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 06/07/2019

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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 6/4/19 through 6/7/19. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. One complaint was investigated during the survey.	E 000	Wayland Nursing and Rehabilitation center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with the applicable rules and provisions of quality of care of residents. This Plan of Correction is submitted as a written allegation of compliance. Wayland Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Wayland Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	
E 036 SS=D	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set 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. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set 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 §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency	E 036		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE: Administrator — (X6) DATE: 7/1/19

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.

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

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 06/07/2019

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
E 036	Continued From page 1 preparedness training, testing and patient orientation program that is based on the emergency plan set 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, testing and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to evidence documentation that the facility has a written training and testing program that meets the requirements of the regulation and documentation that the training and testing program has been reviewed and updated on, at least an annual basis. The findings include: An interview was conducted with ASM (administrative staff member) #1, the administrator, regarding the emergency preparedness plan, specifically about the training and testing program and review of the program and any updates completed on an annual basis. ASM #1 informed this surveyor that they did not have documentation that the training and testing program has been reviewed and updated on an annual basis. ASM #1, the administrator, ASM #2, the director of nursing, and ASM #4, the facility nurse consultant, were made aware of the above	E 036	E-36 The emergency Preparedness Plan was updated and completed to include training and testing and was reviewed and approved. Staff will maintain evidence of testing in a log book and the log will be updated as necessary. Evidence of training and testing of the EP will be submitted to the Safety Committee of the facility for compliance and proper documentation. Minutes of the Safety Committee will be submitted to the facility's QAPI committee for review and suggestions.	7/21/19

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 06/07/2019

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
E 036	Continued From page 2 concerns on 6/6/19 at 7:35 p.m.	E 036		
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their	E 037	E-37 Staff will receive training and instructions on the facility's Emergency preparedness training. Documentation of new hires initial training will be kept in the SDC office. The administrator or his designee will conduct annual training sessions with staff to educate them on the Emergency Plan and any updates that may have occurred. Proof of annual in-service training on the EP will be kept in the SDC office and Submitted to the facility Safety Committee for review and compliance. The meetings of the Safety committee as well as proof of annual and initial in-service training on the EP will be submitted to the QAPI Committee for review and compliance.	7/21/19

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 06/07/2019

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
E 037	Continued From page 3 expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in	E 037		

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 06/07/2019

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
E 037	Continued From page 4 case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency	E 037		

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 06/07/2019

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
E 037	Continued From page 5 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 by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to evidence documentation of the facility's initial emergency preparedness training and annual emergency preparedness training offerings and documentation that facility staff have received initial & annual emergency preparedness training. The findings include: An interview was conducted with ASM (administrative staff member) #1, the administrator on 6/6/19 at 6:47 p.m. ASM #1 was asked for the facility's initial emergency preparedness training and annual emergency preparedness training offerings and documentation that facility staff have received initial & annual emergency preparedness training. ASM #1 stated the facility did not have	E 037		

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 06/07/2019

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
E 037	Continued From page 6 documentation of the initial emergency preparedness training and the annual emergency preparedness training. He stated the employees get the information in orientation but the annual training has not been completed. ASM #1, the administrator, ASM #2, the director of nursing, and ASM #4, the facility nurse consultant, were made aware of the above concerns on 6/6/19 at 7:35 p.m.	E 037		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted from 6/4/19 through 6/7/19. Complaints were investigated during this survey. Corrections are required for compliance with the following 42 CFR Part 483 of the Federal Long Term Care requirements. The life safety code survey/report will follow. The census at this 90 certified bed facility was 51 at the time of the survey. The survey sample consisted of 27 current residents and 6 closed records.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or	F 550		

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 06/07/2019

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 550	Continued From page 7 her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it was determined the facility staff failed to ensure and promote dignity for one of 33 residents in the survey sample, Resident #10. Resident #10's indwelling urinary catheter (1) collection bag was uncovered with urine in the bag during multiple observations.	F 550	F-550 Resident #10's catheter bag was emptied of urine and properly covered to ensure privacy and dignity. An inspection of other residents with indwelling catheters was conducted and there were no other issues found. Nursing staff will be responsible for maintain privacy bags on residents with indwelling catheters. The RN Charge nurse will report any non-compliance with catheter bags to the Cardinal IDT members at their morning and/or evening meeting. Non-compliance will be corrected immediately. Results of the Cardinal IDT meetings Catheter log will be reviewed weekly to ensure compliance. The logs will be reviewed by the QAPI committee at its monthly meeting.	7/25/19

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 06/07/2019

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 550	Continued From page 8 The findings include: Resident #10 was admitted to the facility on 2/21/19 with the diagnoses of but not limited to high blood pressure, chronic obstructive pulmonary disease (2), obstructive and reflux uropathy (3), benign prostatic hyperplasia with lower urinary tract symptoms, and retention of urine. The most recent MDS (Minimum Data Set), a Significant Change in Status Medicare assessment, with an ARD (Assessment reference date) of 3/18/19, coded the resident as scoring a 9 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the resident had moderate cognitive impairment for daily decision making. The resident was coded as having an indwelling urinary catheter. On 6/4/19 at 3:12 p.m., 4:20 p.m., and 5:18 p.m., Resident #10's indwelling urinary catheter collection bag was observed uncovered, exposed, and hanging on the bed frame. During each observation, urine was observed in the bag. On 6/5/19 at 8:19 a.m., Resident #10's indwelling urinary catheter collection bag was observed uncovered, exposed, and hanging on the bed frame. During this observation, urine was observed in the bag. On 6/6/19 at 12:43 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #3. LPN #3 was asked about the process staff follow in regards to a resident Foley collection bag. LPN #3 stated, "It needs to be covered for privacy." LPN #3 was asked if it was acceptable for a Foley collection bag to be uncovered. LPN #3 stated, "Yes. It is a dignity issue. The Hospice	F 550		

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 06/07/2019

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 550	Continued From page 9 nurse takes care of his Foley and I don't think they have covers. It was just changed on Tuesday." When asked if the facility provides Foley collection bag covers, LPN #3 stated, "I will have to talk with someone about getting covers." On 6/7/19 at 11:48a.m., ASM (Administrative Staff Member) #1, the Administrator, was made aware of the findings. (1) An indwelling catheter is a tube that drains urine from the bladder to a bag outside of the body. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000140.htm (2) Chronic obstructive pulmonary disease: Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. (3) Obstructive and reflux uropathy: Obstructive uropathy is a condition in which the flow of urine is blocked. This causes the urine to back up and injure one or both kidneys. This information was obtained from the website: https://medlineplus.gov/ency/article/000507.htm	F 550		
F 559 SS=D	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his	F 559		

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 06/07/2019

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 559	Continued From page 10 or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to provide notice to the resident and/or responsible representative for a room change for one of 33 residents in the survey sample, Resident #33. The facility staff failed to provide the resident and or resident representative with a written notification/explanation of why a move was required for Resident #33, prior to a room change from the skilled unit to the long-term care unit, and failed to provide an opportunity for the resident to view the room prior to the move. The findings include: Resident #33 was admitted to the facility on 5/1/19 with diagnoses that included but were not limited to: dementia, high blood pressure, diabetes, stroke and COPD (chronic obstructive pulmonary disease - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (1). The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 5/8/19, coded the	F 559	F-559 Resident #33 and her resident representative were provided written explanation as to the reason for moving to another room within the facility. No other resident in the facility was identified as not being notified. Approvals for a room move will be discussed in the morning Cardinal IDT meeting before a room move is done. The administrator or his designee will ensure that the Social Worker properly notifies residents and their RR as to the reason for a room move and that the resident has viewed the room and met any new roommate. Copies of the written notification will be kept in the Social services Office. Room moves will be completed and reported back to the Cardinal IDT members to verify that proper documentation and notifications were completed. Room moves will be monitored weekly by the cardinal IDT members and submitted to the facility QAPI committee for oversight.	7/21/19

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 06/07/2019

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 559	Continued From page 11 resident as scoring a "3" on the BIMS (brief interview for mental status) score, indication she is severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance to being dependent upon one staff member for all of her activities of daily living. The resident was observed to be in a room on the long-term care hall on 6/4/19. Review of the clinical record revealed the resident was previously on the rehabilitation hall for respite care. The resident was transferred to long-term care in the facility on 5/9/19. The nurse's note dated, 6/1/19 at 8:35 p.m., documented, "Res. (resident) transferred to room XXX A bed, adjusting to room, ate in dining room, no problems noted. Pleasant and cooperative." Further review of the progress notes failed to evidence any documentation regarding the resident being shown the room, written or verbal communication with the resident's representative. An interview was conducted with administrative staff member (ASM) #1, the administrator, on 6/5/19 at 4:36 p.m. When asked why Resident #33 was moved from the rehabilitation hallway to the long term care hallway, ASM #1 stated the resident goes to the PACE (Program of All-inclusive Care for the Elderly) program every Tuesday and Thursday. She was originally here just for respite care but could no longer be cared for at home. She was transferred to long-term care through PACE. The reason she was moved rooms was not a matter of convenience, it was felt that she could be closer to the front door for the days she goes out to PACE. She would have to sit up in the front lobby for an extended period.	F 559		

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 06/07/2019

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 559	Continued From page 12 This way she was moved and is closer to the front door and can be sitting in her room if she wished for pick up by PACE driver. An interview was conducted with other staff member (OSM) #4, the social worker, on 6/5/19 at 4:07 p.m. When asked the process when a change is made in the resident's room, OSM #4 stated, "I call both the resident representative (RR) and talk to the resident. Then I document in the computer under room change or roommate change in the clinical record." When asked if the resident and/or family is given anything in writing regarding the room change, OSM #4 stated, "No, I just call them and document it." When asked if Resident #33 or her RR was shown the room prior to transfer and had the opportunity to meet the roommate, OSM #4 stated, "I don't think so." OSM #4 reviewed the notes in the computerized clinical record and stated, "I don't remember writing a note." When asked when she transferred rooms, OSM #4 stated, "June 1st." An interview was conducted with ASM #1 on 6/5/19 at 4:16 p.m. When asked the process when resident have a room change, ASM #1 stated, "The request can come from the resident. A RR can request a room change. We need to notify the roommate they are getting a new roommate. We need to notify the physician." When asked if they give the resident and/or resident representative anything in writing regarding the room change, ASM #1 stated, "If it's the resident's request, I don't believe it is done." When asked if the resident is shown the new room, ASM #1 stated, "Yes, of course." When asked where that is all documented, ASM #1 stated, "In the social worker's notes."	F 559		

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 06/07/2019

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 559	Continued From page 13 The facility policy, "Room Assignments/Room Changes" documented in part, "Rooms are assigned to residents in accordance with their medical and social needs, and their payment source...The resident and the resident's legal representative or an interested family member is informed before the resident's room or roommate is changed. Timely notice should be given to the resident and the family when a resident changes rooms or when a resident received a new roommate...Before and after any room change, the Social Worker will prepare the resident for the change and will monitor the adjustment to the new room and roommate." ASM #1, the administrator and ASM #4, the facility nurse consultant, were made aware of the above findings on 6/6/19 at 7:45 a.m. No further information was obtained prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.	F 559		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the	F 622		

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 06/07/2019

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	(X5) COMPLETION DATE
F 622	Continued From page 14 services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care	F 622	F-622 Physician documentation for transfer was obtained for resident #s 41, 22, 25, 13, 15, 43, 49, 46 and 19. A copy of the resident's care plan for each affected resident was sent to the receiving hospital. A review of discharges for the last 30 days was conducted and no other issues were found. The medical director will be in-serviced on the necessary documentation required for transfers. Nursing staff will be in-serviced on the necessity to include the resident's comprehensive care plan goals. Unplanned discharges will be reviewed by the Cardinal IDT members at its morning meeting to ensure that all documentation and transfer papers are sent. An audit tool of unplanned discharges will be kept by the team and reviewed weekly for compliance. Results of the Unplanned Discharges log will be submitted to the QAPI Committee at its monthly meeting for oversight and direction.	7/21/19

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 06/07/2019

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 622	Continued From page 15 institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to evidence that the required physician documentation was completed and/or the	F 622		

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 06/07/2019

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 622	Continued From page 16	F 622		

required transfer documentation was provided to a receiving facility for facility initiated hospital transfers for nine of 33 sampled residents, Residents #41, #22, #25, #13, #15, #43, #49, #46, and #19.

The findings include:

1. The facility staff failed to evidence the required physician documentation was completed and evidence what, if any, required transfer documentation was provided to the receiving facility when Resident #41 was transferred to the hospital on 4/16/19.

Resident #41 was admitted to the facility on 7/10/18 with the diagnoses of but not limited to, acute respiratory failure, diabetes, high blood pressure, anxiety disorder, breast cancer, bladder disorder, atrial fibrillation, congestive heart failure, chronic obstructive pulmonary disease, and osteoporosis. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 5/3/19. The resident was coded as being moderately impaired in ability to make daily life decisions.

A review of the clinical record revealed the following nurses note: 4/16/19 at 3:39 PM: "Therapy alerted writer that resident was c/o (complaining of) stabbing pain in left arm and o2 [oxygen] sats [saturations] were in the 80's on O2 @ (at) 3L/M (three liters per minute). Writer in to assess resident. Resident continues to c/o sharp pain in left arm, non-radiating. C/o SOB (shortness of breath). O2 sats 90% on O2@3L/M. Resident slow to respond to writers questions. Speech slurred at times. B/P (blood

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 06/07/2019

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 622	Continued From page 17	F 622		

pressure) 130/64, HR (heart rate) 134, RR (respiratory rate) 22. (Name of Nurse Practitioner) made aware and orders received to send to ER (emergency room) for further evaluation. Bed hold policy placed in paperwork and sent with resident. Resident is her own RR (responsible representative) and aware."

Further review of the clinical record failed to reveal any evidence of what, if any, required documentation was provided to the receiving facility. There was no evidence that the required physician documentation (what efforts the facility attempted to prevent the need for hospitalization, why the facility was not able to meet the resident's needs, and what specific services the hospital could provide for the resident that the facility could not) was completed.

An interview was conducted with LPN (licensed practical nurse) #5 on 6/5/19 at 2:37 p.m., regarding the paper work the facility sends with a resident being transferred to the hospital. LPN #5 stated, "The DNR [do not resuscitate] form, immunization record, bed hold policy, copy of the med (medication) list, copy of the order to send to the ER [emergency room]." When asked where staff documents what was sent to the hospital, LPN #5 stated, "We don't always document that we send all of that. We do write a note about the bed hold." When asked if the comprehensive care plan goals are sent with residents, LPN #5 stated, "No, I don't usually. We send the transfer form that has if they are continent or incontinent, the reason they are going to the ER, their insurance information, vital signs and the contact information for the resident representative." When asked if the doctor or nurse practitioner writes a note as to why the resident went to the

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 06/07/2019

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 622	Continued From page 18	F 622		

hospital, LPN #5 stated, "Sometimes when the resident comes back they will document why they were sent to the hospital."

On 6/06/19 at 7:08 p.m., in an interview with LPN #4, she stated that when a resident is sent to the hospital, the facesheet, code status, current MAR (Medication Administration Record) and bed hold policy are sent. She stated that the facility does not use a transfer form; that the care plan goals are not sent; and that she did not know what the requirements for physician documentation were. When asked how the facility evidences that all the required documentation was provided to the hospital, LPN #4 stated, "Unless you put it in a note, which we don't really, there isn't a way to know what was sent."

An interview was conducted with ASM (administrative staff member) #2,, the director of nursing, on 6/5/19 at 2:47 p.m., regarding what documentation the facility provide to the receiving hospital for residents that are transferred. ASM #2 stated, "Face sheet, med [medication] list, DNR [do not resuscitate], order to send to the ER [emergency room], bed hold policy, immunization, lab (laboratory) or x-ray results. I then call 911, call the hospital with report." When asked if the staff send the comprehensive care plan goals, ASM #2 stated, "No, we do not." When asked if the doctor's write a note of why the resident went to the hospital, ASM #2 stated, "Sometimes."

A review of the facility policy, "Transfer and Discharge" documented, "The facility will permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless: a) The transfer or discharge is necessary for the resident's welfare and the resident's needs

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 06/07/2019

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 622	Continued From page 19 cannot be met in the facility;....The facility will have documentation in the resident's medical record that the above situations have occurred. The resident's attending physician will provide documentation that situations discussed in "a" or "b" have occurred....Before a facility transfers or discharges a resident, the facility will: *Notify the resident and, if known, a family member or legal representative of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. *Record the reason(s) in the resident's clinical record." The policy did not include any criteria for the required components of the physician documentation of a hospital transfer; the specific documentation that must be provided to the receiving facility upon a hospital transfer; written notification of the Ombudsman, or the provision of a written bed hold policy. On 6/6/19 at 7:43 PM, ASM #1 (the Administrator), ASM #2 and ASM #4 (Facility Nurse Consultant) were notified of the concerns. ASM #1 inquired about a transfer form for the required transfer information and ASM #2 then stated that the facility does not use a transfer form. (1) Tylenol - is used to treat mild to moderate pain and reduce fever. Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html 2. The facility staff failed to evidence the required physician documentation was completed and evidence that all required transfer documentation was provided to the receiving facility when	F 622		

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 06/07/2019

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 622	Continued From page 20 Resident #22 was transferred to the hospital on 3/11/19 and 4/29/19. Resident #22 was admitted to the facility on 11/23/12 with the diagnoses of but not limited to dementia, atrial fibrillation, diabetes, chronic kidney disease, Alzheimer's disease, and psychotic disorder. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 6/3/19. The resident was coded as being severely cognitively impaired in ability to make daily life decisions. A review of the clinical record revealed a nurse's note dated 3/11/19 at 9:15 a.m., that documented Resident #22 was sent to the hospital after a fall from the wheelchair for evaluation. The note documented in part, "NP (nurse practitioner) was notified and gave order to send to ER (emergency room) for eval (evaluation) and treat. RR (resident representative) made aware. Resident left facility at 0900 (9:00 AM) via (county rescue squad)." A nurse's note dated 3/11/19 at 9:32 AM, documented, "Copy of bed hold policy sent with resident." Further review of the clinical record revealed an "SNF/NF to Hospital Transfer Form" which documented the resident's demographic information, code status, Risk Alerts, Isolation Precautions, Skin/Wound Care, facility contact information, Rehabilitation Therapy status, reason for transfer, Key Clinical Information, functional status, where the resident was sent to, resident representative information, and mental status. There was no documented evidence of the resident's treatments and medications being provided. The area titled "Treatments:	F 622		

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 06/07/2019

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 622	Continued From page 21 Respiratory....Diet....Medications...." were all left blank. There was no evidence that a copy of the Medication Administration Record and Treatment Administration Record (MAR and TAR) were provided. There was no evidence that the comprehensive care plan goals were provided. In addition, this form was dated 3/11/19 and the documented vital signs were dated 3/11/19; however, the form documented that the date of transfer was 9/11/18. Further review also failed to reveal any evidence that the required physician documentation (what efforts the facility attempted to prevent the need for hospitalization, why the facility was not able to meet the resident's needs, and what specific services the hospital could provide for the resident that the facility could not) was completed. Further review of the clinical record revealed a nurse's note dated, 4/29/19 at 1:32 p.m., that documented the resident was sent to the hospital for evaluation. The note documented in part the following: "Writer called NP (nurse practitioner) a0915 (sic) (at 9:15 a.m.) and was given an order to send to ER (emergency room). 0920 (9:20 AM) (county) rescue notified. 0925 (9:25 AM) left message for RR (resident representative) to call facility. 0940 (9:40 AM) Rescue squad arrived. 0945 (9:45 AM) Resident left facility via stretcher and 2 attendants. Attempted to call report to ER and no answer. 1240 (12:40 PM) RR (resident representative) made aware of above." Further review of the clinical record revealed an "SNF/NF to Hospital Transfer Form" dated 4/29/19. The form documented the resident's	F 622		

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 06/07/2019

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 622	Continued From page 22 demographic information, code status, Risk Alerts, Isolation Precautions, Skin/Wound Care, facility contact information. It also documented Rehabilitation Therapy status, reason for transfer, Key Clinical Information, functional status, where the resident was sent to, and resident representative information. There was no documented evidence of the resident's treatments and medications being provided. The area titled, "Treatments: Respiratory....Diet....Medications...." were all left blank. There was no evidence that a copy of the Medication Administration Record and Treatment Administration Record (MAR and TAR) were provided. There was no evidence that the comprehensive care plan goals were provided. An interview was conducted with ASM (administrative staff member) #2,, the director of nursing, on 6/5/19 at 2:47 p.m., regarding what documentation the facility provide to the receiving hospital for residents that are transferred. ASM #2 stated, "Face sheet, med [medication] list, DNR [do not resuscitate], order to send to the ER [emergency room], bed hold policy, immunization, lab (laboratory) or x-ray results. I then call 911, call the hospital with report." When asked if the staff send the comprehensive care plan goals, ASM #2 stated, "No, we do not." When asked if the doctor's write a note of why the resident went to the hospital, ASM #2 stated, "Sometimes." On 6/6/19 at 7:43 PM, ASM #1 (the Administrator), ASM #2 and ASM #4 (Facility Nurse Consultant) were notified of the concerns. ASM #1 inquired about a transfer form for the required transfer information and ASM #2 then stated that the facility does not use a transfer form.	F 622		

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 06/07/2019

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 622	Continued From page 23	F 622		

3. The facility staff failed to evidence what, if any required documentation was provided to the receiving facility when Resident #25 was transferred to the hospital on 3/24/19.

Resident #25 was admitted to the facility on 7/30/18, with the diagnoses of but not limited to, congestive heart failure, dementia, depression, and osteoarthritis. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 5/26/19. The resident was coded as moderately impaired in ability to make daily life decisions.

A review of the clinical record revealed a nurse's note on 5/26/19 that documented Resident #25 was sent to the hospital for shortness of breath. The note documented in part the following: "Order to send to ER (emergency room) for evaluation. RP agreeable. Call made to have res, transferred to (name of hospital) (name of town). Res. picked up at 1520 (3:20 PM) via (county) rescue squad."

Further review failed to reveal any evidence of what, if any, required documentation was provided to the receiving facility. There was no evidence of a transfer form which would contain much of the required information was completed.

