DEPARTMENT OF HEALTH AND HUMA CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 10/09/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Programme Consideration (Consideration Consideration Consi	LE CONSTRUCTION S	COMPLETED		
		495226	B. WING		C 09/12/2018		
and the second s	PROVIDER OR SUPPLIE			E			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION		
F 000	INITIAL COMME	NTS	F 000	,)	W 100		
	survey was condu 9/12/18. Correction	Medicare/Medicaid abbreviated acted on 9/11/18 through ons are required for compliance 483 Federal Long Term Care					
	at the time of the consisted of four	s 90 certified bed facility was 51 survey. The survey sample current resident reviews; bugh #5, and one closed record #1.					
	Develop/Impleme CFR(s): 483.12(b	nt Abuse/Neglect Policies)(1)-(3)	F 60	7			
		acility must develop and policies and procedures that:		1			
	neglect, and exple	phibit and prevent abuse, pitation of residents and of resident property,	ī				
		ablish policies and procedures such allegations, and		M A M			
	paragraph §483.9	lude training as required at 95, ENT is not met as evidenced					
	Based on staff in review, and clinic determined that fa	terview, facility document al record review it was acility staff failed implement the report the follow up investigation			E		
		of abuse to the appropriate state of 5 residents in the survey #1.					
	Resident #1 had	reported to facility staff on 7/6/18	!				
ABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	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.

Event ID: Z9NI11



CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			98	CIVID IV	O. 0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	927/10/03/04/04/05/05/05/05/05/05/05/05/05/05/05/05/05/		ONSTRUCTION		ATE SURVEY OMPLETED
		495226	B. WING			0.	C 9/12/2018
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>		STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
WAYLAN	D NURSING AND RE	HABILITATION CENTER		25020-6	LUNENBURG HIGHW 'SVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 607	Continued From pa	ige 1	F 6	807			
	that a CNA (certifie "pushed her." The implement the abuse of their investigation	d nursing assistant) had facility staff failed to se policy to ensure the findings n for this allegation of abuse riate state agencies.					
	The findings include:		ž	68			
	9/23/16 and readmediagnoses that including blood pressure muscle weakness are eye. Resident #1's data set) assessmed with an ARD (asses 7/18/18. Resident cognitively intact in decisions scoring 1 Interview for Mentawas coded as required from one staff member of and personal hygie one staff member wand total depender bathing.	dmitted to the facility on itted on 10/8/17 with uded but were not limited to e, Parkinson's disease (1), and degeneration to the right most recent MDS (minimum ent was an annual assessment reference date) of #1 was coded as being the ability to make daily 15 out of 15 on the BIMS (Brief al Status) exam. Resident #1 iring extensive assistance on the mobility, toileting, ene; limited assistance from with transfers and dressing; ince on staff member with	,				
	Incidents (FRIS) ar	0 a.m., all Facility Reported nd investigations since last anducted 3/9/18 were ministration.					
	was presented. Th #1 had reported to CNA (certified nurs her." The FRI docu	oximately 11:30 p.m., one FRI is FRI was reviewed. Resident facility staff on 7/6/18 that a sing assistant) had "pushed imented the following: "Report ent Date: 7/6/18. Residents					

involved: (Name of Resident #1). Injuries: No.

