staff intereview it was deternate a complete end of the facility staff fair procedures for a staff included care evacuees, staff residentification of evaluation of evaluati	om the [RNHCl or ASC] which ng: care needs of evacuees. evacuation location(s).	EC	020	The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensure substantial compliance. Staff educated on 10/17/18 by ADON on the Comprehensive Emergency Preparedness Plan safe evacuation from the (facility) which includes consideration of care and treatment needs of evacuees; star responsibilities, transportation; identification of evacuation location(s and primary and alternate means of communication with external sources assistance. Education will be given monthly X 3 months then yearly. QAPI committee assisted with the Development of the Comprehensive Emergency plan and will review month X 3 months then annually. Date of Compliance: 10/30/2018	s) of	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COMP) DATE SURVEY COMPLETED C	
		495255	B. WING	i		1	7/2018	
	ROVIDER OR SUPPLIER * SPRINGS REHAB A	AND NURSING CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 0 MONTVUE DRIVE URAY, VA 22835			
(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)	D BE	(X5) COMPLETION DATE	
E 020	preparedness plan staff member) #11, OSM #7, the maint the facility's emerg	es of assistance.	Е	020				
	evacuation from the treatment needs of responsibilities. Of made aware of this On 9/27/18 at 1:05 staff member), the aware of the above	e facility that included care and evacuees and staff SM #11 and OSM #7 were sconcern. p.m., ASM, (administrative administrator, #1, was made of findings.	A PARTICIPATION OF THE PARTICI			OFFICE AND ADDRESS OF THE ADDRESS OF		
	Policies/Procedure CFR(s): 483.73(b) [(b) Policies and p develop and imple policies and proce plan set forth in passessment at parand the communic this section. The previewed and upder minimum, the policies the follow (4) A means to shand volunteers which (2).(3).(5).(6)]	rocedures. The [facilities] must ment emergency preparedness dures, based on the emergency tragraph (a) of this section, risk ragraph (a)(1) of this section, eation plan at paragraph (c) of solicies and procedures must be ated at least annually. At a cies and procedures must	And the second s	022	A Comprehensive Emergency Preparedness Plan and program was prepared 0n10/16/2018 that meets the requirements that a means to shelter in place for residents, staff and volunteers who remain in the(facility) and how thes policies and procedures are aligned with a facility risk assessment. All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this.			

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	PLETED
		495255	B. WING			i .	7/2018
	SUMMARY ST	AND NURSING CENTER ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	30 Ll	REET ADDRESS, CITY, STATE, ZIP CODE MONTVUE DRIVE URAY, VA 22835 PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP	OBE	(X5) COMPLETION DATE
E 022	[facility]. *[For Inpatient Hosand procedures. (6) The following a hospice-operated The policies and p following: (i) A means to shospice employee This REQUIREMED by: Based on staff intreview it was deterailed to have a copreparedness plant. The facility staff far procedures of how means to shelter younteers who re	spices at §418.113(b):] Policies are additional requirements for inpatient care facilities only. Incoedures must address the shelter in place for patients, so who remain in the hospice. ENT is not met as evidenced serview and facility document remined that the facility staff complete emergency in. Alled to develop policies and with the facility will provide a simplace for patients, staff and main in the facility and how it procedures are aligned with a sment.		022	The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensure substantial compliance. Staff educat on 10/17/18 by ADON on the Comprehensive Emergency Prepare Plan in means to shelter in place for residents, staff and volunteers who remain in the(facility) and how these policies and procedures are aligned with a facility risk assessment. Education will be given monthly X 3 months then yearly. QAPI committee assisted with the Development of the Comprehensive Emergency plan and will review mo X 3 months then annually. Date of Compliance: 10/30/2018	ed dness e	
	preparedness pla staff member) #1 OSM #7, the main the facility's emer to evidence docu procedures of ho- means to shelter volunteers who re those policies and	0 a.m., the facility's emergency n was reviewed with OSM (other 1, the maintenance director, and ntenance assistant. Review of gency preparedness plan failed mentation of policies and w the facility will provide a in place for patients, staff and emain in the facility and how d procedures are aligned with a sment. OSM #11 and OSM #7 e of this concern.					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	C	LETED
		495255	B. WING			09/2	7/2018
	PROVIDER OR SUPPLIER V SPRINGS REHAB A	AND NURSING CENTER		30	STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835		
(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 SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
	staff member), the aware of the above No further informat Policies/Procedure	p.m., ASM, (administrative administrator, #1, was made findings. ion was obtained prior to exit. s for Medical Documentation	T T T T T T T T T T T T T T T T T T T	022	A Comprehensive Emergency	Accountment	
SS=C	[(b) Policies and prodevelop and impler policies and proced plan set forth in parassessment at parand the communic this section. The previewed and updaminimum, the policies and reserves patient is confidentiality of parand maintains ava (3),(4),(6)] A system of maintains ava (3),(4),(6)] A system of maintains ava (5),(4),(6)] A system of maintains ava (6),(6) Preserves patient is procedures. (7) A strategies and maintains ava (1) Preserves patient (1) Protects confidentiality of parand maintains ava (1) Preserves patient (1) Protects confidentiality of parand maintains ava (1) Preserves patient (1) Protects confidentiality of parand maintains ava (1) Preserves patient (1) Protects confidentiality of parand maintains ava (2) Protects confidentiality of parand maintains ava (3), (4), (6) Preserves patient (1) Protects confidentiality of parand maintains ava (2), (4), (6) Preserves patient (1) Protects confidentiality of parand maintains ava (2), (3), (4), (6) Preserves patient (1) Protects confidentiality of parand maintains ava (3), (4), (6) Preserves patient (1) Protects confidentiality of parand maintains ava (3), (4), (6) Preserves patient (1) Protects (1) Prote	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 ated at least annually. At a cies and procedures must ing:] edical documentation that information, protects atient information, and secures ilability of records. [(5) or m of medical documentation ient information, protects atient information, and secures ilability of records. 403.748(b):] Policies and system of care documentation wing:			Preparedness Plan and program was prepared 0n10/16/2018 that meets the requirements that a system of medical documentation that preserves resident information protects confidentiality of resident information, and secures and maintains availability of records. All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this. The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensure substantial compliance. Staff educated on 10/17/18 by ADON on the Comprehensive Emergency Preparedness Plan that a system of medical docume that preserves resident information protects confidentiality of resident information, and secures and maintains availability of records is in p Education will be given monthly X 3 months then yearly.	ess entation	

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	ROVIDER OR SUPPLIER	AND NURSING CENTER		30	TREET ADDRESS, CITY, STATE, ZIP CODE D MONTVUE DRIVE URAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 023	donor information, potential and actual secures and maint. This REQUIREME by: Based on staff intereview it was deterfailed to have a corpreparedness plan. The facility staff fail procedures of how information, protectinformation, and seavailability of record The findings included the facility's emergence and the facility's emergence and the facility's emergence documprocedures of how information, protectinformation, protectinformation, and seavailability of record evidence aware. On 9/27/18 at 1:05 staff member), the aware of the above	t preserves potential and actual protects confidentiality of all donor information, and ains the availability of records. NT is not met as evidenced erview and facility document mined that the facility staff mplete emergency in the facility preserves patient ests confidentiality of patient ecures and maintains eds. de: a.m., the facility's emergency in was reviewed with OSM (other in, the maintenance director, and tenance assistant. Review of gency preparedness plan failed mentation of policies and in the facility preserves patient ects confidentiality of patient ects end		023	QAPI committee assisted with the Development of the Comprehensive Emergency plan and will review month X 3 months then annually. Date of Compliance: 10/30/2018	thly	
E 024		ation was obtained prior to exit. es-Volunteers and Staffing	E	024			

PRINTED: 10/11/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	СОМ	PLETED
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	PROVIDER OR SUPPLIEF V SPRINGS REHAB	AND NURSING CENTER	I	3	TREET ADDRESS, CITY, STATE, ZIP CODE 0 MONTVUE DRIVE .URAY, VA 22835	-	
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 024 SS=C	CFR(s): 483.73(b) [(b) Policies and proceed of the policies and proceed plan set forth in proceed and the communication of the previewed and updominimum, the policies and the communication of the procedures in an estaffing strategies for integration of the procedures. (6) The procedures of the proc	rocedures. The [facilities] must ement emergency preparedness dures, based on the emergency aragraph (a) of this section, risk ragraph (a)(1) of this section, cation plan at paragraph (c) of policies and procedures must be ated at least annually. At a cies and procedures must be ated at least annually. At a cies and procedures must be ated at least annually. At a cies and procedures must be ated at least annually. At a cies and procedures must be ated at least annually. At a cies and procedures must be ated at least annually. At a cies and procedures must be ated at least annually. At a cies and procedures must be ated at least annually. At a cies and role state and Federally designated asionals to address surge needs and he use of volunteers in an an an aterior emergency staffing less surge needs during an entry is not met as evidenced aterview and facility document ermined that the facility staff complete emergency in. The facility document ermined to develop policies and le use of volunteers in the lade:		024	A Comprehensive Emergency Preparedness Plan and program was prepared 0n10/16/2018 that meets the requirements that addresses the use of volunteers in a emergency and other emergency staffing strategies and to address sur needs during an emergency. All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this. The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensure substantial compliance. Staff educat on 10/17/18 by ADON on the Comprehensive Emergency Prepared Plan that addresses the use of volur in an emergency and other emergen staffing strategies to address surge needs during an emergency. Education will be given monthly X 3 months then yearly. QAPI committee assisted with the Development of the Comprehensive Emergency plan and will review mor X 3 months then annually. Date of Compliance: 10/30/2018	ed Iness Iteers	
	On 9/27/18 at 8:3	0 a.m., the facility's emergency					

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

Event ID: K51C11

Facility ID: VA0166

Creation affor sheet Page 21 of 218

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STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	LETED
		495255	B. WING				7/2018
	PROVIDER OR SUPPLIER V SPRINGS REHAB	AND NURSING CENTER		30	REET ADDRESS, CITY, STATE, ZIP CODE MONTVUE DRIVE JRAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT 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 APPROPOSITION OF THE PROPOSITION OF THE PR)BE	(X5) COMPLETION DATE
E 024 E 026 SS=C	staff member) #11 OSM #7, the main the facility's emerg to evidence docum procedures for the emergency plan. made aware of thi On 9/27/18 at 1:03 staff member), the aware of the abov No further informa Roles Under a Wa CFR(s): 483.73(b) [(b) Policies and p develop and imple policies and proce plan set forth in p assessment at pa and the communi this section. The p reviewed and upd minimum, the pol address the follow (8) [(6), (6)(C)(iv) [facility] under a w in accordance wit provision of care	n was reviewed with OSM (other, the maintenance director, and tenance assistant. Review of gency preparedness plan failed nentation of policies and use of volunteers in the OSM #11 and OSM #7 were sconcern. 5 p.m., ASM, (administrative administrator, #1, was made a findings. ation was obtained prior to exit. Activer Declared by Secretary (a) (b) brocedures. The [facilities] must be dement emergency preparedness and procedures must be lated at least annually. At a dicies and procedures must	A CONTRACT OF THE CONTRACT OF	024	A Comprehensive Emergency Preparedness Plan and program was prepared 0n10/16/2018 that meets the requirements that addresses the role of the facility und a waiver declared by the Secretary, accordance with section1135 of the in the provision of care and treatme at an alternate care site identified b emergency management officials. All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this.	in Act, ent	
	procedures. (8) T	§403.748(b):] Policies and he role of the RNHCI under a by the Secretary, in accordance		,			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG		PLETED
		495255	B. WING _			27/2018
	PROVIDER OR SUPPLIER V SPRINGS REHAB A	AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 30 MONTVUE DRIVE LURAY, VA 22835		
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 026	with section 1135 of at an alternative car management official. This REQUIREMED by: Based on staff intereview it was determined to have a compreparedness plan. The facility staff fair procedures in the each the facility's role in at alternate care since the facility's role in at alternate care since for the facility's emerged to evidence documprocedures in the facility's role in at alternate care since for evidence documprocedures in the facility's role in at alternate care since for evidence documprocedures in the facility's role in at alternate care since for evidence documprocedures in the facility's role in at alternate care since for evidence documprocedures in the facility's role in at alternate care since for evidence documprocedures in the facility's role in at alternate care since for evidence documprocedures in the facility's role in at alternate care since for evidence documprocedures in the facility's role in at alternate care since for evidence documprocedures in the facility's role in at alternate care since for evidence documprocedures in the facility is role in at alternate care since for evidence documprocedures in the facility is role in at alternate care since for evidence documprocedures in the facility is role in at alternate care since for evidence	of Act, in the provision of care are site identified by emergency als. NT is not met as evidenced erview and facility document mined that the facility staff implete emergency. Iled to develop policies and emergency plan that describe providing care and treatment tes under an 1135 waiver. Ite: I a.m., the facility's emergency is was reviewed with OSM (other, the maintenance director, and tenance assistant. Review of pency preparedness plan failed mentation of policies and emergency plan that describe providing care and treatment ites under an 1135 waiver. M #7 were made aware of this Is p.m., ASM, (administrative endministrator, #1, was made e findings.	EO2	The Comprehensive Emergency Preparedness Plan and prograr completed per regulations to e substantial compliance. Staff er on 10/17/18 by ADON on the Comprehensive Emergency Preplan addresses the role of the a waiver declared by the Secre accordance with section1135 of in the provision of care and treat an alternate care site identification will be given month X 3 months then yearly. QAPI committee assisted with Development of the Comprehe Emergency plan and will review X 3 months then annually. Date of Compliance: 10/30/20	n was nsure ducated eparedness facility under tary, in of the Act, eatment fied by als. ely the ensive w monthly	
E 029 SS=C	Development of C CFR(s): 483.73(c)	tion was obtained prior to exit. ommunication Plan ust develop and maintain an	EO		am for a	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	СОМ	E SURVEY IPLETED
		495255	B. WING				27/2018
		AND NURSING CENTER		3(TREET ADDRESS, CITY, STATE, ZIP CODE D MONTVUE DRIVE URAY, VA 22835		
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E 029	that complies with and must be revie annually. This REQUIREME by: Based on staff intreview it was deterailed to have a copreparedness plane Facility staff failed plan. The findings included on 9/27/18 at 8:30 preparedness planestaff member) #11 OSM #7, the main the facility's emerging to evidence documplan. OSM #11 arof this concern.	redness communication plan Federal, State and local laws wed and updated at least ENT is not met as evidenced erview and facility document rmined that the facility staff emplete emergency n. to develop a communication de: D. a.m., the facility's emergency n was reviewed with OSM (other , the maintenance director, and stenance assistant. Review of gency preparedness plan failed mentation of a communication and OSM #7 were made aware		029	All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this. The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensure substantial compliance. Staff educate on 10/17/18 by ADON on the Comprehensive Emergency Prepared Plan for a development of a complet Communication plan. Education will be given monthly X 3 months then yearly. QAPI committee assisted with the Development of the Comprehensive Emergency plan and will review month X 3 months then annually. Date of Compliance: 10/30/2018	ness e	
E 030 SS=C	staff member), the aware of the above No further information Names and Contact CFR(s): 483.73(c) [(c) The [facility, etransplant centers maintain an emergen communication pl	ation was provided prior to exit.	E	030	A Comprehensive Emergency Preparedness Plan and program was prepared 0n10/16/2018 that meets the requirements for a complete communication plan that includes all required facility contacts are included in the communication p	i	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED			
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	CUBANADV STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	N	(X5) COMPLETION	
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E 030	(1) Names and corfollowing: (i) Staff. (ii) Entities providin (iii) Patients' physic (iv) Other [facilities (v) Volunteers. *[For RNHCls at §4 communication plat following: (1) Names and corfollowing: (i) Staff. (ii) Entities providir (iii) Next of kin, gual (iv) Other RNHCls (v) Volunteers. *[For ASCs at §41 plan must include (1) Names and corfollowing: (i) Staff. (ii) Staff.	anually. The communication all of the following:] Intact information for the ag services under arrangement. It is is a service and is a servi		030	All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this. The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensure substantial compliance. Staff education 10/17/18 by ADON on the Comprehensive Emergency Prepared Plan for a development of a comple Communication plan that includes a Required facility contacts. Education will be given monthly X 3 months then yearly. QAPI committee assisted with the Development of the Comprehensive Emergency plan and will review mo X 3 months then annually. Date of Compliance: 10/30/2018	ed dness te II		
	(iv) Volunteers. *[For Hospices at communication plates following: (1) Names and confollowing: (i) Hospice employed	§418.113(c):] The an must include all of the intact information for the	Constitution of the Consti					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
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E 030	Continued From page 25 (iii) Patients' physicians. (iv) Other hospices.		ΕO	30			
	*[For OPOs at §486 plan must include a (1) Names and confollowing: (i) Staff. (ii) Entities providing (iii) Volunteers. (iv) Other OPOs. (v) Transplant and of Donation Service Arthis REQUIREMENTS Based on staff intereview it was determined to have a compreparedness plan. Facility staff failed to facility contacts were communication plants. The findings included On 9/27/18 at 8:30 apreparedness plants staff member) #11, OSM #7, the mainterest to evidence that all included in the communication of the communication of the facility's emergent to evidence that all included in the communication of the communication	is 360(c):] The communication and the following: tact information for the grant services under arrangement. Idonor hospitals in the OPO's rea (DSA). It is not met as evidenced review and facility document nined that the facility staff aplete emergency It is evidence that all required e included in the included in					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495255		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
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E 030	Continued From page 26 No further information was provided prior to exit.		E 0	30		
SS=C	Emergency Officials CFR(s): 483.73(c)(2 [(c) The [facility] mu emergency prepared that complies with Fand must be review annually.] The commall of the following: (2) Contact informat (i) Federal, State, emergency prepared (ii) Other sources *[For LTC Facilities a information for the folion for the foli	st develop and maintain an dness communication plan dederal, State and local laws ed and updated at least munication plan must include ion for the following: tribal, regional, and local dness staff. of assistance. at §483.73(c):] (2) Contact collowing: bal, regional, or local dness staff. ing and Certification Agency. State Long-Term Care f assistance. 33.475(c):] (2) Contact collowing: bal, regional, and local dness staff. assistance. 33.475(c):] (2) Contact collowing: bal, regional, and local dness staff. assistance. 35.475(c):] (5) Contact collowing: bal, regional, and local dness staff. assistance. 36.475(c):] (1) Contact collowing: bal, regional, and local dness staff. assistance. 37.475(c):] (2) Contact collowing: bal, regional, and local dness staff. assistance. 38.475(c):] (2) Contact collowing: bal, regional, and local dness staff. assistance. 39.475(c):] (2) Contact collowing: bal, regional, and local dness staff. assistance.	EO	A Comprehensive Emergency Preparedness Plan and program was prepared 0n10/16/2018 that meets the requirements for a complete communication plan that includes contact information on festate, tribal, regional, and local emergency preparedness staff and other sources of assistance. All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this. The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensure substantial compliance. Staff education 10/17/18 by ADON on the Comprehensive Emergency Prepared Plan for a complete communication that includes contact information on federal, state, tribal, regional, and ic emergency preparedness staff and other sources of assistance. Education will be given monthly X 3 months then yearly.	deral,	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	emergency official's included in the com The findings included On 9/27/18 at 8:30 a preparedness plant staff member) #11, 10SM #7, the mainted the facility's emerge to evidence that all recontact information communication plant were made aware of On 9/27/18 at 1:05 pstaff member), the aware of the above. No further information of the primary/Alternate M CFR(s): 483.73(c)(3) [(c) The [facility] must emergency prepared	o evidence that all required contact information was munication plan. e: a.m., the facility's emergency was reviewed with OSM (other the maintenance director, and enance assistant. Review of ncy preparedness plan failed required emergency official's was included in the a. OSM #11 and OSM #7 f this concern. b.m., ASM, (administrative administrator, #1, was made findings. on was provided prior to exit. eans for Communication of the communication plan	EO	QAPI committee assisted with Development of the Compressive Emergency plan and will revolve X 3 months then annually. Date of Compliance: 10/30/	cy gram 8			
	and must be reviewed annually.] The commall of the following: (3) Primary and alter communicating with (i) [Facility] staff.	the following: ibal, regional, and local		complete communication p includes communication pl primary and alternate mear communication with facility federal, state, tribal, and loc emergency management ag	lan that an for as for y staff, cal			