An interview was conducted with ASM (administrative staff member) #2,, the director of nursing, on 6/5/19 at 2:47 p.m., regarding what documentation the facility provide to the receiving hospital for residents that are transferred. ASM #2 stated, "Face sheet, med [medication] list,

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 06/07/2019

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 622	Continued From page 24 DNR [do not resuscitate], order to send to the ER [emergency room], bed hold policy, immunization, lab (laboratory) or x-ray results. I then call 911, call the hospital with report." When asked if the staff send the comprehensive care plan goals, ASM #2 stated, "No, we do not." When asked if the doctor's write a note of why the resident went to the hospital, ASM #2 stated, "Sometimes." On 6/6/19 at 7:43 PM, ASM #1 (the Administrator), ASM #2 and ASM #4 (Facility Nurse Consultant) were notified of the concerns. ASM #1 inquired about a transfer form for the required transfer information and ASM #2 then stated that the facility does not use a transfer form. (1) BNP - Brain natriuretic peptide (BNP) test is a blood test that measures levels of a protein called BPN that is made by your heart and blood vessels. BNP levels are higher than normal when you have heart failure. Information obtained from https://medlineplus.gov/ency/article/007509.htm (2) Lasix - is a diuretic used to treat high blood pressure by reducing the excess water in the body. Information obtained from https://medlineplus.gov/druginfo/meds/a682858.html (3) Levaquin - is an antibiotic. Information obtained from https://medlineplus.gov/druginfo/meds/a697040.html	F 622		

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 06/07/2019

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 622	Continued From page 25 4. The facility staff failed to evidence what, if any documentation was provided to the receiving facility when Resident #13 was transferred to the hospital on 2/15/19. Resident #13 was admitted on 2/6/15 with the diagnoses of atrial fibrillation, hypothyroidism, depression, chronic obstructive pulmonary disease, anxiety disorder, intestinal obstruction, hemiplegia, respiratory failure, and neurogenic bladder. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 3/22/19. The resident was coded as moderately impaired in ability to make daily life decisions. A review of the clinical record revealed a nurse note dated 2/15/19 at 9:00 a.m., that documented the resident was sent to the hospital for evaluation after vomiting. The note documented in part the following: "FNP (Family Nurse Practitioner) notified and order received to send to ER (emergency room) for eval (evaluation) and treatment. Left message for RR. Bed Hold policy sent with paperwork to ER." Further review of the clinical record revealed an "SNF/NF to Hospital Transfer Form" dated 2/15/19 which documented the resident's demographic information, code status, Risk Alerts, Isolation Precautions, Skin/Wound Care, facility contact information, Rehabilitation Therapy status, reason for transfer, Key Clinical Information, functional status, where the resident was sent to, and resident representative information. The area titled "Treatments: Respiratory....Diet....Medications...." documented that the resident was on nebulizer therapy for a	F 622		

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 06/07/2019

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 622	Continued From page 26 chronic condition, and was on Macrobid (3). However, the reason was not documented nor was the dose. In addition, no other medications or treatments were documented. There was no evidence that a copy of the Medication Administration Record and Treatment Administration Record (MAR and TAR) were provided. There was no evidence that the comprehensive care plan goals were provided to the receiving hospital. An interview was conducted with ASM (administrative staff member) #2,, the director of nursing, on 6/5/19 at 2:47 p.m., regarding what documentation the facility provide to the receiving hospital for residents that are transferred. ASM #2 stated, "Face sheet, med [medication] list, DNR [do not resuscitate], order to send to the ER [emergency room], bed hold policy, immunization, lab (laboratory) or x-ray results. I then call 911, call the hospital with report." When asked if the staff send the comprehensive care plan goals, ASM #2 stated, "No, we do not." When asked if the doctor's write a note of why the resident went to the hospital, ASM #2 stated, "Sometimes." On 6/6/19 at 7:43 PM, ASM #1 (the Administrator), ASM #2 and ASM #4 (Facility Nurse Consultant) were notified of the concerns. ASM #1 inquired about a transfer form for the required transfer information and ASM #2 then stated that the facility does not use a transfer form. (1) Zofran - is used to prevent nausea and vomiting. Information obtained from https://medlineplus.gov/druginfo/meds/a601209.html	F 622		

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 06/07/2019

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 622	Continued From page 27 (2) Phenergan - is used to prevent and control nausea and vomiting. Information obtained from https://medlineplus.gov/druginfo/meds/a682284.html 5. The facility staff failed to evidence that all required physician documentation was completed and evidence what, if any, required transfer documentations was provided to the receiving facility when Resident #15 was transferred to the hospital on 4/11/19. Resident #15 was admitted to the facility on 12/2/13 with the diagnoses of but not limited to dementia, with behavioral disturbances, anxiety disorder, Huntington's disease (1) and history of falling. The most recent MDS (Minimum Data Set), a Quarterly Medicare assessment, with an ARD (Assessment reference date) of 4/3/19, coded the resident per staff assessment, as having short-term memory problems, long-term memory problems, and severe impairment of daily decision-making. . A review of the clinical record revealed a nurse's noted dated 4/11/19 at 02:21 a.m., that documented in part, " ...observed resident on mat beside bed. no apparent injury found...Will send to ER [emergency room] for evaluation and treatment ..." A review of the clinical record failed to reveal a physician's note documenting the reason for Resident #15's transfer to the hospital on 4/11/19. An interview was conducted with ASM (administrative staff member) #2,, the director of	F 622		

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 06/07/2019

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 622	Continued From page 28 nursing, on 6/5/19 at 2:47 p.m., regarding what documentation the facility provide to the receiving hospital for residents that are transferred. ASM #2 stated, "Face sheet, med [medication] list, DNR [do not resuscitate], order to send to the ER [emergency room], bed hold policy, immunization, lab (laboratory) or x-ray results. I then call 911, call the hospital with report." When asked if the staff send the comprehensive care plan goals, ASM #2 stated, "No, we do not." When asked if the doctor's write a note of why the resident went to the hospital, ASM #2 stated, "Sometimes." On 6/7/19 at 11:48 a.m., ASM (Administrative Staff Member) #1, the Administrator, was made aware of the findings. No further information was provided by the end of the survey. (1) Huntington's disease: is an inherited disease that causes certain nerve cells in the brain to waste away. People are born with the defective gene, but symptoms usually don't appear until middle age. Early symptoms of HD may include uncontrolled movements, clumsiness, and balance problems. Later, HD can take away the ability to walk, talk, and swallow. Some people stop recognizing family members. Others are aware of their environment and are able to express emotions. This information was obtained from the following website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=huntington%27s+disease&_ga=2.114498181.349992197.1560176578-904618792.1557758561 6. The facility staff failed to evidence what, if any,	F 622		

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 06/07/2019

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 622	Continued From page 29 required transfer documentations was provided to the receiving facility when Resident #43 was transferred to the hospital on 4/12/19, 5/5/19 and 5/6/19, and all required physician documentation was completed when Resident #43 was transferred to the hospital on 5/5/19. Resident #43 was admitted to the facility on 2/22/19 with the diagnoses of but not limited to dementia with behavioral disturbances, Alzheimer's disease, chronic kidney disease, and high blood pressure. The most recent MDS (Minimum Data Set), a Quarterly Medicare assessment, with an ARD (Assessment reference date) of 5/6/19, coded the resident per staff assessment as having short-term memory problems, long-term memory problems, and moderate impairment of daily decision-making. A review of the clinical record revealed a nurse's noted dated 4/12/19 at 10:15 a.m., documented in part, "Upon entering room resident noted sitting on floor in front of bed ...FNP (Family Nurse Practitioner) notified and order received to send to ER (Emergency Room) for eval and treatment. RR (Resident Representative) aware and bed hold policy given to RR in facility." A review of the clinical record revealed a physician's note dated 4/13/19 at 10:45 a.m., documented in part, " ...She was evaluated at (name of) hospital 4/12/19 ...She was found to have a urinary tract infection ..." A review of the clinical record failed to evidence that the required transfer documents were provided to the receiving facility for Resident #43's transfer to the hospital on 4/12/19.	F 622		

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 06/07/2019

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 622	Continued From page 30 A review of the clinical record revealed a nurse's noted dated 5/5/19 at 7:10 a.m., that documented in part, "Called to room due to resident vomiting ...called FNP and order received to send to ER (emergency room) for eval (evaluation) and treatment ..." A review of the clinical record failed to reveal a physician's note documenting the reason for Resident #43's transfer to the hospital on 5/5/19. Further review failed to evidence the required documents including the comprehensive care plan, were provided to the receiving facility when Resident #43 was transfer to the hospital on 5/5/19. A review of the clinical record revealed a nurse's noted dated 5/6/19 at 4:58 p.m. that documented in part, "Resident with inspiratory expiratory wheeze ...called (name of) NP new order send to ER for evaluation A review of the clinical record revealed a physician's note dated 5/11/19 at 11:15 a.m., that documented in part, " ...She was evaluated at (name of) hospital 5/6/19 - 5/9/19 for fever and found to have an EBSL (Extended Spectrum Beta-Lactamase) urinary tract infection ..." A review of the clinical record failed to evidence the required documents including the comprehensive care plan, were provided to the receiving facility when Resident #43 was transferred to the hospital on 5/6/19. An interview was conducted with ASM (administrative staff member) #2,, the director of nursing, on 6/5/19 at 2:47 p.m., regarding what documentation the facility provide to the receiving	F 622		

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 06/07/2019

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 622	Continued From page 31 hospital for residents that are transferred. ASM #2 stated, "Face sheet, med [medication] list, DNR [do not resuscitate], order to send to the ER [emergency room], bed hold policy, immunization, lab (laboratory) or x-ray results. I then call 911, call the hospital with report." When asked if the staff send the comprehensive care plan goals, ASM #2 stated, "No, we do not." When asked if the doctor's write a note of why the resident went to the hospital, ASM #2 stated, "Sometimes." On 6/7/19 at 11:48 AM, ASM (Administrative Staff Member) #1, the Administrator, was made aware of the findings. No further information was provided by the end of the survey. 7. The facility staff failed to evidence what, if any, required transfer documentation was provided to the receiving facility when Resident #49 was transferred to the hospital on 5/12/19. Resident #49 was admitted to the facility on 4/23/19 with the diagnoses of but not limited to type 2 diabetes mellitus, high blood pressure, heart failure, chronic obstructive pulmonary disease (1), obstructive and reflux uropathy (2), and retention of urine. The most recent MDS (Minimum Data Set), a 14-day Medicare assessment, with an ARD (Assessment reference date) of 5/28/19, coded the resident as scoring a 6 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had severe cognitive impairment for daily decision making. A review of the clinical record revealed a nurse's note dated 5/12/19 at 9:16 PM, documented in	F 622		

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 06/07/2019

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 622	Continued From page 32 part, "No acute changes. (Name of) NP (Nurse Practitioner) aware of resident's complaints of chest pain and gave order to transport to ER (Emergency room) ..." A review of the clinical record revealed a physician's note dated 5/15/19 at 10 PM, documented in part, " ...He was evaluated at (name of) Hospital 5/13/19 - 5/15/19 for exacerbation of his congestive heart failure ..." A review of the clinical record failed to reveal what and if any of the required information was provided to the receiving facility when Resident #49 was transferred to the hospital on 5/12/19. An interview was conducted with ASM (administrative staff member) #2,, the director of nursing, on 6/5/19 at 2:47 p.m., regarding what documentation the facility provide to the receiving hospital for residents that are transferred. ASM #2 stated, "Face sheet, med [medication] list, DNR [do not resuscitate], order to send to the ER [emergency room], bed hold policy, immunization, lab (laboratory) or x-ray results. I then call 911, call the hospital with report." When asked if the staff send the comprehensive care plan goals, ASM #2 stated, "No, we do not." When asked if the doctor's write a note of why the resident went to the hospital, ASM #2 stated, "Sometimes." On 6/7/19 at 11:48 AM, ASM (Administrative Staff Member) #1, the Administrator, was made aware of the findings. No further information was provided by the end of the survey. (1) Chronic obstructive pulmonary disease: Disease that makes it difficult to breath that can	F 622		

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 06/07/2019

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 622	Continued From page 33 lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. (2) Obstructive and reflux uropathy: Obstructive uropathy is a condition in which the flow of urine is blocked. This causes the urine to back up and injure one or both kidneys. This information was obtained from the website: https://medlineplus.gov/ency/article/000507.htm 8. The facility staff failed to what, if any, required transfer documentations was provided to the receiving facility when Resident #46 was transferred to the hospital on 5/28/19. Resident #46 was admitted to the facility on 9/18/17 with the diagnoses of but not limited to high blood pressure, heart attack, heart failure, chronic obstructive pulmonary disease (1), and asthma. The most recent MDS (Minimum Data Set), a five-day Medicare assessment, with an ARD (Assessment reference date) of 5/17/19, coded the resident as scoring a 13 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had no cognitive impairment for daily decision making. The resident required extensive assistance for eating: total care for hygiene, bathing, dressing, toileting, and transfers; and was always incontinent of bladder and bowel. A review of the clinical record revealed a nurse's note dated 5/28/19 at 8:44 AM, documented in part, " ...order received from FNP (Family Nurse Practitioner) to send to ER (Emergency room) for	F 622		

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 06/07/2019

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 622	Continued From page 34 eval and treatment ..." A review of the clinical record revealed a physician's note dated 5/20/19 at 8:45 PM, documented in part, " ...She was hospitalized at (name of) Hospital 5/28/19 - 6/3/19 for abdominal pain ..." A review of the clinical record failed to reveal required transfer documents of Resident #46's transfer to the hospital on 5/28/19 was provided to the receiving facility. An interview was conducted with ASM (administrative staff member) #2,, the director of nursing, on 6/5/19 at 2:47 p.m., regarding what documentation the facility provide to the receiving hospital for residents that are transferred. ASM #2 stated, "Face sheet, med [medication] list, DNR [do not resuscitate], order to send to the ER [emergency room], bed hold policy, immunization, lab (laboratory) or x-ray results. I then call 911, call the hospital with report." When asked if the staff send the comprehensive care plan goals, ASM #2 stated, "No, we do not." When asked if the doctor's write a note of why the resident went to the hospital, ASM #2 stated, "Sometimes." On 6/7/19 at 11:48 AM, ASM (Administrative Staff Member) #1, the Administrator, was made aware of the findings. No further information was provided by the end of the survey. (1) Chronic obstructive pulmonary disease: Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. 9. The facility staff failed to provide the receiving	F 622		

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 06/07/2019

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 622	Continued From page 35 facility the comprehensive care plan goals upon Resident #19's transfer to the hospital on 3/7/19. Resident #19 was admitted to the facility on 1/5/17 with a recent readmission on 3/11/19 with diagnoses that included but were not limited to: diabetes, high blood pressure, stroke, history of falls and anemia (condition in which the hemoglobin content of the blood is below normal limits) (1). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/28/19, coded the resident as scoring a "4" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. The nurse's note dated, 3/7/19 at 10:45 a.m. documented in part, "Hearing resident call out, observed resident on floor laying on his right side beside his bed. He tells nurse that he was trying to stand from wheelchair. Nursing assessment completed...Neurological assessment, tells nurse he did not hit his head. Resident complains of pain in right abdomen rating 9 on the pain scale of 1-10 and complains of shoulder pain. NP (nurse practitioner) made aware with orders to send to ER (emergency room) for evaluation. ...RR (resident representative) made aware, report called to ER at (name of hospital)." The physician's order dated 3/7/19 documented, "Send to ER for eval (evaluation), S/P (status post fall)." An interview was conducted with administrative	F 622		

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 06/07/2019

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 622	Continued From page 36 staff member (ASM) #2, the director of nursing, on 6/5/19 at 2:47 p.m. When asked what paperwork is sent with a resident on transfer to the hospital, ASM #2 stated, "The face sheet, med list, DNR form, order to send to the ER, bed hold policy, immunizations and any recent laboratory or x-ray results." When asked if the facility sends a copy of the comprehensive care plan goals, ASM #2 stated, "No, we do not." Administrative staff member (ASM) #1, ASM #2 and ASM #4, the facility-nursing consultant, were made aware of the above findings on 6/6/19 at 7:35 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 33.	F 622		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and	F 623		

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 06/07/2019

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 623	Continued From page 37 (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow 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. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in	F 623	F-623 The resident representative and the Ombudsman were sent proper written notification of a hospital transfer for resident #s 41, 22, 25, 13, 15, 43, 49, 46, and 19. A review of unplanned discharges for the previous 30 days was conducted and no other issues were found. Unplanned discharges will be reviewed by the Cardinal IDT. The Social worker will keep a log to indicate that proper notifications to the Resident representative and the Ombudsman was done. She will report her findings in the daily meeting as necessary. The Cardinal IDT will review the SS logs weekly to ensure and oversee compliance. Results of non- compliance will be immediately corrected and Reported to the facility QAPI committee monthly,	7/2/19

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 06/07/2019

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 623	Continued From page 38 completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally 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 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 §	F 623		

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 06/07/2019

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 623	Continued From page 39 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to evidence that the Ombudsman and/or resident representative was provided the required written notification of a hospital transfer for nine of 33 residents in the survey sample; Residents #41, #22, #25, #13, #15, #43, #49, #46, and #19. The findings include: 1. The facility staff failed to evidence the required written notification of a hospital transfer was provided to the resident representative when Resident #41 was transferred to the hospital on 4/16/19. Resident #41 was admitted to the facility on 7/10/18 with the diagnoses of but not limited to, acute respiratory failure, diabetes, high blood pressure, anxiety disorder, breast cancer, bladder disorder, atrial fibrillation, congestive heart failure, chronic obstructive pulmonary disease, and osteoporosis. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 5/3/19. The resident was coded as being moderately impaired in ability to make daily life decisions. A review of the clinical record revealed the following nurses note: 4/16/19 at 3:39 PM: "Therapy alerted writer that resident was c/o (complaining of) stabbing pain in left arm and o2 [oxygen] sats [saturations] were in the 80's on O2	F 623		

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 06/07/2019

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 623	Continued From page 40 @ (at) 3L/M (three liters per minute). Writer in to assess resident. Resident continues to c/o sharp pain in left arm, non-radiating. C/o SOB (shortness of breath). O2 sats 90% on O2@3L/M. Resident slow to respond to writers questions. Speech slurred at times. B/P (blood pressure) 130/64, HR (heart rate) 134, RR (respiratory rate) 22. (Name of Nurse Practitioner) made aware and orders received to send to ER (emergency room) for further evaluation. Bed hold policy placed in paperwork and sent with resident. Resident is her own RR (responsible representative) and aware." Further review failed to reveal any evidence that written notification of the hospital transfer was provided to the resident representative. On 6/06/19 at 7:22 PM, in an interview with OSM #4 (Other Staff Member, the social worker) OSM #4 stated, "I do not send a written letter (to the family)." She stated that she sends written notification to the Ombudsman every week of the recent transfers and discharges. A review of the facility policy, "Transfer and Discharge" documented, "The facility will permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless: a) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;....The facility will have documentation in the resident's medical record that the above situations have occurred. The resident's attending physician will provide documentation that situations discussed in "a" or "b" have occurred....Before a facility transfers or discharges a resident, the facility will: *Notify the resident and, if known, a family member or legal	F 623		

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 06/07/2019

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 623	Continued From page 41 representative of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. *Record the reason(s) in the resident's clinical record." The policy did not include any criteria for the required components of the written notification of the Ombudsman. On 6/6/19 at 7:43 PM, ASM #1 (Administrative Staff Member - the Administrator), ASM #2 (the Director of Nursing) and ASM #4 (Facility Nurse Consultant) were notified of the concerns. No further information was provided by the end of the survey. (1) Tylenol - is used to treat mild to moderate pain and reduce fever. Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html 2. The facility staff failed to evidence the required written notification of a hospital transfer was provided to the resident representative and the Ombudsman when the Resident #22 was transferred to the hospital on 3/11/19. In addition, failed to ensure that the resident representative was provided written notification when the resident was transferred to the hospital on 4/29/19. Resident #22 was admitted to the facility on 11/23/12 with the diagnoses of but not limited to dementia, atrial fibrillation, diabetes, chronic kidney disease, Alzheimer's disease, and psychotic disorder. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of	F 623		

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 06/07/2019

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 623	Continued From page 42 6/3/19. The resident was coded as being severely cognitively impaired in ability to make daily life decisions. A review of the clinical record revealed a nurse's note dated 3/11/19 at 9:15 a.m., that documented Resident #22 was sent to the hospital after a fall from the wheelchair for evaluation. The note documented in part, "NP (nurse practitioner) was notified and gave order to send to ER (emergency room) for eval (evaluation) and treat. RR (resident representative) made aware. Resident left facility at 0900 (9:00 AM) via (county rescue squad)." A nurse's note dated 3/11/19 at 9:32 AM, documented, "Copy of bed hold policy sent with resident." Further review of the clinical record failed to reveal evidence that the resident representative and Ombudsman were provided with written documentation of the hospital transfer. Further review of the clinical record revealed a nurse's note dated, 4/29/19 at 1:32 p.m., that documented the resident was sent to the hospital for evaluation. The note documented in part the following: "Writer called NP (nurse practitioner) a0915 (sic) (at 9:15 a.m.) and was given an order to send to ER (emergency room). 0920 (9:20 AM) (county) rescue notified. 0925 (9:25 AM) left message for RR (resident representative) to call facility. 0940 (9:40 AM) Rescue squad arrived. 0945 (9:45 AM) Resident left facility via stretcher and 2 attendants. Attempted to call report to ER and no answer. 1240 (12:40 PM) RR (resident representative) made aware of above." Further review of the clinical record failed to reveal evidence that the resident representative	F 623		

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 06/07/2019

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 623	Continued From page 43 was provided with written documentation of the hospital transfer. On 6/06/19 at 7:22 PM, in an interview with OSM #4 (Other Staff Member, the social worker) OSM #4 stated, "I do not send a written letter (to the family)." She stated that she sends written notification to the Ombudsman every week of the recent transfers and discharges. On 6/07/19 at 7:50 AM, in a follow up interview with OSM #4, she stated that for Resident #22 the Ombudsman was not notified of the 3/11/19 transfer because the resident was a transfer to the emergency room and back, and was not admitted to the hospital. She provided evidence that she sent the Ombudsman notification on this morning, 6/7/19, approximately 3 months after the hospital transfer. On 6/6/19 at 7:43 PM, ASM #1 (Administrative Staff Member - the Administrator), ASM #2 (the Director of Nursing) and ASM #4 (Facility Nurse Consultant) were notified of the concerns. No further information was provided by the end of the survey. 3. The facility staff failed to evidence the required written notification of a hospital transfer was provided to the resident representative and Ombudsman when Resident #25 was transferred to the hospital on 3/24/19. Resident #25 was admitted to the facility on 7/30/18, with the diagnoses of but not limited to, congestive heart failure, dementia, depression, and osteoarthritis. The most recent MDS	F 623		

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 06/07/2019

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 623	Continued From page 44 (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 5/26/19. The resident was coded as moderately impaired in ability to make daily life decisions. A review of the clinical record revealed a nurse's note on 5/26/19 that documented Resident #25 was sent to the hospital for shortness of breath. The note documented in part the following: "Order to send to ER (emergency room) for evaluation. RP agreeable. Call made to have res, transferred to (name of hospital) (name of town). Res. picked up at 1520 (3:20 PM) via (county) rescue squad." Further review failed to reveal any evidence of that the resident representative and Ombudsman were provided with written documentation of the hospital transfer. On 6/06/19 at 7:22 PM, in an interview with OSM #4 (Other Staff Member, the social worker) OSM #4 stated, "I do not send a written letter (to the family)." She stated that she sends written notification to the Ombudsman every week of the recent transfers and discharges. On 6/07/19 at 7:50 AM, in a follow up interview with OSM #4, she stated that for Resident #25 the Ombudsman was not notified of the 3/24/19 transfer because the resident was a transfer to the emergency room and back, and was not admitted to the hospital. She provided evidence that she sent the Ombudsman notification on this morning, 6/7/19, approximately two and a half months after the hospital transfer. On 6/6/19 at 7:43 PM, ASM #1 (Administrative Staff Member - the Administrator), ASM #2 (the	F 623		

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 06/07/2019

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 623	Continued From page 45 Director of Nursing) and ASM #4 (Facility Nurse Consultant) were notified of the concerns. No further information was provided by the end of the survey. (1) BNP - Brain natriuretic peptide (BNP) test is a blood test that measures levels of a protein called BPN that is made by your heart and blood vessels. BNP levels are higher than normal when you have heart failure. Information obtained from https://medlineplus.gov/ency/article/007509.htm (2) Lasix - is a diuretic used to treat high blood pressure by reducing the excess water in the body. Information obtained from https://medlineplus.gov/druginfo/meds/a682858.html (3) Levaquin - is an antibiotic. Information obtained from https://medlineplus.gov/druginfo/meds/a697040.html 4. The facility staff failed to evidence the required written notification of a hospital transfer was provided to the resident representative when Resident #13 was transferred to the hospital on 2/15/19. Resident #13 was admitted on 2/6/15 with the diagnoses of atrial fibrillation, hypothyroidism, depression, chronic obstructive pulmonary disease, anxiety disorder, intestinal obstruction, hemiplegia, respiratory failure, and neurogenic bladder. The most recent MDS (Minimum Data Set) was a significant change assessment with an	F 623		

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 06/07/2019

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 623	Continued From page 46 ARD (Assessment Reference Date) of 3/22/19. The resident was coded as moderately impaired in ability to make daily life decisions. A review of the clinical record revealed a nurse note dated 2/15/19 at 9:00 a.m., that documented the resident was sent to the hospital for evaluation after vomiting. The note documented in part the following: "FNP (Family Nurse Practitioner) notified and order received to send to ER (emergency room) for eval (evaluation) and treatment. Left message for RR. Bed Hold policy sent with paperwork to ER." Further review of the clinical record failed to reveal evidence that the resident representative was provided with written documentation of the hospital transfer. On 6/06/19 at 7:22 PM, in an interview with OSM #4 (Other Staff Member, the social worker) OSM #4 stated, "I do not send a written letter (to the family)." She stated that she sends written notification to the Ombudsman every week of the recent transfers and discharges. On 6/6/19 at 7:43 PM, ASM #1 (Administrative Staff Member - the Administrator), ASM #2 (the Director of Nursing) and ASM #4 (Facility Nurse Consultant) were notified of the concerns. No further information was provided by the end of the survey. (1) Zofran - is used to prevent nausea and vomiting. Information obtained from https://medlineplus.gov/druginfo/meds/a601209.html	F 623		