DEPARTMENT OF HEALTH AND HUN CENTERS FOR MEDICARE & MEDICARD SERVICES



AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETE		
		495226	B. WING			C 09/12/20	18
AND CONTRACTOR OF STREET	PROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, S 730 LUNENBURG HIGHV KEYSVILLE, VA 2394	V		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECT CROSS-REFERENCE	PLAN OF CORRECTION FIVE ACTION SHOULD CED TO THE APPROPR FICIENCY)	BE COME	(X5) PLETION JATE
F 607	Describe incident, taken: (Name of CNA) pure or under what circumsuspended, drug to suspended pendir. Review of the fax incident was report licensure and cert following was door Date: 7/6/18Will investigation wher 7/11/18." The fax the face sheet documented the face statement documented the face sident and asked mean to her. Resimean," "I don't know stated, "(Name of writer asked how stated she wanted pushed me to dinit she ran over my fawriter asked how wheelchair if she wanted 7/6/18 documented 7/6/18 documented 7/6/18 documented the face she wanted by the stated she wanted pushed me to dinit she ran over my fawriter asked how wheelchair if she wanted 7/6/18 documented 7/6/18 documented 7/6/18 documented 7/6/18 documented 7/6/18 documented 7/6/18 documented face 7/	egation of abuse/mistreatment. including location, and action desident #1) Staes (sic) that ushed her. Did not state when umstances. Employee was rested, and has been an investigation." face sheet revealed that this red to the OLC (office of ification) on 7/6/18. The umented on the face sheet: forward completed in completed on or before confirmation date at the top of cumented the following date in	<u>t</u>	07			
FORM CMS-2	567(02-99) Previous Version	ns Obsolete Event ID: Z9NI1	1	Facility ID: VA0050	If continuar	tion sheet Page	3 of 16



STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILD	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495226	B. WING		00	C 9/12/2018
	PROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		77 120 10
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 607	a drug screen was 7/6/18. Review of the conc	e investigations revealed that collected and conducted on lusion to the investigation	F 6	07		TO STANDARD STANDARD
	education will be do honoring a resident Therapy received a wheelchair mobility (Name of CNA) wa	mented the following: "Staff one with staff regarding 's request for meal service. referral on (Resident #1) for and proper positioning. s interviewed by the APS rvices) worker and was work."				
	was forwarded to the certification) after in On 9/12/18 at appropriet requested that the they had sent the foolog. ASM (admin ADON (assist direct provide this information would check with A	ence that the follow-up report the OLC (office of licensure and investigations were completed. Eximately 8:30 a.m., it was facility provide evidence that follow-up investigation to the distrative staff member) #3, the for of nursing) was asked to ation. ASM #3 stated that she SM #1, the administrator.	The state of the s			CONTRACT SCHOOL SE CONTRACT SE SENSE SCHOOL SCHOOL SE SENSE SCHOOL SCHOOL SE SENSE SCHOOL SE S
	provide evidence the investigation to the had been looking for could not find it. AS follow up investigat stated, "I know we dinvestigation." Whe for reporting an alleappropriate state aghe was responsible coordinator. ASM #	D p.m., ASM #1 could not pat they had sent the follow-up OLC. ASM #1 stated that he par the fax confirmation and M #1 stated he had sent the fon to the OLC. ASM #1 did it because we did the en asked who was responsible gation of abuse to the gencies, ASM #1 stated that because he was the abuse 1 stated that an allegation of dimmediately and within 2				



	LAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED			
		495226	B. WING _		09	C /12/2018	
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 607	ASM #1 stated that follow up of the invistate agencies with stated that he would up to the OLC agaplan of correction. The facility policy Misappropriation of documents in part administrator is recomplaints of abumisappropriation of unknown origin be initiated to previous stigation and appropriate state and federal minimediate written incident, an addition complaint unit at the Certification within alleged event."	use was identified or suspected. at he is supposed to send a vestigation to the appropriate hin five days or less. ASM #1 uld go ahead and fax the follow ain and it would be a part of his					
F 600	neurodegenerative causes a gradual dopamine that is r muscle movemen from The National		F 60	199			
. 000				50元K 毎		2	