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	D: 10/11/2018 MAPPROVED D: 0938-0391
LAND PLAN OF CORRECTION LINEWITH INCIDENTIAL MILITARED.		1	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
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SKYVIEW SPRINGS REHAB AND NURSING CENTER				30 MONTVUE DRIVE LURAY, VA 22835		
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	*[For ICF/IIDs at §44 alternate means for ICF/IID's staff, Fede local emergency ma This REQUIREMEN by: Based on staff interreview it was determ failed to have a compreparedness plan. The facility staff failed documentation that includes primary and communicating with tribal, and local emeagencies by reviewing The findings includes On 9/27/18 at 8:30 a preparedness plan with the facility's emerger to evidence documentation plan alternate means for estaff, Federal, State, management agencic communication plan were made aware of On 9/27/18 at 1:05 p	B3.475(c):] (3) Primary and communicating with the ral, State, tribal, regional, and magement agencies. IT is not met as evidenced view and facility document ained that the facility staff plete emergency It to provide evidence of the communication plan alternate means for facility staff, Federal, State, regency management agency management agency management and the communication plan. Im., the facility's emergency was reviewed with OSM (other he maintenance director, and mance assistant. Review of any preparedness plan failed includes primary and communicating with facility tribal, and local emergency es by reviewing the OSM #11 and OSM #7 this concern. Im., ASM, (administrative diministrator, #1, was made	Eos	All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this. The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensur substantial compliance. Staff education on 10/17/18 by ADON on the Comprehensive Emergency Prepared Plan for a complete communication that includes communication plan primary and alternate means for communication with facility staff, federal, state, tribal, and local emergency management agencies assistance. Education will be given monthly X 3 months then yearly. QAPI committee assisted with the Development of the Comprehensive Emergency plan and will review mo X 3 months then annually. Date of Compliance: 10/30/2018	e ted edness n plan for	

No further information was obtained prior to exit.

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			PRINTE	D: 10/11/2018
		& MEDICAID SERVICES				M APPROVED O. 0938-0391
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E 033 SS=C	emergency prepared that complies with Frand must be reviewed annually.] The commall of the following: (4) A method for shad documentation for pacare, as necessary, maintain the continuit (5) A means, in the erelease patient inform CFR 164.510(b)(1)(ii required for HHAs urunder §485.68(c), an §491.12(c).] (6) [(4) or (5)]A mean about the general compatients under the [faunder 45 CFR 164.51) *[For RNHCIs at §400 sharing information and shadow the general compatients under the patients under the patients under the patients under the general compatients under the general	g Information a)-(6) st develop and maintain an idness communication plan ederal, State and local laws ed and updated at least munication plan must include aring information and medical attents under the [facility's] with other health providers to ity of care. Event of an evacuation, to mation as permitted under 45 in [This provision is not inder §484.22(c), CORFs and RHCs/FQHCs under This of providing information and location of acility's] care as permitted and to(b)(4). 3.748(c):] (4) A method for and care documentation for	E 03:	4		
The state of the s	with care providers to care, based on the w made by the patient o representative. *[For RHCs/FQHCs a of providing information	at §491.12(c):] (4) A means				

DEPARTMENT OF HE	ALTH AND HUMAN SERVICES
CENTERS FOR MEDI	CARE & MEDICAID SERVICES

FORM APPROVED OMB NO. 0938-0391

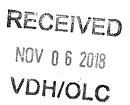
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	facility's care as per 164.510(b)(4). This REQUIREMEN by: Based on staff inter review it was determ failed to have a compreparedness plan. The facility staff faile documentation that the included a method for medical documentation that the facility's care, as necessary as necessary and the general conditions reviewing the communication that the plan also failed the procedures that additional the general conditions reviewing the communication that the facility's energen to evidence spanning information and for patients under the necessary, with other the continuity of care communication plant afacility has developed facility has developed	IT is not met as evidenced rview and facility document nined that the facility staff uplete emergency and to provide evidence of the communication plan for sharing information and ion for patients under the ressary, with other health in the continuity of care by unication plan and he facility has developed. To evidence policies and ress the means the facility attent information to include and location of patients by unication plan. I.m., the facility's emergency has reviewed with OSM (other ne maintenance director, and hance assistant. Review of cry preparedness plan failed neation that the included a method for and medical documentation of facility's care, as the alth providers to maintain	EO	The Comprehensive Emerge Preparedness Plan and procompleted per regulations substantial compliance. State on 10/17/18 by ADON on the Comprehensive Emergency Plan for a complete commit that includes a method for information and medical documentation for resident the facility's care as necessate other health providers to must the continuity of care and the means that the facility to release resident informational include the general conditional location of residents. Educate be given monthly X 3 months and will revise X 3 months then annually. Date of Compliance: 10/30/2	ogram was to ensure aff educated the r Preparedness unication plan sharing ts under ary, with aintain hat address will use tion to n and attion will as then yearly. The the chensive lew monthly		

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

Event ID: K51C11

Facility ID: VA0166

If continuation sheet Page 31 of 218



DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/11/2018 **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: A. BUILDING_ COMPLETED C 495255 B. WING 09/27/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE SKYVIEW SPRINGS REHAB AND NURSING CENTER **LURAY, VA 22835** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) E 033 Continued From page 31 E 033 the means the facility will use to release patient information to include the general condition and location of patients by reviewing the communication plan. OSM #11 and OSM #7 were made aware of this concern. On 9/27/18 at 1:05 p.m., ASM, (administrative staff member), the administrator, #1, was made aware of the above findings. No further information was obtained prior to exit. E 034 Information on Occupancy/Needs E 034 SS=C CFR(s): 483.73(c)(7) A Comprehensive Emergency Preparedness Plan and program [(c) The [facility] must develop and maintain an was prepared 0n10/16/2018 emergency preparedness communication plan that meets the requirements for a that complies with Federal, State and local laws complete communication plan that and must be reviewed and updated at least annually.] The communication plan must include includes a means of providing all of the following: information about the facility needs and its ability to provide assistance, (7) [(5) or (6)] A means of providing information to the authority having jurisdiction, about the [facility's] occupancy, needs, and its on the occupancy of the facility. ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. All residents have the potential to be affected by not having *[For ASCs at 416.54(c)]: (7) A means of the plan in place, Preparing the providing information about the ASC's needs, and

Center, or designee.

its ability to provide assistance, to the authority having jurisdiction, the Incident Command

*[For Inpatient Hospice at §418.113:] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or

plan will correct this.

PRINTED: 10/11/2018 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 C 495255 B. WING 09/27/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE SKYVIEW SPRINGS REHAB AND NURSING CENTER **LURAY, VA 22835** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION PREFIX PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) E 034 Continued From page 32 E 034 The Comprehensive Emergency designee. Preparedness Plan and program was This REQUIREMENT is not met as evidenced completed per regulations to ensure substantial compliance. Staff educated Based on staff interview and facility document review it was determined that the facility staff on 10/17/18 by ADON on the failed to have a complete emergency **Comprehensive Emergency Preparedness** preparedness plan. Plan for a complete communication plan that includes a means of providing The facility staff failed to provide evidence of information about the facility needs documentation that the communication plan and its ability to provide assistance, includes a means of providing information about the facility's needs, and its ability to provide to the authority having jurisdiction, assistance, to the authority having jurisdiction, the on the occupancy of the facility. incident Command Center, or designee by Education will be given monthly reviewing the communication plan and X 3 months then yearly. documentation that the communication plan includes a means of providing information about QAPI committee assisted with the their occupancy.

The findings include:

On 9/27/18 at 8:30 a.m., the facility's emergency preparedness plan was reviewed with OSM (other staff member) #11, the maintenance director, and OSM #7, the maintenance assistant. Review of the facility's emergency preparedness plan failed to evidence documentation that the communication plan includes a means of providing information about the facility's needs, and its ability to provide assistance, to the authority having jurisdiction, the incident Command Center, or designee by reviewing the communication plan and documentation that the communication plan includes a means of providing information about their occupancy. OSM #11 and OSM #7 were made aware of this concern.

On 9/27/18 at 1:05 p.m., ASM, (administrative

Date of Compliance: 10/30/2018

X 3 months then annually.

Development of the Comprehensive

Emergency plan and will review monthly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			DATE SURVEY COMPLETED	
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E 034 E 035 SS=C	staff member), the a aware of the above No further informati LTC and ICF/IID Sh CFR(s): 483.73(c)(8 [(c) The [LTC facility and maintain an emcommunication plan State and local laws updated at least and plan must include all (8) A method for sha emergency plan, that is appropriate, with families or represent This REQUIREMEN by: Based on staff interreview it was determ failed to have a compreparedness plan. The facility staff failed documentation that includes a method for the same proper staff and the same plan.	administrator, #1, was made findings. on was obtained prior to exit. aring Plan with Patients and ICF/IID] must develop ergency preparedness in that complies with Federal, and must be reviewed and mustly.] The communication of the following: aring information from the facility has determined residents [or clients] and their statives. IT is not met as evidenced evidenced enter that the facility document fined that the facility staff uplete emergency ed to provide evidence of the communication plan for sharing information from with residents or clients and esentatives.	EO	A Comprehensive Emergency Preparedness Plan and progra was prepared 0n10/16/2018 that meets the requirements from complete communication plan includes a method for sharing information from the emerger plan with residents and their families or representatives. All residents have the potentiat to be affected by not having the plan in place, Preparing the plan will correct this. The Comprehensive Emergence Preparedness Plan and program completed per regulations to essubstantial compliance. Staff eron 10/17/18 by ADON on the Comprehensive Emergency Preplan for a complete communication from the emergence information from the emergence information from the emergence was preparedness and the plan for a complete communication from the emergence information in the emergence information in the emergence information from the emergence in the programment in the emergence in the plan in t	for a that ncy If m was ensure ducated eparedness cation plan	1 1	
1	preparedness plan v staff member) #11, t OSM #7, the mainte	a.m., the facility's emergency vas reviewed with OSM (other he maintenance director, and nance assistant. Review of ncy preparedness plan failed		plan with residents and their families or representatives. Education will be given month X 3 months then yearly.	ly		

PRINTED: 10/11/2018 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 C 495255 B. WING 09/27/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **30 MONTVUE DRIVE** SKYVIEW SPRINGS REHAB AND NURSING CENTER LURAY, VA 22835 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE **PRÉFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) E 035 Continued From page 34 QAPI committee assisted with the E 035 to evidence documentation that the Development of the Comprehensive communication plan includes a method for Emergency plan and will review monthly sharing information from the emergency with X 3 months then annually. residents or clients and their families or representatives. OSM #11 and OSM #7 were Date of Compliance: 10/30/2018 made aware of this concern. On 9/27/18 at 1:05 p.m., ASM, (administrative staff member), the administrator, #1, was made aware of the above findings. No further information was obtained prior to exit. E 036 | EP Training and Testing E 036 A Comprehensive Emergency CFR(s): 483.73(d) SS=C Preparedness Plan and program was prepared 0n 10/16/2018 (d) Training and testing. The [facility] must that meets the requirements that develop and maintain an emergency preparedness training and testing program that is evidence of documentation that the based on the emergency plan set forth in facility has a written training and paragraph (a) of this section, risk assessment at testing program that meets the paragraph (a)(1) of this section, policies and requirements of the regulation procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this

section. The training and testing program must be reviewed and updated at least annually.

testing. The ICF/IID must develop and maintain

an emergency preparedness training and testing program that is based on the emergency plan set

*[For ICF/IIDs at §483.475(d):] Training and

forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this

section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at

least annually. The ICF/IID must meet the requirements for evacuation drills and training at

All residents have the potential to be affected by not having

the plan in place, Preparing the

plan will correct this.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUBBLIER/CLIA

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495255	B. WING	i		С	
NAME OF	PROVIDER OR SUPPLIER		T	STREET ADDRESS, CITY, STATE, ZIP C	09	/27/2018	
]				30 MONTVUE DRIVE	JUE		İ
SKYVIE	N SPRINGS REHAB A	ND NURSING CENTER		LURAY, VA 22835			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	PECTION	1 00	
PRÉFIX TAG			PREFI) TAG	X (EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE	1
E 036		ge 35	E 0	The Comprehensive Emergency	ev		
	§483.470(h).			Preparedness Plan and progra		}	1
	*IFor ESBD Facilitie	es at §494.62(d):] Training,	•	completed per regulations to	ensure		
	testing, and orientat	ion. The dialysis facility must		substantial compliance. Staff e	ducated		
	develop and mainta	in an emergency		on 10/17/18 by ADON on the			۱
	preparedness trainir	ng, testing and patient		Comprehensive Emergency Pro	eparedness		l
	orientation program			Plan for evidence of documen	tation that the		
	emergency plan set	forth in paragraph (a) of this		facility has a written training a			ı
	this section policies	ment at paragraph (a)(1) of and procedures at paragraph		testing program that meets the	9		١
	(b) of this section, a	nd the communication plan at		requirements of the regulation			
	paragraph (c) of this	section. The training, testing		Education will be given month	ly		
		ram must be reviewed and		X 3 months then yearly.		`	l
	updated at least ann						ı
1	by:	T is not met as evidenced		QAPI committee assisted with		,	
.		view and facility document		Development of the Comprehe	nsive		
-	review it was determ	ined that the facility staff	÷	Emergency plan and will review	/ monthly		
	failed to have a com preparedness plan.	plete emergency		X 3 months then annually.	in many in the second s		
	Mari 6 100 - 24 2 11			Date of Compliance: 10/30/202	18		
		d to provide evidence of					
		he facility has a written program that meets the					
	requirements of the						l
		- gasanorii					
	The findings include:						
.	On 9/27/18 at 8:30 a	.m., the facility's emergency					
	preparedness plan w	as reviewed with OSM (other					
	staff member) #11, th	ne maintenance director, and					
	USM #/, the mainter	nance assistant. Review of			ĺ	,	l
	me racility's emergen to evidence documer	ncy preparedness plan failed nation that the facility has a			WW	*	
-	written training and t	esting program that meets					
	the requirements of t	he regulation. OSM #11 and			-		
1	OSM #7 were made	aware of this concern.					
		.m., ASM. (administrative		,			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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NAME OF	PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
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(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 APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
	staff member), the aware of the above No further informati EP Training Progra CFR(s): 483.73(d)(administrator, #1, was made findings. on was obtained prior to exit. m		036	A Comprehensive Emergency Preparedness Plan and program was prepared 0n 10/16/2018		
	ASCs, PACE organ and dialysis facilities (i) Initial training in a policies and proced staff, individuals programment, and vexpected role. (ii) Provide emerger least annually. (iii) Maintain docum (iv) Demonstrate staprocedures. *[For Hospitals at § at §491.12:] (1) Traor RHC/FQHC] mus (i) Initial training in a policies and proced staff, individuals programment, and vexpected roles. (ii) Provide emerger least annually. (iii) Maintain docum (iv) Demonstrate staprocedures. *[For Hospices at § hospice must do all	n. The [facility, except CAHs, izations, PRTFs, Hospices, s] must do all of the following: emergency preparedness ures to all new and existing oviding services under rolunteers, consistent with their necy preparedness training at tentation 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 ures to all new and existing oviding on-site services under rolunteers, consistent with their necy preparedness training at tentation of the training. aff knowledge of emergency 418.113(d):] (1) Training. The of the following: emergency preparedness		The second secon	that meets the requirements that evidence of documentation that the facility has initial emergency preparedness training and annual emergency preparedness training offerings for volunteers and documentation that facility volunteers have received initial and annual emergency preparedness to the affected by not having the plan in place, Preparing the plan will correct this. The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensure substantial compliance. Staff educated on 10/17/18 by ADON on the Comprehensive Emergency Preparedness Plan for facility has the initial emergency preparedness training and annual emergency preparedness training offerings for volunteers and documentation that facility	ess	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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		490200	D. WHAC			09	/27/2018
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E 037	policies and proced hospice employees services under arra expected roles. (ii) Demonstrate sta procedures. (iii) Provide emerge least annually. (iv) Periodically reviemergency prepare employees (includir special emphasis plants procedures necessated others. *[For PRTFs at §44 program. The PRTF (i) Initial training in expected roles. (ii) After initial training preparedness training (iii) Demonstrate sta procedures. (iv) Maintain docum preparedness training in expected roles. (iv) Maintain docum preparedness training in expected roles. (iv) Maintain docum preparedness training in expected roles. (iv) Initial training in expected roles. (iv) Maintain docum preparedness training in expected roles. (iv) Initial training in expected staff, individuals programagement, contravolunteers, consister	ures to all new and existing, and individuals providing ngement, consistent with their of knowledge of emergency ncy preparedness training at ew and rehearse its dness plan with hospice and no carrying out the acry to protect patients and say to protect patients and say to all of the following: emergency preparedness ures to all new and existing eviding services under colunteers, consistent with their ng, provide emergency ng at least annually.	EO	37	volunteers have received initial and annual emergency preparedness training. Education will be given monthly X 3 months then yearly. QAPI committee assisted with the Development of the Comprehensive Emergency plan and will review mont X 3 months then annually. Date of Compliance: 10/30/2018		

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					M APPROVEL D. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			ATE SURVEY OMPLETED
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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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO	BE	(X5) COMPLETION DATE
	procedures, includir what to do, where to case of an emergen (iv) Maintain docum *[For CORFs at §48 CORF must do all or (i) Provide initial train preparedness policies and existing staff, in under arrangement, with their expected region (ii) Provide emergen least annually. (iii) Maintain docume (iv) Demonstrate star procedures. All new and assigned specifithe CORF's emergentheir first workday. To include instruction in alarm systems and sequipment. *[For CAHs at §485.1] The CAH must do al (i) Initial training in expolicies and procedure porting and extinguand where necessary personnel, and guest cooperation with firef authorities, to all new individuals providing	aff knowledge of emergency or informing participants of or go, and whom to contact in or incy. entation of all training. 5.68(d):](1) Training. The fithe following: ning in emergency es and procedures to all new dividuals providing services and volunteers, consistent coles. cy preparedness training at entation of the training. If knowledge of emergency personnel must be oriented in responsibilities regarding may plan within 2 weeks of the training program must the location and use of signals and firefighting 625(d):] (1) Training program. I of the following: mergency preparedness res, including prompt uishing of fires, protection, y, evacuation of patients, its, fire prevention, and fighting and disaster	EO	37			