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 06/07/2019

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 623	Continued From page 47 (2) Phenergan - is used to prevent and control nausea and vomiting. Information obtained from https://medlineplus.gov/druginfo/meds/a682284.html 5. The facility staff failed to provide Resident #15's representative with the required written notification of why the resident was sent to the hospital on 4/11/19. Resident #15 was admitted to the facility on 12/2/13 with the diagnoses of but not limited to dementia, with behavioral disturbances, anxiety disorder, Huntington's disease (1) and history of falling. The most recent MDS (Minimum Data Set), a Quarterly Medicare assessment, with an ARD (Assessment reference date) of 4/3/19, coded the resident per staff assessment as having short-term memory problems, long-term memory problems, and severe impairment of daily decision-making. The resident required total care for hygiene, bathing, dressing, toileting, transfers, and eating; and was always incontinent of bladder and bowel. A review of the clinical record revealed a nurse's noted dated 4/11/19 at 02:21 AM, that documented in part, "...observed resident on mat beside bed. no apparent injury found...Will send to ER for evaluation and treatment ..." Further review of the clinical record failed to reveal evidence of the required written notification being provided to Resident #15's Resident Representative for Resident #15's transfer to the hospital on 4/11/19. An interview was conducted with LPN (licensed	F 623		

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 06/07/2019

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 623	Continued From page 48 practical nurse) #5 on 6/5/19 at 2:37 p.m. When asked do you give the resident or resident representative anything in writing as to why the resident was sent to the hospital, LPN #5 stated, "Usually we call them and tell them why they are going." An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 6/5/19 at 2:47 p.m. When asked if the facility provides the resident and/or resident representative anything in writing to explain why they have gone to the hospital, ASM #2 stated, "Not in writing, we explain to them when we call them to let them know they are going." When asked who notifies the ombudsman, ASM #2 stated, "The social worker. If she is here the day they go out she sends it, but if it happens over the weekend, she sends it Monday morning." On 6/7/19 at 11:48 AM, ASM (Administrative Staff Member) #1, the Administrator, was made aware of the findings. No further information was provided by the end of the survey. (1) Huntington's disease: is an inherited disease that causes certain nerve cells in the brain to waste away. People are born with the defective gene, but symptoms usually don't appear until middle age. Early symptoms of HD may include uncontrolled movements, clumsiness, and balance problems. Later, HD can take away the ability to walk, talk, and swallow. Some people stop recognizing family members. Others are aware of their environment and are able to express emotions. This information was obtained from the following website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=	F 623		

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 06/07/2019

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 623	Continued From page 49 medlineplus-bundle&query=huntington%27s+disease&_ga=2.114498181.349992197.1560176578-904618792.1557758561 6. The facility staff failed to provide Resident #43's representative with the required written notification of why the resident was sent to the hospital on 4/12/19, 5/5/19, and 5/6/19. Resident #43 was admitted to the facility on 2/22/19 with the diagnoses of but not limited to dementia with behavioral disturbances, Alzheimer's disease, chronic kidney disease, and high blood pressure. The most recent MDS (Minimum Data Set), a Quarterly Medicare assessment, with an ARD (Assessment reference date) of 5/6/19, coded the resident per staff assessment as having short-term memory problems, long-term memory problems, and moderate impairment of daily decision-making. A review of the clinical record revealed a nurse's noted dated 4/12/19 at 10:15 AM, documented in part, " CNA (Certified nursing assistant) reported to nurse that resident had fallen. Upon entering room resident noted sitting on floor in front of bed ...FNP (Family Nurse Practitioner) notified and order received to send to ER (Emergency Room) for eval and treatment. RR (Resident Representative) aware and bed hold policy given to RR (resident representative) in facility." A review of the clinical record revealed a nurse's noted dated 5/5/19 at 7:10 AM, documented in part, "Called to room due to resident vomiting ...called FNP and order received to send to ER for eval and treatment ..."	F 623		

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 06/07/2019

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 623	Continued From page 50 A review of the clinical record revealed a nurse's noted dated 5/6/19 at 4:58 PM, documented in part, "Resident with inspiratory expiratory wheeze ...called (name of) NP new order send to ER for evaluation." Further review of the clinical record failed to reveal evidence of the required written notification being provided to Resident #43's Resident Representative regarding transfers on 4/12/19, 5/5/19, and 5/6/19. An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 6/5/19 at 2:47 p.m. When asked if the facility provides the resident and/or resident representative anything in writing to explain why they have gone to the hospital, ASM #2 stated, "Not in writing, we explain to them when we call them to let them know they are going." When asked who notifies the ombudsman, ASM #2 stated, "The social worker. If she is here the day they go out she sends it, but if it happens over the weekend, she sends it Monday morning." On 6/7/19 at 11:48 AM, ASM (Administrative Staff Member) #1, the Administrator, was made aware of the findings. No further information was provided by the end of the survey. 7. The facility staff failed to provide Resident #49's representative with the required written notification of why the resident was sent to the hospital on 5/12/19. Resident #49 was admitted to the facility on 4/23/19 with the diagnoses of but not limited to type 2 diabetes mellitus, high blood pressure,	F 623		

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 06/07/2019

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 623	Continued From page 51	F 623		

heart failure, chronic obstructive pulmonary disease (1), obstructive and reflux uropathy (2), and retention of urine. The most recent MDS (Minimum Data Set), a 14-day Medicare assessment, with an ARD (Assessment reference date) of 5/28/19, coded the resident as scoring a 6 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had severe cognitive impairment for daily decision making.

A review of the clinical record revealed a nurse's note dated 5/12/19 at 9:16 PM, documented in part, "No acute changes. (Name of) NP (Nurse Practitioner) aware of resident's complaints of chest pain and gave order to transport to ER (Emergency room) ..."

Further review of the clinical record failed to reveal evidence of the required written notification being provided to Resident #49's Resident Representative regarding transfers on 5/12/19.

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 6/5/19 at 2:47 p.m. When asked if the facility provides the resident and/or resident representative anything in writing to explain why they have gone to the hospital, ASM #2 stated, "Not in writing, we explain to them when we call them to let them know they are going." When asked who notifies the ombudsman, ASM #2 stated, "The social worker. If she is here the day they go out she sends it, but if it happens over the weekend, she sends it Monday morning."

On 6/7/19 at 11:48 AM, ASM (Administrative Staff Member) #1, the Administrator, was made aware of the findings. No further information was

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 06/07/2019

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 623	Continued From page 52 provided by the end of the survey. (1) Chronic obstructive pulmonary disease: Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. (2) Obstructive and reflux uropathy: Obstructive uropathy is a condition in which the flow of urine is blocked. This causes the urine to back up and injure one or both kidneys. This information was obtained from the website: https://medlineplus.gov/ency/article/000507.htm 8. The facility staff failed to provide Resident #46's representative with the required written notification of why the resident was sent to the hospital on 5/28/19. Resident #46 was admitted to the facility on9/18/17 with the diagnoses of but not limited to high blood pressure, heart attack, heart failure, chronic obstructive pulmonary disease (1), and asthma. The most recent MDS (Minimum Data Set), a five-day Medicare assessment, with an ARD (Assessment reference date) of 5/17/19, coded the resident as scoring a 13 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had no cognitive impairment for daily decision making. A review of the clinical record revealed a nurse's note dated 5/28/19 at 8:44 AM, documented in part, " ...order received from FNP (Family Nurse Practitioner) to send to ER (Emergency room) for eval and treatment ..."	F 623		

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 06/07/2019

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 623	Continued From page 53 A review of the clinical record revealed a physician's note dated 5/20/19 at 8:45 PM, documented in part, " ...She was hospitalized at (name of) Hospital 5/28/19 - 6/3/19 for abdominal pain ..." Further review of the clinical record failed to reveal evidence of the required written notification being provided to the Resident #46's Resident Representative regarding the transfer to the hospital on 5/28/19. An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 6/5/19 at 2:47 p.m. When asked if the facility provides the resident and/or resident representative anything in writing to explain why they have gone to the hospital, ASM #2 stated, "Not in writing, we explain to them when we call them to let them know they are going." When asked who notifies the ombudsman, ASM #2 stated, "The social worker. If she is here the day they go out she sends it, but if it happens over the weekend, she sends it Monday morning." On 6/7/19 at 11:48 AM, ASM (Administrative Staff Member) #1, the Administrator, was made aware of the findings. No further information was provided by the end of the survey. (1) Chronic obstructive pulmonary disease: Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. 9. The facility staff failed to provide the resident and/or the resident representative with a written notification as to the reason the resident was transferred to the hospital on 3/7/19 for Resident	F 623		

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 06/07/2019

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 623	Continued From page 54 #19. Resident #19 was admitted to the facility on 1/5/17 with a recent readmission on 3/11/19 with diagnoses that included but were not limited to: diabetes, high blood pressure, stroke, history of falls and anemia (condition in which the hemoglobin content of the blood is below normal limits) (1). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/28/19, coded the resident as scoring a "4" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. The nurse's note dated, 3/7/19 at 10:45 a.m. documented in part, "Hearing resident call out, observed resident on floor laying on his right side beside his bed. He tells nurse that he was trying to stand from wheelchair. Nursing assessment completed...Neurological assessment, tells nurse he did not hit his head. Resident complains of pain in right abdomen rating 9 on the pain scale of 1-10 and complains of shoulder pain. NP (nurse practitioner) made aware with orders to send to ER (emergency room) for evaluation. ...RR (resident representative) made aware, report called to ER at (name of hospital)." The physician's order dated 3/7/19 documented, "Send to ER for eval (evaluation), S/P (status post fall)." An interview was conducted with LPN (licensed practical nurse) #5 on 6/5/19 at 2:37 p.m. When asked if she or anyone in the facility provides	F 623		

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 06/07/2019

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 623	Continued From page 55 written notification to the resident and/or resident representative of the reason why the resident is going to the hospital, LPN #5 stated, "No, we usually call then and tell them why they are going and document it in the clinical record." An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 6/5/19 at 2:47 p.m. When asked if you give the resident and/or the RR anything in writing as to why they went to the hospital, ASM #2 stated, "Not in writing, we explain to them on the phone when we call them." Administrative staff member (ASM) #1, ASM #2 and ASM #4, the facility-nursing consultant, were made aware of the above findings on 6/6/19 at 7:35 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 33.	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §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	F 625		

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 06/07/2019

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 625	Continued From page 56 facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies 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, facility document review, and clinical record review, it was determined that the facility staff failed to evidence that a written bed hold notice was provided to the resident and/or resident representative in a timely manner for seven of 33 residents in the survey sample; Residents #41, #22, #13, #15, #43, #49, and #46. The findings include: 1. The facility staff failed to evidence that a bed hold notice was provided to the resident representative when Resident #41 was transferred to the hospital on 4/29/19. Resident #41 was admitted to the facility on 7/10/18 with the diagnoses of but not limited to, acute respiratory failure, diabetes, high blood	F 625	F-625 Notification of our bed Hold policy was provided to Resident #' 41, 22, 13, 15, 43, 49, and 46 and also to their Resident Representative. A review of unplanned discharges for the previous 30 days was conducted and no issues were found. Licensed Nursing Staff will be in-serviced on the Bed hold Policy and the requirement that it be included in the transfer packet. The Cardinal IDT members will review unplanned discharges in its morning meeting to ensure compliance. The Social worker will maintain a log that verifies and ensures that the Resident and Resident Representative received proper notification of the Bed Hold Policy. The unplanned Discharges log will be reviewed weekly for compliance with proper notifications and results of the reviews submitted to the facility's QAPI Committee at its monthly meeting.	7/2/19

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 06/07/2019

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 625	Continued From page 57 pressure, anxiety disorder, breast cancer, bladder disorder, atrial fibrillation, congestive heart failure, chronic obstructive pulmonary disease, and osteoporosis. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 5/3/19. The resident was coded as being moderately impaired in ability to make daily life decisions. A review of the clinical record revealed the following nurses note: 4/16/19 at 3:39 PM: "Therapy alerted writer that resident was c/o (complaining of) stabbing pain in left arm and o2 [oxygen] sats [saturations] were in the 80's on O2 @ (at) 3L/M (three liters per minute). Writer in to assess resident. Resident continues to c/o sharp pain in left arm, non-radiating. C/o SOB (shortness of breath). O2 sats 90% on O2@3L/M. Resident slow to respond to writers questions. Speech slurred at times. B/P (blood pressure) 130/64, HR (heart rate) 134, RR (respiratory rate) 22. (Name of Nurse Practitioner) made aware and orders received to send to ER (emergency room) for further evaluation. Bed hold policy placed in paperwork and sent with resident. Resident is her own RR (responsible representative) and aware." Further review of the clinical record failed to reveal evidence that the resident representative was provided with the written bed hold notification. An interview was conducted with LPN (licensed practical nurse) #5 on 6/5/19 at 2:37 p.m., regarding the facility process for bed hold when a resident is sent to the hospital. When asked where do you document what was sent to the	F 625		

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 06/07/2019

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 625	Continued From page 58 hospital, LPN #5 stated, "We write a note about the bed hold." A review of the facility policy, "Transfer and Discharge" revealed the policy did not include any criteria for the provision of a written bed hold policy. On 6/6/19 at 7:43 PM, ASM #1 (Administrative Staff Member - the Administrator), ASM #2 (the Director of Nursing) and ASM #4 (Facility Nurse Consultant) were notified of the concerns. No further information was provided by the end of the survey. 2. The facility staff failed to evidence that a bed hold notice was provided to the resident representative when Resident #25 was transferred to the hospital on 3/24/19. Resident #25 was admitted to the facility on 7/30/18, with the diagnoses of but not limited to, congestive heart failure, dementia, depression, and osteoarthritis. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 5/26/19. The resident was coded as moderately impaired in ability to make daily life decisions. A review of the clinical record revealed a nurse's note on 5/26/19 that documented Resident #25 was sent to the hospital for shortness of breath. The note documented in part the following: "Order to send to ER (emergency room) for evaluation. RP agreeable. Call made to have res, transferred to (name of hospital) (name of town). Res. picked up at 1520 (3:20 PM) via (county) rescue squad."	F 625		

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 06/07/2019

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 625	Continued From page 59 Further review of the clinical record failed to reveal evidence that the resident representative was provided with the written bed hold notification. An interview was conducted with LPN (licensed practical nurse) #5 on 6/5/19 at 2:37 p.m., regarding the facility process for bed hold when a resident is sent to the hospital. When asked where do you document what was sent to the hospital, LPN #5 stated, "We write a note about the bed hold." On 6/6/19 at 7:43 PM, ASM #1 (Administrative Staff Member - the Administrator), ASM #2 (the Director of Nursing) and ASM #4 (Facility Nurse Consultant) were notified of the concerns. No further information was provided by the end of the survey. (1) BNP - Brain natriuretic peptide (BNP) test is a blood test that measures levels of a protein called BPN that is made by your heart and blood vessels. BNP levels are higher than normal when you have heart failure. Information obtained from https://medlineplus.gov/ency/article/007509.htm (2) Lasix - is a diuretic used to treat high blood pressure by reducing the excess water in the body. Information obtained from https://medlineplus.gov/druginfo/meds/a682858.html (3) Levaquin - is an antibiotic. Information obtained from https://medlineplus.gov/druginfo/meds/a697040.h	F 625		

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 06/07/2019

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 625	Continued From page 60 tml 3. The facility staff failed to evidence that a bed hold notice was provided to the resident representative when Resident #13 was transferred to the hospital on 2/15/19. Resident #13 was admitted on 2/6/15 with the diagnoses of atrial fibrillation, hypothyroidism, depression, chronic obstructive pulmonary disease, anxiety disorder, intestinal obstruction, hemiplegia, respiratory failure, and neurogenic bladder. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 3/22/19. The resident was coded as moderately impaired in ability to make daily life decisions. A review of the clinical record revealed a nurse note dated 2/15/19 at 9:00 a.m., that documented the resident was sent to the hospital for evaluation after vomiting. The note documented in part the following: "FNP (Family Nurse Practitioner) notified and order received to send to ER (emergency room) for eval (evaluation) and treatment. Left message for RR. Bed Hold policy sent with paperwork to ER." Further review of the clinical record failed to reveal evidence that the resident representative was provided with the written bed hold notification within the required 24-hour time frame of the hospital transfer. The note documenting the bed hold notice being provided was 7 days after the resident was transferred. An interview was conducted with LPN (licensed practical nurse) #5 on 6/5/19 at 2:37 p.m.,	F 625		

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 06/07/2019

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 625	Continued From page 61 regarding the facility process for bed hold when a resident is sent to the hospital. When asked where do you document what was sent to the hospital, LPN #5 stated, "We write a note about the bed hold." On 6/6/19 at 7:43 PM, ASM #1 (Administrative Staff Member - the Administrator), ASM #2 (the Director of Nursing) and ASM #4 (Facility Nurse Consultant) were notified of the concerns. No further information was provided by the end of the survey. (1) Zofran - is used to prevent nausea and vomiting. Information obtained from https://medlineplus.gov/druginfo/meds/a601209.html (2) Phenergan - is used to prevent and control nausea and vomiting. Information obtained from https://medlineplus.gov/druginfo/meds/a682284.html 4. The facility staff failed to provide Resident #15's representative written notification of the bed hold policy within the required timeframe when the resident was transferred to the hospital on 4/11/19. Resident #15 was admitted to the facility on 12/2/13 with the diagnoses of but not limited to dementia, with behavioral disturbances, anxiety disorder, Huntington's disease (1) and history of falling. The most recent MDS (Minimum Data Set), a Quarterly Medicare assessment, with an ARD (Assessment reference date) of 4/3/19,	F 625		

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 06/07/2019

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 625	Continued From page 62 coded the resident per staff assessment as having short-term memory problems, long-term memory problems, and severe impairment of daily decision-making. A review of the clinical record revealed a nurse's noted dated 4/11/19 at 02:21 AM, that documented in part, "...observed resident on mat beside bed. no apparent injury found...Will send to ER for evaluation and treatment ..." Further review of the clinical record failed to reveal evidence of the required written notification of the bed hold policy within the required timeframe when the resident was transferred to the hospital on 4/11/19. An interview was conducted with LPN (licensed practical nurse) #5 on 6/5/19 at 2:37 p.m., regarding the facility process for bed hold when a resident is sent to the hospital. When asked where do you document what was sent to the hospital, LPN #5 stated, "We write a note about the bed hold." On 6/7/19 at 11:48 AM, ASM (Administrative Staff Member) #1, the Administrator, was made aware of the findings. No further information was provided by the end of the survey. (1) Huntington's disease: is an inherited disease that causes certain nerve cells in the brain to waste away. People are born with the defective gene, but symptoms usually don't appear until middle age. Early symptoms of HD may include uncontrolled movements, clumsiness, and balance problems. Later, HD can take away the ability to walk, talk, and swallow. Some people stop recognizing family members. Others are	F 625		

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 06/07/2019

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 625	Continued From page 63 aware of their environment and are able to express emotions. This information was obtained from the following website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=huntington%27s+disease&_ga=2.114498181.349992197.1560176578-904618792.1557758561 5. The facility staff failed to provide Resident #43's representative written notification of the bed hold policy within the required timeframe when the resident was transferred to the hospital on 5/5/19, and 5/6/19. Resident #43 was admitted to the facility on 2/22/19 with the diagnoses of but not limited to dementia with behavioral disturbances, Alzheimer's disease, chronic kidney disease, and high blood pressure. The most recent MDS (Minimum Data Set), a Quarterly Medicare assessment, with an ARD (Assessment reference date) of 5/6/19, coded the resident per staff assessment as having short-term memory problems, long-term memory problems, and moderate impairment of daily decision-making. A review of the clinical record revealed a nurse's noted dated 5/5/19 at 7:10 AM, documented in part, "Called to room due to resident vomiting ...called FNP (family nurse practitioner) and order received to send to ER (emergency room) for eval (evaluation) and treatment ..." A review of the clinical record revealed a nurse's noted dated 5/6/19 at 4:58 PM, documented in part, "Resident with inspiratory expiratory wheeze	F 625		

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 06/07/2019

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 625	Continued From page 64 ...called (name of) NP new order send to ER [emergency room] for evaluation." Further review of the clinical record failed to reveal evidence of the required written notification of the bed hold policy within the required timeframe for Resident #43's transfers on 5/5/19, and 5/6/19. An interview was conducted with LPN (licensed practical nurse) #5 on 6/5/19 at 2:37 p.m., regarding the facility process for bed hold when a resident is sent to the hospital. When asked where do you document what was sent to the hospital, LPN #5 stated, "We write a note about the bed hold." On 6/7/19 at 11:48 AM, ASM (Administrative Staff Member) #1, the Administrator, was made aware of the findings. No further information was provided by the end of the survey. 6. The facility staff failed to provide Resident #49's representative written notification of the bed hold policy within the required timeframe when the resident was transferred to the hospital on 5/12/19. Resident #49 was admitted to the facility on 4/23/19 with the diagnoses of but not limited to type 2 diabetes mellitus, high blood pressure, heart failure, chronic obstructive pulmonary disease (1), obstructive and reflux uropathy (2), and retention of urine. The most recent MDS (Minimum Data Set), a 14-day Medicare assessment, with an ARD (Assessment reference date) of 5/28/19, coded the resident as scoring a 6 out of 15 on the BIMS (Brief Interview for	F 625		

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 06/07/2019

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 625	Continued From page 65 Mental Status) score, indicating the Resident had severe cognitive impairment for daily decision making. A review of the clinical record revealed a nurse's note dated 5/12/19 at 9:16 PM, documented in part, "No acute changes. (Name of) NP (Nurse Practitioner) aware of resident's complaints of chest pain and gave order to transport to ER (Emergency room) ..." Further review of the clinical record failed to reveal evidence of the required written notification of the bed hold policy within the required timeframe for Resident #49's transfers on 5/12/19. An interview was conducted with LPN (licensed practical nurse) #5 on 6/5/19 at 2:37 p.m., regarding the facility process for bed hold when a resident is sent to the hospital. When asked where do you document what was sent to the hospital, LPN #5 stated, "We write a note about the bed hold." On 6/7/19 at 11:48 AM, ASM (Administrative Staff Member) #1, the Administrator, was made aware of the findings. No further information was provided by the end of the survey. (1) Chronic obstructive pulmonary disease: Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. (2) Obstructive and reflux uropathy: Obstructive uropathy is a condition in which the flow of urine is blocked. This causes the urine to back up and	F 625		

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 06/07/2019

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 625	Continued From page 66 injure one or both kidneys. This information was obtained from the website: https://medlineplus.gov/ency/article/000507.htm 7. The facility staff failed to provide Resident #46's representative written notification of the bed hold policy when the resident was transferred to the hospital on 5/28/19. Resident #46 was admitted to the facility on9/18/17 with the diagnoses of but not limited to high blood pressure, heart attack, heart failure, chronic obstructive pulmonary disease (1), and asthma. The most recent MDS (Minimum Data Set), a five-day Medicare assessment, with an ARD (Assessment reference date) of 5/17/19, coded the resident as scoring a 13 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had no cognitive impairment for daily decision making. A review of the clinical record revealed a nurse's note dated 5/28/19 at 8:44 AM, documented in part, " ...order received from FNP (Family Nurse Practitioner) to send to ER (Emergency room) for eval and treatment ..." Further review of the clinical record failed to reveal evidence of the required written notification of the bed hold policy within the required timeframe of Resident #46's transfer to the hospital on 5/28/19. An interview was conducted with LPN (licensed practical nurse) #5 on 6/5/19 at 2:37 p.m., regarding the facility process for bed hold when a resident is sent to the hospital. When asked	F 625		