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



	OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495226	B. WING_		05	0/12/2018	
	PROVIDER OR SUPPLIER D NURSING AND RI	EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			0011212010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	Continued From p CFR(s): 483.12(c)		F 60	09			
		oonse to allegations of abuse, on, or mistreatment, the facility					
	involving abuse, n mistreatment, incl source and misap are reported imme hours after the alle that cause the alle	eure that all alleged violations eglect, exploitation or uding injuries of unknown propriation of resident property, ediately, but not later than 2 egation is made, if the events egation involve abuse or result in					
	the events that ca abuse and do not the administrator officials (including adult protective se for jurisdiction in k	ry, or not later than 24 hours if use the allegation do not involve result in serious bodily injury, to of the facility and to other to the State Survey Agency and ervices where state law provides ong-term care facilities) in				A Common Action Common Common Action Common	
	§483.12(c)(4) Reprinvestigations to the designated repressing accordance with Survey Agency, wincident, and if the appropriate correct This REQUIREMED by: Based on staff intreview, and clinical determined that face	cort the results of all the administrator or his or her sentative and to other officials in State law, including to the State ethic at a state ithin 5 working days of the ethic action must be taken. ENT is not met as evidenced therefore, facility document all record review it was ecility staff failed to report the legation of abuse to the					
		agencies for one of 5 residents					



		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	26.	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495226	B. WING		09	C /12/2018	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 609	Resident #1 had r that a CNA (certifi "pushed her." The findings of their in	eported to facility staff on 7/6/18 ed nursing assistant) had a facility staff failed to report the vestigation for this allegation of opriate state agencies.	Fé	609			
	Resident #1 was a 9/23/16 and readr diagnoses that inchigh blood pressu muscle weakness eye. Resident #1' data set) assessm with an ARD (asse 7/18/18. Residen cognitively intact i decisions scoring Interview for Ment was coded as req from one staff me and personal hygione staff member	admitted to the facility on mitted on 10/8/17 with cluded but were not limited to re, Parkinson's disease (1), and degeneration to the right is most recent MDS (minimum nent was an annual assessment essment reference date) of t #1 was coded as being in the ability to make daily 15 out of 15 on the BIMS (Brief cal Status) exam. Resident #1 uiring extensive assistance mber with bed mobility, toileting, ene; limited assistance from with transfers and dressing; ence on staff member with					
	Incidents (FRIS) a standard survey or requested by adm On 9/11/18 at app was presented. The standard survey or requested by adm On 9/11/18 at app was presented. The first standard survey of the standard s	30 a.m., all Facility Reported and investigations since last conducted 3/9/18, were ninistration aroximately 11:30 p.m., one FRI his FRI was reviewed. Resident of facility staff on 7/6/18 that a raing assistant) had "pushed cumented the following: "Report dent Date: 7/6/18. Residents of Resident #1). Injuries: No.					



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	(X3) DATE SURVEY COMPLETED	
		495226	B. WING		09/12/2018
	PROVIDER OR SUPPLIER D NURSING AND RE	HABILITATION CENTER	730	EET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW YSVILLE, VA 23947	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLÉTION
F 609	Continued From pa	age 7	F 609		
	Describe incident, taken: (Name of Ro (Name of CNA) puror under what circususpended; drug to suspended pending Review of the fax form incident was report licensure and certiful following was document of the fax form of the	ace sheet revealed that this ed to the OLC (office of ication) on 7/6/18. The mented on the face sheet:			
	Further review of the investigations were witness statement documented the foresident and asked mean to her. Resident and invested, "(Name of the writer asked how with the stated she wanted pushed me to dining she ran over my fewriter asked how significantly the stated she wanted pushed me to dining she ran over my fewriter asked how significantly the stated she wanted pushed me to dining she ran over my fewriter asked how significantly the stated she wanted pushed me to dining she ran over my fewriter asked how significantly the stated she was a stated she wanted she was a stated she wanted she wanted she was a stated she wanted she was a stated she wanted she was a stated she				CONTRACTOR OF CO
	dated 7/6/18 docur	nent from the accused CNA nented the following: " I have ame of Resident #1 or			

