STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 09/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	730 LUNENBURG HIGHW KEYSVILLE, VA 23947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted on 9/11/18 through 9/12/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The census in this 90 certified bed facility was 51 at the time of the survey. The survey sample consisted of four current resident reviews; Residents #2 through #5, and one closed record review, Resident #1.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, 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 implement the abuse policies to report the follow up investigation for an allegation of abuse to the appropriate state agencies for one of 5 residents in the survey sample, Resident #1. Resident #1 had reported to facility staff on 7/6/18	F 607		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 607	Continued From page 1	F 607		

that a CNA (certified nursing assistant) had "pushed her." The facility staff failed to implement the abuse policy to ensure the findings of their investigation for this allegation of abuse were to the appropriate state agencies.

The findings include:

Resident #1 was admitted to the facility on 9/23/16 and readmitted on 10/8/17 with diagnoses that included but were not limited to high blood pressure, Parkinson's disease (1), muscle weakness and degeneration to the right eye. Resident #1's most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 7/18/18. Resident #1 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #1 was coded as requiring extensive assistance from one staff member with bed mobility, toileting, and personal hygiene; limited assistance from one staff member with transfers and dressing; and total dependence on staff member with bathing.

On 9/11/18 at 10:30 a.m., all Facility Reported Incidents (FRIS) and investigations since last standard survey conducted 3/9/18 were requested from administration.

On 9/11/18 at approximately 11:30 p.m., one FRI was presented. This FRI was reviewed. Resident #1 had reported to facility staff on 7/6/18 that a CNA (certified nursing assistant) had "pushed her." The FRI documented the following: "Report Date: 7/6/18, Incident Date: 7/6/18. Residents involved: (Name of Resident #1). Injuries: No.

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F 607	Continued From page 2	F 607		

Incident Type: Allegation of abuse/mistreatment. Describe incident, including location, and action taken: (Name of Resident #1) Staes (sic) that (Name of CNA) pushed her. Did not state when or under what circumstances. Employee was suspended, drug tested, and has been suspended pending an investigation."

Review of the fax face sheet revealed that this incident was reported to the OLC (office of licensure and certification) on 7/6/18. The following was documented on the face sheet: Date: 7/6/18...Will forward completed investigation when completed on or before 7/11/18." The fax confirmation date at the top of the face sheet documented the following date in error "6/22/13 at 03:38."

Further review of the FRI revealed that investigations were completed on 7/6/18. The witness statement obtained from Resident #1 documented the following: "This writer spoke with resident and asked resident who she stated was mean to her. Resident stated "Whole lot of mean," "I don't know their names." Resident stated, "(Name of CNA) roughed me up." This writer asked how was she "roughed up." Resident stated she wanted me to go to dining room and pushed me to dining room to eat. Resident stated she ran over my feet with the wheelchair. This writer asked how staff ran over her feet with the wheelchair if she was in it. She stated, I don't know."

The witness statement from the accused CNA dated 7/6/18 documented the following: "I have never push (sic) (Name of Resident #1) or mistreated her."

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F 607	Continued From page 3	F 607		

Further review of the investigations revealed that a drug screen was collected and conducted on 7/6/18.

Review of the conclusion to the investigation dated 7/9/18, documented the following: "Staff education will be done with staff regarding honoring a resident's request for meal service. Therapy received a referral on (Resident #1) for wheelchair mobility and proper positioning. (Name of CNA) was interviewed by the APS (adult protective services) worker and was allowed to return to work."

There was no evidence that the follow-up report was forwarded to the OLC (office of licensure and certification) after investigations were completed.

On 9/12/18 at approximately 8:30 a.m., it was requested that the facility provide evidence that they had sent the follow-up investigation to the OLC. ASM (administrative staff member) #3, the ADON (assist director of nursing) was asked to provide this information. ASM #3 stated that she would check with ASM #1, the administrator.