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 06/07/2019

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 625	Continued From page 67 where do you document what was sent to the hospital, LPN #5 stated, "We write a note about the bed hold." On 6/7/19 at 11:48 AM, ASM (Administrative Staff Member) #1, the Administrator, was made aware of the findings. No further information was provided by the end of the survey. (1) Chronic obstructive pulmonary disease: Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview facility document review and clinical record review, it was determined the facility staff failed to ensure a complete and accurate MDS (minimum data set) assessment for one of 33 residents in the survey sample, Resident #27. The findings include: The facility staff failed to accurately code Section C of the quarterly assessment with an ARD (assessment reference date) of 4/29/19, the annual assessment with an ARD of 1/28/19 and the quarterly assessment with an ARD of 10/31/18 for Resident #27.	F 641		

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

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 06/07/2019

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 641	Continued From page 68 Resident #27 was admitted to the facility on 1/31/04 with diagnoses that included but were not limited to: stroke, depression, high blood pressure and Parkinson's Disease (a slowly progressive neurological disorder characterized by resting tremor, shuffling gait, stooped posture, rolling motions of the fingers, drooling and muscle weakness, sometimes with emotional instability) (1). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD of 4/29/19, coded the resident in Section B - Hearing, Speech and Vision as sometimes making himself understood and usually understanding others. In Section C - Cognitive Patterns, the resident interview was not completed. The staff interview was completed. The resident was coded as having both short and long-term memory difficulties and was coded as having modified independence in making daily cognitive decisions, some difficulty in new situations only. The annual assessment, with an ARD of 1/28/19, coded the resident in Section B - Hearing, Speech and Vision as sometimes making himself understood and usually understanding others. In Section C - Cognitive Patterns, the resident interview was not completed. The staff interview was completed. The resident was coded as having both short and long-term memory difficulties and was coded as having modified independence in making daily cognitive decisions, some difficulty in new situations only. The quarterly assessment, with an ARD of 10/31/19, coded the resident in Section B -	F 641	F-641 The MDS for Resident #27 was corrected and updated during the survey. No other assessments in Section C were found to be incorrect. An in-service training for the Social Worker was conducted by the Facility MDS nurse to educate the SS on the proper coding for Section C of the MDS. The MDS nurse will oversee the coding efforts of the Social Worker to ensure that the coding is accurate and complete. Any non-compliance will result in further education and training.	7/21/19

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 06/07/2019

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 641	Continued From page 69 Hearing, Speech and Vision as sometimes making himself understood and usually understanding others. In Section C - Cognitive Patterns, the resident interview was not completed. The staff interview was completed. The resident was coded as having both short and long-term memory difficulties and was coded as having modified independence in making daily cognitive decisions, some difficulty in new situations only. The instructions on the top of the page for Section C - Cognitive Patterns, documented, "Should Brief Interview for Mental Status be Conducted? Attempt to conduct interview with all residents. Code: 0. No (resident is rarely/never understood) - skip to and complete C0700-C1000, Staff Assessment for Mental Status. Code 1. Yes, Continue to C0200, Repetition of Three Words." The resident was coded on all three MDS assessments above as a Zero; resident is rarely/never understood. At the bottom of the Section it is documented, "C0500 - BIMS (brief interview for mental status) Score - Enter 99 if the resident was unable to complete the interview." An interview was conducted on 6/5/19 at 1:54 p.m. with RN (registered nurse) #1, the MDS coordinator. When asked who completes Section C of the MDS assessments, RN #1 stated the social worker. When asked who completes Section B, RN #1 stated that she did Section B. RN #1 was asked to review the above MDS assessment in Section B and Section C. RN #1 stated, "It (the interview) should have been completed. He is not rarely/never understood. An interview was conducted with OSM (other staff	F 641		

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 06/07/2019

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 641	Continued From page 70 member) #4, the social worker, on 6/5/19 at 2:01 p.m. When asked if she reads Section B prior to completing Section C, OSM #4 stated, "No, Ma'am." The above MDS assessments, Section C were reviewed with OSM #4. OSM #4 stated, "When I ask him the questions he only replies "bowlly ball." When asked which reference the facility uses to complete the MDS assessments, OSM #4 stated, "The RAI (resident assessment instrument) manual." The facility document, the RAI manual, documented in part, "Coding Instructions- Code 0, no: if the interview should not be attempted because the resident is rarely/never understood, cannot respond verbally or in writing; or an interpreter is needed but not available. Code1, yes: if the interview should be attempted because the resident is at least sometimes understood verbally or in writing, and if an interpreter is needed, one is available....If the interview is stopped, do the following: 1. Code -, dash in C0400A, C0400B, and C0400C. 2. Code 99 in the summary score in C0500. 3. Code 1, yes, in C0600 Should the Staff Assessment for Mental Status be Conducted? 4. Complete the Staff Assessment for Mental Status." Administrative staff member (ASM) #1, the administrator, and ASM #4, the facility nurse consultant, were made aware of the above findings on 6/6/19 at 7:45 a.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 437.	F 641		

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 06/07/2019

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 656 F 656 SS=E	Continued From page 71 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) 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)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial 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 physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate	F 656 F 656	F-656 Staff were in-serviced on the care plans for resident #s 33, 34, 44, 10, 49, 48, and 14.The education emphasized the need for care plan compliance for pain, oxygen, blood pressure medication, psychotropic medication, and antipsychotic medications. Results of further observations indicated no further care plan non-compliance. Nursing staff members will receive monthly in-services on the resident care plans to ensure continued compliance and also to be aware of any care plan updates or changes. The Director of Nursing or her designee will conduct weekly checks to determine that care plans are being followed. The results of the checks will be discussed in the Cardinal IDT meetings and results submitted to the facility QAPI committee.	7/21/19

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 06/07/2019

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 656	Continued From page 72 entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to implement the comprehensive care plan for seven of 33 residents in the survey sample, Residents # 33, #34, #44, #10, #49, #48, and #14. 1. The facility staff failed to implement the care plan for the treatment of high blood pressure for Resident #33. 2. The facility staff failed to implement the care plan for the use of psychotropic medications for Resident #34. 3. The facility staff failed to implement the care plan for pain for Resident #44. 4. For Resident #44 the facility staff failed to follow the comprehensive care plan for the administration of an antipsychotic medication. 5. The facility staff failed to implement the comprehensive care plan for the administration of oxygen for Resident #10. 6. The facility staff failed to implement the comprehensive care plan for the administration of oxygen for Resident #49. 7. The facility staff failed to implement the	F 656		

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 06/07/2019

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 656	Continued From page 73 comprehensive care plan for the administration of oxygen for Resident #48. 8. The facility staff failed to implement the comprehensive care plan for the use of psychotropic medication for Resident #14. The findings include: 1. The facility staff failed to implement the care plan for the treatment of high blood pressure for Resident #33. Resident #33 was admitted to the facility on 5/1/19 with diagnoses that included but were not limited to: dementia, high blood pressure, diabetes, stroke and COPD (chronic obstructive pulmonary disease - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (1). The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 5/8/19, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indication she is severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance to being dependent upon one staff member for all of her activities of daily living. The comprehensive care plan dated, 5/3/19, documented in part, "Focus: Hypertension (high blood pressure): at risk for complications of renal failure, arteriosclerotic disease and/or retinopathy." The "Interventions" documented in	F 656		

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 06/07/2019

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 656	Continued From page 74 part, "Monitor blood pressure per facility protocol and/or as ordered by physician." The physician order dated, 5/2/19 documented, "Metoprolol Tartrate (used to treat high blood pressure) (2), 25 mg (milligrams) 1/2 = 12.5 mg by mouth twice daily. Hold for SBP (systolic blood pressure) less than 100 or HR (heart rate) less than 50." The May MAR (medication administration record) documented the above medication. On the following dates and time, the following blood pressure/pulse was not documented prior to the administration of the medication: 5/8/19 at 9:00 a.m. - no pulse was documented 5/8/19 at 9:00 p.m. - no pulse was documented 5/10/19 at 9:00 a.m. - no pulse was documented 5/11/19 at 9:00 p.m. - no pulse was documented 5/12/19 at 9:00 p.m. - no pulse was documented 5/15/19 at 9:00 p.m. - no pulse was documented 5/16/19 at 9:00 p.m. - no pulse was documented 5/20/19 at 9:00 p.m. - no pulse was documented 5/21/19 at 9:00 p.m. - no pulse was documented 5/22/19 at 9:00 a.m. - no blood pressure or pulse was documented 5/22/19 at 9:00 p.m. - no pulse was documented 5/23/19 at 9:00 p.m. - no blood pressure or pulse was documented 5/24/19 at 9:00 p.m. - no pulse was documented 5/25/19 at 9:00 p.m. - no pulse was documented 5/26/19 at 9:00 a.m. - no pulse was documented 5/26/19 at 9:00 p.m. - no pulse or blood pressure was documented 5/28/19 at 9:00 p.m. - no blood pressure or pulse was documented 5/29/19 at 9:00 p.m. - no blood pressure or pulse was documented 5/30/19 at 9:00 a.m. - no pulse was documented	F 656		

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 06/07/2019

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 656	Continued From page 75 5/30/19 at 9:00 p.m. - no pulse or blood pressure was documented. Review of the nurse's notes for the above listed dates and times failed to evidence documentation of the missing blood pressure or pulse. Review of the vital signs tab in the computerized record, failed to evidence the missing pulse or blood pressure readings. An interview was conducted with LPN (licensed practical nurse) #2 on 6/5/19 at 3:29 p.m. LPN #2 was asked to read the above order for Metoprolol. When asked if a resident has that order, what is the nurse to do LPN #2 stated, "You have to take the blood pressure and pulse before giving it." When asked if you have to take both, LPN #2 stated, "I would think so since it asks for both." When asked if the care plan says to give medications as ordered, is that following the care plan, LPN #2 stated, "No." An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 6/5/19 at 3:36 p.m. Had ASM #2 read the above order. When asked what is the nurse supposed to do, ASM #2 stated, "Take the blood pressure and pulse." When asked why there is no documentation of a pulse or blood pressure on some days, ASM #2 stated, "Well the order does say 'or." .When asked if the care plan says to give medications as ordered, and it's not given as ordered, is that following the care plan, ASM #2 stated, "No, it's not." The facility policy, "Resident Care Plan" documented in part, "It is the policy of the facility to provide a written resident-centered care plan based upon physician's orders, and the	F 656		

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 06/07/2019

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 656	Continued From page 76 assessment of the resident needs and preferences...Development and implementation of the resident's care plan will occur by participating disciplines available in the facility at a team conference under the director of the RN (registered nurse) Coordinator." ASM #1, the administrator and ASM #4, the facility nurse consultant, were made aware of the above findings on 6/6/19 at 7:45 a.m. No further information was obtained prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682864.html. 2. The facility staff failed to implement the care plan for the use of psychotropic medications for Resident #34. Resident #34 was admitted to the facility on 10/17/17 with diagnoses that included but were not limited to: diabetes, dementia, depression, stroke, high blood pressure, and bradycardia (A slow heart beat lower than 60 in adults) (1). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/10/19, coded the resident as scoring "3" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. In Section E - Behaviors, the resident was not coded as having any behaviors	F 656		

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 06/07/2019

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 656	Continued From page 77 during the look back period and not indicators of psychosis. The comprehensive care plan dated, 10/22/18 documented in part, "Focus: Problematic manner in which resident acts characterized by ineffective coping; verbal/physical aggression or combativeness related to: anger." The "Interventions" documented in part, "Monitor and document behavior (physical behaviors) per facility protocol." The care plan further documented, "Focus: Problematic manner in which resident acts characterized by ineffective coping; Sleeplessness/insomnia related to: restlessness." The "Interventions" documented in part, "Administer medication. Monitor sleep pattern and quality of sleep/rest, document episodes, and notify physician of changes for possible interventions as appropriate." The care plan documented "Focus: Use of psychoactive drugs with the POTENTIAL FOR or characterized by SIDE EFFECTS of cardiac, neuromuscular, gastrointestinal systems AEB (as exhibited by) or/due to diagnoses of: antipsychotic, antidepressant (GDR [gradual dose reduction] antipsychotic 7/6/18.)" The "Interventions" documented, "Administer medications per physician's orders. Observe resident's mental status functioning on ongoing basis." The review of the clinical record from 12/1/18 through 6/6/19, failed to evidence any documentation related to any physical behavior or sleep patterns. The review of the nurse's notes from 12/1/19 through 6/6/19 documented the following behaviors: "1/25/19 at 2:40 p.m. - message left for RR	F 656		

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 06/07/2019

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 656	Continued From page 78 (resident representative) regarding condition of resident's feet. Ares remain dry continuing with the cream however he frequently refused to allow it to be put on. "2/2/19 at 10:45 p.m., Resident has short term memory loss. Wants to go to bed as soon as he eats supper. Staff has to remind him every night that we are in the middle of supper ad feeding other residents. Resident will say OK, then a few minutes later will be calling for help. Is saying he wants to go to bed. Wife brings him snack food and drinks from home, which he eats before supper. "2/13/19 at 2:51 p.m. Nurse called and spoke with RR about resident refusal with shaving. She stated that she had already brought razor up to facility, use what is here. "2/26/19 at 11:52 a.m. Resident flagging x 3days no BM (bowel movement). Nurse attempted to administer MOM (milk of magnesia) and resident stated, 'I'm not taking that.' Resident continues to refuse. "3/6/19 at 2:38 p.m. RR aware about refusal of taking MOM x3 day d/t (due to) no BM and refusal of shower. "3/7/19 at 6:20 a.m. Per CNA (certified nursing assistant) resident refused to be shaved this morning, writer offered to so still resident refused. "3/15/19 at 10:06 a.m. Flagging x3 days no BM. nurse attempted to administer MOM and resident refused. "3/30/19 at 8:41 a.m., Resident refused shower. "4/8/19 at 12:02 p.m. resident flagging for no BM x 3 days, would only accept half (15 ml [milliliters]) of MOM of 30 ml dose. "4/8/19 at 7:00 p.m. REFUSAL - resident refused to be lifted by CNA w/lift (with lift) under direct supervision. "4/18/19 at 2:08 p.m. resident flagging for no BM	F 656		

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 06/07/2019

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 656	Continued From page 79 x 3 days, resident only accepted 15 cc (cubic centimeters) MOM. "4/22/19 at 11:08 a.m., Resident flagged for no BM x3 days, resident refused to take MOM per protocol. "4/24/19 at 5:52 a.m. Resident flagging for no bowel movement in the past three days. Due to refusal of MOM. "5/15/19 at 5:51 a.m. Resident flagging for no BM x3 days, MOM refused. "5/17/19 at 10:29 a.m. Resident flagging for no BM x 3 days. MOM given but resident would only take apprx (approximately) 15 cc. The physician notes dated 11/26/18, documented in part, "Psych (psychiatric): he is pleasant and understand who I am as the doctor. No other documentation regarding his mood or behaviors. The physician note dated, 12/3/18, failed to evidence documentation related to mood or behaviors. The physician note dated, 4/1/19, failed to evidence any documentation related to mood or behaviors. The nurse practitioner note dated, 12/5/18, documented in part, "Past Medical History - depression. Review of Systems: Psychiatric - no increased nervousness or suicidal ideations. Physical Exam: Psychiatric: no increased nervousness or suicidal ideations. The nurse practitioner note dated, 2/22/19, documented in part, "Past Medical History - depression. Review of Systems: Psychiatric - no mood swings, increased nervousness or suicidal	F 656		

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 06/07/2019

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 656	Continued From page 80 ideations. Physical Exam: Psychiatric - Mood and affect pleasant, resident oriented to person and place. The nurse practitioner note dated, 5/30/19 documented in part, "His nurse reports resident compliance with his medication and diet.... (Resident #34) has depression. His nurse reports irritability, mood swings and decreased motivation. She reports he is compliant with his medication and cooperative with his care. He denies any suicidal ideations or homicidal ideations...Past Medical History - Depression. Review of Systems: Psychiatric: no changes in cognition or increased nervousness...Physical Exam: Psychiatric: Mood and affect flat; resident oriented to person and place. An interview was conducted with LPN (Licensed practical nurse) #2 on 6/5/19 at 5:43 p.m. When asked where behaviors are documented, LPN #2 stated, on the back of the MAR (medication administration record) and in the progress notes." When asked what Resident #34's targeted behaviors are for the use of Seroquel, LPN #2 stated, "When he first came he was on it but it's been cut back. His wife said he took it at home to help him sleep. Lately his behaviors are much improved." When asked when she would document a behavior, LPN #2 stated she's document it if she saw the resident having a behavior or something that is out of their norm." When asked if documenting behaviors and sleep patterns are on the care plan, is that following the care plan, LPN #2 stated, "I guess not because we don't usually document on sleep patterns, just document if they have problems sleeping." ASM #1, the administrator, ASM #2, the director	F 656		

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 06/07/2019

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 656	Continued From page 81 of nursing, and ASM #4, the facility nurse consultant were made aware of the above concern on 6/6/19 at 7:35 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 87. 3.a. The facility staff failed to implement the care plan for pain for Resident #44. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 5/16/19, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of one staff member for most of her activities of daily living. In Section J - Health Conditions, the resident was coded under J0800 as not having been observed as having any non-verbal signs, vocal complaints of pain or facial grimacing indicating pain. The resident was coded as not having documentation of any pain. The comprehensive care plan dated, 1/16/17 and revised on 5/20/19, documented in part, "Focus: Risk for Potential Pain, chronic related to impaired mobility, hx (history of) osteoarthritis, bilateral knees, femur, right arm pain and CVA (stroke)." The "Interventions" documented in part, "Administer pain medication as per MD (doctor) orders and note the effectiveness. Give PRN (as needed) meds (medications) for breakthrough	F 656		

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 06/07/2019

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 656	Continued From page 82 pain as per MD orders and note the effectiveness. Monitor and document characteristics of pain: location, severity and frequency, precipitating factors, etc." The physician order dated, 5/15/19, documented, "Ultram (Tramadol) (used to treat moderate to moderately severe pain) (3), 50 mg (milligrams), 1 by mouth three times a day as needed for pain." The May 2019 MAR (medication administration record) documented the above order for Tramadol. The medication was documented as having been administered on the following dates and times: 5/16/19 at 6:00 a.m. - no effectiveness documented. 5/16/19 at 10:00 p.m. - no effectiveness documented 5/19/19 at 11:45 p.m. - no effectiveness documented 5/20/19 at 3:15 p.m. - medication was helpful 5/21/19 at 2:15 a.m. - effective 5/27/19 at 4:45 p.m. - sleeping 5/28/19 at 8:40 a.m. - effective 5/29/19 at 4:30 p.m. - effective 5/30/19 at 4:30 p.m. - effective. None of the above documentation documented any pain scale prior to the administration or after the administration of the medication. Review of the nurse's notes for the above dates failed to evidence any documentation of a pain scale or effectiveness of the medication. Review of the "Pain Level Summary" in the clinical record failed to evidence any level of pain from 5/1/19 through 6/6/19.	F 656		

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 06/07/2019

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 656	Continued From page 83 The May 2019 MAR documented the above order for Tramadol. The medication was documented as having been administered on the following dates and times: 6/3/19 at 6:00 p.m. - effective. Review of the nurse's notes for the above date failed to evidence any documentation of a pain scale prior to the administration or after the administration of the Tramadol. An interview was conducted with LPN (licensed practical nurse) #3 on 6^19 at 10:31 a.m. When asked the process for when a resident complains of pain, LPN #3 stated, "First you assess the resident, ask the pain scale, and try non-pharmacological interventions like repositioning or distraction. If that is not effective we give the pain medication and then follow up with the resident in 30-60 minutes." When asked where all of that is documented, LPN #3 stated, 'It's in the nurse's notes." When asked the purpose of the care plan, LPN #3 stated it's the plan of care for each resident. When asked if it should be followed, LPN #3 stated, "Absolutely." An interview was conducted with LPN #1 on 6/6/19 at 10:35 a.m. When asked the process for when a resident complains of pain, LPN #1 stated, "I evaluate the resident, assess them, ask the pain scale, try non-pharmacological interventions. If that is not effective, I will give the pain medication and follow up with them in 30 minutes to see if it's effective." When asked where the assessment and pain scale is documented, LPN #1 stated, "There is a tab under the vital signs section of the computerized clinical record and we can enter the pain scale there. And you should write a progress note."	F 656		

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 06/07/2019

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 656	Continued From page 84 When asked the purpose of the care plan, LPN #1 stated it how we give care ot the resident based on their needs and preferences. When asked if it should be followed, LPN #1 stated, "Yes, unless it needs to be reviewed and revised based on resident need." Administrative staff member (ASM) #1, ASM #2 and ASM #4, the facility nursing consultant, were made aware of the above findings on 6/6/19 at 7:35 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 72. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 422. (3) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a695011.html 4. For Resident #44 the facility staff failed to follow the comprehensive care plan for the administration of an antipsychotic medication. Resident #44 was admitted to the facility on 5/8/12 with the diagnoses of but not limited to severe major depression with psychotic symptoms, dementia with behavior, bipolar disorder, anxiety disorder, psychotic disorder, high blood pressure, diabetes, and cataracts. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD	F 656		

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 06/07/2019

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 656	Continued From page 85 (Assessment Reference Date) of 5/16/19. The resident was coded as being cognitively intact in ability to make daily life decisions, scoring a 14 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, eating, toileting and hygiene; and was continent of bowel and bladder. A review of the clinical record revealed a physician's order dated 5/20/19 for Risperdal (1) 0.5 mg (milligrams) bid (twice daily) prn (as needed) for agitation and bipolar. (Note: Anxiety is not an approved use for Risperdal). On 6/05/19 08:24 AM, LPN #1 was observed to prepare and administer the following medications to Resident #44: Zaditor (2) eye drops, 1 drop in each eye Miralax (3) 17 grams Voltaren gel (4), applied to both knees Depakote (5) sprinkle 125 mg (milligrams), gave 2 tabs Calcium (6) 250mg, with Vitamin D3 125 units, gave 1 tab Risperdal 0.5 mg prn for agitation, gave 1 tab. At this time she asked Resident #44 if she needed her "medication for anxiety." The resident stated she did. The resident did not appear anxious or agitated. The resident was in her wheelchair appearing very calm. There were no apparent signs of anxiety or agitation. LPN #1 did not offer any non-pharmacological interventions at this time. She then took the resident's Risperdal from the medication cart drawer. As she was preparing the Risperdal, the resident asked her what it was. She stated to the	F 656		

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 06/07/2019

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 656	Continued From page 86 resident it was for her anxiety. She then went with the resident to her room to administer the medications. She assisted the resident up and applied the Voltaren gel to the resident's knees. She then assisted the resident back into the wheelchair and administered the Zaditor eye drops and then gave the resident the cup of the pills, including the Risperdal. After administering medications, she then assisted the resident to bed. On 6/05/19 at 2:24 PM, in an interview with LPN #1, when asked what is Risperdal used for, she stated, "anxiety." When informed of the observation of the resident being offered an as-needed (prn) antipsychotic, she stated that the resident had requested the Risperdal "for anxiousness and had been yelling out, saying she was tired, saying I can't stay up, and I gotta go." When asked if it was ordered for anxiety, she stated it was. When asked to show where the order stated it was for anxiety, she was unable to show that the Risperdal was ordered for anxiety. When asked about offering non-pharmacological interventions, she stated that the resident was agitated earlier about her clothes being twisted and bunched up and she assisted her with readjusting her clothes. When it was stated that by the time she met the resident at the medication cart at 8:24 AM, to give her medications, the resident was not showing any signs of anxiety or agitation, and she still offered the Risperdal without offering nonpharmacological interventions, she stated that she had repositioned her clothes a second time (in her room with the administration of Voltaren gel to her knees) and assisted her to bed (after administering all medications) because one of the issues the resident expressed was that she was	F 656		

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 06/07/2019

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 656	Continued From page 87	F 656		

tired. When it was noted that these additional interventions were done only in conjunction with or after providing the medication, and not beforehand and then re-evaluated for effectiveness, she stated the resident had asked for the medication and it was her right to have it. When asked what is the process for determining if a resident needs a PRN medication, she stated that staff should try to figure out why the resident wants the medication, try to fix whatever the situation might be by offering non pharmacological interventions, and give the medication only after other attempts are ineffective.

