STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495348	A. BUILDING _____ B. WING _____	C 10/03/2019

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SKYLINE NURSING & REHABILITATION CENTER	237 FRANKLIN PIKE ROAD, SE FLOYD, VA 24091

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 9/30/19 through 10/3/19. One complaint was investigated during the survey. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. The census in this 90 certified bed facility was 72 at the time of the survey. The survey sample consisted of 18 current Resident reviews and 3 closed record reviews. A complaint was investigated during the course of the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid Standard survey was conducted 9/30/19 through 10/3/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 90 certified bed facility was 72 at the time of the survey. The survey sample consisted of 18 current Resident reviews and 3 closed record reviews. A complaint was investigated during the course of the survey.	F 000		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been	F 585	1. On 10/15/19, the Executive Director met with the resident council to review the outstanding concerns from previous meetings (May 2019, Feb 2019, Dec 2018, Nov 2018, and Sept 2018). The resident council member voiced that the previous concerns had been resolved as of 10/15/19. During the meeting, the Executive Director explained follow up will occur with in 72 hours once grievance is received.	11/15/19

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

Vickie D. Clark | Administrator | 11/13/19

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.

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F 585	Continued From page 1 furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is	F 585	2. On 10/18/19, Activities Director and the facility social worker sent patient satisfaction surveys to resident's responsible parties with a self addressed, stamped return envelope. Resident satisfaction surveys were also completed with residents. Grievances and resolutions will be documented on facility grievance form by facility social worker. 3. On 10/18/19, Director of Nursing/Designee re-educated Activities Director, and Social Worker on reporting resident council grievances process, to include timely follow up within 72 hours by facility Social Worker/Designee. 4. Social Worker/Designee to complete Quality Improvement Monitoring of resident council grievances to ensure follow up and resolution. This will be completed monthly x 3 then quarterly and as needed. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.	11/15/19 11/15/19 11/15/19

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F 585	Continued From page 2 responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents'	F 585		

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F 585	Continued From page 3 rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and facility document review, facility staff failed to make prompt efforts to resolve resident grievances. The findings included: The facility failed to act upon grievances voiced at resident council for the months of September 2018, November 2018, December 2018, February 2019, and May 2019. The surveyor reviewed the resident council minutes and the following was noted in the July 2019 minutes "There are outstanding concerns from previous meetings (2 from May 2019, 2 from Feb. 2019, 2 from Dec. 2018, 5 from Nov. 2018 and 4 from Sept. 2018). I will continue to try and get responses/resolutions from those departments." The August 2019 minutes stated in part, "Residents stated that most of the outstanding concerns from previous meetings has been resolved". On 10/01/19 at approximately 10:30 am, surveyor spoke with the activities director concerning the unresolved resident concerns documented in the Resident Council Minutes. He stated that he started in this position approximately one month ago and stated during his first resident council meeting in August, the residents stated there were no unresolved issues at that time. The activities director stated that he notifies the	F 585		

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F 585	Continued From page 4 administrator of any resident concerns and she takes care of them. The concern of the facility not following up on grievances voiced at resident council was discussed with the administrator during a meeting on 10/01/19 at approximately 10:40 am. The administrator stated the activities director in the position at the time of the reported grievances is no longer employed at the facility. No further information was provided prior to exit conference on 10/03/19.	F 585		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 657	1. Resident #72 care plan was reviewed and updated on 11/8/19 by MDS/ Care Plan Coordinator to reflect falls/interventions occurring on 7/28/19 and 8/2/19. 2. Resident #72 fall care plan was reviewed by medical director on 11/11/19 with no new interventions recommended. 3. On 11/8/19, an audit was completed of current residents with falls in last 90 days to ensure care plans were up to date with fall interventions by MDS/Care Plan Coordinator. 4. On 10/18/19, Director of Nursing/Designee re-educated MDS/Care Plan Coordinators on the importance of updating fall interventions immediately on care plan. 5. MDS/Care Plan Coordinator to complete Quality Improvement Monitoring of care plans to ensure fall interventions are added timely. This will be completed weekly x 6, monthly x 2 and as needed. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule to be modified based on finding	11/15/19 11/15/19 11/15/19 11/15/19 11/15/19