On 9/12/18 at 12:00 p.m., ASM #1 could not provide evidence that they had sent the follow-up investigation to the OLC. ASM #1 stated that he had been looking for the fax confirmation and could not find it. ASM #1 stated he had sent the follow up investigation to the OLC. ASM #1 stated, "I know we did it because we did the investigation." When asked who was responsible for reporting an allegation of abuse to the appropriate state agencies, ASM #1 stated that he was responsible because he was the abuse coordinator. ASM #1 stated that an allegation of abuse was reported immediately and within 2

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F 607	Continued From page 4 hours if actual abuse was identified or suspected. ASM #1 stated that he is supposed to send a follow up of the investigation to the appropriate state agencies within five days or less. ASM #1 stated that he would go ahead and fax the follow up to the OLC again and it would be a part of his plan of correction. The facility policy titled "Abuse Neglect or Misappropriation of Resident Property" documents in part, the following: "The administrator is responsible to ensure that complaints of abuse, neglect, exploitation or misappropriation of resident property and injuries of unknown origin are investigated. Measures will be initiated to prevent further abuse while is the investigation is in progress. The administrator is responsible to review the results of the investigation and report the alleged incident to the appropriate state agencies in accordance with state and federal regulations...Following the immediate written notification of the alleged incident, an additional report will be faxed to the complaint unit at the Office of Licensure and Certification within five (5) working days of the alleged event." No further information was presented prior to exit. (1) Parkinson's Disease- is a progressive neurodegenerative disease. Parkinson's disease causes a gradual loss of the neurotransmitter dopamine that is responsible for coordinating muscle movement. This information was obtained from The National Institutes of Health. https://www.niehs.nih.gov/health/topics/conditions/parkinson/index.cfm.	F 607		
F 609	Reporting of Alleged Violations	F 609		

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F 609 SS=D	Continued From page 5 CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review it was determined that facility staff failed to report the follow up for an allegation of abuse to the appropriate state agencies for one of 5 residents in the survey sample, Resident #1.	F 609		

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F 609	Continued From page 6	F 609		

Resident #1 had reported to facility staff on 7/6/18 that a CNA (certified nursing assistant) had "pushed her." The facility staff failed to report the findings of their investigation for this allegation of abuse to the appropriate state agencies.

The findings include:

Resident #1 was admitted to the facility on 9/23/16 and readmitted on 10/8/17 with diagnoses that included but were not limited to high blood pressure, Parkinson's disease (1), muscle weakness and degeneration to the right eye. Resident #1's most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 7/18/18. Resident #1 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #1 was coded as requiring extensive assistance from one staff member with bed mobility, toileting, and personal hygiene; limited assistance from one staff member with transfers and dressing; and total dependence on staff member with bathing.

On 9/11/18 at 10:30 a.m., all Facility Reported Incidents (FRIS) and investigations since last standard survey conducted 3/9/18, were requested by administration

On 9/11/18 at approximately 11:30 p.m., one FRI was presented. This FRI was reviewed. Resident #1 had reported to facility staff on 7/6/18 that a CNA (certified nursing assistant) had "pushed her." The FRI documented the following: "Report Date: 7/6/18, Incident Date: 7/6/18. Residents involved: (Name of Resident #1). Injuries: No.

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F 609	Continued From page 7	F 609		

Incident Type: Allegation of abuse/mistreatment. Describe incident, including location, and action taken: (Name of Resident #1) Staes (sic) that (Name of CNA) pushed her. Did not state when or under what circumstances. Employee was suspended; drug tested, and has been suspended pending an investigation."

Review of the fax face sheet revealed that this incident was reported to the OLC (office of licensure and certification) on 7/6/18. The following was documented on the face sheet: Date: 7/6/18...Will forward completed investigation when completed on or before 7/11/18." The fax confirmation date at the top of the face sheet documented the following date in error "6/22/13 at 03:38."

Further review of the FRI revealed that investigations were completed on 7/6/18. The witness statement obtained from Resident #1 documented the following: "This writer spoke with resident and asked resident who she stated was mean to her. Resident stated "Whole lot of mean," "I don't know there names." Resident stated, "(Name of CNA) roughed me up." This writer asked how was she "roughed up." Resident stated she wanted me to go to dining room and pushed me to dining room to eat. Resident stated she ran over my feet with the wheelchair. This writer asked how staff ran over her feet with the wheelchair if she was in it. She stated, I don't know."

The witness statement from the accused CNA dated 7/6/18 documented the following: " I have never push (sic) (Name of Resident #1 or mistreated her."

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F 609	Continued From page 8	F 609		

Further review of the investigations revealed that a drug screen was collected and conducted on 7/6/18.

Review of the conclusion to the investigation dated 7/9/18, documented the following: "Staff education will be done with staff regarding honoring a resident's request for meal service. Therapy received a referral on (name of Resident #1) for wheelchair mobility and proper positioning. (Name of CNA) was interviewed by the APS (adult protective services) worker and was allowed to return to work."

There was no evidence that the follow-up report was forwarded to the OLC (office of licensure and certification) after investigations were completed.