Further review of the clinical record failed to reveal any nurses notes documenting the nature of the resident's anxiety and agitation or any non-pharmacological interventions attempted. A review of the back of the MAR (Medication Administration Record) for June 2019 for Resident #44 revealed the Risperdal was administered for "resident request for anxiousness."

On 6/06/19 at 7:11 PM, in an interview with LPN #4, she stated that Risperdal is an antipsychotic used for aggressive behaviors. She stated that it is not used for anxiety. She stated that she would not give a resident Risperdal if they say they have anxiety. She stated that to give it, there would need to be combative or aggressive behaviors or exhibiting some type of psychotic behaviors. She stated she would not give it if the resident was not showing these symptoms. She stated that the care plan was not followed because the Risperdal was given for the wrong reason.

A review of the comprehensive care plan

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 06/07/2019

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 656	Continued From page 88	F 656		

revealed one for "Problematic manner in which resident acts characterized by ineffective coping: verbal/ physical Aggression or Combativeness related to: Cognitive impairments/phys (physical) changes in the brain." This care plan was dated 2/8/18. The interventions included one dated 2/8/18 for "Monitor and document behavior per facility protocol" and one dated 5/31/18 for "Give medication as prescribed by MD (medical doctor); and one dated 3/25/19 for "Document episodes of anxiety per facility protocol and notify MD of changes as indicated." In addition, a care plan dated 6/5/12 documented, "Use of psychotropic drugs with the potential for or characterized by side effects due to use of medications, antidepressants, antipsychotic." This care plan documented the intervention dated 6/5/12 for "Administer medications per physician's order."

A review of the facility policy, "Resident Care Plans" did not document that the care plan must be followed.

On 6/6/19 at 7:43 PM, ASM #1 (Administrative Staff Member - the Administrator), ASM #2 (the Director of Nursing) and ASM #4 (Facility Nurse Consultant) were notified of the concerns. No further information was provided by the end of the survey.

(1) Risperdal - is an antipsychotic and is used to treat schizophrenia, mania, mixed mood episodes, and behaviors.
Information obtained from https://medlineplus.gov/druginfo/meds/a694015.html

(2) Zaditor - is an opthalmic solution used to relieve the itching of allergic pinkeye.

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 06/07/2019

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 656	Continued From page 89 Information obtained from https://medlineplus.gov/druginfo/meds/a604033.html (3) Miralax - is used to treat constipation. Information obtained from https://medlineplus.gov/druginfo/meds/a603032.html (4) Voltaren - is a topical gel used to treat pain from osteoarthritis. Information obtained from https://medlineplus.gov/druginfo/meds/a611002.html (5) Depakote - is used to treat seizures and bipolar disorder. Information obtained from https://medlineplus.gov/druginfo/meds/a682412.html (6) Calcium - Calcium is a mineral found in many foods. The body needs calcium to maintain strong bones and to carry out many important functions. Almost all calcium is stored in bones and teeth, where it supports their structure and hardness. The body also needs calcium for muscles to move and for nerves to carry messages between the brain and every body part. In addition, calcium is used to help blood vessels move blood throughout the body and to help release hormones and enzymes that affect almost every function in the human body. Information obtained from https://ods.od.nih.gov/factsheets/Calcium-Consumer/	F 656		

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 06/07/2019

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 656	Continued From page 90 5. The facility staff failed to implement the comprehensive care plan for the administration of oxygen for Resident #10. Resident #10 was admitted to the facility on 2/21/19 with the diagnoses of but not limited to high blood pressure, chronic obstructive pulmonary disease (1), obstructive and reflux uropathy (2), benign prostatic hyperplasia with lower urinary tract symptoms, and retention of urine. The most recent MDS (Minimum Data Set), a Significant Change in Status Medicare assessment, with an ARD (Assessment reference date) of 3/18/19, coded the resident as scoring a 9 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had moderate cognitive impairment for daily decision making. The resident required extensive assistance for eating: total care for hygiene, bathing, dressing, toileting, and transfers; and had an indwelling urinary catheter and was occasionally incontinent of bowel. On 6/5/19 at 8:44 AM, and at 2:32 PM, it was observed that Resident #10's oxygen flowrate on the oxygen concentrator was set at 3 ½ liters per minute. A review of the clinical record revealed a physician's order dated 6/1/19, that documented in part, "O2 (oxygen) at 3LPM (3 liters per minute) via NC (nasal cannula) ..." Further review of the clinical record revealed a MAR (medication administration record) that was dated June 2019, which documented in part, "O2	F 656		

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 06/07/2019

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 656	Continued From page 91 at 3LPM via NC ..." Further review of the clinical record revealed a comprehensive care plan dated 3/12/19, that documented in part, "Potential for or Actual Ineffective Breathing Patter." The comprehensive care plan documented in part, "Interventions" that noted in part, "Oxygen therapy (3L/M) via (NC) as ordered." On 6/6/19 at 12:43 PM an interview was conducted with LPN (Licensed Practical Nurse) #3. When LPN #3 was asked what rate Resident #10's oxygen is to be set at, she stated, "His is three." When LPN #3 was asked if Resident #10 is care planned for oxygen at 3 liters per minute, she stated, "Yes." When LPN #3 was asked if Resident #10's oxygen rate is to be at 3 ½ liters per minute, she stated, "It is not supposed to be at 3 ½." When LPN #3 was asked if Resident #10's oxygen set at the wrong rate is a problem, she stated, "It is not following orders and the care plan." A review of the facility's policy "Resident Care Plan," with a revision date of 11/13/2017, documented in part, "Baseline care plans will include the instructions needed to provide effective and patient-centered care for residents that meet professional standard of quality care ..." According to Potter and Perry's, Fundamentals of Nursing, 7th Edition, page 269 states "A written care plan communicates nursing care priorities to other health care professionals. The nursing care plan enhances the continuity of care by listing specific nursing interventions needed to achieve the goals of care. The complete care plan is the blueprint for nursing action. It provides direction	F 656		

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 06/07/2019

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 656	Continued From page 92 for implementation of the plan plus the framework for evaluation of the client's response to nursing actions." On 6/7/19 at 11:48 AM, ASM (Administrative Staff Member) #1, the Administrator, was made aware of the findings. No further information was provided by the end of the survey. (1) Chronic obstructive pulmonary disease: Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. (2) Obstructive and reflux uropathy: Obstructive uropathy is a condition in which the flow of urine is blocked. This causes the urine to back up and injure one or both kidneys. This information was obtained from the website: https://medlineplus.gov/ency/article/000507.htm 6. The facility staff failed to implement the comprehensive care plan for the administration of oxygen for Resident #49. Resident #49 was admitted to the facility on 4/23/19 with the diagnoses of but not limited to type 2 diabetes mellitus, high blood pressure, heart failure, chronic obstructive pulmonary disease (1), obstructive and reflux uropathy (2), and retention of urine. The most recent MDS (Minimum Data Set), a 14-day Medicare assessment, with an ARD (Assessment reference date) of 5/28/19, coded the resident as scoring a 6 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had	F 656		

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 06/07/2019

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 656	Continued From page 93 severe cognitive impairment for daily decision making. The resident required supervision and set up for eating; extensive assistance for hygiene, dressing, toileting, transfers: total care for bathing; had an indwelling urinary catheter and was occasionally incontinent of bowel. On 6/4/19 at 6:00 PM and 6/5/19 at 8:36 AM, it was observed that Resident #49's oxygen flowrate on the oxygen concentrator was set at 2 ½ liters per minute. A review of the clinical record revealed a physician's order dated 6/1/19, that documented in part, "O2 (oxygen) at 2L (2 liters per minute) via NC (nasal cannula) ..." Further review of the clinical record revealed a MAR (medication administration record) that was dated June 2019, which documented in part, "O2 at 2L via NC ..." Further review of the clinical record revealed a comprehensive care plan, dated 5/9/19, that documented in part, "Potential for or Actual Ineffective Breathing Patter ..." The comprehensive care plan documented in part, "Interventions" that noted in part, "Oxygen therapy (2L/M) via (NC) as ordered." On 6/6/19 at 12:43 PM an interview was conducted with LPN (Licensed Practical Nurse) #3. When LPN #3 was asked what Resident #49's oxygen rate is to be set at, she stated, "2 liters." When LPN #3 was asked if Resident #49's oxygen rate is to be set at 2 liters per minute, how do you know where to set the ball, she stated, "You get down on eye level to set it.	F 656		

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 06/07/2019

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 656	Continued From page 94 The ball would be on the 2 line, not below or above it." When LPN #3 was asked if Resident #49's oxygen rate set at the wrong rate is following the care plan, she stated, "Apparently not." A review of the facility's policy "Resident Care Plan" with a revision date of 11/13/2017 that documented in part, "Baseline care plans will include the instructions needed to provide effective and patient-centered care for residents that meet professional standard of quality care ..." According to Potter and Perry's, Fundamentals of Nursing, 7th Edition, page 269 states "A written care plan communicates nursing care priorities to other health care professionals. The nursing care plan enhances the continuity of care by listing specific nursing interventions needed to achieve the goals of care. The complete care plan is the blueprint for nursing action. It provides direction for implementation of the plan plus the framework for evaluation of the client's response to nursing actions." On 6/7/19 at 11:48 AM, ASM (Administrative Staff Member) #1, the Administrator, was made aware of the findings. No further information was provided by the end of the survey. (1) Chronic obstructive pulmonary disease: Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. (2) Obstructive and reflux uropathy: Obstructive uropathy is a condition in which the flow of urine is blocked. This causes the urine to back up and injure one or both kidneys. This information was	F 656		

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 06/07/2019

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 656	Continued From page 95 obtained from the website: https://medlineplus.gov/ency/article/000507.htm 7. The facility staff failed to implement the comprehensive care plan for the administration of oxygen for Resident #48. Resident #48 was admitted to the facility on 12/18/19 with the diagnoses of but not limited to adult failure to thrive, osteoporosis with current pathological fracture, and displaced intertrochanteric fracture of right femur. The most recent MDS (Minimum Data Set), a Quarterly Medicare assessment, with an ARD (Assessment reference date) of 5/20/19, coded the resident as scoring a 3 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had severe cognitive impairment for daily decision making. The resident was independent for eating; required extensive assistance for hygiene and dressing; total care for toileting and bathing; and was frequently incontinent of bladder and bowel. On 6/5/19 at 8:30 AM and 10:24 AM, it was observed that Resident #48's oxygen flowrate on the oxygen concentrator was set at 3 liters per minute. A review of the clinical record revealed a physician's order dated 5/4/19, that documented in part, "Oxygen at 2 liters (per minute) via N/C (nasal cannula) ..." Further review of the clinical record revealed a MAR (medication administration record) that was	F 656		

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 06/07/2019

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 656	Continued From page 96 dated June 2019, which documented in part, "Oxygen at 2 liters (per minute) via N/C (nasal cannula) ..." Further review of the clinical record revealed a comprehensive care plan that was dated 12/19/18, that documented in part, "Potential for or Actual Ineffective Breathing Patter ..." The comprehensive care plan documented in part, "Interventions" that noted in part, "Oxygen therapy (3L) via (NC) as ordered." On 6/6/19 at 12:43 PM an interview was conducted with LPN (Licensed Practical Nurse) #3. When LPN #3 was asked what Resident #48's oxygen rate is to be set at, she stated, "His was 2 too." When LPN #3 was asked if Resident #48's care plan was updated to reflect the current oxygen order, she stated, "Apparently not." A review of the facility's policy "Resident Care Plan" with a revision date of 11/13/2017 that documented in part, "Baseline care plans will include the instructions needed to provide effective and patient-centered care for residents that meet professional standard of quality care ..." According to Potter and Perry's, Fundamentals of Nursing, 7th Edition, page 269 states "A written care plan communicates nursing care priorities to other health care professionals. The nursing care plan enhances the continuity of care by listing specific nursing interventions needed to achieve the goals of care. The complete care plan is the blueprint for nursing action. It provides direction for implementation of the plan plus the framework for evaluation of the client's response to nursing actions."	F 656		

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 06/07/2019

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 656	Continued From page 97 On 6/7/19 at 11:48 AM, ASM (Administrative Staff Member) #1, the Administrator, was made aware of the findings. No further information was provided by the end of the survey. 8. The facility staff failed to implement the comprehensive care plan for the use of psychotropic medication for Resident #14. Resident #14 was admitted to the facility on 8/24/18 with the diagnoses of but not limited to dementia without behavioral disturbance, brief psychotic disorder, anxiety disorder, and high blood pressure. The most recent MDS (Minimum Data Set), a Quarterly Medicare assessment, with an ARD (Assessment reference date) of 4/1/19, coded the resident as scoring a 12 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had moderate cognitive impairment for daily decision making. The resident was independent for bathing, transfers, dressing, and toileting; required supervision and set up assistance for eating; and was always continent of bladder and bowel. On 6/4/19 at 11:03 AM, it was observed that Resident #14 exhibited no behaviors while in the dining room. On 6/5/19 at 11:43 AM, and 6/6/19 at 9:35 AM, it was observed that Resident #14 exhibited no behaviors while in her room. On 6/6/19 at 11:06 AM, it was observed that Resident #14 exhibited no behaviors while in her	F 656		

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 06/07/2019

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 656	Continued From page 98 wheelchair in the hallway. A review of the clinical record revealed nurse's notes dated 4/9/19, which documented in part, "Re-evaluated resident for wandering. Wandering not at risk, removed wander guard bracelet." Review of the clinical record revealed nurse's notes dated 5/8/19 at 3:30 AM, which documented in part, "observed resident resting quietly in bed with eyes closed." Further review of the clinical record revealed no further nurse's notes documenting behaviors. A review of the clinical record revealed a physician's order dated 6/1/19, that documented in part, " ...Seroquel (1) 12.5 mg (milligrams) po (by mouth) QHS (every evening at bed time) for insomnia/psychosis ..." Further review of the clinical record revealed a MAR (medication administration record) that was dated June 2019, which documented in part, " ...Seroquel 12.5 mg po QHS for insomnia/psychosis ..." Further review of the clinical record revealed a comprehensive care plan that was dated 8/24/18, that documented in part, "Use of psychotropic drugs with the potential for or characterized by side effects of ...AEB (As Evidenced By): or / due to diagnosis of: psychosis, Insomnia, use of anti-psychotic (GDR Seroquel 5/6/19) (Gradual Dose Reduction)." The comprehensive care plan documented in part, "Interventions" that noted in part, "Observe interaction or resident with others for appropriateness ...observe resident's mental	F 656		

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 06/07/2019

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 656	Continued From page 99 status functioning on an ongoing basis ... A review of the clinical record revealed a physician's note dated 12/15/18, which documented in part, " ...Review of systems...psychiatric: No increased nervousness or suicidal ideations...Physical exam...Psychiatric: Mood and affect pleasant; patient oriented to person and place...Plan: medications and plan of care reviewed by provider...continue with present plan of care... Further review of the clinical record revealed a physician's note dated 12/23/18, which documented in part, " ...Review of systems...psychiatric: No increased nervousness no changes in cognition...Physical exam...Psychiatric: Mood and affect pleasant; patient oriented to person and place...Plan: medications and plan of care reviewed by provider..." Further review of the clinical record revealed a physician's note dated 3/23/19, which documented in part, " ...Review of systems...psychiatric: No increased nervousness or suicidal ideations...Physical exam...Psychiatric: Mood and affect pleasant; patient oriented to person and place...Plan: medications and plan of care reviewed by provider..." Further review of the clinical record revealed a physician's note dated 4/3/19, which documented in part, " ...Review of systems...psychiatric: No changes in cognition or increased nervousness...Physical exam...Psychiatric: Mood and affect pleasant; patient oriented to person and place...Plan: medications and allergies reviewed by provider..."	F 656		

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 06/07/2019

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 656	Continued From page 100 Further review of the clinical record revealed a physician's note dated 4/19/19, which documented in part, "...(name of resident) has dementia. She requires direction from the staff for meals and assistance with her activities of daily living. She enjoys playing bingo and group activities...Review of systems...psychiatric: No changes in cognition or crying spells...Physical exam...Psychiatric: Mood and affect pleasant; patient oriented to person and place...Plan: medications and plan of care reviewed by provider..." A review of the clinical record revealed MDS dated 11/27/18, a Quarterly - modified Medicare assessment, with an ARD of 8/24/18, which documented in part, "Section E: 100: None of the above; 200: Behavior not exhibited; 800: Behavior not exhibited; 900: Behavior not exhibited." A review of the clinical record revealed MDS dated 1/4/19, a Quarterly - modified Medicare assessment, with an ARD of 1/4/19, which documented in part, "Section E: 100: None of the above; 200: Behavior not exhibited; 800: Behavior not exhibited; 900: Behavior not exhibited." A review of the clinical record revealed MDS dated 3/8/19, a Quarterly Medicare assessment, with an ARD of 3/8/19, which documented in part, "Section E: 100: None of the above; 200: Behavior not exhibited; 800: Behavior not exhibited; 900: Behavior not exhibited." A review of the clinical record revealed MDS dated 4/1/19, a Quarterly Medicare assessment, with an ARD of 4/1/19, which documented in part, "Section E: 100: None of the above; 200:	F 656		

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 06/07/2019

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 656	Continued From page 101 Behavior not exhibited; 800: Behavior not exhibited; 900: Behavior not exhibited." On 6/6/19 at 12:43 PM an interview was conducted with LPN (Licensed Practical Nurse) #3. When LPN #3 was asked if Resident #14 receives Seroquel, she stated, "Not on my shift, but I think she does." When LPN #3 was asked if Resident #14 exhibits any behaviors indicating the need for Seroquel, she stated, "She was when she was moved from back here to long term care. She had some behaviors." When LPN #3 was asked when Resident #14 was moved, she stated, "It was in Nov 2018." When LPN #3 was asked if Resident #14 exhibited any behaviors since, she stated, "Maybe one or two and I guess that is why they are decreasing it." When LPN #3 was asked should Resident #14's behaviors be care planned, she stated, "Yes." When LPN #3 was asked where the nurses would document Resident #14's behaviors, she stated, "You would put them in the progress notes under behavior." When LPN #3 was asked should Resident #14's behaviors be documented, she stated, "Yes." When LPN #3 was asked if there is a problem when behaviors are not documented even when no behaviors are noted, she stated, "Yes." When LPN #3 was asked if it is a problem if no behaviors are documented, she stated, "Yes, not following the care plan." A review of the facility's policy "Resident Care Plan" with a revision date of 11/13/2017 that documented in part, "Baseline care plans will include the instructions needed to provide effective and patient-centered care for residents that meet professional standard of quality care ..." According to Potter and Perry's, Fundamentals of	F 656		

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 06/07/2019

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 656	Continued From page 102 Nursing, 7th Edition, page 269 states "A written care plan communicates nursing care priorities to other health care professionals. The nursing care plan enhances the continuity of care by listing specific nursing interventions needed to achieve the goals of care. The complete care plan is the blueprint for nursing action. It provides direction for implementation of the plan plus the framework for evaluation of the client's response to nursing actions." On 6/7/19 at 11:48 AM, ASM (Administrative Staff Member) #1, the Administrator, was made aware of the findings. No further information was provided by the end of the survey. (1) "Seroquel (Quetiapine) tablets and extended-release (long-acting) tablets are used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions). Quetiapine tablets and extended-release tablets are also used alone or with other medications to treat episodes of mania (frenzied, abnormally excited or irritated mood) or depression in patients with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods). In addition, quetiapine tablets and extended-release tablets are used with other medications to prevent episodes of mania or depression in patients with bipolar disorder. Quetiapine extended-release tablets are also used along with other medications to treat depression. Quetiapine tablets may be used as part of a treatment program to treat bipolar disorder and schizophrenia in children and teenagers. Quetiapine is in a class of medications called	F 656		

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 06/07/2019

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 656	Continued From page 103 atypical antipsychotics. It works by changing the activity of certain natural substances in the brain." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a698019.html	F 656		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure care and services in accordance with professional standards and the comprehensive care plan for three of 33 residents in the survey sample, Residents # 33, #13, #10 and #48. The facility staff failed to administer medications to Resident #33 per the physician's orders and failed to ensure a current order for hospice services was in place for Resident's #13, #10 and #49. The findings include: 1. The facility staff failed to administer the medication according to the physician order for Resident #33.	F 684		

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 06/07/2019

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 684	Continued From page 104 Resident #33 was admitted to the facility on 5/1/19 with diagnoses that included but were not limited to: dementia, high blood pressure, diabetes, stroke and COPD (chronic obstructive pulmonary disease - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (1). The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 5/8/19, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indication she is severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance to being dependent upon one staff member for all of her activities of daily living. The physician order dated, 5/2/19 documented, "Metoprolol Tartrate [used to treat high blood pressure (2)], 25 mg (milligrams) 1/2 = 12.5 mg by mouth twice daily. Hold for SBP (systolic blood pressure) less than 100 or HR (heart rate) less than 50." Review of the May 2019 MAR (medication administration record) documented the above medication order. The medication was not signed off on 5/22/19 at 9:00 a.m., 5/23/19 at 9:00 p.m. and 5/26/19 at 9:00 p.m. The reverse side of the MAR failed to evidence documentation as to why the medication was not given. Review of the nurse's notes for the above listed dates and times failed to evidence documentation as to why the medication was not given.	F 684	F-684 The nurse responsible for Resident #33 was in-serviced regarding the physician order pertaining to blood pressure medication. Hospice orders were obtained for resident #s 13, 10, and 48. Upon further observation no other resident was found not to have proper orders. The physician orders will be reviewed each month to ensure that Hospice orders are in place. Nursing staff will be in-serviced as to the importance of detailed compliance with Physician orders especially when dictated parameters are involved. The Director of Nursing or her designee will review the monthly orders to ensure that the Orders are complete and properly documented. The monthly compliance review will be submitted to the Cardinal IDT members for any follow –up. Reviews will then be submitted to the facility's QAPI members for oversight,	7/21/19

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 06/07/2019

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 684	Continued From page 105 The comprehensive care plan dated, 5/3/19, documented in part, "Focus: Hypertension (high blood pressure): at risk for complications of renal failure, arteriosclerotic disease and/or retinopathy." The "Interventions" documented in part, "Monitor blood pressure per facility protocol and/or as ordered by physician." An interview was conducted with LPN (licensed practical nurse) #2 on 6/5/19 at 3:29 p.m. LPN #2 was asked to read the above order for Metoprolol. When asked what staff should do if a resident has that order, LPN #2 stated, "You have to take the blood pressure and pulse before giving it." When asked what the blank spaces on the MAR were, LPN #2 stated, "It either wasn't done or wasn't signed off." When asked if that is following the physician's orders, LPN #2 stated, "No, Ma'am." An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 6/5/19 at 3:36 p.m. When asked what the blank spaces on the MAR meant, ASM #2 stated, "Maybe it wasn't done or maybe they forgot to sign it off." The policy "Medication Administration" documented in part, "N. Any deviation from the following principles shall be considered a medication error: 1. To the right resident. 2. Administration of the right medication. 3. In the right dose. 4. By the right route. 5. By the right method. 6. At the right time." The policy failed to document any mention of obtaining the prescribed vital signs prior to administration of a medication.	F 684		

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 06/07/2019

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 684	Continued From page 106 ASM #1, the administrator and ASM #4, the facility nurse consultant, were made aware of the above findings on 6/6/19 at 7:45 a.m. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682864.html 2. The facility staff failed to ensure a current order was in place for the provision of Hospice services to Resident #13 Resident #13 was admitted on 2/6/15 with the diagnoses of atrial fibrillation, hypothyroidism, depression, chronic obstructive pulmonary disease, anxiety disorder, intestinal obstruction, hemiplegia, respiratory failure, and neurogenic bladder. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 3/22/19. The resident was coded as moderately impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing, toileting and transfers; extensive assistance for dressing; supervision for eating; and was incontinent of bowel and had an indwelling catheter for bladder. A review of the clinical record revealed an order dated 3/18/19 for "Admit to Hospice (name of hospice company)...." This order was signed by the physician on 3/20/19. A review of the physician's order sheet (POS) of current orders, for May 2019 (signed by the	F 684		