(ii) Provide emergency preparedness training at

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/11/2018

PRINTED: 10/11/2018 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 _ C 495255 B. WING 09/27/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE SKYVIEW SPRINGS REHAB AND NURSING CENTER **LURAY, VA 22835** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) E 037 Continued From page 39 E 037 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 with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced 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 provide evidence of documentation of the facility's initial emergency preparedness training and annual emergency preparedness training offerings for volunteers and documentation that facility volunteers have received initial & annual emergency preparedness training. The findings include:

On 9/27/18 at 8:30 a.m., the facility's emergency preparedness plan was reviewed with OSM (other staff member) #11, the maintenance director, and OSM #7, the maintenance assistant. Review of the facility's emergency preparedness plan failed

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER W SPRINGS REHAB A	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835		See a / mo t C	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				
E 039 SS=C	to evidence docume emergency prepare emergency prepare volunteers and docivolunteers have recemergency prepare OSM #7 were made On 9/27/18 at 1:05 staff member), the aware of the above No further informatic EP Testing Required CFR(s): 483.73(d)(2) (2) Testing. The [fac RNHCIs and OPOstest the emergency [facility, except for Fall of the following: *[For LTC Facilities The LTC facility must the emergency plan unannounced staff of procedures. The LTC following:] (i) Participate in a fucommunity-based of exercise is not acceptacility-based. If the actual natural or ma requires activation of [facility] is exempt frommunity-based of community-based of the actual natural or ma requires activation of [facility] is exempt frommunity-based of the community-based of the community	entation of the facility's initial edness training and annual dness training offerings for umentation that facility seived initial & annual dness training. OSM #11 and e aware of this concern. p.m., ASM, (administrative administrator, #1, was made findings. on was obtained prior to exit. ments con was obtained prior to exit.	E O		he		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILD		COMPLETED			
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	include, but is not li (A) A second full- community-based of (B) A tabletop ex discussion led by a clinically-relevant er of problem stateme prepared questions emergency plan. (iii) Analyze the [fact maintain document exercises, and eme [facility's] emergency *[For RNHCIs at §4 §486.360] (d)(2) Te must conduct exercises, and eme [facility's] emergency (i) Conduct a pape least annually. A tal discussion led by a clinically relevant er of problem stateme prepared questions emergency plan. (ii) Analyze the [RN to and maintain doc exercises, and eme [RNHCI's and OPO needed. This REQUIREMEI by: Based on staff inte	itional exercise that may mited to the following: scale exercise that is or individual, facility-based. ercise that includes a group facilitator, using a narrated, mergency scenario, and a set ints, directed messages, or designed to challenge an illity's] response to and ation of all drills, tabletop ergency events, and revise the ey plan, as needed. 03.748 and OPOs at sting. The [RNHCl and OPO] sises to test the emergency and OPO] must do the obletop exercise is a group facilitator, using a narrated, mergency scenario, and a set ints, directed messages, or designed to challenge an allHCl's and OPO's] response elementation of all tabletop ergency events, and revise the elementation of all tabletop ergency events, and revise the regency events and facility document mined that the facility staff inplete emergency	EO	THAT THE PROPERTY OF THE PROPE	The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensure substantial compliance. Staff educate on 10/17/18 by ADON on the Comprehensive Emergency Prepared Plan for evidence of documentation facility has annual tabletop and full scale exercises and document of how the facility's exercise analysis response and how the facility updated its emergency program based on the exercise analysis. Education will be given monthly X 3 months then yearly. QAPI committee assisted with the Development of the Comprehensive Emergency plan and will review mor X 3 months then annually. Date of Compliance: 10/30/2018	ed Iness that the	

		AND MUMAIN SERVICES & MEDICAID SERVICES			FOR	M APPROVI	ΞĎ
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) DA	(X3) DATE SURVEY COMPLETED	
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SKYVIF	W SPRINGS REHAR A	ND NURSING CENTER		30 MONTVUE DRIVE			
	or fill do fill had a	THE MONORING CENTER		LURAY, VA 22835			
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E 039	Continued From page	ge 42	E0	039			
	documentation of th full-scale exercises facility's exercise an						
E 041 SS=C	preparedness plan v staff member) #11, t OSM #7, the mainter the facility's emerger to evidence docume and full-scale exercise and the facility's exercise and the facility updated it on the exercise analywere made aware of On 9/27/18 at 1:05 p staff member), the aware of the above find the power systems based of the power systems based to SM # 10 S	.m., ASM, (administrative dministrator, #1, was made indings. n was obtained prior to exit. C Emergency Power tandby power systems. The lent emergency and standby d on the emergency plan set	E 04	that meets the requirements that evidence of documentation that the facility has the required emergency power systems or			
The state of the s	policies and procedu	and (ii) of this section.		plans in place to maintain safe operations while sheltering in place and a plan of how to keep the generator operational during an emergency.	THE PARTY OF THE P		

DEL VELLAMENTE OL LIEVELLI VIND LIONAN PERAIOES

		AND HUMAN SERVICES			P		D: 10/11/2018 MAPPROVED
STATEMEN	RS FOR MEDICARE T OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		OF CONSTRUCTION	MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
NAME OF	PROVIDER OR SUPPLIER	495255	B. WING			09	C /27/2018
		ND NURSING CENTER		3	STREET ADDRESS, CITY, STATE, ZIP CODE O MONTVUE DRIVE LURAY, VA 22835		
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	[LTC facility and the emergency and star the emergency plan this section. §482.15(e)(1), §483. Emergency generate must be located in a requirements found Code (NFPA 99 and Amendments TIA 12 12-5, and TIA 12-6), and Tentative Interim 12-2, TIA 12-3, and Twhen a new structure structure or building 482.15(e)(2), §483.7 Emergency generate [hospital, CAH and Lithe emergency power and maintenance received the care Facilities Safety Code. 482.15(e)(3), §483.7 Emergency generato LTC facilities] that mate power emergency for how it will keep er operational during the evacuates. *[For hospitals at §48 and CAHs §485.625(standby power systems. The CAH] must implement adby power systems based on set forth in paragraph (a) of set forth in paragraph (a) of set forth in paragraph (a) of set forth in paragraph (a) of set forth in paragraph (a) of set forth in paragraph (a) of set forth in paragraph (a) of location. The generator ccordance with the location in the Health Care Facilities Tentative Interim -2, TIA 12-3, TIA 12-4, TIA Life Safety Code (NFPA 101 Amendments TIA 12-1, TIA TIA 12-4), and NFPA 110, and sis built or when an existing is renovated. 3(e)(2), §485.625(e)(2) or inspection and testing. The TC facility] must implement or system inspection, testing, quirements found in the set Code, NFPA 110, and Life set Code, NFPA 110, and NFPA 110, a	EO	4	All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this. The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensure substantial compliance. Staff educated on 10/17/18 by ADON on the Comprehensive Emergency Preparedness Plan for evidence of documentation the facility has the required emergency power systems or plans in place to maintain safe operations while shelter in place and a plan of how to keep the generator operational during an emergency. Education will be given monthly X 3 months then yearly. QAPI committee assisted with the Development of the Comprehensive Emergency plan and will review month X 3 months then annually. Date of Compliance: 10/30/2018	ness hat y ring	

section are approved for incorporation by

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCES

AND DIAN OF CORRECTION INCIDENTIFICATION MUNICIPAL		1 ' '	TIPLE CONSTRUCTION ING	CON	(X3) DATE SURVEY COMPLETED	
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E 041	Federal Register in 552(a) and 1 CFR p material from the so inspect a copy at the Center, 7500 Secur or at the National Al Administration (NAF availability of this m 202-741-6030, or go http://www.archives_federal_regulations of any changes in the incorporated by refedocument in the Fethe changes. (1) National Fire Probatterymarch Park, Quincy, MA 02169, 1.617.770.3000. (i) NFPA 99, Health edition, issued Auguition, issued Auguition, issued Auguition, issued Auguition, issued Auguition, issued Auguition, in TIA 12-3 to NFP (v) TIA 12-5 to NFP (vi) TIA 12-6 to NFP (vii) NFPA 101, Life issued August 11, 2 (viii) TIA 12-1 to NF 2011. (ix) TIA 12-2 to NFP 2012. (x) TIA 12-3 to NFP 2013.	rector of the Office of the accordance with 5 U.S.C. part 51. You may obtain the ources listed below. You may e CMS Information Resource ity Boulevard, Baltimore, MD rechives and Records RA). For information on the aterial at NARA, call to to: .gov/federal_register/code_of s/ibr_locations.html. is edition of the Code are erence, CMS will publish a deral Register to announce obtection Association, 1 www.nfpa.org, Care Facilities Code, 2012 Just 11, 2011. In amendment (TIA) 12-2 to 19 gust 11, 2011. In A 99, issued August 9, 2012. In A 99, issued August 1, 2013. In A 99, issued March 7, 2013. In A 99, issued March 3, 2014. Safety Code, 2012 edition,	E	141		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	TIPLE CONSTRUCTION ING	0	(X3) DATE SURVEY COMPLETED	
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E 041	(xiii) NFPA 110, Sta Standby Power Systandby Power Systandby Power Systands to chapter 7, in This REQUIREMEI by: Based on staff intereview it was detentabled to have a compreparedness plan. Facility staff failed to that the facility has standby power systandby power s	andard for Emergency and stems, 2010 edition, including ssued August 6, 2009. NT is not met as evidenced erview and facility document mined that the facility staff inplete emergency. To evidence documentation the required emergency and tems, has emergency power in place to maintain safe lettering in place and a plan of inerator operational during an they plan to evacuate. The facility's emergency was reviewed with OSM (other the maintenance director, and enance assistant. Review of ency preparedness plan failed that the facility has the y and standby power systems, wer systems or plans in place erations while sheltering in how to keep the generator an emergency unless they plan #11 and OSM #7 were made ern. p.m., ASM, (administrative administrator, #1, was made	ΕO	41		

PRINTED: 10/11/2018 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 C 495255 B. WING 09/27/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE SKYVIEW SPRINGS REHAB AND NURSING CENTER **LURAY, VA 22835** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) E 042 Integrated EP Program E 042 A Comprehensive Emergency CFR(s): 483.73(f) SS=C Preparedness Plan and program was prepared 0n 10/16/2018 (e) [or (f)]Integrated healthcare systems. If a that meets the requirements that [facility] is part of a healthcare system consisting the facility has evidence has or has of multiple separately certified healthcare facilities that elects to have a unified and integrated not opted to be part of its emergency preparedness program, the [facility] healthcare system's unified and may choose to participate in the healthcare integrated emergency preparedness system's coordinated emergency preparedness program. program. If elected, the unified and integrated emergency All residents have the potential preparedness program must- [do all of the following: to be affected by not having the plan in place, Preparing the (1) Demonstrate that each separately certified plan will correct this. facility within the system actively participated in the development of the unified and integrated The Comprehensive Emergency emergency preparedness program. Preparedness Plan and program was (2) Be developed and maintained in a manner completed per regulations to ensure that takes into account each separately certified substantial compliance. Staff educated facility's unique circumstances, patient on 10/17/18 by ADON on the populations, and services offered. **Comprehensive Emergency Preparedness** Plan for evidence that the facility has (3) Demonstrate that each separately certified or has not opted to be part of its facility is capable of actively using the unified and integrated emergency preparedness program and healthcare system's unified and is in compliance [with the program]. integrated emergency preparedness program. Education will be given (4) Include a unified and integrated emergency monthly X 3 months then yearly. plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and QAPI committee assisted with the integrated emergency plan must also be based Development of the Comprehensive on and include the following:

(i) A documented community-based risk

assessment, utilizing an all-hazards approach.

(ii) A documented individual facility-based risk

Emergency plan and will review monthly

X 3 months then annually.

Date of Compliance: 10/30/2018

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION ING		COMPLETED	
		495255	B. WING		1	C /27/2018
	PROVIDER OR SUPPLIER N SPRINGS REHAB A	ND NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835			21/2010
(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 X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
E 042	within the health sylapproach. (5) Include integrat that meet the requirements of section, and training at the requirements of section, respectivel This REQUIREMENT by: Based on staff intereview it was determined to have a compreparedness plan.	ch separately certified facility stem, utilizing an all-hazards red policies and procedures rements set forth in paragraph a coordinated communication and testing programs that meet is paragraphs (c) and (d) of this y. NT is not met as evidenced rview and facility document mined that the facility staff applete emergency of evidence that the facility has be part of its healthcare dintegrated emergency ram.	EO	42		
	preparedness plan staff member) #11, OSM #7, the mainted the facility's emerged to evidence that the to be part of its head integrated emergent OSM #11 and OSM concern.	a.m., the facility's emergency was reviewed with OSM (other the maintenance director, and enance assistant. Review of ency preparedness plan failed facility has or has not opted lithcare system's unified and cy preparedness program. #7 were made aware of this p.m., ASM, (administrative administrator, #1, was made findings.				

CENT	HUMENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES			PRINTE! FOR!	D: 10/11/2018 APPROVED
STATEME	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	OMB NC (X3) DA	0. 0938-0391 TE SURVEY MPLETED
Materia		495255	B. WING		no	C /27/2018
	F PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	21/2010
SKYVI	EW SPRINGS REHAB A	ND NURSING CENTER		30 MONTVUE DRIVE LURAY, VA 22835		
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E 042	Continued From pag	ie 48	E0	40		
F 000	No further information	on was provided prior to exit.	F O		-	
	survey was conducted Complaints were involved Corrections are requivered CFR Part 483 Federa requirements. The Linding of the consisted of 39 currer (Residents #24, #17, #94, #103, #38, #106, #102, #8, #20, #79, #44, #29, #14, #100, #83, #87, #85 and #44 reviews (Residents #15 Safe/Clean/Comfortal CFR(s): 483.10(i)(1)-(\$483.10(i) Safe Environment and the facility must proving \$483.10(i)(1) A safe, cohomelike environment use his or her personal possible. (i) This includes ensuring composition of the control of the personal possible. (ii) This includes ensuring composition of the control of the cont	fe Safety code survey/report 10 certified bed facility was survey. The survey sample int resident reviews #22, #27, #64, #111, #36, , #55, #97, #2, #53, #90, 88, #57, #45, #31, #56, #30, #42, #99, #92, #23, #118, 8) and four closed record [19, #121, #169 and #117). [ble/Homelike Environment 7) Indicate the component and grafely. Idean, comfortable, and grafely. Idean, comfortable, and grafely. Idean, comfortable, and grafely. Idean, comfortable, and grafely. Idean, comfortable, and grafely. Idean, comfortable, and grafely. Idean, comfortable, and grafely. Idean, comfortable, and grafely. Idean, comfortable, and grafely. Idean, comfortable, and grafely. Idean, comfortable, and grafely. Idean, comfortable, and grafely. Idean, comfortable, and grafely. Idean, comfortable, and grafely. Idean, comfortable, and grafely. Idean, comfortable, and grafely. Idean, comfortable, and grafely.	F 584	Residents #103 room will be Repaired and painted by the Maintenance department By 10/30/18. Resident #27 fan Was cleaned on 09/26/18. Resident # 97 will be served Food in day room without trays. Stained dishware removed from Service. A room rounds will be conducted By the Administrator by 10/18/18 to observe for any more rooms the	at	
	physical layout of the fa	acility maximizes resident as not pose a safety risk.		may be need of repair due to torn wall paper, or scratches.		

DEPAF CENTE	RTMENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES			PRINTI FOR	ED: 10/11/2018 RM APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	E	ELTIPLE CONSTRUCTION DING	OMB N	O. 0938-0391 ATE SURVEY OMPLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		9/27/2018
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i rfesf() 1#n	steeprotection of the or theft. §483.10(i)(2) Housel services necessary to and comfortable interested in good condition; §483.10(i)(3) Clean bein good condition; §483.10(i)(4) Private resident room, as specified in all areas; §483.10(i)(5) Adequated levels in all areas; §483.10(i)(6) Comfort levels. Facilities initial 1990 must maintain at 81°F; and §483.10(i)(7) For the resound levels. This REQUIREMENT by: Based on observation interview, facility policy review and it was detered alled to maintain a clean clean transport of three survey sample (Reside Resident #97), and in control in good remarks, torn wallpaper, and in good remarks, torn wallpaper,	exercise reasonable care for resident's property from loss keeping and maintenance or maintain a sanitary, orderly, rior; bed and bath linens that are closet space in each ecified in §483.90 (e)(2)(iv); the and comfortable lighting table and safe temperature ly certified after October 1, temperature range of 71 to maintenance of comfortable is not met as evidenced in, resident interview, staff or review and clinical record rimined, the facility staff from comfortable homelike of 43 residents in the ent #103, Resident #27 and one of 5 dining rooms and in the kitchen.	F 58	All fans being utilized in facility we Checked on 09/26/18 by unit material To ensure cleanness. Staff education 09/26/18 that meals served in date Can not be on trays. An audit comby dietary manager on stained distand will be replaced with new. Maintenance Department will combo Room rounds quarterly to ensure Rooms are kept in good repair. Housekeeping will put fans on a Weekly cleaning schedule to ensure Free of dust. Residents will not be On trays in day room. Staff educated 10/18/18 by ADON on this. Dishwate replaced and a water softener of Dishware free of lime stains. Results of room rounds will be taken to QAPI for review and recommendations. Management staff will more dishware when stains noted. Administrator will observe weekly dishware for any stains and replaced needed. Management staff will more taken to QAPI meeting for review recommendations. Date of Compliance: 10/30/2018	nagers ted on y room npleted shware duct that e served ed on are will vill be keep en staff bserve will w	

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F 584	27's room in a sanii gray dust was obse and the front and re 12-inch tabletop far in the direction of R 3. The facility staff in a homelike mann 4. a. The facility staresidents were serviced was homelike and appearance. 4.b. The facility staresident #97 was sthat was home like unsightly. The findings include 1. Resident #103 w 2/6/14, and readmit with diagnoses that to: chronic obstruct (COPD) (1), acute a (2), major depression anxiety disorder, at blood pressure. The most recent Miday assessment, w reference date) of 9 having a score of 1 interview for mental	failed to maintain Resident # tary, homelike environment; rved coating the fan blades ear finger guard setting of a n pointed towards and blowing resident # 27's bed. Failed to serve residents meals her in the south wing, day area. Failed to ensure that the red meals with dishware that hot heavily worn stained in If failed to ensure that served her meal in dishware and not heavily stained and	F5	84			