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



		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUC A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495226	B. WING	×		09	C /12/2018
	PROVIDER OR SUPPLIE	R REHABILITATION CENTER		730	EET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW YSVILLE, VA 23947		33
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG	Contract (C)	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 609	Continued From	page 8	, F	609			
		the investigations revealed that is collected and conducted on					
	dated 7/9/18, doc education will be honoring a reside Therapy received #1) for wheelchai (Name of CNA) v	nclusion to the investigation cumented the following: "Staff done with staff regarding ent's request for meal service. I a referral on (name of Resident r mobility and proper positioning. was interviewed by the APS services) worker and was to work."					15. 15.
	was forwarded to	dence that the follow-up report the OLC (office of licensure and investigations were completed.					1
	requested that the they had sent the OLC. ASM (adm ADON (assist dir provide this information)	proximately 8:30 a.m., it was e facility provide evidence that follow-up investigation to the inistrative staff member) #3, the ector of nursing) was asked to mation. ASM #3 stated that she ASM #1, the administrator.					
	provide evidence investigation to the had been looking could not find it. If follow up investigated, "I know winvestigation." We for reporting an appropriate state he was responsit coordinator. ASM	that they had sent the follow-up that they had sent the follow-up the OLC. ASM #1 stated that he for the fax confirmation and ASM #1 stated he had sent the ation to the OLC. ASM #1 e did it because we did the when asked who was responsible allegation of abuse to the agencies, ASM #1 stated that to be because he was the abuse 1 #1 stated that an allegation of ted immediately and within 2					

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



		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
					С		
		495226	B. WING		09	9/12/2018	
	PROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		ULD BE	(X5) COMPLETION DATE	
F 609	ASM #1 stated that follow up of the invistate agencies with stated that he wou up to the OLC agaplan of correction. The facility policy to Misappropriation of documents in part, administrator is recomplaints of abus misappropriation of unknown originable initiated to previnvestigation and mappropriate state as state and federal minimediate written incident, an addition complaint unit at the Certification within alleged event."	se was identified or suspected. It he is supposed to send a restigation to the appropriate hin five days or less. ASM #1 and it would be a part of his littled, "Abuse Neglect or a f Resident Property" and injuries are investigated. Measures will ent further abuse while is the progress. The administrator is ew the results of the agencies in accordance with egulationsFollowing the notification of the alleged and report will be faxed to the ne Office of Licensure and five (5) working days of the tion was presented prior to exit.		609			
	neurodegenerative causes a gradual le dopamine that is remuscle movement from The National	sease- is a progressive disease. Parkinson's disease oss of the neurotransmitter esponsible for coordinating. This information was obtained Institutes of Health. hih.gov/health/topics/conditions fm.	CONTRACTOR OF THE PROPERTY OF				



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495226	B. WING		09/12/2018
	PROVIDER OR SUPPLIE	1000		STREET ADDRESS, CITY, STATE, ZIP COD 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 657	Continued From (page 10	F 657		
	Care Plan Timing CFR(s): 483.21(b		F 657		
	§483.21(b)(2) A complete side side side side side side side sid	n interdisciplinary team, that it limited to- physician. In physician. It is with responsibility for the with responsibility for the with responsibility for the food and nutrition services staff. practicable, the participation of the resident's representative(s). The participation of the resident to representative is determined or the development of the an. It is staff or professionals in the permined by the resident's needs			
	assessments. This REQUIREM by: Based on observ document review was determined to and revise the ca the survey sample	50-02-00 Petrolia W20 Cess (1910 Cess)			
FORM CMS 3	For Resident #3,	facility staff failed to revise the DIS Obsolete Event ID: Z9NI11		acility ID: VA0050 If cor	ntinuation sheet Page 11 of 16

DEPARTMENT OF HEALTH AND HUNGER SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES