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 06/07/2019

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 684	Continued From page 107 physician on 5/4/19), and for June 2019, signed by the physician on 6/1/19, failed to reveal any current order in place for the provision of Hospice services. Further review of the clinical record revealed the most recent note referring to Hospice, dated 5/30/19 at 12:41 PM: "Scheduled care plan meeting invitation mailed to RR (resident representative), and Hospice (name of hospice company)..." indicating that the resident was still receiving Hospice services, without a current order. In addition, there was a "Hospice Comprehensive Assessment and Plan of Care Update Report" dated 5/16/19, indicating that the resident was still receiving Hospice after the May 2019, POS was signed on 5/4/19 without a current Hospice order included on the POS. On 6/06/19 at 3:05 PM, in an interview with LPN #3, she stated that the resident was still on Hospice. LPN #3 stated that, after reviewing the May 2019 and June 2019 POS, that the resident was getting Hospice without a current order because the physician had signed the POS indicating that those orders were all the current orders and treatments, and that Hospice was not on it. A review of the facility policy, "Hospice Residents" did not document that a current physician's order was required for the provision of Hospice services. On 6/6/19 at 7:43 PM, ASM #1 (Administrative Staff Member - the Administrator), ASM #2 (the Director of Nursing) and ASM #4 (Facility Nurse	F 684		

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 06/07/2019

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 684	Continued From page 108 Consultant) were notified of the concerns. No further information was provided by the end of the survey. 3. The facility staff failed to ensure current orders were in place for the provision of Hospice services to Resident #10. Resident #10 was admitted to the facility on 2/21/19 with the diagnoses of but not limited to high blood pressure, chronic obstructive pulmonary disease (1), obstructive and reflux uropathy (2), benign prostatic hyperplasia with lower urinary tract symptoms, and retention of urine. The most recent MDS (Minimum Data Set), a Significant Change in Status Medicare assessment, with an ARD (Assessment reference date) of 3/18/19, coded the resident as scoring a 9 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had moderate cognitive impairment for daily decision making. The resident required extensive assistance for eating: total care for hygiene, bathing, dressing, toileting, and transfers; had an indwelling urinary catheter and was occasionally incontinent of bowel. A review of the clinical record failed to reveal a physician's order for Hospice care for the months of April 2019, May 2019, and June 2019. A review of the clinical record revealed a comprehensive care plan dated 3/12/19, which documented in part, " ...Hospice Care due to Other: Adult Failure to thrive ..."	F 684		

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 06/07/2019

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 684	Continued From page 109 On 6/6/19 at 3:40 PM, an interview was conducted with LPN (Licensed Practical Nurse) #3. LPN #3 was asked if Resident #10 is currently on Hospice Care. LPN #3 stated, "Yes." When asked if Resident #10 has a current order for Hospice, LPN #3 stated, "I don't see one." On 6/6/19 at 3:50 PM, LPN #3 presented to the surveyor a handwritten order for Hospice Care, dated March 2019. A review of the facility policy "Hospice Residents," with an effective date of 1/2009, documented in part, "When a resident has also elected the hospice benefits, the hospice agency and the nursing facility will communicate, establish, and agree upon a coordinated plan of care for both providers ..." Although LPN #3 provided the handwritten order for hospice care, dated March 2019, there was no evidence to indicate that this order was ever entered or carried over into the physician order system for the months of April 2019, May 2019, and June 2019. On 6/7/19 at 11:48 AM, ASM (Administrative Staff Member) #1, the Administrator, was made aware of the findings. No further information was provided by the end of the survey. (1) An indwelling catheter is a tube that drains urine from the bladder to a bag outside of the body. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000140.htm	F 684		

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 06/07/2019

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 684	Continued From page 110 (2) Chronic obstructive pulmonary disease: Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. (3) Obstructive and reflux uropathy: Obstructive uropathy is a condition in which the flow of urine is blocked. This causes the urine to back up and injure one or both kidneys. This information was obtained from the website: https://medlineplus.gov/ency/article/000507.htm 4. The facility staff failed to ensure orders were in place for the provision of Hospice services for Resident #48. Resident #48 was admitted to the facility on 12/18/19 with the diagnoses of but not limited to adult failure to thrive, osteoporosis with current pathological fracture, and displaced intertrochanteric fracture of right femur. The most recent MDS (Minimum Data Set), a Quarterly Medicare assessment, with an ARD (Assessment reference date) of 5/20/19, coded the resident as scoring a 3 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had severe cognitive impairment for daily decision making. The resident was independent for eating; required extensive assistance for hygiene and dressing; total care for toileting and bathing; and was frequently incontinent of bladder and bowel. A review of the clinical record revealed a MDS	F 684		

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 06/07/2019

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 684	Continued From page 111 dated 5/20/19, section O, documented in part, " ...Hospice care ..." the box for "while a resident" was checked. A review of the clinical record failed to reveal a physician's order for Hospice care for the month of May 2019. A review of the clinical record revealed a comprehensive care plan dated 12/19/18, which documented in part, " ...Hospice Care due to disease process ..." On 6/6/19 at 3:40 PM, an interview with LPN (Licensed Practical Nurse) #3 was conducted. LPN #3 was asked if Resident #10 is currently on Hospice Care. LPN #3 stated, "Yes." When asked if Resident #10 has a current order for Hospice, LPN #3 stated, "I don't see one." On 6/6/19 at 3:50 PM, LPN #3 returned, and stated, "There is no order for Hospice Care." A review of the facility policy "Hospice Residents," with an effective date of 1/2009, documented in part, "When a resident has also elected the hospice benefits, the hospice agency and the nursing facility will communicate, establish, and agree upon a coordinated plan of care for both providers ..." On 6/7/19 at 11:48 AM, ASM (Administrative Staff Member) #1, the Administrator, was made aware of the findings. No further information was provided by the end of the survey.	F 684		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		

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 06/07/2019

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 695	Continued From page 112 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it was determined the facility staff failed to provide respiratory care and services consistent with professional standards of practice, the comprehensive person-centered care plan for five of 33 sampled residents, (Resident #10, #49, #48, #46 and Resident #33). The facility staff failed to administer oxygen according to the physician's orders to Resident's #10, #49, #48, and #46, and failed to ensure Resident #33's nebulizer mask was stored in a sanitary manner. The findings include: 1. The facility staff failed to administer Resident #10's oxygen according to the physician's orders. Resident #10 was admitted to the facility on 2/21/19 with the diagnoses of but not limited to high blood pressure, chronic obstructive pulmonary disease (1), obstructive and reflux uropathy (2), benign prostatic hyperplasia with lower urinary tract symptoms, and retention of urine. The most recent MDS (Minimum Data Set), a Significant Change in Status Medicare assessment, with an ARD (Assessment reference	F 695	F-695 The oxygen level was adjusted to the proper flow for Residents #10,, 49, 48, and 46. The oxygen Nebulizer for resident #33 was properly cleaned and stored. Other residents requiring Oxygen were observed and necessary adjustments were done. No other nebulizers were located. Nursing staff will be in-serviced on the proper settings of Oxygen and the proper way to observe the rate of flow per physician orders. Each shift will document through observation that oxygen flow meters are at the proper settings, there will be a log kept at each nurses' station that will indicate observations and settings. Nebulizers will be checked daily for proper cleanliness and storage. The bag in which the nebulizer is kept will be dated to indicate the latest date checked and cleaned. Oxygen settings log will be reviewed weekly by the Cardinal IDT members to ensure compliance.	7/2/19

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 06/07/2019

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 695	Continued From page 113 date) of 3/18/19, coded the resident as scoring a 9 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had moderate cognitive impairment for daily decision making. The resident required extensive assistance for eating: total care for hygiene, bathing, dressing, toileting, and transfers; had an indwelling urinary catheter and was occasionally incontinent of bowel. On 6/5/19 at 8:44 AM, and at 2:32 PM, Resident #10's oxygen flowrate on the oxygen concentrator was observed set at three and a half liters per minute. A review of the clinical record revealed a physician's order dated 6/1/19, that documented in part, "O2 (oxygen) at 3LPM (3 liters per minute) via NC (nasal cannula) ..." Further review of the clinical record revealed a MAR (medication administration record) that was dated June 2019, which documented in part, "O2 at 3LPM via NC ..." Further review of the clinical record revealed a comprehensive care plan dated 3/12/19, that documented in part, "Potential for or Actual Ineffective Breathing Patter." The comprehensive care plan documented in part, "Interventions" that noted in part, "Oxygen therapy (3L/M) via (NC) as ordered." On 6/6/19 at 12:43 PM, an interview was conducted with LPN (Licensed Practical Nurse) #3. LPN #3 was asked what flow rate Resident #10's oxygen was ordered at, LPN #3 stated, "His is three." When asked if Resident #10 was care planned for oxygen at 3 liters per minute, LPN #3	F 695		

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 06/07/2019

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 695	Continued From page 114 stated, "Yes." When was asked if Resident #10's oxygen rate is to be at 3 ½ liters per minute, LPN #3 stated, "It is not supposed to be at 3 ½." When asked what it meant if the oxygen was not set at the rate ordered by the physician, LPN #3 stated, "It is not following orders and the care plan." A review of the facility's policy "Oxygen Therapy," with a revision date of April 2017, documented in part, " ...Adjust the flow meter to prescribed rate ..." According to Fundamentals of Nursing, 6th edition, Potter and Perry, 2005, page 1122, "Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity (Thomson, 2002). As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration." On 6/7/19 at 11:48 AM, ASM (Administrative Staff Member) #1, the Administrator, was made aware of the findings. No further information was provided by the end of the survey. (1) Chronic obstructive pulmonary disease: Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. (2) Obstructive and reflux uropathy: Obstructive uropathy is a condition in which the flow of urine is blocked. This causes the urine to back up and	F 695		

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 06/07/2019

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 695	Continued From page 115 injure one or both kidneys. This information was obtained from the website: https://medlineplus.gov/ency/article/000507.htm 2. The facility staff failed to administer Resident #49's oxygen according to the physician's orders. Resident #49 was admitted to the facility on 4/23/19 with the diagnoses of but not limited to type 2 diabetes mellitus, high blood pressure, heart failure, chronic obstructive pulmonary disease (1), obstructive and reflux uropathy (2), and retention of urine. The most recent MDS (Minimum Data Set), a 14-day Medicare assessment, with an ARD (Assessment reference date) of 5/28/19, coded the resident as scoring a 6 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had severe cognitive impairment for daily decision making. The resident required supervision and set up for eating; extensive assistance for hygiene, dressing, toileting, transfers: total care for bathing; had indwelling urinary catheter and was occasionally incontinent of bowel. On 6/4/19 at 6:00 PM and 6/5/19 at 8:36 AM, Resident #49's oxygen flowrate on the oxygen concentrator was observed set at 2 ½ liters per minute. A review of the clinical record revealed a physician's order dated 6/1/19, that documented in part, "O2 (oxygen) at 2L (2 liters per minute) via NC (nasal cannula) ..." Further review of the clinical record revealed a MAR (medication administration record) that was dated June 2019, which documented in part, "O2	F 695		

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 06/07/2019

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 695	Continued From page 116 at 2L via NC ..." Further review of the clinical record revealed a comprehensive care plan, dated 5/9/19, that documented in part, "Potential for or Actual Ineffective Breathing Patter ..." The comprehensive care plan documented in part, "Interventions" that noted in part, "Oxygen therapy (2L/M) via (NC) as ordered." On 6/6/19 at 12:43 PM, an interview was conducted with LPN (Licensed Practical Nurse) #3. When asked what Resident #49's oxygen flow rate was per the physician order, LPN #3 stated, "2 liters." When asked how staff should set the oxygen flow rate on the oxygen concentrator, LPN #3 stated, "You get down on eye level to set it. The center of the ball would be on the 2 line, not below or above it." When asked what it meant if the oxygen was not set at the rate ordered by the physician, LPN #3 stated, "It is not following orders and the care plan." A review of the facility's policy "Oxygen Therapy" with a revision date of April 2017, documented in part, " ...Adjust the flow meter to prescribed rate ..." According to Fundamentals of Nursing, 6th edition, Potter and Perry, 2005, page 1122, "Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity (Thomson, 2002). As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of	F 695		

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 06/07/2019

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 695	Continued From page 117 medication administration also pertain to oxygen administration." On 6/7/19 at 11:48 AM, ASM (Administrative Staff Member) #1, the Administrator, was made aware of the findings. No further information was provided by the end of the survey. (1) Chronic obstructive pulmonary disease: Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. (2) Obstructive and reflux uropathy: Obstructive uropathy is a condition in which the flow of urine is blocked. This causes the urine to back up and injure one or both kidneys. This information was obtained from the website: https://medlineplus.gov/ency/article/000507.htm 3. The facility staff failed to administer Resident #48's oxygen according to the physician's orders. Resident #48 was admitted to the facility on 12/18/19 with the diagnoses of but not limited to Adult failure to thrive, osteoporosis with current pathological fracture, and displaced intertrochanteric fracture of right femur. The most recent MDS (Minimum Data Set), a Quarterly Medicare assessment, with an ARD (Assessment reference date) of 5/20/19, coded the resident as scoring a 3 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had severe cognitive impairment for daily decision making. The resident was independent for eating; required	F 695		

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 06/07/2019

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 695	Continued From page 118 extensive assistance for hygiene and dressing; total care for toileting and bathing; and was frequently incontinent of bladder and bowel. On 6/5/19 at 8:30 AM and 10:24 AM, Resident #48's oxygen flowrate on the oxygen concentrator was observed set at 3 liters per minute. A review of the clinical record revealed a physician's order dated 5/4/19, that documented in part, "Oxygen at 2 liters (per minute) via N/C (nasal cannula) ..." Further review of the clinical record revealed a MAR (medication administration record) that was dated June 2019, which documented in part, "Oxygen at 2 liters (per minute) via N/C (nasal cannula) ..." Further review of the clinical record revealed a comprehensive care plan that was dated 12/19/18, that documented in part, "Potential for or Actual Ineffective Breathing Patter ..." The comprehensive care plan documented in part, "Interventions" that noted in part, "Oxygen therapy (3L) via (NC) as ordered." On 6/6/19 at 12:43 PM, an interview was conducted with LPN (Licensed Practical Nurse) #3. When asked what Resident #48's oxygen rate was per the physician's orders, LPN #3 stated, "2 liters." When asked how staff should set the oxygen flow rate on the oxygen concentrator, LPN #3 stated, "You get down on eye level to set it. The center of the ball would be on the 2 line, not below or above it." When asked what it meant if the oxygen was not set at the rate ordered by the physician, LPN #3 stated, "It is not	F 695		

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 06/07/2019

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 695	Continued From page 119 following orders and the care plan." A review of the facility's policy "Oxygen Therapy" with a revision date of April 2017, that documented in part, " ...Adjust the flow meter to prescribed rate ..." According to Fundamentals of Nursing, 6th edition, Potter and Perry, 2005, page 1122, "Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity (Thomson, 2002). As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration." On 6/7/19 at 11:48 AM, ASM (Administrative Staff Member) #1, the Administrator, was made aware of the findings. No further information was provided by the end of the survey. 5. The facility staff failed to store a nebulizer mask in a sanitary manner for Resident #33. Resident #33 was admitted to the facility on 5/1/19 with diagnoses that included but were not limited to: dementia, high blood pressure, diabetes, stroke and COPD (chronic obstructive pulmonary disease - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (1). The most recent MDS (minimum data set) assessment, an admission assessment, with an	F 695		

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 06/07/2019

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 695	Continued From page 120 assessment reference date of 5/8/19, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indication she is severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance to being dependent upon one staff member for all of her activities of daily living. Observation was made of Resident #33's room on 6/4/19 at 2:28 p.m. The resident was not in the room. There was a nebulizer mask noted on the nightstand uncovered, not in a bag, with some of the resident's clothing on top of it. An interview was conducted with LPN (licensed practical nurse) #2 on 6/5/19 at 4:32 p.m. LPN #2 had just provided the resident with her nebulizer treatment. When asked how the nebulizer mask should be stored when not in use, LPN #2 stated, "It's supposed to be in a plastic bag. They (respiratory equipment) are all supposed to be in containers when not in use." The facility policy, "Oxygen Equipment Policy" documented in part, "When temporarily not in use the mask or cannulas should be covered or placed in a plastic bag to protect it from airborne contamination. The covering or bag should not be airtight in order to prevent the growth of bacteria which occurs in a moist environment." ASM #1, the administrator and ASM #4, the facility nurse consultant, were made aware of the above findings on 6/6/19 at 7:45 a.m. No further information was obtained prior to exit. (1) Barron's Dictionary of Medical Terms for the	F 695		

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 06/07/2019

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 695	Continued From page 121 Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.	F 695	F-697 The nurse in charge of resident #44 was re-educated on the proper documentation required for the administration of pain medication including non-pharmacological interventions and the necessity of documenting the effectiveness of the medication. The documentation for other residents receiving pain medication were reviewed and found to be in compliance. Nursing staff will be re-educated on the proper documentation of pain medications. Residents receiving pain medications will be reviewed weekly by the DON or her Designee to ensure that proper documentation is in place. The results of these reviews will be documented on the pain log in the Cardinal IDT meeting room and submitted monthly to the facility's QAPI Committee.	7/21/19
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to maintain a comprehensive pain management program for one of 33 residents in the survey sample, (Resident #44). The facility staff failed to assess and document a pain scale rating when administering as needed pain medication to Resident #44 and failed to document the effectiveness of the medication. The findings include: Resident #44 was admitted to the facility on 5/8/12 with a recent readmission on 5/9/19 with diagnoses that included but were not limited to: depression, diabetes, dementia, bipolar disorder [a mental disorder characterized by episodes of mania and depression (1)], anxiety disorder, high blood pressure and osteoarthritis [characterized by degenerative changes in the joints, pain, stiffness and swelling can develop after exercise (2)]. The most recent MDS (minimum data set) assessment, a significant change assessment,	F 697		

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 06/07/2019

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 697	Continued From page 122 with an assessment reference date of 5/16/19, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of one staff member for most of her activities of daily living. In Section J - Health Conditions, the resident was coded under J0800 as not having been observed as having any non-verbal signs, vocal complaints of pain or facial grimacing indicating pain. The resident was coded as not having documentation of any pain. The physician order dated, 5/15/19, documented, "Ultram (Tramadol) [used to treat moderate to moderately severe pain (3)] 50 mg (milligrams), 1 by mouth three times a day as needed for pain." The May 2019 MAR (medication administration record) documented the above order for Tramadol. The medication was documented as having been administered on the following dates and times: 5/16/19 at 6:00 a.m. - no effectiveness documented. 5/16/19 at 10:00 p.m. - no effectiveness documented 5/19/19 at 11:45 p.m. - no effectiveness documented 5/20/19 at 3:15 p.m. - medication was helpful 5/21/19 at 2:15 a.m. - effective 5/27/19 at 4:45 p.m. - sleeping 5/28/19 at 8:40 a.m. - effective 5/29/19 at 4:30 p.m. - effective 5/30/19 at 4:30 p.m. - effective. None of the above documentation evidenced any pain scale rating prior to the administration or after the administration of the medication.	F 697		

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 06/07/2019

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 697	Continued From page 123 Review of the nurse's notes for the above dates failed to evidence any documentation of a pain scale or effectiveness of the medication. Review of the "Pain Level Summary" in the clinical record failed to evidence any level of pain from 5/1/19 through 6/6/19. The June 2019 MAR documented the above order for Tramadol. The medication was documented as administered on the following dates and times: 6/3/19 at 6:00 p.m. - effective. Review of the nurse's notes for the above date failed to evidence any documentation of a pain scale prior to the administration or after the administration of the Tramadol. The "Pain Assessment" dated 5/9/19, documented the resident could verbalize expression of pain. The resident was documented as having a pain level of "3" on a pain scale of 0-10 - ten being the worse pain ever. It was documented the resident's pain is in her right hip. The resident describes the pain as "aching." What makes the pain better, the resident answered, "medication." The "Pain Assessment" dated 5/16/19, documented the resident could verbalize expression of pain. The resident was documented as having a pain level of "0." The comprehensive care plan dated, 1/16/17 and revised on 5/20/19, documented in part, "Focus: Risk for Potential Pain, chronic related to impaired mobility, hx (history of) osteoarthritis, bilateral knees, femur, right arm pain and CVA	F 697		

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 06/07/2019

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 697	Continued From page 124 (stroke)." The "Interventions" documented in part, "Administer pain medication as per MD (doctor) orders and note the effectiveness. Give PRN (as needed) meds (medications) for breakthrough pain as per MD orders and not the effectiveness. Monitor and document characteristics of pain: location, severity and frequency, precipitating factors, etc." An interview was conducted with LPN (licensed practical nurse) #3 on 6/6/19 at 10:31 a.m. When asked about the process staff follows for resident complaints of pain, LPN #3 stated, "First you assess the resident, ask the pain scale, and try non-pharmacological interventions like repositioning or distraction. If that is not effective we give the pain medication and then follow up with the resident in 30-60 minutes." When asked where all of that information is documented, LPN #3 stated, 'It's in the nurse's notes." An interview was conducted with LPN #1 on 6/6/19 at 10:35 a.m. When asked about the process staff follows for resident complaints of pain, LPN #1 stated, "I evaluate the resident, assess them, ask the pain scale, try non-pharmacological interventions. If that is not effective, I will give the pain medication and follow up with them in 30 minutes to see if it's effective." When asked where the assessment and pain scale is documented, LPN #1 stated, "There is a tab under the vital signs section of the computerized clinical record and we can enter the pain scale there. And you should write a progress note." The facility policy, "Pain Management Policy and Procedure" failed to evidence anything related to the administration of as needed medication and	F 697		

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 06/07/2019

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 697	Continued From page 125 the documentation of the pain scale. Administrative staff member (ASM) #1, ASM #2 and ASM #4, the facility nursing consultant, were made aware of the above findings on 6/6/19 at 7:35 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 33. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 422. (3) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a695011.html	F 697		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist	F 756		

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 06/07/2019

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 756	Continued From page 126 during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and facility document review, it was determined that the facility staff failed to develop a medication regimen review policy that included time frames to address recommendations from the pharmacist to the physician for five of 33 residents in the survey sample; Residents #41, #44, #25, #11, and #8. The facility staff failed to ensure the Monthly Regimen Review policy specified time frames in which the physician was to act upon any pharmacy recommendations for Resident's #44, #41, #25, #11, and #8. The findings include: 1. Resident #44 was admitted to the facility on	F 756	F756 The pharmacy recommendations for Residents# 44, 41 25, 11, and 8 were completed and signed by the physician. The facility will adopt a specific policy requiring that pharmacy recommendations will be followed up within 30 days from the time of receipt. This policy will be reviewed and signed by the facility, Medical Director and consulting Pharmacist. An in-service education will be conducted with the DON and her administrative staff to ensure compliance with this new policy Documentation of compliance will be recorded in the resident's chart and reviewed by the consulting pharmacist each month.	7/31/19

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 06/07/2019

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 756	Continued From page 127 5/8/12 with the diagnoses of but not limited to severe major depression with psychotic symptoms, dementia with behavior, bipolar disorder, anxiety disorder, psychotic disorder, high blood pressure, diabetes, and cataracts. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 5/16/19. The resident was coded as being cognitively intact in ability to make daily life decisions, scoring a 14 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of the clinical record revealed a pharmacy recommendation dated 2/28/19 for the reduction of the dose of Buspar (1) from 5 mg (milligrams) three times daily to 2.5 mg three times daily. The physician disagreed with this recommendation and signed it on 3/8/19. Review of the clinical record revealed a pharmacy recommendation dated 3/27/19 for the reduction of the dose of Protonix (2) from 40 mg daily to 20 mg daily. They physician agreed with this recommendation and signed it on 4/6/19. A review of the facility policy, "Consultant Pharmacist's Responsibilities" failed to reveal any specified time frames in which the physician must act upon pharmacy recommendations. On 6/6/19 at 7:43 PM, ASM #1 (Administrative Staff Member - the Administrator), ASM #2 (the Director of Nursing) and ASM #4 (Facility Nurse Consultant) were notified of the concerns regarding the policy not specifying a time frame in which the physician is required to act upon pharmacy recommendations. ASM #4 stated she would look and see what else they have. On	F 756		

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 06/07/2019

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 756	Continued From page 128 6/7/19 at 8:00 AM, ASM #4 stated that the facility does not have any other policies on the matter. She reviewed the policy that was provided and stated that it did not specify required time frames. (1) Buspar - is used to treat anxiety disorder. Information obtained from https://medlineplus.gov/druginfo/meds/a688005.html (2) Protonix - is used to treat gastroesophageal reflux. Information obtained from https://medlineplus.gov/druginfo/meds/a601246.html 2. Resident #41 was admitted to the facility on 7/10/18 with the diagnoses of but not limited to acute respiratory failure, diabetes, high blood pressure, anxiety disorder, breast cancer, bladder disorder, atrial fibrillation, congestive heart failure, chronic obstructive pulmonary disease, depression, and osteoporosis. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 5/3/19. The resident was coded as being moderately impaired in ability to make daily life decisions. Review of the clinical record revealed a pharmacy recommendation dated 2/26/19 for the reduction of the use of Paxil (1) from 20 mg (milligrams) daily to 10 mg daily. The physician agreed and signed it on 3/8/19. Review of the clinical record revealed a pharmacy recommendation dated 12/26/18 for the cessation	F 756		

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 06/07/2019

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 756	Continued From page 129 of Vitamin C (2) (dose not provided). The recommendation documented, "If this was for wound healing, has the wound resolved and could the Vit C be stopped?" The physician agreed and signed it on 1/2/19. A review of the facility policy, "Consultant Pharmacist's Responsibilities" failed to reveal any specified time frames in which the physician must act upon pharmacy recommendations. On 6/6/19 at 7:43 PM, ASM #1 (Administrative Staff Member - the Administrator), ASM #2 (the Director of Nursing) and ASM #4 (Facility Nurse Consultant) were notified of the concerns regarding the policy not specifying a time frame in which the physician is required to act upon pharmacy recommendations. ASM #4 stated she would look and see what else they have. On 6/7/19 at 8:00 AM, ASM #4 stated that the facility does not have any other policies on the matter. She reviewed the policy that was provided and noted that it did not specify required time frames. (1) Paxil - is used to treat depression, panic disorder, social anxiety disorder, obsessive-compulsive disorder, generalized anxiety disorder, post traumatic stress disorder, premenstral dysphoric disorder, and hot flashes in menopause. Information obtained from https://medlineplus.gov/druginfo/meds/a698032.html (2) Vitamin C - is an antioxidant. It is important for your skin, bones, and connective tissue. It promotes healing and helps the body absorb iron. Information obtained from https://medlineplus.gov/vitaminc.html	F 756		

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 06/07/2019

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 756	Continued From page 130	F 756		

3. Resident #25 was admitted to the facility on 7/30/18 with the diagnoses of but not limited to congestive heart failure, atrial fibrillation, high blood pressure, fractured humerus, stroke, dementia, depression, pulmonary embolism, and osteoarthritis. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 5/26/19. The resident was coded as moderately impaired in ability to make daily life decisions.