On 9/12/18 at approximately 8:30 a.m., it was requested that the facility provide evidence that they had sent the follow-up investigation to the OLC. ASM (administrative staff member) #3, the ADON (assist director of nursing) was asked to provide this information. ASM #3 stated that she would check with ASM #1, the administrator.

On 9/12/18 at 12:00 p.m., ASM #1 could not provide evidence that they had sent the follow-up investigation to the OLC. ASM #1 stated that he had been looking for the fax confirmation and could not find it. ASM #1 stated he had sent the follow up investigation to the OLC. ASM #1 stated, "I know we did it because we did the investigation." When asked who was responsible for reporting an allegation of abuse to the appropriate state agencies, ASM #1 stated that he was responsible because he was the abuse coordinator. ASM #1 stated that an allegation of abuse was reported immediately and within 2

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F 609	Continued From page 9	F 609		

hours if actual abuse was identified or suspected. ASM #1 stated that he is supposed to send a follow up of the investigation to the appropriate state agencies within five days or less. ASM #1 stated that he would go ahead and fax the follow up to the OLC again and it would be a part of his plan of correction.

The facility policy titled, "Abuse Neglect or Misappropriation of Resident Property" documents in part, the following: "The administrator is responsible to ensure that complaints of abuse, neglect, exploitation or misappropriation of resident property and injuries of unknown origin are investigated. Measures will be initiated to prevent further abuse while is the investigation is in progress. The administrator is responsible to review the results of the investigation and report the alleged incident to the appropriate state agencies in accordance with state and federal regulations...Following the immediate written notification of the alleged incident, an additional report will be faxed to the complaint unit at the Office of Licensure and Certification within five (5) working days of the alleged event."

No further information was presented prior to exit.

(1) Parkinson's Disease- is a progressive neurodegenerative disease. Parkinson's disease causes a gradual loss of the neurotransmitter dopamine that is responsible for coordinating muscle movement. This information was obtained from The National Institutes of Health. https://www.niehs.nih.gov/health/topics/conditions/parkinson/index.cfm.

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F 657	Continued From page 10	F 657		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that facility staff failed to review and revise the care plan for one of 5 residents in the survey sample, Resident #3. For Resident #3, facility staff failed to revise the	F 657		

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F 657	Continued From page 11	F 657		

care plan when it was no longer needed to have non-skid strips in place to the resident's bedside.

The findings include:

Resident #3 was admitted to the facility on 6/26/15 and readmitted on 3/6/17 with diagnoses that included but were not limited to cognitive communication deficit, hemiplegia (one-sided paralysis) following cerebrovascular disease (stroke) affecting right dominant side, muscle wasting, type two diabetes, and high blood pressure. Resident #3's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 8/14/18. Resident #3 was coded as being severely impaired in cognitive function scoring 03 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #3 was coded as requiring extensive assistance from two plus persons with transfers; extensive assistance from one staff member with bed mobility, locomotion on and off the unit, and dressing; and total dependence on one staff member with toileting, personal hygiene, and bathing.

Review of Resident #3's fall care plan dated 3/6/17 documented the following: "Risk for falls as characterized by history of falls/UTI (Urinary tract infections)'s, recent hospitalizations, immobility, incontinence; hx (history) of CVA (cerebrovascular disease), with right sided hemiparesis, HTN (high blood pressure), DM (diabetes mellitus), poor safety awareness, and non-compliance with safety precautions, multiple risk factors related to: Impaired mobility, unsteady gait...Interventions: Non-skid strips on floor at bedside." This intervention was initiated on 2/16/17.

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F 657	Continued From page 12	F 657		

On 9/11/18 at 4:30 p.m., an observation was made of Resident #3's room. He did not have non-skid strips to his floor.

On 9/12/18 at 8:23 a.m., an observation was made of Resident #3's room. He did not have non-skid strips to his floor.

Review of Resident #3's Fall Risk Evaluation dated 8/14/18, revealed that he was "Not at risk" for falls.

Review of Resident #3's clinical record revealed that he had one fall this year on 1/11/18. His fall note documented in part, the following: Reported to this nurse that resident observed on the floor in front of the wheelchair at the end of the hall outside his room door, resident assessed with no injuries, resident denies pain, taken to restroom. MD (medical doctor) and RP (responsible party) made aware." Resident #3's care plan was updated after this fall.