PRINTED: 10/09/2018 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		495226	B. WING		C 09/12/2018		
	PROVIDER OR SUPPLIED D NURSING AND R	R EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	1 00.12.00		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	D BE COMPLETION		
F 657	Continued From page care plan when it non-skid strips in The findings inclusion. The findings inclusion is a session of the tincluded but communication deparatysis) following (stroke) affecting wasting, type two pressure. Reside (minimum data seassessment with date) of 8/14/18, being severely imscoring 03 out of for Mental Status; as requiring externersons with transone staff member on and off the unit dependence on opersonal hygiene. Review of Reside 3/6/17 documents as characterized.	page 11 was no longer needed to have place to the resident's bedside. de: admitted to the facility on mitted on 3/6/17 with diagnoses were not limited to cognitive efficit, hemiplegia (one-sided g cerebrovascular disease right dominant side, muscle diabetes, and high blood in #3's most recent MDS et) assessment was a quarterly an ARD (assessment reference Resident #3 was coded as paired in cognitive function 15 on the BIMS (Brief Interview exam. Resident #3 was coded as paired in cognitive function 15 on the BIMS (Brief Interview exam. Resident #3 was coded as paired in cognitive function 15 on the BIMS (Brief Interview exam. Resident #3 was coded as paired in cognitive function 15 on the BIMS (Brief Interview exam. Resident #3 was coded as paired in cognitive function 15 on the BIMS (Brief Interview exam. Resident #3 was coded as paired in cognitive assistance from two plus afters; extensive assistance from two plus afters; extensive assistance from two plus afters; extensive assistance from two plus afters and dressing; and total the staff member with toileting,	F6	DEFICIENCY)	RIATE		
	(cerebrovascular hemiparesis, HTN (diabetes mellitus non-compliance v risk factors relate gaitInterventions	inence; hx (history) of CVA disease), with right sided I (high blood pressure), DM), poor safety awareness, and with safety precautions, multiple d to: Impaired mobility, unsteady s: Non-skid strips on floor at tervention was initiated on		Ti T			

Event ID: Z9NI11



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		495226	B. WING		09/12/2018	
	PROVIDER OR SUPPLIER	HABILITATION CENTER	73	TREET ADDRESS. CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION	
F 657	Continued From pa	age 12	F 657			
		p.m., an observation was #3's room. He did not have ais floor.				
ä		a.m., an observation was #3's room. He did not have iis floor.			5 5 6	
		t #3's Fall Risk Evaluation ealed that he was "Not at risk"				
;	that he had one fal note documented i to this nurse that re	t #3's clinical record revealed I this year on 1/11/18. His fall In part, the following: Reported esident observed on the floor in				
	outside his room d injuries, resident do MD (medical docto	hair at the end of the hall oor, resident assessed with no enies pain, taken to restroom. r) and RP (responsible party) sident #3's care plan was all.				
	conducted with CN #1, an aide who fre #3. When asked h residents from falli	8 a.m., an interview was A (certified nursing assistant) equently works with Resident low nursing aides prevent ng, CNA#1 stated that she all preventive interventions that				
	were listed on the restated that the care resident's closet. A responsible for ensignate to the resider she would think the responsible. When fall risk, CNA #1 st.	resident's care guide. CNA #1 e guide was kept in the When asked who would be suring non-skid strips were in nt's floor, CNA #1 stated that e maintenance department was n asked if Resident #3 was a ated, "I haven't heard of him ed if non-skid strips were on			20 20 20 21 21	

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

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES		-		1
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			D 1495/0	12		C
		495226	B. WING	- AL		09/12/2018
	ROVIDER OR SUPPLIER D NURSING AND RE	HABILITATION CENTER		730 LI	ET ADDRESS, CITY, STATE, ZIP CODE UNENBURG HIGHW SVILLE, VA 23947	
12.173.1740			- <u>AN</u> E			MI OVE
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
E 657	Continued From pa	age 13	· F(657		
1.001	reduction beat intermediateless betoday through a could describe an experience of		-			
	Resident #3's care	guide, CNA #1 stated that she r seeing non-skid strips to any				
	does not recall eve	de. At 10:15 a.m., this writer				
5	followed CNA #1 to	Resident #3's room. CNA #1				
	confirmed that non	-skid strips were not on his				
	care quide or to his	floor. CNA#1 was not sure if				
	Resident #3 was s	upposed to have non-skid				•
	strips in place. CN	A #1 stated that Resident #3				6
	used the sit to stan	d lift and that he did not				
	ambulate or stand	on his own. CNA #1 stated that				0
	the nursing aides of	lid not have access to the				12
	entire resident care	e plan on the computer.				39
	On 9/12/18 at 10:3	3 a.m., an interview was				£ 6
	conducted with LP	N (licensed practical nurse) #1,				200
		e. When asked who was		20		5
	responsible for rev	iewing and revising the care d that the MDS nurse was				
	plan, LPN #1 State	dating the care plan with any				
	responsible for up	sked the purpose of the care		85		20
	plan I DN #1 state	d that the purpose of the care				
	nlan was for the st	aff to know the type of care and	j			
	interventions that	need to be implemented to care	;			II.
	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		Ţ		Ī
	listed out intervent	ions the aides needed to follow				
	When asked who	was responsible for ensuring				
	non-skid strips we	re in place to the resident's				
	ricor, LPN #1 state	ed the director of maintenance		6		
	Would install the Si	rips once alerted by nursing. sident #3 needed non-skid				
	string to his floor	LPN #1 stated, "No, he doesn't	11 15	9		義
8	stand or try to get	up. He uses a lift to get up."				
	LPN #1 stated tha	t Resident #3 used to be able				
		d get up but that he had				
	declined in his AD	L (activities of daily living)				
	function. LPN #1 s	stated, "Unless he stands with		7%		