Review of the clinical record revealed a pharmacy recommendation dated 4/26/19 for the reduction of the dose of Protonix (1) from 40 mg daily to 20 mg daily. They physician agreed with this recommendation and signed it on 5/4/19.

A review of the facility policy, "Consultant Pharmacist's Responsibilities" failed to reveal any specified time frames in which the physician must act upon pharmacy recommendations.

On 6/6/19 at 7:43 PM, ASM #1 (Administrative Staff Member - the Administrator), ASM #2 (the Director of Nursing) and ASM #4 (Facility Nurse Consultant) were notified of the concerns regarding the policy not specifying a time frame in which the physician is required to act upon pharmacy recommendations. ASM #4 stated she would look and see what else they have. On 6/7/19 at 8:00 AM, SAM #4 stated that the facility does not have any other policies on the matter. She reviewed the policy that was provided and noted that it did not specify required time frames.

(1) Protonix - is used to treat gastroesophageal

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 06/07/2019

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 756	Continued From page 131 reflux. Information obtained from https://medlineplus.gov/druginfo/meds/a601246.html 4. Resident #11 was admitted to the facility on 1/29/19 with the diagnoses of but not limited to congestive heart failure, urinary retention, chronic kidney disease, gout, spinal stenosis, rhabdomyolysis, syncope, implanted cardiac defibrillator, contractures of bilateral knees, prostate disorder, and uropathy reflux. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 6/3/19. The resident was coded as being severely impaired in ability to make daily life decisions. Review of the clinical record revealed a pharmacy recommendation dated 3/28/19 that documented that Resident #11 was getting Benadryl (1) 25 mg (milligrams) every night at bedtime for insomnia. The recommendation documented, "If the use of this medication is necessary, CMS (Centers for Medicare and Medicaid Services) requires an assessment of risk vs (versus) benefit. Please indicate which of the following apply: 1. This medication improves the quality of this resident's life. The resident is responding to this medication and is experiencing no adverse effects. The benefits outweigh the risks when this medication is used for this resident. 2. Possible adverse effect from this medication have been noted, but alternative therapy has failed or continued therapy is warranted for the following reason: _____. Benefits outweigh the risks at this time for this resident. Will continue to monitor the	F 756		

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 06/07/2019

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 756	Continued From page 132 resident's response. 3. Discontinue medication at this time as indicated below." The physician chose option 1 and documented, "#1 applies." The physician signed this recommendation on 4/6/19. Further review of the clinical record revealed a pharmacy recommendation dated 2/27/19 that documented, "The indication(s) for use are unclear from the limited chart records. Please consider updating chart records with supporting indication(s) or discontinue medication(s) if no longer required. Colace (2) Indication: _____. Neurontin (3) Indication: _____." The physician documented, "constipation" on the line for the Colace and "peripheral neuropathy" on the line for the Neurontin and signed the recommendation on 3/8/19. A review of the facility policy, "Consultant Pharmacist's Responsibilities" failed to reveal any specified time frames in which the physician must act upon pharmacy recommendations. On 6/6/19 at 7:43 PM, ASM #1 (Administrative Staff Member - the Administrator), ASM #2 (the Director of Nursing) and ASM #4 (Facility Nurse Consultant) were notified of the concerns regarding the policy not specifying a time frame in which the physician is required to act upon pharmacy recommendations. ASM #4 stated she will look and see what else they have. On 6/7/19 at 8:00 AM, ASM #4 stated that the facility does not have any other policies on the matter. She reviewed the policy that was provided and noted that it did not specify required time frames.	F 756		

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 06/07/2019

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 756	Continued From page 133 (1) Benadryl - is used to relieve red, irritated, itchy, watery eyes; sneezing; and runny nose caused by hay fever, allergies, or the common cold....is also used to relieve cough caused by minor throat or airway irritation ....is also used to prevent and treat motion sickness, and to treat insomnia....is also used to control abnormal movements in people who have early stage parkinsonian syndrome...." Information obtained from https://medlineplus.gov/druginfo/meds/a682539.html (2) Colace - is used to treat constipation. Information obtained from https://medlineplus.gov/druginfo/meds/a601113.html (3) Neurontin - is used to treat seizures, neuralgia, restless leg syndrome, diabetic neuropathy, hot flashes related to the treatment of breast cancer or related to menopause. Information obtained from https://medlineplus.gov/druginfo/meds/a694007.html 5. Resident #8 was admitted to the facility on 10/12/17 with the diagnoses of but not limited to neuropathic bladder, hemiplegia, heart failure, obstructive uropathy, respiratory failure, arthritis, chronic kidney disease, high blood pressure, diabetes, depression, peripheral vascular disease, morbid obesity, and dysphagia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 3/12/19. The resident was coded as being moderately impaired in ability to	F 756		

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 06/07/2019

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 756	Continued From page 134 make daily life decisions. Review of the clinical record revealed a pharmacy recommendation dated 3/27/19 requesting a registered dietician consult. The physician documented that one bad been obtained as well as weekly monitoring. The physician signed this recommendation on 4/6/19. Review of the clinical record revealed a pharmacy recommendation dated 12/26/18 requesting a registered dietician consult. The physician agreed and signed this recommendation on 1/2/19. (See above recommendation as well.) Review of the clinical record revealed a pharmacy recommendation dated 12/26/18 for the reduction of Zoloft (1) from 75 mg (milligrams) daily to 50 mg daily. The physician agreed and signed this recommendation on 1/2/19. Review of the clinical record revealed a pharmacy recommendation dated 12/26/18 for the cessation of Vitamin C (2). The recommendation documented, "If this was for wound healing, has the wound resolved and could the Vit C be stopped?" The physician agreed and signed this recommendation on 1/2/19. A review of the facility policy, "Consultant Pharmacist's Responsibilities" failed to reveal any specified time frames in which the physician must act upon pharmacy recommendations. On 6/6/19 at 7:43 PM, ASM #1 (Administrative Staff Member - the Administrator), ASM #2 (the Director of Nursing) and ASM #4 (Facility Nurse Consultant) were notified of the concerns regarding the policy not specifying a time frame in	F 756		

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 06/07/2019

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 756	Continued From page 135 which the physician is required to act upon pharmacy recommendations. ASM #4 stated she would look and see what else they have. On 6/7/19 at 8:00 AM, ASM #4 stated that the facility does not have any other policies on the matter. She reviewed the policy that was provided and noted that it did not specify required time frames. (1) Zoloft - is used to treat depression, panic disorder, social anxiety disorder, obsessive-compulsive disorder, generalized anxiety disorder, post traumatic stress disorder, and premenstral dysphoric disorder. Information obtained from https://medlineplus.gov/druginfo/meds/a697048.html (2) Vitamin C - is an antioxidant. It is important for your skin, bones, and connective tissue. It promotes healing and helps the body absorb iron. Information obtained from https://medlineplus.gov/vitaminc.html	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its	F 757		

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 06/07/2019

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	(X5) COMPLETION DATE
F 757	Continued From page 136 use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure one of 33 residents in the survey sample was free of unnecessary medications, Resident #33. The facility staff failed to monitor the resident's blood pressure and pulse prior to the administration of a blood pressure medication for Resident #33. The findings include: Resident #33 was admitted to the facility on 5/1/19 with diagnoses that included but were not limited to: dementia, high blood pressure, diabetes, stroke and COPD (chronic obstructive pulmonary disease - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (1). The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 5/8/19, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indication she is severely Impaired to make daily cognitive decisions.	F 757	F-757 The charge nurse for resident #33 was re-educated on the current physician order and the necessity to monitor and record the blood pressure anc pulse of Resident #33 prior to the administration of blood pressure medication. Resident #33 was found to be the only resident that was out of compliance with the order involving blood pressure medication Nursing staff will be re-educated on the necessity of following physician orders especially when the order gives specific parameters. The DON or her designee will review the documentation weekly on those residents specifically having orders with specific parameters to ensure continued compliance. Results of these reviews will be submitted to the Cardinal IDT members for oversight and review. The QAPI committee will incorporate any findings of non-compliance and make further recommendations.	7/25/19

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 06/07/2019

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 757	Continued From page 137 The physician order dated, 5/2/19 documented, "Metoprolol Tartrate (used to treat high blood pressure) (2), 25 mg (milligrams) 1/2 = 12.5 mg by mouth twice daily. Hold for SBP (systolic blood pressure) less than 100 or HR (heart rate) less than 50." The May MAR (medication administration record) documented the above physician's medication order. On the following dates and time, the blood pressure/pulse was not documented prior to the administration of the medication to Resident #33: 5/8/19 at 9:00 a.m. - no pulse was documented 5/8/19 at 9:00 p.m. - no pulse was documented 5/10/19 at 9:00 a.m. - no pulse was documented 5/11/19 at 9:00 p.m. - no pulse was documented 5/12/19 at 9:00 p.m. - no pulse was documented 5/15/19 at 9:00 p.m. - no pulse was documented 5/16/19 at 9:00 p.m. - no pulse was documented 5/20/19 at 9:00 p.m. - no pulse was documented 5/21/19 at 9:00 p.m. - no pulse was documented 5/22/19 at 9:00 a.m. - no blood pressure or pulse was documented 5/22/19 at 9:00 p.m. - no pulse was documented 5/23/19 at 9:00 p.m. - no blood pressure or pulse was documented 5/24/19 at 9:00 p.m. - no pulse was documented 5/25/19 at 9:00 p.m. - no pulse was documented 5/26/19 at 9:00 a.m. - no pulse was documented 5/26/19 at 9:00 p.m. - no pulse or blood pressure was documented 5/28/19 at 9:00 p.m. - no blood pressure or pulse was documented 5/29/19 at 9:00 p.m. - no blood pressure or pulse was documented 5/30/19 at 9:00 a.m. - no pulse was documented 5/30/19 at 9:00 p.m. - no pulse or blood pressure was documented.	F 757		

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 06/07/2019

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 757	Continued From page 138 Review of the nurse's notes for the above listed dates and times failed to evidence documentation of the missing blood pressure or pulse. Review of the vital signs tab in the computerized record, failed to evidence the missing pulse or blood pressure readings. The comprehensive care plan dated, 5/3/19, documented in part, "Focus: Hypertension (high blood pressure): at risk for complications of renal failure, arteriosclerotic disease and/or retinopathy." The "Interventions" documented in part, "Monitor blood pressure per facility protocol and/or as ordered by physician." An interview was conducted with LPN (licensed practical nurse) #2 on 6/5/19 at 3:29 p.m., LPN #2 was asked to read the above physician's order for Metoprolol. LPN #2 was asked what staff should do if a resident has this order. LPN #2 stated, "You have to take the blood pressure and pulse before giving it." When asked if you have to take both, LPN #2 stated, "I would think so since it asks for both." An interview was conducted with administrative staff member (ASM) #2, the director of nursing; on 6/5/19 at 3:36 p.m., ASM #2 read the above physician's order. When asked what is the nursing staff should do, ASM #2 stated, "Take the blood pressure and pulse." When asked why there is no documentation of a pulse or blood pressure on some days, ASM #2 stated, "Well the order does say 'or." The policy "Medication Administration" documented in part, "N. Any deviation from the following principles shall be considered a medication error: 1. To the right resident. 2.	F 757		

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 06/07/2019

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 757	Continued From page 139 Administration of the right medication. 3. In the right dose. 4. By the right route. 5. By the right method. 6. At the right time." The policy failed to document any mention of obtaining the prescribed vital signs prior to administration of a medication. "Your blood pressure should be checked regularly to determine your response to metoprolol. Your doctor may ask you to check your pulse (heart rate). Ask your pharmacist or doctor to teach you how to take your pulse. If your pulse is faster or slower than it should be, call your doctor." (2). ASM #1, the administrator and ASM #4, the facility nurse consultant, were made aware of the above findings on 6/6/19 at 7:45 a.m. No further information was obtained prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682864.html.	F 757		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant;	F 758		

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

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 06/07/2019

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 758	Continued From page 140 (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.	F 758	F-758 The Nursing staff was re-educated on the physician orders, necessity of documentation, and requirements for identifications of targeted behaviors on Residents #44 and 34. No other residents were identified as being out of compliance with documentation. A review of policy and procedures for PRN medications and documentation requirements will be conducted. Staff will then receive education regarding PRN documentation and the proper areas to document targeted behaviors. Gradual Dose Reductions and physician documentation of continued medication usage will be covered.	

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 06/07/2019

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 758	Continued From page 141 This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interview, and facility document review, it was determined that the facility staff failed to ensure residents were free of unnecessary psychotropic medications for one of 6 residents in the medication administration observation (Resident #44) and for two of 33 residents in the survey sample; Residents #44, and #34. 1. The facility staff failed to ensure adequate indications prior to administering an as needed (prn) antipsychotic medication (Risperdal) to Resident #44. Staff administered the Risperdal to Resident #44 for complaints of anxiety, which was not a documented diagnosis for the administration of the medication and without attempting non-pharmacological interventions. 2. The facility staff failed to ensure adequate indications for the administration of as needed (PRN) Risperdal an antipsychotic medication and failed to administer the medication to Resident #44 per the physician's orders. 3. The facility staff failed to ensure targeted behaviors were identified, documented and monitored for the administration of the antipsychotic medication Seroquel to Resident #34. The findings include: 1. The facility staff failed to ensure adequate indications prior to administering an as needed (prn) antipsychotic medication (Risperdal) to	F 758	The DON or her designee will conduct a monthly review of physician orders to identify GDRs and PRN medications within the facility. Residents identified in these categories will be monitored by the Cardinal IDT in its morning meetings to ensure compliance with regulations. The Medical Director will receive a report of the IDT findings at the Monthly QAPI meeting and will make suggestions as needed.	7/21/19

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 06/07/2019

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 758	Continued From page 142 Resident #44. Staff administered the Risperdal to Resident #44 for complaints of anxiety, which was not a documented diagnosis for the administration of the medication and without attempting non-pharmacological interventions. Resident #44 was admitted to the facility on 5/8/12 with the diagnoses of but not limited to severe major depression with psychotic symptoms, dementia with behavior, bipolar disorder, anxiety disorder, psychotic disorder, high blood pressure, diabetes, and cataracts. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 5/16/19. The resident was coded as being cognitively intact in ability to make daily life decisions, scoring a 14 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. A review of the clinical record revealed a physician's order dated 5/20/19 for Risperdal (1) 0.5 mg (milligrams) bid (twice daily) prn (as needed) for agitation and bipolar. (Note: Anxiety is not an approved use for Risperdal). On 6/05/19 08:24 AM, LPN #1 was observed to prepare and administer the following medications to Resident #44: Zaditor (2) eye drops, 1 drop in each eye Miralax (3) 17 grams Voltaren gel (4), applied to both knees Depakote (5) sprinkle 125 mg (milligrams), gave 2 tabs (tablets) Calcium (6) 250mg, with Vitamin D3 125 units, gave 1 tab Risperdal 0.5 mg prn (as needed) for agitation, gave 1 tab.	F 758		

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 06/07/2019

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 758	Continued From page 143 At this time, she asked Resident #44 if she needed her "medication for anxiety." The resident stated she did. The resident did not appear anxious or agitated. The resident was in her wheelchair and appeared very calm. There were no apparent signs of anxiety or agitation. LPN #1 did not offer any non-pharmacological interventions at this time. She then took the resident's Risperdal from the medication cart drawer. As she was preparing the Risperdal, the resident asked her what it was. She stated to the resident it was for her anxiety. She then went with the resident to her room to administer the medications. She assisted the resident up and applied the Voltaren gel to the resident's knees. She then assisted the resident back into the wheelchair, and administered the Zaditor eye drops and then gave the resident the cup of the pills, including the Risperdal. After administering medications, LPN #1 then assisted the resident to bed. On 6/05/19 at 2:24 PM, in an interview with LPN #1, when asked what Risperdal isused for, LPN #1 stated, "anxiety." When informed of the observation of the resident being offered an as-needed (prn) antipsychotic, LPN #1 stated that the resident had requested the Risperdal "for anxiousness and had been yelling out, saying she was tired, saying I can't stay up, and I gotta go." When asked if it was ordered for anxiety, LPN #1 stated it was. When asked to show where the order stated it was for anxiety, LPN #1 was unable to show that the Risperdal was ordered for anxiety. When asked about offering non-pharmacological interventions prior to administering the medication, LPN #1 stated that the resident was agitated earlier about her clothes being twisted and bunched up and she	F 758		

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 06/07/2019

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 758	Continued From page 144	F 758		

assisted her with readjusting her clothes. When informed of the observation of the resident not showing any signs of anxiety or agitation, at the medication cart at 8:24 AM, and still being offered the Risperdal without offering non -pharmacological interventions. LPN #1 stated that she had repositioned her clothes a second time (in her room with the administration of Voltaren gel to her knees) and assisted her to bed (after administering all medications) because one of the issues the resident expressed was that she was tired. When it was noted that these additional interventions were done only in conjunction with or after providing the medication, and not before, LPN #1 stated the resident had asked for the medication and it was her right to have it. LPN #1 was asked about the process the staff follows for determining if a resident needs a PRN (as needed) medication. LPN #1 stated that staff should try to figure out why the resident wants the medication, try to fix whatever the situation might be by offering non pharmacological interventions, and give the medication only after other attempts are ineffective.

Further review of the clinical record failed to reveal any nurses notes documenting the nature of the resident's anxiety and agitation or any non-pharmacological interventions attempted. A review of the back of the MAR (Medication Administration Record) for June 2019 for Resident #44 revealed the Risperdal was administered for "resident request for anxiousness."

On 6/06/19 at 7:11 PM, in an interview with LPN #4, she stated that Risperdal is an antipsychotic used for aggressive behaviors. She stated that it

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 06/07/2019

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 758	Continued From page 145 is not used for anxiety. She stated that she would not give a resident Risperdal if they say they have anxiety. She stated that to give it, there would need to be combative or aggressive behaviors or exhibiting some type of psychotic behaviors. She stated she would not give it if the resident were not showing these symptoms. She stated that the care plan was not followed because the Risperdal was given for the wrong reason. A review of the comprehensive care plan revealed one for "Problematic manner in which resident acts characterized by ineffective coping: verbal/ physical Aggression or Combativeness related to: Cognitive impairments/phys (physical) changes in the brain." This care plan was dated 2/8/18. The interventions included one dated 2/8/18 for "Monitor and document behavior per facility protocol" and one dated 5/31/18 for "Give medication as prescribed by MD (medical doctor); and one dated 3/25/19 for "Document episodes of anxiety per facility protocol and notify MD of changes as indicated." In addition, a care plan dated 6/5/12 documented, "Use of psychotropic drugs with the potential for or characterized by side effects due to use of medications, antidepressants, antipsychotic." This care plan documented the intervention dated 6/5/12 for "Administer medications per physician's order." A review of the facility policy, "Antipsychotic Drug Therapy" documented, "A. Purpose: 1. To encourage appropriate utilization of antipsychotic drugs....2. To provide for the monitoring of the resident receiving such drugs for possible adverse consequences and to measure progress in achieving therapeutic objectives. 3. To encourage the use of non-drug interventions prior to and, if indicated, in conjunction with	F 758		

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 06/07/2019

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 758	Continued From page 146 antipsychotic drug therapy as well as the use of other pharmacological interventions when possible...." On 6/6/19 at 7:43 PM, ASM #1 (Administrative Staff Member - the Administrator), ASM #2 (the Director of Nursing) and ASM #4 (Facility Nurse Consultant) were notified of the concerns. No further information was provided by the end of the survey. (1) Risperdal - is an antipsychotic and is used to treat schizophrenia, mania, mixed mood episodes, and behaviors. Information obtained from https://medlineplus.gov/druginfo/meds/a694015.html (2) Zaditor - is an opthalmic solution used to relieve the itching of allergic pinkeye. Information obtained from https://medlineplus.gov/druginfo/meds/a604033.html (3) Miralax - is used to treat constipation. Information obtained from https://medlineplus.gov/druginfo/meds/a603032.html (4) Voltaren - is a topical gel used to treat pain from osteoarthritis. Information obtained from https://medlineplus.gov/druginfo/meds/a611002.html (5) Depakote - is used to treat seizures and bipolar disorder. Information obtained from https://medlineplus.gov/druginfo/meds/a682412.h	F 758		

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 06/07/2019

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 758	Continued From page 147 tml (6) Calcium - Calcium is a mineral found in many foods. The body needs calcium to maintain strong bones and to carry out many important functions. Almost all calcium is stored in bones and teeth, where it supports their structure and hardness. The body also needs calcium for muscles to move and for nerves to carry messages between the brain and every body part. In addition, calcium is used to help blood vessels move blood throughout the body and to help release hormones and enzymes that affect almost every function in the human body. Information obtained from https://ods.od.nih.gov/factsheets/Calcium-Consumer/ 2. The facility staff failed to ensure adequate indications for the administration of as needed (PRN) Risperdal an antipsychotic medication and failed to administer the medication to Resident #44 per the physician's orders. Resident #44 was admitted to the facility on 5/8/12 with a recent readmission on 5/9/19 with diagnoses that included but were not limited to: depression, diabetes, dementia, bipolar disorder [a mental disorder characterized by episodes of mania and depression (1)], anxiety disorder, high blood pressure and osteoarthritis [characterized by degenerative changes in the joints, pain, stiffness and swelling can develop after exercise (2)]. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 5/16/19, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating	F 758		

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 06/07/2019

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 758	Continued From page 148	F 758		

the resident was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of one staff member for most of her activities of daily living. In Section N - Medications, the resident was coded as having received an antipsychotic medication on four days during the last seven-day look back period.