PRINTED: 10/11/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	495255		B. WING		00	C 09/27/2018	
NAME OF PROVIDER OR SUPPLIER SKYVIEW SPRINGS REHAB AND NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835			1 03/2//2016	
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 584	On 09/25/18 at app observation was marks, torn wallpap wall measuring app behind the resident On 09/26/18 at app second observation room. The room was cratch marks, torn the wall measuring behind the resident On 09/27/18 at app observation was mawith OSM (other stamp Maintenance Direct observed, OSM #11 behind the bed is to On 09/25/18 at app interview was conditioned when asked if the croom is something home, the resident On 09/27/18 at app interview was conditioned in the procedure staff resident's room. Climaintenance slip at out and leave it in a maintenance check On 09/27/18 at app	roximately 12:33 p.m., an ade of Resident #103's room. erved with multiple scratch per, and indentations in the proximately 24 x 6 inches 's bed. roximately 3:00 p.m., a was made of Resident #103's as observed with multiple wallpaper, and indentations in approximately 24 x 6 inches 's bed. roximately 12:50 p.m., a third ade of Resident #103's room aff member) #11, the for. When asked what he replied, "The wall paper orn and the wall is scratched." roximately 12:33 p.m., an ucted with Resident #103. condition of the walls in her that she would have fixed at	F 5	84			

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

Event ID: K51C11

Facility ID: VA0166

RECEIVED If continuation sheet Page 52 of 218

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VDH/OLG

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
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F 584	practical nurse) #1, asked if a maintena to repair the wall be LPN #1 stated that On 09/27/18 at app interview was conduasked about the counterview was conducted in a work of fixed it." When asked repair this wall, OSI The facility was una regarding maintaini On 09/27/18 at app (administrative staff Administrator and A Nursing were made) No further information. 1. A disease that main cause of to substances that in this is usually cigar chemical fumes, or information was obto https://www.nlm.nih. 2. A condition in who	the Unit Manager. When ance request had been made whind Resident #103's bed, she was not aware of one. Toximately 12:50 p.m., and acted with OSM #11. When andition of the wall in Resident #11 stated, "Yes sir. It should mediately. The housekeeper his while cleaning the room and then we would come end is there a work order to M #11 responded "No." Able to locate the policy and a homelike environment. Toximately 3:30 p.m., ASM member) #1, the asm #2, the Director of aware of the findings. To was provided prior to exit. Takes it difficult to breath that ass of breath. The two main ronchitis and emphysema. COPD is long-term exposure rritate and damage the lungs. The test	F 5	884				
And the analysis of the production of the second of the se	from your lungs into was obtained from t	your blood. This information						

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		495255	B. WING			C 9 /27/2018	
	PROVIDER OR SUPPLIER W SPRINGS REHAB A	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 30 MONTVUE DRIVE LURAY, VA 22835		72112010	
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F 584	ilure.html. 3. A problem with the heartbeat. This information the website: https://www.nlm.nihon.html. 2. The facility staff 27's room in a saningray dust was observation of Resident # 27 was 06/28/2016 with dianot limited to: atrial dyspnea (3) and hy Resident # 27's moset), a quarterly assessment reference Resident # 27 as so interview for mentary 15, 15 - being cog decisions. Resident # 27 as so interview for mentary 15, 15 - being cog decisions. Resident # 27 as so interview for mentary 15, 15 - being cog decisions. Resident # 27 as so interview for mentary 15, 15 - being cog decisions. Resident # 27 as so interview for mentary 15, 15 - being cog decisions. Resident # 27 as so interview for mentary 15, 15 - being cog decisions. Resident # 27 as so interview for mentary 15, 15 - being cog decisions. Resident # 27 as so interview for mentary 15, 15 - being cog decisions. Resident # 27 as so interview for mentary 15, 15 - being cog decisions. Resident # 27 as so interview for mentary 15, 15 - being cog decisions. Resident # 27 as so interview for mentary 15, 15 - being cog decisions. Resident # 27 as so interview for mentary 15, 15 - being cog decisions. Resident # 27 as so interview for mentary 15, 15 - being cog decisions. Resident # 27 as so interview for mentary 15, 15 - being cog decisions. Resident # 27 as so interview for mentary 15, 15 - being cog decisions. Resident # 27 as so interview for mentary 15, 15 - being cog decisions. Resident # 27 as so interview for mentary 15, 15 - being cog decisions. Resident # 27 as so interview for mentary 15, 15 - being cog decisions.	ne speed or rhythm of the ormation was obtained from a gov/medlineplus/atrialfibrillati failed to maintain Resident # tary, homelike environment; rved coating the fan blades ear finger guard setting of a pointed towards and blowing esident # 27's bed. admitted to the facility on gnoses that included but were fibrillation (1), heart failure (2), pertension (4). st recent MDS (minimum data sessment with an ARD noce date) of 07/03/18, coded coring a 15 on the brief I status (BIMS) of a score of 0 nitively intact for making daily at # 27 was coded as requiring se of one staff member for	F 5	84			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER N SPRINGS REHAB A	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 30 MONTVUE DRIVE LURAY, VA 22835	DE	<u></u>	21/2010
(X4) ID PREFIX TAG			ID PREFI TAG		SHOULD B		(X5) COMPLETION DATE
F 584	On 09/25/18 at app 2:22 p.m., observat revealed she was nobservation of the rabletop fan setting room, pointed towa of Resident # 27's brevealed gray dust front and rear finge. On 09/25/18 at app an interview with Reobservation of the rabletop fan setting room, pointed towa of Resident # 27's brevealed gray dust front and rear finge the fan Resident # 27's brevealed gray dust front and rear finge the fan Resident # 27's rooroom. Further obsea 12-inch tabletop fin the room, pointed direction of Resider the fan revealed gray and the front and resident must be for the fan revealed gray and the front and resident was conducted from was conducted from was conducted from was conducted from was conducted from the fan be for the fan be roximately 2:19 p.m., and at ions of Resident # 27's room of in her room. Further come revealed a 12-inch on the sink counter in the rd and blowing in the direction coding the fan blades and the reguards. roximately 5:11 p.m., during esident # 27 in her room, come revealed a 12-inch on the sink counter in the rd and blowing in the direction coding the fan blades and the reguards. When asked about 27 stated it kept her cool. roximately 8:25 a.m., and at p.m., observations of merevealed she was not in her ervations of the room revealed an setting on the sink counter of toward and blowing in the counter of toward and blowing in the counter of toward and blowing in the content and the fan blades and the fan blades and dust coating the fan blades	F	584				

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	495255	B. WING		09/27/2018	
NAME OF PROVIDER OR SUPPLIER SKYVIEW SPRINGS REHAB AND NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835		
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during room rounds." fan from Resident # 2 On 09/26/18 at appro (administrative staff in administrator and ASI were made aware of the No further information. References: (1) A problem with the heartbeat. This information the website: https://www.nlm.nih.gon.html. (2) A condition in which to pump oxygen-rich lefficiently. This cause throughout the body. obtained from the well https://medlineplus.go. (3) When you're short uncomfortable for you body needs. You may enough air. Sometimes breathing problems be intense exercise. But also be a sign of a see information was obtain https://medlineplus.go. (4) High blood pressure obtained from the well obtained fro	It should be checked daily LPN # 2 then removed the 27's room. Eximately 5:50 p.m., ASM member) # 1, the M # 2, director of nursing the findings. In was provided prior to exit. It is speed or rhythm of the mation was obtained from gov/medlineplus/atrialfibrillati It the heart is no longer able blood to the rest of the body as symptoms to occur. This information was bsite: In the symptoms to occur. This information was besite: It of breath, it's hard or is to take in the oxygen your of feel as if you're not getting es you can have mild ecause of a stuffy nose or shortness of breath can be income and is ease. This independent in the website: It is information was income in the website: It is information was income in the income in the website: It is information was income in the information was inc	F 5	84		

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F 584	homelike manner in residents were serva a cafeteria, institution at 12:32 p.m. in the were four residents residents at one take another table and of chair. All of the resilunches on trays. On 09/25/18 at appinterview was condimember) # 3, dieta describe the dining OSM # 3 stated, "In up the tables with taken off the trays a residents, like a residents	failed to serve residents in a the south wing, day area, wed the lunch meal on trays, in onal like manner. In was conducted on 09/26/18 a south wing, day area. There seated at two tables; two ole and two residents at one resident seated in a Gerri dents were served their Troximately 2:59 p.m., an ucted with OSM (other staff ry manager. When asked to process for the residents at the dining room we try to set able clothes or place mat, we all on the trays, the plates are and placed in front of the staurant. In the day room we see dining room, we don't take theys. When asked is there a didents ate their meals on trays o specific reason, it has never the would probably be more cause they don't want to come	F 58-	4			
	On 09/25/18 at app interview was cond nursing assistant) # lunch to the resider today CNA # 4 state describe how the m	roximately 3:22 p.m., an ucted with CNA (certified 4. When asked if she served ats in the south wing day room ed, "Yes." When asked to leal was served to the stated, "I put the trays with the		RECEIVED NOV 0 6 2018 VDH/OLG)		

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F 584	food on it in front or residents by opening and provided clothing wanted them." What to the residents CN home." When asked for the residents to tray CNA # 4 stated say that, no. This is never gave it a thorough the considered it home asked what the fact the residents in the sound on 09/25/18, OSM asked to describe the residents in the sound on 09/25/18, OSM asked to describe the residents on the sound made sure item asked what the fact the residents on asked what the fact the considered it home and eat meals on a know. It would mal on the table instead to serve the meals On 09/26/18 at app (administrative staff)	If the residents. Set up the and drinks, cutting up the food, and protector for those who are asked what the facility was IA # 4 stated, "The resident's ed if she considered homelike be serve and eat meals on a d, "Not really but now that you is always how it's done. We ught." Proximately 9:52 a.m., an ucted with OSM (other staff pitality aide. When asked to insibilities OSM # 15 stated, "I er pitchers, and get supplies ms, pass breakfast and lunch sidents by cutting up food and . I pick up trays after meals. I ide resident care, no hands on if she served lunch to the uth wing day room yesterday # 15 stated, "Yes." When now the meal was served to # 15 stated, "I set up the meal ers, cutting up food if needed in were accessible. When eliky was to the residents OSM eir home." When asked if she like for the residents to serve a tray OSM # 15 stated, "I don't ke it nicer to serve the meals of on the trays. I was trained on the trays in the day areas." Proximately 5:50 p.m., ASM if member) # 1, the asm # 2, director of nursing	F5	84			

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F 584	4. a. The facility staresidents were served was homelike and rappearance. On 9/26/18 at 11:23 made of the lunch rappearance. On 9/26/18 at 11:23 made of the lunch rappearance in the lunch rappea	ge 58 on was provided prior to exit. aff failed to ensure that the red meals with dishware that not heavily worn stained in 3 AM, an observation was meal tray-line service in the ed that the dark blue hard-type is used to cover each plate of residents in the dining room re heavily stained and utside with a white substance, are of being unclean, and 3 then made of a rack of facility re cleaned and stored for use. The entire inside surface of the could be scraped with a 3 p.m., in an interview with fif Member) and OSM #4, both hey agreed that the condition and dome covers were esidents should not be served the condition observed on #3 stated she "had been ement for years to replace oximately 1:30 p.m., ASM #1 f Member) the Administrator,	F 5				
WWW. William Landon State Conference Confere	was made aware of she had been at the	the findings. ASM #1 stated facility since February 2018, never asked her about					

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	NAME OF PROVIDER OR SUPPLIER SKYVIEW SPRINGS REHAB AND NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835		
(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 SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETION	
F 584	replacing these item ever noticed the colduring meal times, approximately 7 monot. She stated she stacked on top of the did not notice that the a white, residue. A review of the facili documented, "3. Apattractive china, cleachippedc. Have giftee of stains and sprovided by the end. On 9/27/18 at 9:30 aware of the finding provided by the end. 4. b. The facility star Resident #97 was sthat was home like a unsightly. Resident #97 was a 2/22/18 with the dia. Alzheimer's disease pacemaker, pain, dedeficiency. The model of the coldural set of the resident was colimpaired in ability to the resident require hygiene; extensive as	if she had if she cups and dome covers since being at facility for onths, ASM #1 stated she had shad seen the dome covers be food carts on the units but ney were heavily stained with ity policy, "Serving of Meals" pearance of the Tray: a. Use an, matched and not lasses sparkling clean and bots." a.m., ASM #1 was made s. No further information was	F 5	34		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495255	B. WING			C 09/27/2018	
NAME OF PROVIDER OR SUPPLIER SKYVIEW SPRINGS REHAB AND NURSING CENTER			1	STREET ADDRESS, CITY, STATE, ZIP CO 30 MONTVUE DRIVE LURAY, VA 22835	·······	72172010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 584	Continued From pa	ge 60	F 5	84			
	A review of the clini physician's order da	cal record revealed a ated 3/21/18 for regular diet, stency, and may have finger					
	made of the lunch r kitchen. During tray of the meal prepara Resident #97's mea The food for Reside putting pureed varia mashed potatoes, a individual hard-type Hot water was obse and mixed with the texture to more of a standard pureed for each cup and the co Resident #97. The observed with heav staining on the entir	a.m., an observation was neal tray-line service in the y-line, observation was made tion for Resident #97's meal. It was liquid puree texture. It was prepared by ation of turkey with gravy, and zucchini, each into plastic dark blue coffee cups. It was being added to each cup pureed food, reducing the liquid consistency, than od. Lids were then placed on ups placed on the tray for coffee cups used were y brown residue (coffee) the inside surface of the cups. It ghtly and the residue could be bernail.					
	#5 (Certified Nursin Resident #97 drinks cups, and she is giv #5 stated she never	p.m., in an interview with CNA g Assistant) she stated that sher food from the coffee ren them one at a time. CNA noticed if they were stained, should not be served to coffee cups.					
	OSM #3 (Other State dietary managers, to of the coffee cups we residents should no	p.m., in an interview with ff Member) and OSM #4, both hey agreed that the condition were unsightly and that the served food in dishware erved on these items. OSM					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED	
	495255 B. WING			C 09/27/2018	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 09/2//2018
SKYVIEW SPRINGS REHAB AND NURSING CENTER				30 MONTVUE DRIVE LURAY, VA 22835	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLÉTION
F 584 F 622 SS=E	#3 stated she "had management for ye A review of the facil documented, "3. Ap attractive china, cleichippedc. Have giftee of stains and sp. On 9/27/18 at 9:30 A Staff Member) the A aware of the finding provided by the end Transfer and Dischargement for years.	been fighting with ars to replace them." Ity policy, "Serving of Meals" pearance of the Tray: a. Use an, matched and not lasses sparkling clean and pots." AM, ASM #1 (Administrative dministrator, was made so the survey. Ity policy, "Serving of Meals" pearance of the survey. Ity policy, "Serving of Meals" pearance of the survey. Ity policy, "Serving of Meals" pearance of the survey. Ity policy, "Serving of Meals" pearance of the survey. Ity policy, "Serving of Meals" pearance of the survey. Ity policy, "Serving of Meals" pearance of the survey. Ity policy, "Serving of Meals" pearance of the Tray: a. Use and not last pearance of the Tray: a. Use	F 58		
	remain in the facility discharge the reside (A) The transfer or cresident's welfare at cannot be met in the (B) The transfer or obecause the resider sufficiently so the reservices provided by (C) The safety of incendangered due to status of the resider (D) The health of incotherwise be endang (E) The resident has appropriate notice, tunder Medicare or Nonpayment applies	y requirements- permit each resident to , and not transfer or ent from the facility unless- lischarge is necessary for the nd the resident's needs e facility; lischarge is appropriate nt's health has improved sident no longer needs the of the facility; lividuals in the facility is the clinical or behavioral ent; lividuals in the facility would		corrected as they were discharged without the Care Plan goals and returned to facility. Residents who have been discharged have been affected by this deficient practice and cannot be corrected at this time. Education was given to Licensed Nurses on the requirement of sending the care plan goals with resident while being discharged by th Administrator on 10/18/18.	ie.

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495255	B. WING	i		C 09/27/2018		
	PROVIDER OR SUPPLIER W SPRINGS REHAB A	ND NURSING CENTER		3	STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835	1 007		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CONTROL OF THE PROPERTY OF T	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 622	Medicare or Medicaresident refuses to resident who become admission to a facility resident only alloward 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 under any in paragraphs (c)(1) section, the facility that failure to transferor safety of the resident under any in paragraphs (c)(1) section, the facility for discharge is door medical 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 atterneeds, and the service facility to meet the resident only allowed the service of	e third party, including aid, denies the claim and the pay for his or her stay. For a nes eligible for Medicaid after ity, the facility may charge a able charges under Medicaid; ses to operate. In transfer or discharge the ppeal is pending, pursuant to paper, when a resident right to appeal 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 b(i)(A) through (F) of this must ensure that the transfer umented in the resident's appropriate information is the receiving health care er. In the resident's medical record the transfer per paragraph (c)(1) aragraph (c)(1)(i)(A) of this tresident need(s) that cannot mpts to meet the resident vice available at the receiving	F6		All discharged residents will be audited by the Administration Team within 24 hours to ensure Compliance. Results will be taken To the QAPI committee for review And recommendations. Date of Compliance: 10/31/2018			