the 3-11 shift and is just weaker in the morning. I

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MUL A. BUILD	LTIPLE CONSTRUCTION DING	COMPLETED
		495226	B. WING		09/12/2018
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP C 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	;OD€
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		N SHOULD BE COMPLETION
F 657	conducted with RI MDS nurse. Whe for updating the canyone could updating the canyone could updating in condition the purpose of the individual received Resident #3 need RN #1 stated, "He directed this survestatus on his care documented on his care documented on his care or maintain maxin for TRANSFERRI another related to (physical) limitation Lift: Sabina Lift (swas initiated on 9 was not sure who care plan or if he #1 stated that the necessary now. Rechanges with the should be immedithat the care plan depending on her On 9/12/18 at 11: conducted with Riesident #3 was requiring extensive staff members with a lift for transfers,	A4 a.m., an interview was N (registered nurse) #1, the en asked who was responsible are plans, RN #1 stated that ated the care plan after a on such as a fall. When asked a care plan, RN #1 stated that a care plan was make sure each a proper care. When asked if ed non-skid strips to his floor, a doesn't ambulate." RN #1 eyor to look at this transfer plan. The following was is transfer care plan dated as assistance /potential to restore num function of self-sufficiency NG from one position to: lack of strength, physons, unsteady gaitMechanical it to stand)." This intervention (12/17. RN #1 stated that she added the non-skid strips to his needed them at one time. RN non-skid strips were not ately updated. RN #1 stated was also updated quarterly,		657	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION 3		C C CASE CASE CASE CASE CASE CASE CASE C	
		495226	B. WING		09	/12/2018	
	PROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 657	Continued From pa	age 15	F 65	7			
	and is therefore co RN #1 stated that i	ded as extensive assistance. f the resident used a Hoyer lift, as being totally dependent on				and the state of the state of	
	staff member) #2, f	4 a.m., ASM (administrative the DON (Director of Nursing) of the above concerns. ASM #2 ald have the care plan updated					
	CARE PLAN" docu facility to provide a plan based upon p	ty's policy titled, "RESIDENT imented, "It is the policy of the written resident-centered care hysician's orders, the					
	preferencesThe ongoing process a problems and/or ne	resident needs and resident's care plan will be (sic) nd will include current eeds identified from a complete new problem or need of the	en en				
	scheduled care pla	dentified between his/her in review, will be addressed on appropriate disciplines"				N N	
	No further informat	ion was obtained prior to exit.					
	Williams and Wilking documented, "A wr	amentals of Nursing Lippincott ns 2007 pages 65-77 itten care plan serves as a					
	members that help careThe nursing	I among health care team s ensure continuity of care plan is a vital source of		E		e u	
	and goals. It conta achieving the goals and is used to dire	he patient's problems, needs, lins detailed instructions for s established for the patient ct careexpect to review,					
		the care plan regularly, when in condition, treatments, and		1 1			