The physician order dated, 5/15/19, documented, "Risperdal [used to treat schizophrenia and bipolar disease (3)], 0.5 mg (milligrams) 1 (tablet) po (by mouth) BID (twice a day) PRN (as needed) for agitation."

The nurse practitioner note dated, 5/18/19, documented in part, "Her risperidone (Risperdal) was changed from twice a day on a scheduled basis to twice a day as needed for agitation."

The review of the clinical record failed to evidence documentation evidencing the need for the continued use of a PRN antipsychotic medication by the attending physician or the nurse practitioner. As of the end of survey on 6/7/19, 23 days after the initial order for the as needed (PRN) Risperdal, no documentation was found evidencing the need for the continued use of Risperdal.

The May 2019 MAR (medication administration record) documented the above physician's order. The medication was documented as given on 5/25/19 at 6:00 p.m. for "anxiety." Review of the nurse's notes failed to evidence any documentation on 5/25/19 regarding the administration of the above medication.

The June 2019 MAR documented the above

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 06/07/2019

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 758	Continued From page 149	F 758		

physicians order. The medication was documented as given on 6/3/19 at 6:00 p.m. and 6/4/19 at 6:30 a.m. for "anxiety." Review of the nurse's notes for the above dates failed to evidence any documentation on 6/3/19 and 6/4/19 related to the administration of the above medication.

The comprehensive care plan dated, 2/8/18, documented in part, "Focus: Problematic manner in which resident acts characterized by ineffective coping; verbal/physical aggression or combativeness related to: cognitive impairment/physical changes in brain." The "Interventions" documented in part, "Monitor and document behavior per facility protocol." The care plan dated, 5/31/18, further documented, "Focus: Problematic manner in which resident acts characterized by ineffective coping; Agitation/Combativeness related to: Drug side effects, frustration." The "Interventions" documented in part, "Give medication as prescribed by MD (medical doctor). Monitor and document behaviors per facility protocol.

An interview was conducted with ASM (administrative staff member) # 3, the assistant director of nursing, on 6/6/19 at 11:20 a.m. When asked if Risperdal can administered as needed (PRN), ASM #3 stated, "'It's dictated by the order." The order above for agitation was reviewed with ASM #3. When asked if Risperdal could be administered for anxiety, ASM #3 stated, "I don't think so." When asked how often are PRN antipsychotic medications are renewed, ASM #3 stated, "It's based on what (name of nurse practitioner) wants us to do." ASM #3 was asked if an as needed antipsychotic medication is reviewed periodically to evaluate to need for

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 06/07/2019

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 758	Continued From page 150	F 758		

continued use. ASM #3 stated, "The pharmacist reviews the medications and makes recommendations on a monthly basis." When asked if she was aware of the regulation regarding the use of PRN antipsychotic medications, ASM #3 stated, "No, I am not."

An interview was conducted with ASM #2, the director of nursing; on 6/6/19 at 11:47 a.m. ASM #2 was asked to review the order above. When asked the nurses give the as needed Risperdal for anxiety when the order documented agitation, ASM #2 stated, "Anxiety can show as a sign of agitation." ASM #2 stated the physician and nurse practitioners don't like to change those medications around. When asked if the resident, who was just readmitted on 5/9/19, to the facility after a psychiatric admission to the hospital on 4/11/19, has been seen by the facility psychiatric services, ASM #2 stated she's have to look into that. On 6/6/19 at approximately 4:45 p.m., ASM #2 presented the psychiatric consults. The last one was dated 3/25/19.

An interview was conducted with ASM #4, the facility nurse consultant, on 6/7/19 at 7:52 a.m. When asked if there are any special requirements for the use of a PRN antipsychotic medication, ASM #4 stated, "They can only be written for 14 day and have to be reevaluated and has to be documented after a thorough evaluation by the physician."

An interview was conducted with other staff member (OSM) #7, the facility pharmacy consultant, on 6/7/19 at 9:32 a.m. When asked if PRN (as needed) antipsychotics are allowed to be used in a facility, OSM #7 stated, "There is a

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 06/07/2019

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 758	Continued From page 151 14 day period that they can be used but after that 14 days they have to be reevaluated by the physician and documentation of their continued use." The facility policy, "Antipsychotic Drug Therapy" failed to evidence documentation related to the use of PRN antipsychotic medications and their limitation in use. ASM #1, the administrator, ASM #2, the director of nursing, and ASM #4, the facility nurse consultant, were made aware of the above findings on 6/6/19 at 7:35 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 72. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 422. (3) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a694015.html 3. The facility staff failed to ensure targeted behaviors were identified, documented and monitored for the administration of the antipsychotic medication Seroquel to Resident #34. Resident #34 was admitted to the facility on 10/17/17 with diagnoses that included but were	F 758		

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 06/07/2019

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 758	Continued From page 152 not limited to: diabetes, dementia, depression, stroke, high blood pressure, and bradycardia (A slow heart beat lower than 60 in adults) (1). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/10/19, coded the resident as scoring "3" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. In Section E - Behaviors, the resident was not coded as having any behaviors during the look back period and as not having indicators of psychosis. The MDS assessment, a quarterly assessment, with an assessment reference date of 2/28/19, in Section E - Behaviors, did not code the resident as having any behaviors during the look back period and as not having indicators of psychosis. The MDS assessment, a quarterly assessment, with an assessment reference date of 11/29/18, documented in Section E - Behaviors, did not code the resident as having any behaviors during the look back period and as not having indicators of psychosis. The MDS assessment, an annual assessment, with an assessment reference date of 8/31/18, documented in Section E - Behaviors, did not code the resident as having any behaviors during the look back period and as not having indicators of psychosis. The physician order dated, 8/20/18, documented, "Seroquel (Quetiapine -generic) [used to treat schizophrenia and along with other medications, depression (2)] tab (tablet) 25 mg (milligrams) 1/2	F 758		

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 06/07/2019

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 758	Continued From page 153 = 12.5 mg by mouth every night at bedtime for depression/insomnia." A review of the May and June 2019 MAR (medication administration record) documented the above physician medication order and documented the medication was administered every day as ordered. A review of the nurse's notes from 12/1/19 through 6/6/19 documented the following behaviors: "1/25/19 at 2:40 p.m. - message left for RR (resident representative) regarding condition of resident's feet. Ares remain dry continuing with the cream however, he frequently refused to allow it to be put on. "2/2/19 at 10:45 p.m., Resident has short term memory loss. Wants to go to bed as soon as he eats supper. Staff has to remind him every night that we are in the middle of supper and feeding other residents. Resident will say OK, then a few minutes later will be calling for help. Is saying he wants to go to bed. Wife brings him snack food and drinks from home, which he eats before supper. "2/13/19 at 2:51 p.m. Nurse called and spoke with RR about resident refusal with shaving. She stated that she had already brought razor up to facility, use what is here. "2/26/19 at 11:52 a.m. Resident flagging x 3days no BM (bowel movement). Nurse attempted to administer MOM (milk of magnesia) and resident stated, 'I'm not taking that.' Resident continues to refuse. "3/6/19 at 2:38 p.m. RR aware about refusal of taking MOM x3 day d/t (due to) no BM and refusal of shower. "3/7/19 at 6:20 a.m. Per CNA (certified nursing	F 758		

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 06/07/2019

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 758	Continued From page 154 assistant) resident refused to be shaved this morning, writer offered to so still resident refused. "3/15/19 at 10:06 a.m. Flagging x3 days no BM. nurse attempted to administer MOM and resident refused. "3/30/19 at 8:41 a.m., Resident refused shower. "4/8/19 at 12:02 p.m. resident flagging for no BM x 3 days, would only accept half (15 ml [milliliters]) of MOM of 30 ml (milliliter) dose. "4/8/19 at 7:00 p.m. REFUSAL - resident refused to be lifted by CNA w/lift (with lift) under direct supervision. "4/18/19 at 2:08 p.m. resident flagging for no BM x 3 days, resident only accepted 15 cc (cubic centimeters) MOM. "4/22/19 at 11:08 a.m., Resident flagged for no BM x3 days, resident refused to take MOM per protocol. "4/24/19 at 5:52 a.m. Resident flagging for no bowel movement in the past three days. Due to refusal of MOM. "5/15/19 at 5:51 a.m. Resident flagging for no BM x3 days, MOM refused. "5/17/19 at 10:29 a.m. Resident flagging for no BM x 3 days. MOM given but resident would only take apprx (approximately) 15 cc [cubic centimeter]. The physician notes dated 11/26/18, documented in part, "Psych (psychiatric): he is pleasant and understand who I am as the doctor. No other documentation regarding his mood or behaviors. The physician note dated, 12/3/18, failed to evidence documentation related to mood or behaviors. The physician note dated, 4/1/19, failed to	F 758		

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 06/07/2019

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 758	Continued From page 155 evidence any documentation related to mood or behaviors. The nurse practitioner note dated, 12/5/18, documented in part, "Past Medical History - depression. Review of Systems: Psychiatric - no increased nervousness or suicidal ideations. Physical Exam: Psychiatric: no increased nervousness or suicidal ideations. The nurse practitioner note dated, 2/22/19, documented in part, "Past Medical History - depression. Review of Systems: Psychiatric - no mood swings, increased nervousness or suicidal ideations. Physical Exam: Psychiatric - Mood and affect pleasant, resident oriented to person and place. The nurse practitioner note dated, 5/30/19 documented in part, "His nurse reports resident compliance with his medication and diet.... (Resident #34) has depression. His nurse reports irritability, mood swings and decreased motivation. She reports he is compliant with his medication and cooperative with his care. He denies any suicidal ideations or homicidal ideations...Past Medical History - Depression. Review of Systems: Psychiatric: no changes in cognition or increased nervousness...Physical Exam: Psychiatric: Mood and affect flat; resident oriented to person and place. The comprehensive care plan dated, 10/22/18 documented in part, "Focus: Problematic manner in which resident acts characterized by ineffective coping; verbal/physical aggression or combativeness related to: anger." The "Interventions" documented in part, "Monitor and document behavior (physical) behaviors) per	F 758		

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 06/07/2019

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 758	Continued From page 156 facility protocol." The care plan further documented, "Focus: Problematic manner in which resident acts characterized by ineffective coping; Sleeplessness/insomnia related to: restlessness." The "Interventions" documented in part, "Administer medication. Monitor sleep pattern and quality of sleep/rest, document episodes, and notify physician of changes for possible interventions as appropriate." The care plan documented "Focus: Use of psychoactive drugs with the POTENTIAL FOR or characterized by SIDE EFFECTS of cardiac, neuromuscular, gastrointestinal systems AEB (as exhibited by) or/due to diagnoses of: antipsychotic, antidepressant (GDR [gradual dose reduction] antipsychotic 7/6/18." The "Interventions" documented, "Administer medications per physician's orders. Observe resident's mental status functioning on ongoing basis." An interview was conducted with LPN (Licensed practical nurse) #2 on 6/5/19 at 5:43 p.m. When asked where behaviors are documented, LPN #2 stated, on the back of the MAR (medication administration record) and in the progress notes." LPN #2 was asked what Resident #34's targeted behaviors are for the use of Seroquel. LPN #2 stated, "When he first came he was on it but it's been cut back. His wife said he took it at home to help him sleep. Lately his behaviors are much improved." When asked when she would document a behavior, LPN #2 stated she's document it if she saw the resident having a behavior or something that is out of their norm." An interview was conducted with RN (registered nurse) #2, on 6/5/19 at 5:45 p.m. When asked where behaviors are documented, RN #2 stated in the computer under behavior notes. When	F 758		

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 06/07/2019

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 758	Continued From page 157 asked what the targeted behaviors for Resident #34 are for the use of Seroquel, RN #2 stated, "I don't know." An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 6/5/19 at 5:47 p.m. When asked about the process for documenting targeted resident behaviors, ASM #2 stated, "They should be in the progress notes under health status or behavior." ASM #2 was asked what Resident #34's targeted behaviors are for the use of Seroquel. ASM #2 stated she would have to check. An interview, via telephone, was conducted with ASM #5, the nurse practitioner, on 6/6/19 at 8:33 a.m. When asked the reason Resident #34 was on Seroquel, ASM # 5 stated, "Bipolar disorder and depression." When ASM #5 was informed the clinical record documented, the Seroquel was for depression/insomnia. ASM #5 stated, "The resident has been maintained on this medication since admission. (10/17/17). When asked if insomnia is an indication for Seroquel, ASM #5 stated, "No, it's not." When asked what Resident #34's behaviors are for the use of the Seroquel, ASM #5 stated, "He has depression and behaviors. When asked what the targeted behaviors are as the review of the clinical record failed to evidence documentation of behaviors, expect for refusing MOM and to be shaved, ASM #5 stated, "I talk to the nurse and CNAs and they tell me his behaviors. I can't control their documentation." When asked if there were psychiatric services available in the building, ASM #5 stated, "Yes, but it's done by video chat. I am not satisfied with the psych (psychiatric) services. I am a family nurse practitioner, not a psychiatric	F 758		

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 06/07/2019

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 758	Continued From page 158 nurse practitioner. Transportation is an issue to get the resident to an outside psychiatrist. We are going to look into getting other psych (psychiatric) services once the survey is over." When asked if a GDR (gradual dose reduction) should be attempted, as the resident does not have documented behaviors and is on a low dose of Seroquel, ASM #5 stated, "I guess it can be attempted but my experience with GDR is that the resident either have to be hospitalized or their behaviors return and increase." An interview was conducted with ASM #2, the director of nursing; on 6/6/19 at 11:37 a.m., ASM #2 was asked if the psychiatrist had seen Resident #34. ASM #2 stated, "I don't think so." When asked why Resident #34 was on Seroquel, ASM #2 stated, "He first came here he was very angry, mad and came from the hospital with it. My doctors and nurse practitioner are hesitant to change things. He was kicking and cursing at staff." ASM #2 stated she would check on psychiatric notes. ASM #2 then returned and stated she had no notes from psychiatric services for this resident. She presented an admission history and physical dated, 10/13/17, that documented under the "Assessment/Plan: We will place him on some Seroquel. That will probably help with his insomnia and hallucinations." Review of the clinical record failed to evidence any documentation of Resident #34 having or exhibiting hallucinations. ASM #1, the administrator, ASM #2, the director of nursing, and ASM #4, the facility nurse consultant were made aware of the above concern on 6/6/19 at 7:35 p.m.	F 758		

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 06/07/2019

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 758	Continued From page 159 No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 87. (2) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a698019.html.	F 758		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880		

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 06/07/2019

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 880	Continued From page 160 procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its	F 880	F-880 The maintenance person has received further training on the facility's legionella program. Areas subject to infection will be identified and water testing logs will be maintained. Infection control logs will be updated. Staff will receive in service education on the facility's Infection Control program and the requirements thereof. An individual RN will be secured to administer the program. Maintenance testing logs for the Legionella program will be maintained in the maintenance office and reported to the Safety Committee monthly. Infection control logs will be maintained in the SDC/IC office and presented each month to the QA Committee. The QAPI Committee will receive reports from the Safety Committee and the IC Nurse to provide oversight and review.	7/21/19

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 06/07/2019

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 880	Continued From page 161 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to have a Legionella policy and a complete infection control program, as evidenced by a lack of infections control tracking logs for the months of April 2019 through May 2019, and incomplete tracking logs for the months of December through March 2019; and failed to follow infection control practices during medication administration for one of six residents in the medication administration observation, Resident #41. The facility staff touched a pill with their bare hands and then administered the medication to Resident #41. The findings include: 1. On 6/4/19 at approximately 12:15 p.m., upon entrance to the facility a copy of the policy and procedure for the water management to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in the facility water systems, was requested. On 6/6/19 at 2:32 p.m. Administrative staff member (ASM) #1, the administrator, presented a packet of papers entitled, "Developing a Water Management Program to Reduce Legionella Growth and Spread in Buildings." When asked if this was their policy, ASM #1 informed the survey team that he has been through three different maintenance men in the past year. His current maintenance director has only been in the building for three week and is learning all of the things that are to be done is his department. The	F 880		

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 06/07/2019

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 880	Continued From page 162 corporate office is working on training him and getting the Legionella program into effect in the building. On 6/6/19 at 3:32 p.m., ASM #1 returned to the survey team and stated he has looked through the maintenance department and cannot locate any documentation regarding the program and any testing that has been completed. He could not locate what areas that would be of concern in a Legionella program. Administrative staff member (ASM) #1, ASM #2 and ASM #4, the facility-nursing consultant, were made aware of the above findings on 6/6/19 at 7:35 p.m. No further information was provided prior to exit. 2. The facility staff failed to have any infections control tracking logs for the months of April 2019 through May 2019 and had incomplete tracking logs for the months of December through March 2019. On 6/4/19 at approximately 12:00 PM, an entrance conference was conducted with the Administrator (ASM #1 - Administrative Staff Member) and ASM #2 (the Director of Nursing). The infection control tracking logs for the last 6 months was requested. The information provided was a "Monthly Infection Control Report" which was not a line-item listing of each specific resident and their identified infections and treatments. On 6/6/19 at 7:43 PM, ASM #1 (Administrative Staff Member - the Administrator), ASM #2 (the	F 880		

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 06/07/2019

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 880	Continued From page 163 Director of Nursing) and ASM #4 (Facility Nurse Consultant) were notified of the concerns that there appeared to be no infection control tracking provided. On 6/7/19 at 8:46 AM, ASM #3 (the Assistant Director of Nursing) provided the line-item tracking logs from December 2018 through March 2019. There was no evidence of any infections that were not treated with an antibiotic being tracked. There were no logs for April 2019 and May 2019 provided. ASM #3 stated that she "created the logs last night" based on data left by the former infection control nurse, who was no longer at the facility, but that there was no data to create the logs for April 2019 and May 2019, after the former infection control nurse had left. A review of the facility policy, "Infection Prevention and Control Program (IPCP)" documented, "The objectives of this IPCP are to: *Establish system for the prevention, identification, investigation, and control of infection of residents, staff, and visitors." No further information was provided by the end of the survey. 3. The facility staff touched a pill with their bare hands and then administered the medication to Resident #41. Resident #41 was admitted to the facility on 7/10/18 with the diagnoses of but not limited to acute respiratory failure, diabetes, high blood pressure, anxiety disorder, breast cancer, bladder disorder, atrial fibrillation, congestive heart failure, chronic obstructive pulmonary disease, depression, and osteoporosis. The most recent	F 880		

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 06/07/2019

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 880	Continued From page 164 MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 5/3/19. The resident was coded as being moderately impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting, and hygiene; supervision for eating; and was usually continent of bowel and bladder. On 6/04/19 at 4:34 PM, LPN #2 was observed to prepare and administer the following medications to Resident #41: Lopressor (1) 12.5 mg (milligrams) (1/2 of a 25 mg tablet) Calcium (2) 500 mg, 1 tablet Megace (3) 20 mg, 1 tablet Muro (4) 128 solution, left eye, 1 drop While preparing the Calcium, LPN #2 popped, the tablet into the medication cup then picked it up with her bare fingers and placed the pill into the pill cutter, cut the pill in half, and placed it into the medication cup. She also did not sanitize the pill cutter before or after using it. 06/05/19, 05:49 PM, in an interview with LPN #2, she stated, "I handled the pill with my hand. I should have put gloves on." When asked if she realized at the time that she had done that, LPN #2 stated she did but "I thought silence is golden." When asked what she should have done, LPN #2 stated that she should have discarded it, put gloves on and poured another one. On 6/6/19 at 7:43 PM, ASM #1 (Administrative Staff Member - the Administrator), ASM #2 (the Director of Nursing) and ASM #4 (Facility Nurse Consultant) were made aware of the findings. No	F 880		

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 06/07/2019

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 880	Continued From page 165 further information was provided by the end of the survey. (1) Lopressor - used to treat high blood pressure. Information obtained from https://medlineplus.gov/druginfo/meds/a682864.html (2) Calcium - Calcium is a mineral found in many foods. The body needs calcium to maintain strong bones and to carry out many important functions. Almost all calcium is stored in bones and teeth, where it supports their structure and hardness. The body also needs calcium for muscles to move and for nerves to carry messages between the brain and every body part. In addition, calcium is used to help blood vessels move blood throughout the body and to help release hormones and enzymes that affect almost every function in the human body. Information obtained from https://ods.od.nih.gov/factsheets/Calcium-Consumer/ (3) Megace - used to treat loss of appetite, malnutrition, and severe weight loss. Information obtained from https://medlineplus.gov/druginfo/meds/a682003.html (4) Muro - used to treat corneal edema. Information obtained from http://www.bausch.com/our-products/dry-eye-products/corneal-edema/muro-128-ointment	F 880		
F 947 SS=C	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4)	F 947		

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 06/07/2019

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 947	Continued From page 166 §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined the facility staff failed to provide the required annual in-service trainings for three of three CNA (certified nursing assistant) record reviews. The facility staff failed to provide the required 12 hours of trainings for three of nine CNAs that were employed for greater than one year, CNA#3, CNA #4, and CNA #5. The findings include: On 6/5/19 at approximately 9:30 a.m. a list of CNAs who were employed at the facility for more than one year was provided by OSM (other staff member) #6, the payroll/accounts payable staff	F 947		

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 06/07/2019

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 947	Continued From page 167 member. A sample of three of nine was selected from the list provided. The annual 12 hours of training was requested at this time for the three CNAs. The hire dates of the above CNAs: CNA #3 - 5/16/13 CNA #4 - 2/6/91 CNA #5 - 11/16/96 On 6/5/19 at 4:13 p.m. ASM (administrative staff member) #1, the administration provided training documentation. There were two educations regarding abuse prevention policy and reporting. CNA # 3 was the only one that received this education. ASM #1 was asked to present the documentation of the 12 hours of training for the above three CNAs. ASM #1 stated they do not have the documentation of the 12 hours of training for any of the CNAs that have been employed greater than one year. They do not have a staff -development staff member at this time. They have gone through the previous employees records and could not locate the twelve hours. The facility policy, "In-service policy" documented in part, "C. Monthly In-service Programs: Monthly in service programs predetermined to meet the needs for the aged, ill and disabled resident will be held. Nursing personnel will be encouraged to attend. Attendance records at in service meetings and minutes of the meeting will be kept. Individual in service records will be kept on all employees. Nursing assistants are required to attend at least twelve (12) hours per anniversary date year. It is the responsibility of the SDC (staff development coordinator)/designee to offer	F 947	F-947 A Staff Development Nurse has been hired by the facility to conduct required in service training for Nurses' Aides. CNAs who are currently lacking annual documentation of required training will be targeted to gain compliance. The Staff Development and training program will be supervised by the DON or her Designee and Administration. Results of the annual training and compliance will be reported to the facility's QAPI Committee for oversight and continued compliance.	7/21/19

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 06/07/2019

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 947	Continued From page 168 in-services during all three shifts for staff convenience in compliance with twelve (12) hour requirements. Facilities will post in-service hours accumulated per quarter for nursing assistants in order to keep facility and staff current with the requirements. D. Mandatory In-services: Accidents/safety/hazard communications, advanced directives, bloodbourne pathogens/exposure control plan/HVB , HIV and AIDS, combative residents, confidentiality, corporate compliance employee packet, correct use of gait belt, dental, dementia management, disaster preparedness, and emergency Procedures - Code." ASM #1, the administrator, ASM #2, the director of nursing, and ASM #4, the facility nurse consultant, were made aware of the above findings on 6/6/19 at 7:35 p.m. No further information was provided prior to exit.	F 947		