AND PLAN OF CORRECTION I IDENTIFICATION NUMBER:		1 ' '		E CONSTRUCTION	COMPLETED		
		495255	B. WING			i	C 27/2018
	PROVIDER OR SUPPLIER V SPRINGS REHAB A	ND NURSING CENTER		30	TREET ADDRESS, CITY, STATE, ZIP CODE D MONTVUE DRIVE URAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREFI TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	discharge is necess (A) or (B) of this sec (B) A physician whe necessary under pathis section. (iii) Information proving the include a mini (A) Contact information responsible for the (B) Resident repression contact information (C) Advance Direction (C) Advance Direction (D) All special instruction (C) Advance Direction (D) All special instruction (E) Comprehensive (F) All other necession (F) All other necessio	must be made by- hysician when transfer or eary under paragraph (c) (1) ction; and in transfer or discharge is aragraph (c)(1)(i)(C) or (D) of rided to the receiving provider mum of the following: tion of the practitioner care of the resident entative information including ve information actions or precautions for apropriate. care plan goals; sary information, including a 's discharge summary, 3.21(c)(2) as applicable, and fation, as applicable, to ensure transition of care. IT is not met as evidenced view and clinical record mined that the facility staff propriate transfer e of 43 residents in the survey #79, #119, #56, #103, and ailed to evidence that the e plan goals were provided to er for a facility initiated	. F 6	622			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED			
		495255	B. WING	B. WING		ŀ	C 27/2018
	PROVIDER OR SUPPLIER V SPRINGS REHAB A	ND NURSING CENTER		STREET ADDRESS, CITY, STA 30 MONTVUE DRIVE LURAY, VA 22835	TE, ZIP CODE	1 00/	2112010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	((EACH CORRECTIVE CROSS-REFERENCED		BE	(X5) COMPLETION DATE
F 622	on 8/23/18, for Resi 3. The facility staff of documentation to the facility-initiated trans 6/18/18. 4. The facility staff comprehensive can the receiving provide transfer of Resident 5. The facility staff of the comprehensive required documents upon a transfer to the Resident #87. The findings included 1. Resident # 79 was 09/30/2017 with dia not limited to: demed disturbances (1), redepressive disorder Resident # 79's moset), a quarterly ass (assessment refere Resident # 79 as so interview for mental - 15, 4 (four) - being cognition for making The nurse's "Progradated 09/08/18 doct (certified nursing as resident when resident when resident when resident when resident was resident when resident was resident when resident was resident when resident was re	ailed to provide the required be receiving provider for a sfer of Resident #56 on failed to evidence that the eplan goals were provided to er for a facility initiated to #103 on 8/30/18. ailed to provide evidence that care plan goals and other were sent with the resident he hospital on 7/17/18 for example of the second with the sec	F6	22			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495255	B. WING				C 27/2018
	PROVIDER OR SUPPLIER V SPRINGS REHAB A	ND NURSING CENTER		30	REET ADDRESS, CITY, STATE, ZIP CODE MONTVUE DRIVE URAY, VA 22835	1 03/	2//2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	(emergency room) (message) left for go the condition, LPN #7 state everything left for go the condition to see the condition of the condition	and 911 called. Msg granddaughter to call." ess Notes" for Resident #79 umented, "3:26 p.m. This lame of Hospital) and was ent was being admitted for LLL pneumonia). NP and DON aware." (electronic health record) for d to evidence that Resident we care plan goals were eiving facility upon her sfer to the hospital on a.m., an interview was a (licensed practical nurse) #7. cribe the process for sending spital for an acute change in stated that first she would	F 6	522	in the second se		
	medical doctor. LPI form included comp if nursing sent the c the resident to the I	d then notify the family and N #7 was asked if the transfer prehensive care plan goals or comprehensive care plan with nospital. LPN #7 stated, "No." roximately 5:50 p.m., ASM f member) # 1, the		AND THE REAL PROPERTY OF THE P			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1''	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
	495255 B. WING			ng	C /27/2018		
	PROVIDER OR SUPPLIER W SPRINGS REHAB A	AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 30 MONTVUE DRIVE LURAY, VA 22835		12112010	
(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)	OULD BE	(X5) COMPLETION DATE	
F 622	were made aware of No further information References: (1) Psychological symptoms are controlled the controlled	of the findings. Ion was provided prior to exit. Improved and behavioral common and prominent ementia. They include depression, anxiety a gagression, disinhibition, aces. Approximately 30% to a dementia suffer from such s. There are complex are complex n cognitive deficits, and behavioral information was obtained m.nih.gov/pmc/articles/PMC31 Igh oxygen passes from your d. This information was	F6	·			
	blue, unhappy, mise Most of us feel this short periods. Clini disorder in which fe or frustration interfe or more. This infort website: https://medlineplus. (4) Fear. This infort website:	be described as feeling sad, erable, or down in the dumps. way at one time or another for cal depression is a mood elings of sadness, loss, anger, are with everyday life for weeks mation was obtained from the gov/ency/article/003213.htm. mation was obtained from the .gov/medlineplus/anxietv.html					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495255	B. WING		O.	C 9 /27/2018
	PROVIDER OR SUPPLIER N SPRINGS REHAB A	AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 30 MONTVUE DRIVE LURAY, VA 22835		72172010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 622	#summary. 2. The facility staff of the comprehensive with the resident up on 8/23/18, for Res Resident #119 was 9/2/14, with diagnost limited to: left sided dementia, high bloomuscle spasms. The data set) assessment coded the resident (brief interview for residents [sic] room SOB (shortness of back, diaphoresis (sBP (blood pressure (temperature)-101.5 check blood sugar) notified and gave or (emergency room) attorney) notified." Review of the clinication that Resident #119/5 comprehensive care him upon transfer to On 9/27/18 at 8:31 conducted with LPN When asked about	failed to provide evidence that care plan goals were sent on a transfer to the hospital ident #119. admitted to the facility on ses that included but were not weakness due to a stroke, of pressure, diabetes, and se most recent MDS (minimum ent, an annual assessment, at reference date of 8/5/18, as scoring a "9" on the BIMS mental status) score, indicating ognitive impairment for daily ated 8/23/18 at 2:19 p.m. "This nurse was called to resident was complaining breath) with pain radiating to sweating). Unable to obtain [Sic] temp [5, pulse 60, finger stick (to 388. NP (nurse practitioner) reder to send to ER for evaluation. PO (power of eal record failed to evidence is comprehensive care plan or eplan goals were sent with	F6	22		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 '	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED			
		495255	B. WING				C 27/2018
	PROVIDER OR SUPPLIER	AND NURSING CENTER		STREET ADDRESS, CITY 30 MONTVUE DRIVE LURAY, VA 22835	, STATE, ZIP CODE	1 09/	2172010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION COTIVE ACTION SHOULD INCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	would assess the indetermination to se stated that she wo face sheet, medica nursing notes, receiver form. LPN #7 state everything togethe all the printed infor #7 stated she wou medical doctor. Wi included comprehe nursing sent the cothe resident to the On 9/27/18 at 11:5 conducted with LP facility started usin 24th of this year (2 On 9/27/18 at 1:05 staff member), the aware of the above if it was possible thout for Resident #18/23/18. ASM #1 scompleted ones ar him (Resident #119). No further information to the facility-initiated trans 6/18/18. Resident #56 was 1/23/18 and readment	n, LPN #7 stated that first she resident before making the end the resident out. LPN #7 uld then print out the resident's ation list, advanced directives, ent vital signs, and a transfer ed that once she had r, she would call 911 and send mation with the resident. LPN ld then notify the family and hen asked if the transfer form ensive care plan goals, or if omprehensive care plan with hospital, LPN #7 stated, "No." 6 a.m., an interview was N #2. LPN #2 stated that the g the transfer sheets on August 018). p.m., ASM, (administrative administrator, #1, was made entitled in the end there is no transfer sheet for end there is no transfer sheet for end there is no transfer sheet for end there is no transfer for ansfer of Resident #56 on admitted to the facility on littled on 6/20/18 with	F 6	22			
		uded but were not limited to unspecified dementia without					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495255	5 B. WING 09,			C 9/27/2018	
	PROVIDER OR SUPPLIER V SPRINGS REHAB	AND NURSING CENTER	30	TREET ADDRESS, CITY, STATE, ZIP CODE MONTVUE DRIVE URAY, VA 22835	<u>, 00,</u>	2.72010	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 622	chronic heart failure disorder. Resident (minimum data set with an ARD (asses 8/2/18. Resident #5 cognitively intact so (Brief Interview for Review of Resident that he was sent out The following nursi (vital signs): T (tem BP (blood pressure being transferred th out. Foley catheter replaced x 2 along attempt by NP (nur Obtained orders to catheter placed dudysfunction, BPH ((enlarged prostate) (responsible party) The next nursing not the following: "Resident nursing not the following: "Resident nursing not the following: "Resident nursident, corpractitioner responsible party) There was no evided documentation; corpractitioner responsible party including contact in information, All specifor ongoing care, as	e, and major depressive #56's most recent MDS) was a quarterly assessment ssment reference date) of 66 was coded as being coring 11 out of 15 on the BIMS Mental Status) exam. If #56's clinical record revealed at to the hospital on 6/18/18. Ing note was documented: "VS sperature): 99.0, P (pulse): 76, a): 128/70. While resident was has been attempted to be with caude catheter (1) se practitioner) with no results. send resident out to have to history of muscular Benign Prostatic Hyperplasia) (2), and urinary retention. RP made aware." In the dated 6/18/18 documented dent transferred to (Name of Dence that the required matact information of the sible for the care of the representative information formation, Advance Directive recial instructions or precautions	F 622				
бе «О-г)н на на основни на пред на на на основни на ос	the resident upon to information would be	ransfer to the hospital. This be documented on a hospital was missing from Resident				A TOTAL AND A TOTA	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	TIPLE CON	(X3) DATE SURVEY COMPLETED			
		495255	B. WING		·		C 27/2018
	PROVIDER OR SUPPLIER N SPRINGS REHAB A	ND NURSING CENTER		30 MON	ADDRESS, CITY, STATE, ZIP CODE ITVUE DRIVE 7, VA 22835		7-1-1-1-1-1-1
(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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	#56's clinical record On 9/26/18 at the eleapproximately 6 p.m. to evidence Reside 6/18/18, or any docrequired information receiving hospital with transferred to the homogeneous form of the homogeneous staff follow hospital for an acut stated that first she before making the cresident out. LPN # print out the resident advanced directives signs, and a transfer once she had every 911 and send all the resident. LPN #7 stramily and medical transfer form including goals, or if nursing splan with the resident stated, "No." On 9/27/18 at 11:56 conducted with LPN facility started using 24th of this year. LF not have a transfer On 9/27/18 at appropriate the staff of	and of day meeting at m., Administration was asked at #56's transfer sheet dated umentation evidencing all a was provided to the when Resident #56 was aspital on 6/18/18. a.m., an interview was al (licensed practical nurse) #7, when asked about the second for sending a resident to the experience of	F 6	22			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495255	B. WING	i			C 27/2018
	PROVIDER OR SUPPLIER	AND NURSING CENTER		3	STREET ADDRESS, CITY, STATE, ZIP CODE TO MONTVUE DRIVE LURAY, VA 22835	1 09/	2112018
(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 622	(1) Caude or Coud catheter that is recence encounters difficult regular technique. from The National https://www.ncbi.nl 92169/. (2) This information National Institutes that included but wobstructive pulmon and chronic respirate depressive disorde atrial fibrillation (3) most recent MDS (assessment, with a date) of 9/8/18 cod score of 15 of 15 of mental status) indic cognitively intact to Review of Resident	é catheter is a reinforced tip ommended when one y placing a catheter using the This information was obtained Institutes of Health. m.nih.gov/pmc/articles/PMC26 in was obtained from The of Health. gov/enlargedprostatebph.html failed to evidence that the re plan goals were provided to der for a facility initiated	F	622			
	on 8/30/18. A nursi	ng note dated 8/30/18 at 8:00 "Resident found to be	THE STATE OF THE S				

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	COM	E SURVEY IPLETED
		495255	B. WING			l	C 27/2018
	PROVIDER OR SUPPLIER	<u>.l</u>		30	TREET ADDRESS, CITY, STATE, ZIP CODE MONTVUE DRIVE URAY, VA 22835	<u>; 09/</u>	2//2010
(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 622	lethargic, responsive respiratory distress informed, 911 calle (emergency room) There was no docuclinical record that comprehensive careceiving provider to the residents to On 9/27/18 at 8:31 conducted with LPI When asked if the comprehensive care "No." On 09/27/18 at apprinterview was conducted with a care plan goals we	we and breathing heavily in s, NP (Nurse Practitioner) and and resident was sent to ER."		622			
	(administrative stat Administrator and A Nursing were made	oroximately 3:30 p.m., ASM if member) #1, the ASM #2, the Director of aware of the findings.	diputament de la companya de la companya de la companya de la companya de la companya de la companya de la comp	WHITE AND ADDRESS OF THE PROPERTY OF THE PROPE			
	1. A disease that n can lead to shortne types are chronic b The main cause of to substances that This is usually ciga chemical fumes, or	nakes it difficult to breath that ess of breath. The two main pronchitis and emphysema. COPD is long-term exposure irritate and damage the lungs. The rette smoke. Air pollution, and dust can also cause it. This tained from the website:					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		TIPLE CONSTRUCTION (X3)		E SURVEY PLETED
		495255	B. WING			1	C 27/2018
	PROVIDER OR SUPPLIER V SPRINGS REHAB A	ND NURSING CENTER		30	REET ADDRESS, CITY, STATE, ZIP CODE MONTVUE DRIVE JRAY, VA 22835		
(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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	https://www.nlm.nih 2. A condition in wh passes from your luinformation was obth https://www.nlm.nih ilure.html. 3. A problem with the heartbeat. This information was information was obth https://www.nlm.nih on.html. 5. The facility staff of the comprehensive required documents upon a transfer to the Resident #87. Resident #87 was a 8/31/16 with a recensive required documents upon a transfer to the Resident #87. Resident #87 was a 8/31/16 with a recensive required documents of the collood pressure, der The most recent MI assessment, a Med with an assessment (brief interview for inthe resident was secognitive daily decision the night shift. Ferome of the resident was secognitive daily decision the night shift. Ferome of the resident was secognitive daily decision the night shift. Ferome of the resident was secognitive daily decision the night shift. Ferome of the resident was secognitive daily decision the night shift. Ferome of the resident was secognitive daily decision the night shift. Ferome of the resident was secognitive daily decision the night shift. Ferome of the resident was secognitive daily decision the night shift. Ferome of the resident was secognitive daily decision the night shift. Ferome of the resident was secognitive daily decision the night shift. Ferome of the resident was secognitive daily decision the night shift. Ferome of the resident was secognitive daily decision the night shift. Ferome of the resident was secognitive daily decision the night shift. Ferome of the resident was secognitive daily decision the night shift. Ferome of the resident was secognitive daily decision the night shift. Ferome of the resident was secognitive daily decision the night shift.	nich not enough oxygen ings into your blood. This rained from the website: .gov/medlineplus/respiratoryfa the speed or rhythm of the ormation was obtained from .gov/medlineplus/atrialfibrillati ailed to provide evidence that care plan goals and other is were sent with the resident the hospital on 7/17/18 for admitted to the facility on the readmission on 7/30/18, included but were not limited lon, retention of urine, high mentia, and depression. OS (minimum data set) icare 30 day assessment, a reference date of 8/25/18, as scoring a "4" on the BIMS nental status) score, indicating verely impaired to make	F 6	222			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	TIPLE CONSTRUCTION DING		TE SURVEY MPLETED
		495255	B. WING		nc	C /27/2018
	PROVIDER OR SUPPLIER V SPRINGS REHAB A	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835		72112010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE
F 622	[laboratory] work, up practitioner) informed administrator and it sent out to ER (emercevaluation)." The physician order "Send to ER to evaluation to ER to evaluation to ER to evaluate to ER	nable to obtain. NP (nurse ed unit supervisor and was agreed that resident be ergency room) for eval r dated, 7/17/18, documented, and treat." e clinical record failed to ntation evidencing the required ent to the receiving hospital on a.m., an interview was a #2, the unit manager. When he paperwork that is sent with lity-initiated transfer, LPN # copies of any nursing and notes, physician's orders, list edications, the code status, transfer form." roximately 7:55 a.m., LPN #2 by of the facility's transfer form roximately 8:05 a.m., LPN #2 ave a transfer form for (name a.m., an interview was a (licensed practical nurse) #7. if nursing sent the eplan with the resident to the	F6	522		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495255	B. WING		C 09/27/2018	
	PROVIDER OR SUPPLIER V SPRINGS REHAB A	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835		
(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 COMPLÉTIO	N
F 622	nursing, were made on 9/27/18 at 10:43	aware of the above concern a.m.	F 6	22		
	Notice Requirement CFR(s): 483.15(c)(3) Notice Before a facility trarresident, the facility (i) Notify the resident representative(s) of the reasons for the language and mannality must send a representative of the Long-Term Care Or (ii) Record the reasons discharge in the reasons discharge in the reasons discharge in the reasons discharge in the reasons discharge in the reasons discharge in the reasons discharge in the reasons discharge in the reasons discharge in the reasons discharge in the reasons discharge in the reasons discharge in the reasons discharge required made by the facility resident is transferr (ii) Notice must be represented in the section; (B) The health of in	e before transfer. Insfers or discharges a must- Int and the resident's Ithe transfer or discharge and move in writing and in a Ither they understand. The Ither copy of the notice to a Ither of the State Ither or of the State Ither or or of the Ither Ither or or of the Ither Ither or or of the Ither Ither or or of the Ither Ither or or of the Ither Ither or or of the Ither Ither or or of the Ither Ither or or or of the Ither Ither or or or or of the Ither Ither or	F 6	Resident #79, #117, #119, #56, #103 and #87 cannot be corrected as they were discharged without the proper notice and returned to the facility. Residents who have been discharged have been affected by this deficient practice and cannot be corrected at this time. Residents who potential can be discharged will be reviewed for correct discharge notification and notification to state ombudsman. Education was given to Licensed Nurses on the proper discharge notice to resident or responsible representative prior to discharge SSD/Designee was given education on notification to the State Ombudsman when a resident is discharged by the Administrator on 10/18/18.		

						FOR	D: 10/11/2018 M APPROVED
SKYVIEW SPRINGS REHAB AND NURSING CENTER Continued From page 76 Follow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.		(X3) D/	O. 0938-0391 ATE SURVEY				
AND I LAIV	or connection	IDENTIFICATION NOMBER.	A. BUILD	ING _		CC	OMPLETED
		495255	B. WING			n n	C 9/27/2018
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		<u> </u>
SKYVIE	N SPRINGS REHAB A	ND NURSING CENTER					
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	(C) The resident's hallow a more immedunder paragraph (c) (D) An immediate trrequired by the resident paragraph (c) (E) A resident has notice specified in paragraph (c) (E) A resident has notice specified in paragraph (c) (i) The reason for tr (ii) The effective data (iii) The location to ware transferred or discharacteristic (iv) A statement of the including the name, and telephone number completing the form hearing request; (v) The name, addretelephone number of Long-Term Care Om (vi) For nursing facilities, the maillitelephone number of the protection and ac developmental disabilities, the maillitelephone number of the Developmental disab C of the Developmer and Bill of Rights Act codified at 42 U.S.C. (vii) For nursing facilities and facilities at 42 U.S.C. (viii) For nursing facilities and facilities at 42 U.S.C. (viii) For nursing facilities and facilities at 42 U.S.C. (viii) For nursing facilities and facilities at 42 U.S.C. (viii) For nursing facilities and facilities at 42 U.S.C. (viii) For nursing facilities and facilities at 42 U.S.C. (viii) For nursing facilities and facilities at 42 U.S.C. (viii) For nursing facilities and facilities and facilities are sent and facilities and facilities at 42 U.S.C. (viii) For nursing facilities and facilities and facilities and facilities are sent and facilities and facili	ealth improves sufficiently to diate transfer or discharge, o(1)(i)(B) of this section; ansfer or discharge is dent's urgent medical needs, (1)(i)(A) of this section; or ot resided in the facility for 30 onts of the notice. The written aragraph (c)(3) of this section owing: ansfer or discharge; e of transfer or discharge; hich the resident is arged; he resident's appeal rights, address (mailing and email), her of the entity which sts; and information on how form and assistance in and submitting the appeal ses (mailing and email) and if the Office of the State abudsman; ty residents with intellectual disabilities or related and and email address and if the agency responsible for divocacy of individuals with dilities established under Part and Disabilities Assistance of 2000 (Pub. L. 106-402,	F 6	23	All discharged residents will be audited by the Administration Team within 24 hours to ensure Compliance for proper discharge notice and notice to state Ombudsman. Results will be taken To the QAPI committee for review And recommendations. Date of Compliance: 10/30/2018		