On 9/12/18 at 10:08 a.m., an interview was conducted with CNA (certified nursing assistant) #1, an aide who frequently works with Resident #3. When asked how nursing aides prevent residents from falling, CNA #1 stated that she would implement fall preventive interventions that were listed on the resident's care guide. CNA #1 stated that the care guide was kept in the resident's closet. When asked who would be responsible for ensuring non-skid strips were in place to the resident's floor, CNA #1 stated that she would think the maintenance department was responsible. When asked if Resident #3 was a fall risk, CNA #1 stated, "I haven't heard of him falling." When asked if non-skid strips were on

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	495226	A. BUILDING _____ B. WING _____	C 09/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	730 LUNENBURG HIGHW KEYSVILLE, VA 23947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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Resident #3's care guide, CNA #1 stated that she does not recall ever seeing non-skid strips to any resident's care guide. At 10:15 a.m., this writer followed CNA #1 to Resident #3's room. CNA #1 confirmed that non-skid strips were not on his care guide or to his floor. CNA #1 was not sure if Resident #3 was supposed to have non-skid strips in place. CNA #1 stated that Resident #3 used the sit to stand lift and that he did not ambulate or stand on his own. CNA #1 stated that the nursing aides did not have access to the entire resident care plan on the computer.

On 9/12/18 at 10:33 a.m., an interview was conducted with LPN (licensed practical nurse) #1, Resident #3's nurse. When asked who was responsible for reviewing and revising the care plan, LPN #1 stated that the MDS nurse was responsible for updating the care plan with any changes. When asked the purpose of the care plan, LPN #1 stated that the purpose of the care plan was for the staff to know the type of care and interventions that need to be implemented to care for the residents. When asked if CNAs had access to the care plans, LPN #1 stated that they used a care guide in the resident's closet that listed out interventions the aides needed to follow. When asked who was responsible for ensuring non-skid strips were in place to the resident's floor, LPN #1 stated the director of maintenance would install the strips once alerted by nursing. When asked if Resident #3 needed non-skid strips to his floor, LPN #1 stated, "No, he doesn't stand or try to get up. He uses a lift to get up." LPN #1 stated that Resident #3 used to be able to stand, pivot, and get up but that he had declined in his ADL (activities of daily living) function. LPN #1 stated, "Unless he stands with the 3-11 shift and is just weaker in the morning. I

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don't know."

On 9/12/18 at 10:44 a.m., an interview was conducted with RN (registered nurse) #1, the MDS nurse. When asked who was responsible for updating the care plans, RN #1 stated that anyone could updated the care plan after a change in condition such as a fall. When asked the purpose of the care plan, RN #1 stated that the purpose of the care plan was make sure each individual receives proper care. When asked if Resident #3 needed non-skid strips to his floor, RN #1 stated, "He doesn't ambulate." RN #1 directed this surveyor to look at this transfer status on his care plan. The following was documented on his transfer care plan dated 9/12/17: "Requires assistance /potential to restore or maintain maximum function of self-sufficiency for TRANSFERRING from one position to another related to: lack of strength, phys (physical) limitations, unsteady gait...Mechanical Lift: Sabina Lift (sit to stand)." This intervention was initiated on 9/12/17. RN #1 stated that she was not sure who added the non-skid strips to his care plan or if he needed them at one time. RN #1 stated that the non-skid strips were not necessary now. RN #1 stated that if something changes with the resident's care, the care plan should be immediately updated. RN #1 stated that the care plan was also updated quarterly, depending on her assessment.

On 9/12/18 at 11:38 a.m., further interview was conducted with RN #1. When asked why Resident #3 was coded on his 8/14/18 MDS as requiring extensive assistance from two or more staff members with transfers if the resident uses a lift for transfers, RN #1 stated that the resident has to participate a little bit with a sit to stand lift

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and is therefore coded as extensive assistance. RN #1 stated that if the resident used a Hoyer lift, he would be coded as being totally dependent on staff for transfers.

On 9/12/18 at 11:54 a.m., ASM (administrative staff member) #2, the DON (Director of Nursing) was made aware of the above concerns. ASM #2 stated that she would have the care plan updated.

Review of the facility's policy titled, "RESIDENT CARE PLAN" documented, "It is the policy of the facility to provide a written resident-centered care plan based upon physician's orders, the assessment of the resident needs and preferences...The resident's care plan will be (sic) ongoing process and will include current problems and/or needs identified from a complete assessment...Any new problem or need of the resident, which is identified between his/her scheduled care plan review, will be addressed on the care plan by the appropriate disciplines..."

No further information was obtained prior to exit.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..."