email address and telephone number of the

PHINIED: 10/11/2018

NAME OF PROVIDER OR SUPPLIER SKYVIEW SPRINGS REHAB AND NURSING CENTER SUMMARY STATEMENT OF DEPICIENCIES PREFERY TAG SUMMARY STATEMENT OF DEPICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) F 623 Continued From page 77 agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally III Individuals Act. § 483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. § 483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the 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(t). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide written notification to the resident and / or the residents representative of a facility initiated transfer for six of 43 residents in the survey sample, Residents # 79, #117, #119, #56, #103 and #87. 1. The facility staff failed to provide Resident # 79		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
SKYVIEW SPRINGS REHAB AND NURSING CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION) FOR 3 COntinued From page 77 agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Memally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the 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, facility document review, and clinical record review, it was determined that facility stiff failed to provide written notification to the resident and / or the residents representative of a facility initiated transfer for six of 43 residents in the survey sample, Residents # 79, #117, #119, #56, #103 and #87. 1. The facility staff failed to provide Resident # 79			495255	B. WING		ng		
FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 623 Continued From page 77 agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally III Individuals Act. \$483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. \$483.15(c)(8) Notice in advance of facility closure in the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the 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(i). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide written notification to the resident and / or the resident's representative of a facility initiated transfer for six of 43 residents in the survey sample, Residents # 79, #117, #119, #56, #103 and #87. 1. The facility staff failed to provide Resident # 79			AND NURSING CENTER		30 MONTVUE DRIVE		12172010	
agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally III Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the 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, facility document review, and clinical record review, it was determined that facility staff failed to provide written notification to the residents in the survey sample, Residents # 79, #117, #119, #56, #103 and #87. 1. The facility staff failed to provide Resident # 79	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF	HOULD BE	COMPLETION	
or the resident's representative and the ombudsman written notification when the resident was transferred to the hospital on 09/08/18.	F 623	agency responsible advocacy of individe advocacy of individe established under the for Mentally III Individes 11 Individes 12 Individes 13 Individes 1483.15(c)(6) Charlf the information in effecting the transformust update the reas practicable once becomes available \$483.15(c)(8) Notice In the case of facility the administrator of written notification to the State Survey State Long-Term Content to the State Survey State Long-Term Content 1483.70(I). This REQUIREMED 15 Individed 15	e for the protection and duals with a mental disorder the Protection and Advocacy viduals Act. Inges to the notice. In the notice changes prior to be of the notice as soon to the updated information of the individual who is found the facility must provide prior to the impending closure of Agency, the Office of the eare Ombudsman, residents of the transfer and adequate sidents, as required at § In the transfer and adequate sidents, as required at § In the transfer and it was collity staff failed to provide to the resident and / or the stative of a facility initiated and residents in the survey #79, #117, #119, #56, #103 If ailed to provide Resident #79 presentative and the notification when the resident the hospital on 09/08/18.	F 6	23			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		405055		-	The state of the s	I	С
NAME OF	PROVIDER OR SUPPLIER	495255	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	09/	27/2018
		AND NURSING CENTER		30	MONTVUE DRIVE URAY, VA 22835		
(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 SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	117 or the resident' ombudsman writter was transferred to the strain of the hospital on 8. 4. The facility staff Resident #56, and long term care ombudification docume transfer on 6/18/18. 5. The facility staff with written notification docume transfer dated 8/30. 6. The facility staff documentation to the representative for a failed to notify the continuitiated transfer on The findings included 1. The facility staff or the resident's reprombudsman writter was transferred to the Resident # 79's moset), a quarterly asset (assessment reference Resident # 79 as so interview for mental staff or the resident # 79 as so interview for men	s representative and the notification when the resident the hospital on 09/19/18. failed to provide written dent/Responsible I the ombudsman of a transfer /23/18, for Resident #119. failed to evidence that or the responsible party and oudsmen received written enting reason for hospital failed to provide ombudsman tion of a facility initiated /18 for Resident #103. failed to provide written ne resident and/or resident facility initiated transfer and ombudsman of a facility 7/17/18 for Resident #87. e: failed to provide Resident # 79 oresentative and the notification when the resident he hospital on 09/08/18. st recent MDS (minimum data sessment with an ARD once date) of 08/21/18, coded coring a 4 (four) on the brief I status (BIMS) of a score of 0 g severely impaired of	F	623			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495255	B. WING			C 09/27/2018	
	PROVIDER OR SUPPLIER V SPRINGS REHAB	AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZI 30 MONTVUE DRIVE LURAY, VA 22835	P CODE	332172310	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD HE APPROPE	BE COMPLETION	Z
F 623	dated 09/08/18 dod (certified nursing a resident when resident when resident when resident when resident when resident when resident was age) left for the nurse's "Prograted 09/08/18 dod nurse spoke with (informed that resident was resident was transformed that resident # 79 faile the resident was transformed with LPI 2, unit manager. Veritten notification representative of a hospital, LPN # 2 so On 09/27/18 at application of the organization of the organization of the hospital, OSM social worker emai of each month with	ress Notes" for Resident #79 cumented, "6:44 a.m. CNA ssistant) was talking to dent began shaking and a practitioner) notified, ER and 911 called. Msg granddaughter to call." ress Notes" for Resident #79 cumented, "3:26 p.m. This Name of Hospital) and was lent was being admitted for LLL e pneumonia). NP and DON	F6	REC	EIVEI 0 6 2018 1/OLC		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''			MPLETED
		495255	B. WING		O	C 9/27/2018
	PROVIDER OR SUPPLIER V SPRINGS REHAB A	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 30 MONTVUE DRIVE LURAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 623	Discharges" docume and discharges of reparts of the same for occur for the right reparts of the same for orientation to facility. On 09/26/18 at app (administrative staff administrator and A were made aware of identify the standar follows ASM # 2 staff acility's policies. No further information of the formal identification of the f	"Resident Transfers and pented, "Standard: Transfers esidents between distinct acility or out of the facility will eason, with proper notice and ate adjustment." roximately 5:50 p.m., ASM f member) # 1, the SM # 2, director of nursing of the findings. When asked to d of practice the nursing staff ated that they follow the on was provided prior to exit. Improms and behavioral common and prominent ementia. They include depression, anxiety aggression, disinhibition,	F6	23		
	90% of patients with behavioral disorder interactions between psychological sympabnormalities. This from the website: https://www.ncbi.nlm.81717/. (2) When not enoughings into your blood obtained from the website.	toms, and behavioral s information was obtained m.nih.gov/pmc/articles/PMC31 gh oxygen passes from your d. This information was				

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION (X3)		COM	(3) DATE SURVEY COMPLETED	
		495255	B. WING				C 27/2018	
	PROVIDER OR SUPPLIER N SPRINGS REHAB A	AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP C 30 MONTVUE DRIVE LURAY, VA 22835	ÖDE	USI:	2112010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		I SHOULD	BE	(X5) COMPLETION DATE	
F 623	(3) Depression may blue, unhappy, mis-Most of us feel this short periods. Clinidisorder in which feor frustration interfeor more. This inforwebsite: https://medlineplus. (4) Fear. This inforwebsite: https://www.nlm.nih#summary. 2. The facility staff 117 or the resident' ombudsman writterwas transferred to the Resident # 117 was 07/19/2018 with dianot limited to: atrial depressive disorder Resident # 117 is midata set), a 5 (five)-(assessment references Resident # 117 as sinterview for mentation of the nurse's "Progredated 09/19/18 doc (Resident) eating by the short progredated of the sident of the nurse's "Progredated of the sident) eating by the short progredated of the sident of the	y be described as feeling sad, erable, or down in the dumps. way at one time or another for ical depression is a mood selings of sadness, loss, anger, ere with everyday life for weeks mation was obtained from the gov/ency/article/003213.htm. I mation was obtained from the agov/medlineplus/anxiety.html failed to provide Resident # s representative and the anotification when the resident the hospital on 09/19/18. Is admitted to the facility on agnoses that included but were fibrillation (1), hemiplegia (2), r (3) and hypertension (4). Tost recent MDS (minimum and page 20) and page 20 and page 30 and page 31 and page 32 and page 32 and page 32 and page 34 and page 34 and page 35 and page 36 a	F	623				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			СОМ	E SURVEY IPLETED
		495255	B. WING		1	C 27/2018
	PROVIDER OR SUPPLIER V SPRINGS REHAB A	AND NURSING CENTER	30	REET ADDRESS, CITY, STATE, ZIP CODE MONTVUE DRIVE JRAY, VA 22835	1	21/2010
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 623	Res thought to be of Heimlich Maneuver unresponsive, Res transported to ER ((evaluation) and Trapractitioner) notified. Review of the EHR Resident # 117 fails or the resident's repombudsman were pombudsman with the resident won 09/19/18. On 09/27/18 at 7:20 conducted with LPN 2, unit manager. Workten notification of hospital, LPN # 2 so On 09/27/18 at appinterview was condifused member) # 1, social notify the ombudsman the hospital, OSM # social worker email of each month with discharged from the were transferred." On 09/26/18 at appinterview staff administrative staff administrator and A were made aware of No further information.	choking, this nurse starting when res became breathing and being emergency room) for evaluat (treatment), NP (nurse d and daughter notified." (electronic health record) for ed to evidence Resident # 117 presentative and the provided written notification was transferred to the hospital of a resident's transfer to the tated, "No, just by phone." Proximately 10:35 a.m., an ucted with OSM (other staff all worker. When asked if they han of a resident's transfer to the stated, "The previous ed the ombudsman at the end a list of residents who were en facility but not those who croximately 5:50 p.m., ASM of member) # 1, the LSM # 2, director of nursing	F 623			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	,	495255	B. WING		00	C /27/2018	
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP C 30 MONTVUE DRIVE LURAY, VA 22835			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	heartbeat. This inforthe website: https://www.nlm.nih on.html. (2) Also called: Hen Quadriplegia. Para function in part of y something goes wr pass between your can be complete or both sides of your b one area, or it can t information was obt https://medlineplus. (3) Depression may blue, unhappy, mise Most of us feel this short periods. Clini disorder in which fe or frustration interfe or more. This infort website: https://medlineplus. (4) High blood press obtained from the w https://www.nlm.nih essure.html. 3. The facility staff f notification to Resid Representative and to the hospital on 8/ Resident #119 was 9/2/14, with diagnos limited to: left sided	incommation was obtained from a gov/medlineplus/atrialfibrillati in plegia, Palsy, Paraplegia, lysis is the loss of muscle our body. It happens when ong with the way messages brain and muscles. Paralysis partial. It can occur on one or ody. It can also occur in just be widespread. This tained from the website: gov/paralysis.html. The described as feeling sad, erable, or down in the dumps. way at one time or another for cal depression is a mood elings of sadness, loss, anger, are with everyday life for weeks mation was obtained from the gov/ency/article/003213.htm. Sure. This information was vebsite: "gov/medlineplus/highbloodpr ailed to provide written	F 6	23			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING	l ^o	(X3) DATE SURVEY COMPLETED					
		495255	B. WING			09/9	2 7/2018
	PROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 30 MONTVUE DRIVE LURAY, VA 22835	ODE		27/2016
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF COP X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD B	E ATE	(X5) COMPLETION DATE
F 623	muscle spasms. The data set) assessment with an assessment coded the resident (brief interview for resident interview for residents and commented in part residents [sic] room SOB (shortness of back, diaphoresis (sic) BP (blood pressure (temperature)-101.9 check blood sugar) notified and gave of (emergency room) attorney) notified." On 09/27/18 at 7:28 conducted with LPN 2, unit manager. We written notification to representative or O initiated transfer to "No, just by phone." On 09/27/18 at appinterview was condumember) #1, the soft they notify the Ombit transfer to the hosp previous social work at the end of each rewho were discharged those who were transprovide evidence the conducted with the conducted with the previous social work at the end of each rewho were discharged those who were transprovide evidence the conducted with the conducted with the social work at the end of each rewho were discharged those who were transprovide evidence the conducted with the cond	the most recent MDS (minimum ent, an annual assessment, to reference date of 8/5/18, as scoring a "9" on the BIMS mental status) score, indicating ognitive impairment for daily atted 8/23/18 at 2:19 p.m. If the mass called to a complaining breath was complaining breath) with pain radiating to sweating). Unable to obtain [sic] temp [sic] t	F6	23			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495255	B. WING			C 09/27/2018	
NAME OF S	PROVIDER OR SUPPLIER	+33230	1 51 111115		TREET ADDRESS, CITY, STATE, ZIP CODE	1 09/	2//2018
NAIVIE OF I	FROVIDER ON SUFFLIER						
SKYVIEV	V SPRINGS REHAB A	ND NURSING CENTER			0 MONTVUE DRIVE .URAY, VA 22835		i
(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 DATE
F 623	Continued From pa the hospital on 8/23	_	F	623			
		p.m., ASM, (administrative administrator, #1, was made findings.	ромер календар жана жана жана жана жана жана жана жа				
	No further informati	on was provided prior to exit.					rederangement processors
	Resident #56, and olong term care omb	failed to evidence that or the responsible party and budsmen received written enting reason for hospital	***************************************				
	1/23/18 and readmidiagnoses that inclutype two diabetes, ubehavioral disturbation chronic heart failure disorder. Resident (minimum data set) with an ARD (asses 8/2/18. Resident #5 cognitively intact sc	admitted to the facility on ted on 6/20/18 with uded but were not limited to unspecified dementia without nee, high blood pressure, and major depressive #56's most recent MDS was a quarterly assessment esment reference date) of 6 was coded as being oring 11 out of 15 on the BIMS Mental Status) exam.					
	that he was sent ou The following nursir (vital signs): T (tem BP (blood pressure being transferred th out. Foley catheter replaced x 2 along vattempt by NP (nurs Obtained orders to catheter placed due	#56's clinical record revealed at to the hospital on 6/18/18. In the normal of the hospital on 6/18/18. In the normal of the hospital on 6/18/18. In the normal of the hospital					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	COM	(X3) DATE SURVEY COMPLETED	
		495255	B. WING		ı	C /27/2018	
	PROVIDER OR SUPPLIER V SPRINGS REHAB A	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 623	made aware." The next nursing not the following: "Residuals." There was no evided the responsible partombudsman received documenting the retransfer on 6/18/18. On 9/27/18 at 8:31 conducted with LPN Resident #56's nurside responsible party work transfer to the hosp nursing notified the nurses were supposite to the family if they most of the time not phone. When asked term care ombudsmansferred to the honursing did not. On 09/27/18 at application of the family if they most of the time not phone. When asked term care ombudsmansferred to the honursing did not. On 09/27/18 at application of the hospital. OSM # social worker emails of each month with	ention. RP (responsible party) ote dated 6/18/18 documented dent transferred to (Name of ence in the clinical record that the day and long term care ed written notification ason for Resident #56's	F 6:	23			

NAME OF PROVIDER OR SUPPLIER SKYVIEW SPRINGS REHAB AND NURSING CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	C 09/27/2018 (X5) COMPLETION DATE
NAME OF PROVIDER OR SUPPLIER SKYVIEW SPRINGS REHAB AND NURSING CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION
	COMPLETION
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 623 Continued From page 87 Resident #56's transfer to the hospital on 6/18/18 could not be provided. On 9/27/18 at approximately 12:30 p.m., ASM (administrative staff member) #1, the administrator was made aware of the above concerns. No further information was presented prior to exit. (1) Caude or Coudé catheter is a reinforced tip catheter that is recommended when one encounters difficulty placing a catheter using the regular technique. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC26 92169/. (2) This information was obtained from The National Institutes of Health. https://medlineplus.gov/enlargedprostatebph.html The facility staff failed to provide ombudsman with written notification of a facility initiated transfer dated 8/30/18 for Resident #103. Resident #103 was admitted to the facility on 2/6/14 and readmitted on 9/4/18, with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (COPD) (1), acute and chronic respiratory failure (2), major depressive disorder, generalized anxiety disorder, atrial fibrillation (3) and high blood pressure. The most recent MDS (minimum data set), a five day assessment, with an ARD (assessment reference date) of 9/6/18 coded the resident as having a score of 15 of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions.	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I '	TIPLE CONSTRUCTION			E SURVEY IPLETED
		495255	B. WING				C 27/2018
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SKYVIEV	N SPRINGS REHAB A	AND NURSING CENTER		30 MONTVUE DRIVE LURAY, VA 22835			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		HOULD E	BE	(X5) COMPLETION DATE
F 623	Continued From pa	ıge 88	F 6	623	<u> </u>		
	revealed that she h on 8/30/18. A nursin a.m. documented, " lethargic, responsiv respiratory distress	t #103's clinical record nad been sent to the hospital ng note dated 8/30/18 at 8:00 "Resident found to be ve and breathing heavily in s, NP (Nurse Practitioner) d and resident was sent to ER					
	evidence that the O	ne clinical record failed to Ombudsman was provided a esident #103's transfer to the	derettererererenden minimum merentererenden deretterenden deretterenden deretterenden deretterenden deretteren				
	interview was condi- practical nurse) #7. notification was sen regarding Resident	proximately 8:08 a.m., an lucted with LPN (licensed . LPN #7 was asked if nt to the ombudsman t #103's transfer dated 8/30/18, "Not to my knowledge."					
	interview was condi- member) #1, Social if notification was so- regarding Resident OSM #1 stated, "No would email the om	proximately 10:37 a.m., an lucted with OSM (other staff of Worker. OSM #1 was asked, ent to the ombudsman at #103's transfer dated 8/30/18, o, the previous social worker abudsman at the end of the ges but not transfers."					
	(administrative staff Administrator and A	oroximately 3:30 p.m., ASM if member) #1, the ASM #2, the Director of a aware of the findings.				WATER TO THE PARTY OF THE PARTY	
	No further informati	ion was provided prior to exit.				AND CONTRACTOR OF THE CONTRACT	
	1. A disease that m	akes it difficult to breath that				***************************************	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING		E SURVEY IPLETED
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	PROVIDER OR SUPPLIER V SPRINGS REHAB A	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835	1 03/	2112010
(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 APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 623	can lead to shortne types are chronic by The main cause of to substances that it This is usually cigar chemical fumes, or information was obtained from your lungs into was obtained from the https://www.nlm.nihilure.html. 3. A problem with the heartbeat. This inforthe website: https://www.nlm.nihilure.html. 6. The facility staff documentation to the representative for a failed to notify the orinitiated transfer on Resident #87 was a 8/31/16 with a receivith diagnoses that to: cancer of the coblood pressure, der most recent MDS (rassessment, a Med with an assessment coded the resident (brief interview for medical substance).	ss of breath. The two main ronchitis and emphysema. COPD is long-term exposure rritate and damage the lungs. Tette smoke. Air pollution, dust can also cause it. This rained from the website: .gov/medlineplus/copd.html. ich not enough oxygen passes by your blood. This information the website: .gov/medlineplus/respiratoryfa the speed or rhythm of the parameter of the website: .gov/medlineplus/atrialfibrillati failed to provide written the resident and/or resident facility initiated transfer and mbudsman of a facility 7/17/18 for Resident #87. Indmitted to the facility on the readmission on 7/30/18, included but were not limited lon, retention of urine, high mentia, and depression. The minimum data set) incare 30 day assessment, the reference date of 8/25/18, as scoring a "4" on the BIMS mental status) score, indicating verely impaired to make	F 6	23		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED		
		495255	B. WING		C 09/27/2018
	PROVIDER OR SUPPLIER V SPRINGS REHAB A	ND NURSING CENTER	3	TREET ADDRESS, CITY, STATE, ZIP CODE O MONTVUE DRIVE URAY, VA 22835	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTION
F 623	The nurse's note da documented, "It wan ight shift that reside on the night shift. It however stating that stomach distended. [laboratory] work, upractitioner) informadministrator and it sent out to ER (emote (evaluation)." The physician order "Send to ER to evaluation)." There was no evide the responsible part ombudsman received documenting the retransfer on 7/17/18. On 09/27/18 at 7:29 conducted with LPN asked to describe the resident for a facing stated, "We sends of physician progress of the resident's metace sheet and the they provide written and the resident's metace sheet and the they provide written and the resident's metace sheet and the they provide written and the resident's metace sheet and the they provide written and the resident's metace sheet and the they provide written and the resident's metace sheet and the they provide written and the resident's metace sheet and the they provide written and the resident's metace sheet and the stated, "We on 09/27/18 at app was asked for a copfor Resident # 87.	ated, 7/17/18 at 9:21 a.m. s reported to this nurse by lent had vomited several times Resident awake and alert, at he 'feels bad.' Resident's Staff attempted ordered lab nable to obtain. NP (nurse ed unit supervisor and was agreed that resident be ergency room) for evaluate and treat." Ince in the clinical record that they and long term care ed written notification ason for Resident #87's If a.m., an interview was a with a lity-initiated transfer, LPN # copies of any nursing and notes, physician's orders, list edications, the code status, transfer form." When asked if notification to the resident epresentative of the transfer, use the transfer form."	F 623	RECEIVED NOV 0 6 2018 VDH/OLC	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	ø	495255	B. WING			ļ .	C /27/2018
NAME OF	PROVIDER OR SUPPLIER	,	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	1 09/	2//2010
SKYVIE\	W SPRINGS REHAB A	ND NURSING CENTER			80 MONTVUE DRIVE LURAY, VA 22835		
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	On 9/27/18 at 8:31 conducted with LPN LPN #7 stated she wand medical doctor. responsible party wonursing notified the nurses were suppose notification to the rethe reason for trans nursing could provide to the family if they most of the time not phone. When asked term care ombudsm transferred to the honursing did not. An interview was constaff member (ASM ASM #1 stated the form until she came the ombudsman not monthly, per the omsocial worker would email. ASM #1 stated email account as she and I can't get into it.	a.m., an interview was I (licensed practical nurse) #7. would then notify the family When asked how the as notified, LPN #7 stated that family verbally. When asked if sed to provide written sponsible party documenting fer, LPN #7 stated that de a copy of the nursing note request it. LPN #7 stated that diffication is done over the I if nursing notified the long nan when a resident was ospital, LPN #7 stated that onducted with administrative at the administrator and that diffication was completed budsman. The previous send the notification via ed I do not have access to her the is no longer employed here	F 6	623			
		on was provided prior to exit.	F 62	25	Resident #79, #117, #56, #103, and #87 cannot be corrected as they were discharged without the bed hold policy being given to them per regulation.		

NAME OF PROVIDER OR SUPPLER SKYVIEW SPRINGS REHAB AND NURSING CENTER LURAY, W. 2835 SUMMARY STATEMENT OF DECIGIONIES LURAY, W. 2835 LURAY, W. 2835 SUMMARY STATEMENT OF DECIGIONIES LURAY, W. 2835 LURAY, W. 2835 F 625 Continued From page 92 \$483.15(d)(1) Notice of bed-hold policy and returning facility transfers a resident to a hospital or the resident pose on therapeutic leave, the nursing facility and resume residence in the nursing facility; (ii) The duration of the state bed-hold policy, if any, during which the resident representative that specifies— (i) The duration of the state bed-hold policy if any, during which the resident is permitted to return and resume residence in the nursing facility; (iii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any, (iii) The nursing facility spolicies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section. \$483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative winter notice which specifies the duration of the bed-hold policy, which will be accident and the resident representative winter notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review; it was determined that facility intitated transfer for five of 43 residents in the survey sample, Residents #79, #117, #56, #103 and #87.		FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		TE SURVEY MPLETED
STREET ADDPESS, CITY, STATE, JP CODE 30 MONTIVE DRIVE			495255	B. WING	÷		l .	
SKYVIEW SPRINGS REHAB AND NURSING CENTER 30 MONTWE DRIVE LURAY, Na. 22835	NAME OF	PROVIDER OR SUPPLIER		<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	1 09/	12112010
CAST Display Complete Com					Į.			
FREED TAGE (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 625 Continued From page 92 §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility, (iii) The nursing facility policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that facility staff falled to provide a bed hold policy to the resident or the residents of the resident in the survey	SKYVIEV	V SPRINGS REHAB A	ND NURSING CENTER					
§483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the residence in the nursing facility, (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any, (iii) The nursing facility spolicies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. 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 a bed hold policy to the resident or the resident representative written notice which resident's representative written notice which resident's representative written notice which resident representative written notice which specifies the duration of the bed-hold policy to the resident or the resident's representative written notice which resident's representative upon a facility initiated transfer for five of 43 residents in the survey	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	BE	COMPLETION
The facility staff failed to provide Resident # 79 or the resident's representative written notification	F 625	§483.15(d) (1) Notice of §483.15(d) (1) Notice nursing facility trans the resident goes of nursing facility must the resident or resident or resident or resident or resident or resident or resident or resident or resident or resume of facility; (ii) The duration of the any, during which the return and resume of facility; (ii) The reserve bed plan, under § 447.44 (iii) The nursing facility and periods, we paragraph (e)(1) of resident to return; a (iv) The information of this section. §483.15(d)(2) Bed-of the time of transfer hospitalization or the facility must provide resident representates specifies the duration described in paragratic This REQUIREMENT by: Based on staff interreview, it was deterred to provide a bed hold resident's represent transfer for five of 45 sample, Residents of 1. The facility staff facilit	before transfer. Before a sters a resident to a hospital or in therapeutic leave, the provide written information to lent representative that the state bed-hold policy, if the resident is permitted to residence in the nursing payment policy in the state of this chapter, if any; lity's policies regarding thich must be consistent with this section, permitting a nod specified in paragraph (e)(1) and notice upon transfer. At of a resident for erapeutic leave, a nursing to the resident and the tive written notice which on of the bed-hold policy aph (d)(1) of this section. It is not met as evidenced a residents in the survey the street of the section of the section of the section of the section. It is not met as evidenced that facility staff failed do policy to the resident or the ative upon a facility initiated a residents in the survey the street and the survey the survey the street and the survey the street and the survey the street and the survey the survey the street and the survey the street and the survey the survey the street and the survey the survey the survey the survey the survey the survey the survey the survey the survey the survey the survey the survey the surv	F	525	discharged have been affected by this deficient practice and cannot be corrected at this time. Residents who potential can be discharged will be reviewed for bed hold policy if discharged. Education was given to Licensed Nurses on the proper bed hold notice to resident or responsible representative prior to discharge by the Administrator on 10/18/18. All discharged residents will be audited by the Administration Team within 24 hours to ensure compliance for bed hold policy. Results will be taken to the QAPI committee for review and recommendations.		

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		495255	B. WING			C 9/27/2018	
	PROVIDER OR SUPPLIER V SPRINGS REHAB A	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 30 MONTVUE DRIVE LURAY, VA 22835		332172010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIÉS MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 625	of the bed hold polic transferred to the hold transferred to the hold 2. The facility staff for the resident was transfered hold notification #56 or the responsification and or the resthe bed-hold policy transfer to the hosp for the hosp transfer to the hosp for the resentative upor the hospital on 7/17. The findings includes 1. The facility staff for the resident's report the bed hold policy transfer to the hospital on 7/17. The findings includes 1. The facility staff for the resident's report the bed hold policy transferred to the hold policy transfe	cy when the resident was ospital on 09/08/18. ailed to provide Resident # sepresentative written ed hold policy when the erred to the hospital on ailed to evidence that written has provided to the Resident ble party at the time of a sefer to the hospital on 6/18/18. failed to provide Resident ident's representative with a upon a facility initiated ital on 8/30/18. ailed to evidence a copy of the bed hold policy resident and/or resident a facility initiated transfer to 1/18 for Resident #87. ailed to provide Resident # 79 oresentative written notification by when the resident was ospital on 09/08/18. admitted to the facility on gnoses that included but were entia with behavioral spiratory failure (2),	F 6				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY IPLETED
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	PROVIDER OR SUPPLIER V SPRINGS REHAB A	ND NURSING CENTER		30	REET ADDRESS, CITY, STATE, ZIP CODE MONTVUE DRIVE JRAY, VA 22835	<u> US/.</u>	2//2018
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 625	set), a quarterly ass (assessment refere Resident # 79 as so interview for mental - 15, 4 (four) - being cognition for making. The nurse's "Progredated 09/08/18 doc (certified nursing as resident when resid drooling-NP (nurse (emergency room) a (message) left for g. The nurse's "Progredated 09/08/18 doc nurse spoke with (Ninformed that reside PNA (left lower lobe (director of nursing)). Review of the EHR Resident # 79 failed of written notification provided to Resider representative for a 09/08/18. On 09/27/18 at 10:1 conducted with OSM admissions director	sessment with an ARD noce date) of 08/21/18, coded coring a 4 (four) on the brief I status (BIMS) of a score of 0 g severely impaired of g daily decisions. Sess Notes" for Resident #79 umented, "6:44 a.m. CNA sistant) was talking to ent began shaking and practitioner) notified, ER and 911 called. Msg randdaughter to call." Sess Notes" for Resident #79 umented, "3:26 p.m. This lame of Hospital) and was ent was being admitted for LLL pneumonia). NP and DON	F6	25	DEFICIENCY)		
	responsible party, if call the resident's re wanted to hold the t nurse's notes." Wh	the resident is not then we epresentative and ask if they bed. It is documented in the en asked if the bed hold to the resident's		MATERIAL PROPERTY OF THE PROPE			

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		PLETED
		495255	B. WING			l	C 27/2018
	PROVIDER OR SUPPLIER W SPRINGS REHAB A	ND NURSING CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 0 MONTVUE DRIVE URAY, VA 22835	1 091	2112010
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 625	transfer, OSM # 1 s bed hold policy at the Don 09/26/18 at app (administrative staff administrator and A were made aware of identify the standard follows ASM # 2 staff acility's policies. No further information References: (1) Psychological syabnormalities are of characteristics of disymptoms such as psychosis, agitation and sleep disturbar 90% of patients with behavioral disorder interactions betwee psychological symp abnormalities. Thi from the website: https://www.ncbi.nlr 81717/. (2) When not enoug lungs into your blood obtained from the we https://www.nlm.nih ilure.html. (3) Depression may blue, unhappy, mise	e time of the facility-initiated stated, "No. Nobody sends the ne time of transfer." roximately 5:50 p.m., ASM if member) # 1, the SM # 2, director of nursing of the findings. When asked to do f practice the nursing staff sted that they follow the son was provided prior to exit. If the findings is when asked to do for practice the nursing staff sted that they follow the son was provided prior to exit. If the findings is when asked to do for practice the nursing staff sted that they follow the son was provided prior to exit. If the findings is followed that they follow the sementia. They include depression, anxiety and anxiety and depression, disinhibition, and dementia suffer from such son the finding staff from such son the finding staff from such son the finding staff from such son the finding staff from such son the finding staff from such son the finding staff from such son the finding staff from such son the finding staff from such son the finding staff from such son the finding staff from such son the finding staff from such sta	F6	625			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495255	B. WING			C 09/27/2018	
	PROVIDER OR SUPPLIER W SPRINGS REHAB	AND NURSING CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 0 MONTVUE DRIVE LURAY, VA 22835	1	2112010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT 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 625	short periods. Clin disorder in which for frustration interfor more. This inforwebsite: https://medlineplus (4) Fear. This inforwebsite: https://medlineplus (4) Fear. This inforwebsite: https://www.nlm.nif #summary. 2. The facility staff 117 or the resident notification of the bresident was transf 09/19/18. Resident # 117 was 07/19/2018 with dianot limited to: atrial depressive disorde Resident # 117's m data set), a 5 (five) (assessment reference Resident # 117 as sinterview for mentation - 15, 7 (seven) - be cognition for making The nurse's "Progradated 09/19/18 doc (Resident) eating b CNA (certified nurses thought to be of Heimlich Maneuver unresponsive, Res	ical depression is a mood pelings of sadness, loss, anger, are with everyday life for weeks mation was obtained from the agov/ency/article/003213.htm. Immation was obtained from the agov/medlineplus/anxiety.html If ailed to provide Resident # are representative written ed hold policy when the erred to the hospital on agnoses that included but were fibrillation (1), hemiplegia (2), r (3) and hypertension (4). In ost recent MDS (minimum and approximately assessment with an ARD ence date) of 07/26/18, coded scoring a 7 (seven) on the brief I status (BIMS) of a score of 0 ing severely impaired of g daily decisions. In the series of the sadder of the series of the se	F 6	325			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495255	B. WING		1	C /27/2018	
	PROVIDER OR SUPPLIER V SPRINGS REHAB	AND NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835				
(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 CORRECT ((EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRIDEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 625	Practitioner) notified Review of the EHR Resident # 117 fails of written notification provided to Resider representative for a 09/19/18. On 09/26/18 at app (administrative staf administrator and A were made aware of No further information References: (1) A problem with the artbeat. This information we website: https://www.nlm.nih on.html. (2) Also called: Her Quadriplegia. Para function in part of y something goes wr pass between your can be complete or both sides of your to one area, or it can be information was obe https://medlineplus. (3) Depression may blue, unhappy, miss Most of us feel this	eat (treatment), NP (nurse d and daughter notified." (electronic health record) for ed to evidence documentation on of the bed hold policy being int # 117 or Resident # 117's a facility-initiated transfer on excimately 5:50 p.m., ASM f member) # 1, the aSM # 2, director of nursing of the findings. It ion was provided prior to exit. It is speed or rhythm of the formation was obtained from a gov/medlineplus/atrialfibrillation in plegia, Palsy, Paraplegia, alysis is the loss of muscle our body. It happens when ong with the way messages brain and muscles. Paralysis is partial. It can occur on one or body. It can also occur in just be widespread. This tained from the website:	F6	25			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I '	TIPLE CONSTRUCTION DING	(X3) DAT COM	E SURVEY MPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		.D BE	(X5) COMPLETION DATE
F 625	disorder in which fe or frustration interfe or more. This information website: https://medlineplus. (4) High blood presobtained from the whittps://www.nlm.nihessure.html. 3. The facility staff fibed hold notification #56 or the responsifacility initiated transferiller with the word diagnoses that inclutive two diabetes, ubehavioral disturbation chronic heart failured disorder. Resident filminimum data set) with an ARD (asses 8/2/18. Resident #5 cognitively intact so (Brief Interview for I Review of Resident that he was sent ou The following nursir (vital signs): T (tem BP (blood pressure being transferred thout. Foley catheter replaced x 2 along attempt by NP (nursobtained orders to	elings of sadness, loss, anger, re with everyday life for weeks mation was obtained from the gov/ency/article/003213.htm.	F6	525		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION		E SURVEY IPLETED
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	PROVIDER OR SUPPLIER V SPRINGS REHAB A	AND NURSING CENTER		3	STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835	<u>, 09,</u>	2112010
(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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 625	dysfunction, BPH (E	Benign Prostatic Hyperplasia)	Fe	325			**************************************
	made aware."	ention. RP (responsible party)					
		ote dated 6/18/18 documented dent transferred to (Name of					
	the resident and/or	ence in the clinical record that responsible party received dification at the time of transfer					
		esident #56's clinical record is readmitted to the facility on					
	conducted with LPN Resident #56's nurs did not provide writt resident or respons	a.m., an interview was I (licensed practical nurse) #7, se. LPN #7 stated that nurses en bed hold notification to the ible party. LPN #7 stated that ions was responsible for that.					
	conducted with OSI the admissions dire process followed fo for a transfer to the when a resident is toutside marketer we hospital. OSM #10 s	a.m., an interview was M (other staff remember) #10, ctor. When asked about the r written bed hold notification hospital, OSM #10 stated that ransferred to the hospital, an ould visit the resident in the stated that the outside					
	#10 stated that outs resident at the hosp OSM #10 stated tha own RP (responsibl would call the RP at	on for the nursing home. OSM side marketer would ask the lital about holding their bed. at if the resident is not their e party), she (OSM #10), and ask about holding the bed M #10 stated that if the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495255	B. WING			1	C /27/2018
	PROVIDER OR SUPPLIER V SPRINGS REHAB A	AND NURSING CENTER		30 M	EET ADDRESS, CITY, STATE, ZIP CODE IONTVUE DRIVE RAY, VA 22835	<u> </u>	21/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 625	they would fill out the OSM #10 stated that nursing note if the relation hold. OSM #10 stated not sent with the restransfer. OSM #10 evidence of written Resident #56. On 9/27/18 at appro (administrative staff administrator was not concerns. No further prior to exit. (1) Caude or Coude catheter that is recognized technique. from The National Interest/www.ncbi.nlr 92169/. (2) This information National Institutes of https://medlineplus. 4. The facility staff frest #103 and or the restrained the hold policy transfer to the hosp Resident #103 was 2/6/14 and readmitted.	nember want to hold the bed, he appropriate paperwork. At she also documents in a resident or RP wanted a bed died that the bed hold policy is sident or RP at the time of stated that she did not have bed hold notification for eximately 12:30 p.m., ASM f member) #1, the made aware of the above or information was provided eximple a catheter using the This information was obtained institutes of Health. In was obtained from The of Health. In was obtaine	F	625			
	that included but we	ere not limited to: chronic ary disease (COPD) (1), acute	e de la companie de l				NA AMBRICAN PRINCIPAL PRIN

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER V SPRINGS REHAB A	AND NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			
F 625	and chronic respiral depressive disorde atrial fibrillation (3) most recent MDS (1) assessment, with a date) of 9/8/18 code score of 15 of 15 or mental status) indic cognitively intact to revealed that she with 8/30/18. A nursing ram, documented, lethargic, responsive respiratory distress informed, 911 called (emergency room). Further review of the evidence that written policy was provided resident's represent #103's facility initiated 8/30/18. On 9/27/18 at 10:28 conducted with OSI the admissions diresprocess followed for a transfer to the when a resident is to outside marketer with hospital. OSM #10 marketer is the liais #10 stated that outs resident at the hosp OSM #10 stated that	tory failure (2), major r, generalized anxiety disorder, and high blood pressure. The minimum data set), a five day in ARD (assessment reference ed the resident as having a in the BIMS (brief interview for cating the resident was make daily decisions. It #103's clinical record vas sent to the hospital on note dated 8/30/18 at 8:00 'Resident found to be ve and breathing heavily in , NP (Nurse Practitioner) d and resident was sent to ER	F6	325			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ´	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		495255	B. WING		OS	C 9 /27/2018	
	PROVIDER OR SUPPLIER V SPRINGS REHAB A	AND NURSING CENTER	<u></u>	STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835		// 21/2010	
(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 CORRE X (EACH CORRECTIVE ACTION SHOOT CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 625	the phone. OSM #1 family member war fill out the appropria stated that she also if the resident or RF stated that the bed resident or RP at the On 09/27/18 at appinterview was cond member) #1, Socia if a written notificati given to Resident # the time of transfer OSM #1 replied "I of On 09/27/18 at apping (administrative staff Administrative s	a about holding the bed over 0 stated that if the resident or 10 to hold the bed, they would ate paperwork. OHM #10 of documents in a nursing note 10 wanted a bed hold. OSM #10 hold policy is not sent with the 10 te time of transfer. I worker. OSM #1 was asked on of the bed-hold policy was 103 or her representative at 103 or her representative at 104 to the hospital on 8/30/18, don't know." I worker. OSM #1, the 10 was asked on of the bed-hold policy was 103 or her representative at 104 to the hospital on 8/30/18, don't know." I working a ware of the findings. I was provided prior to exit. I was provided pri	F 6	25			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER V SPRINGS REHAB A	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835	1 00	,27,2030
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 625	3. A problem with the heartbeat. This inforthe website: https://www.nlm.nihon.html. 5. The facility staff of documentation that was provided to the representative upor the hospital on 7/17 Resident #87 was a 8/31/16 with a receivith diagnoses that to: cancer of the coblood pressure, dermost recent MDS (rassessment, a Med with an assessment (brief interview for rather resident was secognitive daily decised to the nurse's note dadocumented, "It wan ight shift that reside on the night shift. Fhowever stating that stomach distended. [laboratory] work, upractitioner) information administrator and it	ne speed or rhythm of the ormation was obtained from a gov/medlineplus/atrialfibrillaticalled to evidence a copy of the bed hold policy resident and/or resident a facility initiated transfer to 7/18 for Resident #87. admitted to the facility on a treadmission on 7/30/18, included but were not limited lon, retention of urine, high mentia, and depression. The minimum data set) licare 30 day assessment, treference date of 8/25/18, as scoring a "4" on the BIMS mental status) score, indicating verely impaired to make	F6	225		
	(evaluation)." The physician order "Send to ER to eval	r dated, 7/17/18, documented, and treat."				***************************************

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		• •	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C	
		495255	B. WING _		l .	7/2018
,	ROVIDER OR SUPPLIER / SPRINGS REHAB A	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835		
(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 SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 625	Continued From pa	ge 104	F 62	5		
F 645 SS=D	conducted with OSi the admissions dire for written bed hold the hospital, OSM # resident is transferr marketer would visit OSM #10 stated that liaison for the nursi outside marketer whospital about hold that if the resident is (responsible party), RP and ask about high phone. OSM #10 stated that she also if the resident or RP at the resident or RP at the Review of the clinic documentation of a OSM #10 regarding. Administrative staff administrator, and nursing, were mad on 9/27/18 at 10:43. No further informat PASARR Screenin CFR(s): 483.20(k)(c)	she (OSM #10), will call the holding the bed over the tated that if the resident or at to hold the bed, they would ate paperwork. OSM #10 o documents in a nursing note wanted a bed hold. OSM #10 hold policy is not sent with the ne time of transfer. The cal record failed to evidence a written bed hold or a note by go the bed hold. The member (ASM) #1, the ASM #2, the director of a aware of the above concern B a.m. The control of the concern B a.m. The control of the concern B a.m.	F 64	A Level 1 PASARR was not Received by them, no correction		
**************************************	individuals with a n	nental disorder and individuals		Can be made for resident #83 at this time.		Audelling of the Augusta State State (1988)

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	3 ' '		LE CONSTRUCTION		TE SURVEY MPLETED
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NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 09/	2//2010
SKYVIE\	W SPRINGS REHAB A	ND NURSING CENTER	. 30 MONTVUE DRIVE LURAY, VA 22835				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE) BE	(X5) COMPLETION DATE
F 645	with intellectual disas §483.20(k)(1) A nur or after January 1, (i) Mental disorder a (ii) of this section, ur authority has determindependent physic performed by a personal teach of the individual services, whether the specialized services (ii) Intellectual disability authority has determined the level of services (iii) Intellectual disability authority has determined (A) That, because of condition of the individual services, whether the level of services and (B) If the individual services, whether the services, whether the specialized services (ii) The preadmission paragraph(k)(1) of the for determinations in to a nursing facility of being admitted to the transferred for care	sing facility must not admit, on 1989, any new residents with: as defined in paragraph (k)(3) nless the State mental health nined, based on an all and mental evaluation son or entity other than the authority, prior to admission, of the physical and mental vidual, the individual requires a provided by a nursing facility; requires such level of the individual requires so or developmental disability nined prior to admission-of the physical and mental vidual, the individual requires a provided by a nursing facility; requires such level of the physical and mental vidual, the individual requires a provided by a nursing facility; requires such level of the individual requires a for intellectual disability. The physical state of the individual requires a for intellectual disability. The physical and mental vidual, the individual requires a for intellectual disability. The physical control of the individual requires a for intellectual disability. The physical and mental vidual requires a for intellectual disability. The physical and mental vidual requires a for intellectual disability. The physical and mental vidual requires a for intellectual disability. The physical and mental vidual requires a for intellectual disability. The physical and mental vidual requires a for intellectual disability.	F	645	PASARR Level 1 screening is To be obtained with every Admission. All admissions have the potential to be affected. An audit was conducted on 09/28/18 by the admission director on admits over the past 30 days to ensure compliance with a PASARR completion. Administrator educated Admission and marketing Director on 09/28 of the Regulation of having a PASARR with each admit. Admissions coordinator will Ensure that a PASARR is obtained prior to each admission. Administra will review each admission for the PASARR monthly. The results will be presented to the QAPI committee for review and recommendations. Date of Compliance: 10/30/2018.	tor	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ' '	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
		495255	B WING		l .	0
NAME OF I	PROVIDER OR SUPPLIER	493233	I D. WING.	STREET ADDRESS, CITY, STATE, ZIP CODE	09/2	27/2018
		ND NURSING CENTER		30 MONTVUE DRIVE LURAY, VA 22835		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	L ID	PROVIDER'S PLAN OF CORRECTION	<u> </u>	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG		BE	COMPLETION DATE
F 645		-	F6	45		
	paragraph (k)(1) of to a nursing facility (A) Who is admitted hospital after receiv hospital, (B) Who requires not condition for which the hospital, and (C) Whose attending before admission to is likely to require lefacility services. §483.20(k)(3) Definisection— (i) An individual is condisorder defined in equivole disorder defined in equipole (ii) An individual is contellectual disability intellectual disability or is a person with a described in 435.10 This REQUIREMENTS. Based on staff interiors	It to the facility directly from a ring acute inpatient care at the ursing facility services for the the individual received care in g physician has certified, the facility that the individual rest than 30 days of nursing rition. For purposes of this considered to have a mental dual has a serious mental dual has a serious mental dual has a serious mental dual has a serious mental dual has a serious mental dual has a serious mental dual has a serious mental dual has an or if the individual has an or as defined in §483.102(b)(3) a related condition as 10 of this chapter.				
	complete a Level I I Resident Review (P	mined the facility staff failed to Preadmission Screening and PASARR) for one of 43 Wey sample, Resident #83.				
	PASARR was compensure the resident	ed to ensure a Level I bleted for Resident #83 to was evaluated and receiving the most integrated setting resident's needs.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION NG	COV	(X3) DATE SURVEY COMPLETED	
		495255	B. WING		i	C /27/2018
	PROVIDER OR SUPPLIER V SPRINGS REHAB A	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 30 MONTVUE DRIVE LURAY, VA 22835		2772010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 645	Resident #83 was a 7/26/18, with diagnout limited to: chror disease (COPD), guisease (GERD), building (GERD), building (GERD), building (GERD), building (GERD), building (GERD), building (GERD), building (GERD), building (GERD), building (GERD), building (GERD), guisease (GERD), building (GERD), guisease (GERD), building (GERD), guisease (GERD), building (GERD), guisease (GERD), building (GERD), guisease (GERD)	admitted to the facility on oses that included but were nic obstructive pulmonary astric esophageal reflux enign prostatic hyperplasia esive disorder and order (A mental condition that of contact with reality od problems [depression or DS (minimum data set) y day assessment, with an once date (ARD) of 8/23/18, as scoring a 13 of 15 on the w for mental status) score, ent was cognitively intact to be as all record failed to evidence RR was completed prior to eximately 11:00 a.m., surveyor of Resident #83's PASARR.	F 6-	45		
	could not evidence PASARR complete Resident #83 had a admission, ASM #1 On 09/26/18 at app interview was cond	med surveyor that the facility Resident #83 had a Level 1 d. ASM #1 was asked if level #1 PASARR at responded "No". roximately 5:14 p.m., a joint ucted with ASM #1 and OSM r) #9, Admission Director.				

NAME OF PROVIDER OR SUPPLIER SKYVIEW SPRINGS REHAB AND NURSING CENTER SYNEMAL OF PROVIDERS, CITY, STATE, ZIP CODE 30 MONTYUE DRIVE LURAY, VA. 22836 SUMMARY STATEMENT OF DEPCISENCIES (EACH DEPICIENCY MUST SE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 645 Continued From page 108 When asked if Resident #83 should have, had a Level 1 PASARR completed prior to admission, ASM #1 and OSM #9 answered "Yes." On 9/26/18 at approximately 6:00 p.m., ASM #1 and ASM #2, Director of Nursing were made aware of the above findings. The director of nursing informed this surveyor on 9/27/18 at approximately 1:00 p.m., the facility did not have a policy for PASARR completion. No further information was provided prior to exit. 1. This information was obtained from the website: Inttps://www.nlm.nih.gov/medlineplus/ency/article/ 00930.htm. \$483.21(b)(1) The facility must develop and implement a comprehensive Care Plans \$483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at \$483.10(c)(2) and \$483.10(c)(2), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocoial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following- (i) The services that are to be furnished to attain or maintain the resident's highest practicable		TEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	ULTIPLE CONSTRUCTION DING			(X3) DATE SURVEY COMPLETED		
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PRINTED: 10/11/2018 FORM APPROVED OMB NO. 0938-0391

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care and complete a follow up pain assessment after the administration of pro (as needed) pain Date of Compliance: 10/30/2018						Date of Compliance: 10/30/2	018			

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	ROVIDER OR SUPPLIER	AND NURSING CENTER		ST 30	REET ADDRESS, CITY, STATE, ZIP CODE MONTVUE DRIVE JRAY, VA 22835	U U Or.	2//2016	
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	9/25/18. 3. The facility staff of #100's comprehens water bottle on an of shift. The findings included of the findings	failed to implement Resident sive care plan to check the oxygen concentrator every e: failed to implement Resident pain management. admitted to the facility on #92's diagnoses included but chronic pain syndrome, repressive disorder. It recent MDS (minimum data sessment with an ARD ence date) of 8/29/18, codeding cognitively intact. Section J 2 as reporting frequent pain ays that limited day-to-day Imprehensive care plan with an 13/17 documented, ain r/t (related to) diagnosis of ees and shoulder, low back irmacological interventions to as relaxation, heat/cold	Fe	556				

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
495255			B. WING			C 09/27/2018		
NAME OF PROVIDER OR SUPPLIER SKYVIEW SPRINGS REHAB AND NURSING CENTER					STREET ADDRESS, CITY, STATE, ZIP CODE 10 MONTVUE DRIVE LURAY, VA 22835		TO P I MAN O 1 V	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ix	(EACH CORRECTIVE ACTION SHOULD	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 656	September 2018 M. record) documented documented, "Proto PLEASE INDICATE THE COMMENT FI 1=Re positioning Diversions: 2=Reading 3=Watching TV 4=Music 5=Eating 6=Getting OOB (ou 7=Laying Down 8=Activities 9=ROM (range of m 10=Refused any alt Further review of RMAR revealed Percadministered on the One tablet on 9/1/1-Two tablets on 9/8/9/22/18. Review of the September detail report revealed interventions were medicated with Reslying in bed and state and needs surgery. Offer non-medication	needed. Resident #92's AR (medication administration d both Percocet orders and ocol: PAIN INTERVENTIONS: THE NUMERIC VALUE(S) IN ELD: t of bed) notion) ernatives." esident #92's September 2018 ocet 5/325 mg was following dates: 8 and 9/7/18. (18, 9/11/18, 9/14/18 and ember 2018 MAR comments 2018 pain clinical monitoring of non-pharmacological not offered to Resident #92 on (18, 9/14/18 and 9/22/18. p.m., an interview was ident #92. The resident was ted he has pain in his knees When asked if the nurses in, interventions prior to or ering his as needed pain	F	356				

	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
	495255				C 09/27/2018		
NAME OF PROVIDER OR SUPPLIER SKYVIEW SPRINGS REHAB AND NURSING CENTER				STREET ADDRESS, CITY, STA 30 MONTVUE DRIVE LURAY, VA 22835	ATE, ZIP CODE	<u></u>	2//2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			((EACH CORRECTIV CROSS-REFERENCE		BE	(X5) COMPLETION DATE
F 656	conducted with LPN LPN #2 was asked care plan. LPN #2 the patient's problem we are going to do problems." When a ensures they follow LPN #2 stated, "Everylans in their compression concerns, you can be plans and review earner interventions and good on 9/27/18 at 6:45 conducted with LPN administering as new #92 in September 2 should be done price pain medication to a would think Tylenol first but a lot of resing some you try to talk can them give some television on. That is asked if she docum interventions that shour pain med (medito put a one, a ten, number in the composition of the compain medication, LP he's rating his pain. I have asked before for him." When ask non-pharmacologicatime she administer	p.m., an interview was I (licensed practical nurse) #2. to explain the purpose of a stated, "It's a guideline of what ms are and the interventions to help assist with those asked how the nursing staff each resident's care plan, eryone has access to the care uters. If they had questions or og into each patient's care ach care plan and what their oals are." a.m., an interview was I #5 (a nurse responsible for reded Percocet to Resident 2018). When asked what or to administering as needed a resident, LPN #5 stated, "I would be an intervention. Try dents know what they want but to or reposition or see if you ething to eat or put the maybe distracts them." When the to the non-pharmacological needs of the stated, "On cation), it has a place for you as to what you tried. You put a ment box." When asked if she cological interventions to to administering as needed PN #5 stated, "I ask him what A lot of times, he rates a ten. of there is anything I can do	F6	56			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (V1) PROVIDED SUPPLIED LED COMP.

NAME OF PROVIDER OR SUPPLIER SKYVIEW SPRINGS REHAB AND NURSING CENTER (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 656 Continued From page 113 On 9/27/18 at 9:35 a.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern.		ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER SKYVIEW SPRINGS REHAB AND NURSING CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 656 Continued From page 113 On 9/27/18 at 9:35 a.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern.		495255					C		
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 656 Continued From page 113 On 9/27/18 at 9:35 a.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern.					30 MONTVUE DRIVE	> CODE	1 09/	2//2010	
On 9/27/18 at 9:35 a.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern.	PREFIX	((EACH DEFICIENCY MUST BE PRECEDED BY FULL			X (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE	ACTION SHOULD BE COMPLET TO THE APPROPRIATE DATE			
The facility policy titled, "Comprehensive Person-Centered Care Planning" documented, "2) The facility will develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs as identified throughout the comprehensive Resident Assessment Instrument (RAI)" No further information was presented prior to exit. (1) Percocet is used to treat pain. This information was obtained from the website: https://medlineplus.gov/ency/article/000949.htm 2. The facility staff failed to implement the plan of care and complete a follow up pain assessment after the administration of prn (as needed) pain medications on 9/13/18 and 9/25/18. Resident #106 was admitted to the facility on 7/10/18 with diagnoses that included but were not limited to diabetes mellitus (type two), high blood pressure, atrial fibrillation, chronic kidney disease, and heart disease. Resident #106's most recent MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 7/18/18. Resident #106 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). Review of Resident #106's September 2018	F 656	On 9/27/18 at 9:35 staff member) #1 (taware of the above The facility policy tit Person-Centered Comprehensive per each resident, that objectives and time medical, nursing, an needs as identified comprehensive Resident (1) Percocet is used information was obth https://medlineplus. 2. The facility staff for care and complete after the administral medications on 9/1: Resident #106 was 7/10/18 with diagnor limited to diabetes a pressure, atrial fibricand heart disease. MDS (minimum data admission assessmenterence date) of 7 coded as being cogmake daily decision BIMS (Brief Interview	a.m., ASM (administrative the administrator) was made a concern. Itled, "Comprehensive Care Planning" documented, develop and implement a rson-centered care plan for includes measurable of the frames to meet a resident's and mental and psychosocial throughout the sident Assessment Instrument ion was presented prior to exit. In the failed to implement the plan of a follow up pain assessment attion of prn (as needed) pain 3/18 and 9/25/18. It admitted to the facility on the sest that included but were not mellitus (type two), high blood illation, chronic kidney disease, Resident #106's most recent that set) assessment was an ment with an ARD (assessment 7/18/18. Resident #106 was gnitively intact in the ability to the secoring 13 out of 15 on the ew for Mental Status exam).		556				

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED C 09/27/2018		
	495255						
NAME OF PROVIDER OR SUPPLIER SKYVIEW SPRINGS REHAB AND NURSING CENTER				30	TREET ADDRESS, CITY, STATE, ZIP CODE D MONTVUE DRIVE URAY, VA 22835		
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	physician order she order: "Oxycodone route 2 times a day Review of Resident (Medication Adminishe received oxyco and times: "9/8/18 a a.m., and 9/25/18 a Review of Resident evidence that non-pwere attempted prior oxycodone on all the no evidence that a conducted on 9/13/in the nursing notes. Review of the "Clinifor September 2018 non-pharmacologic attempted prior to the toxycodone on all the no evidence that a conducted on 9/13/ Resident #106's conducted on 9/13/ Resident #106's conducted on 9/13/ Resident #106's conducted on 9/13/ Resident #106's conducted on 9/13/ Resident #106's conducted on 9/13/ Resident #106's conducted on 9/13/ Resident #106's conducted on 9/13/ Resident #106's conducted on functional compliance, alleviate schedules, and resimpact on functional cognition."	set revealed the following 5 mg (milligrams) by oral as needed (PRN)." #106's September 2018 MAR stration Record) revealed that done on the following dates at 7:00 p.m., 9/13/18 at 2:30 at 7:43 p.m." #106's clinical record failed to charmacological interventions or to the administration of ree dates above. There was follow up pain evaluation was 18 and 9/25/18 on the MAR or it. cal Monitoring Detail Report" 3, failed to evidence that al interventions were the administration of ree dates above. There was follow up pain evaluation was 18 and 9/25/18 on the MAR or it.	F	356			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	495255			ì		C 09/27/2018		
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> US/</u>	2//2018	
SKYVIEV	N SPRINGS REHAB A	AND NURSING CENTER		-	0 MONTVUE DRIVE LURAY, VA 22835			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT 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) BE	(X5) COMPLETION DATE	
F 656	administered, LPN be following up with assessing, and ther pain. When asked we evaluations are doc follow up pain evaludocumented on the meant if documented follow up pain evaludored if documented follow up pain evaludored with asked the puserve as a guide to LPN #7 stated that care plan. When asked the puserve as a guide to LPN #7 stated that care plan to be followed in the staff did not commedication is working the staff did not commedication works we can be concerned in the staff administrative staff administrator was medication to exit. (1) Oxycodone is a relieve moderate to	#7 stated that nursing should in the resident in an hour, in documenting their level of where follow up pain cumented, LPN #7 stated that uations should also be MAR. When asked what it ation could not be found for uations, LPN #7 stated, it wasn't done. They should be up on the MAR to be done." It urpose of the care plan, LPN eurpose of the care plan was to meet the resident's needs. all nurses had access to the sked if it was important for the lowed, LPN #7 stated, "Yes." 2 p.m., an interview was sident #106. When asked if d evaluate if the pain ng, Resident #106 stated that the back but that her pain when she needs it.	F6	356				
	https://www.ncbi.nln T0001326/. 3. The facility staff fa	m.nih.gov/pubmedhealth/PMH ailed to implement Resident sive care plan to check the						