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F 657	Continued From page 5 or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, facility staff failed to review and revise the comprehensive care plan to reflect the resident's status for 1 of 21 residents in the survey sample (Resident #72). Resident #72 was admitted to the facility on 1/31/2018. Diagnoses included cerebral infarct, generalized muscle weakness, dysphagia, aphasia, hemiplegia and hemiparesis after infarct,congestive heart failure, and dementia without behavior disturbance. On the quarterly Minimum Data Set assessment with assessment reference date 9/11/19, the resident scored 6/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care. The resident was assessed as requiring extensive assistance for transfer to or from bed or toilet, cueing or supervision of one person for locomotion on or off the unit, and was unsteady moving from seated to standing, turning around, moving on and off the toilet, and surface to surface transfers. During clinical record review, the surveyor noted the resident had falls on 7/28/19 and 8/2/19. For the fall on 7/28/19, there was no post fall documentation. The next nursing progress note was dated 8/1/19. On 10/02/19 11:00 AM, the surveyor spoke with	F 657		

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F 657	Continued From page 6 director of nursing (DON) about the 8/2 fall. The DON stated that the nurses told her they had been instructed to put all fall documentation on the SBAR form and not in the nurse's notes. The DON said she would check the incident reports for time and situation details about the fall. At 11:32 AM, the DON reported that the incident reports directed the reader to the nurse's notes for details about the incident. The DON provided SBAR (Situation/Background/Assessment/Recomendation) forms for the 2 falls. For the fall on 7/28, the SBAR form described the circumstance of the fall. There was no post-fall documentation. For the fall on 8/2/19, a SBAR assessment form was in the record. The time and situation of the fall was not documented in the SBAR form. The SBAR form referred the reader to the nurse's notes for assessment. The DON provided Post fall questionnaires for the 2 falls. Those questionnaires were not part of the clinical record. The questionnaires documented the resident's general assessment and vital signs at the time of the fall, but no follow-up of the resident's status during the days after the fall. The resident's care plan did address the resident had fallen while in the facility. The care plan was not updated after the resident's fall on either date. The administrator and director of nursing were notified of the concerns during a summary meeting on 10/4/19.	F 657		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		

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F 689	Continued From page 7 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, and facility document review, facility staff failed to ensure an environment free of accident hazards for 6 of 21 residents in the survey sample (Residents #32, 68, 26, 62, 67 and 72) . The findings included: 1. The facility staff failed to perform post fall documentation every shift for 72 hours when Resident #32 had a fall that had occurred on 7/6/19. Resident #32 was admitted to the facility on 3/25/19 with the following diagnoses of, but not limited to anemia, high blood pressure, dementia, anxiety disorder and depression. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/19/19 coded the resident as having short term and long-term memory loss and being severely impaired in daily decision-making. Resident #32 was also coded as requiring extensive assistance of 2 staff members for dressing and personal hygiene and being totally dependent on 2 staff members for bathing. During the clinical record review on 10/3/19, the	F 689	1. Resident #32 was reassessed for falls on 11/8/19. No new fall interventions were required at this time. Resident #68 was reassessed for falls 11/8/19. No new fall interventions were required at this time. Resident #26 was reassessed for falls 11/8/19. No new fall interventions were required at this time. Resident #62 will be reassessed for side rails 11/14/19. Side rails no longer indicated, side rails were discontinued. Resident #67 will be reassessed for elopement 11/14/19.The resident continues to be at risk for elopement. The wander guard order will continue at this time Resident #72's record regarding fall on 7/28/19 and 8/2/19 was reviewed and the care plan was updated to reflect new interventions regarding falls. 2. Residents identified at risk for elopement were reviewed by Director of Nursing/ Designee to ensure that elopement assessments are up to date and care plans reflect residents risk for elopement on 11/14/19. Residents identified with falls in last 90 days were reviewed to ensure that fall risk assessments and care plans reflect resident current interventions on 11/8/19 by Director of Nursing/Designee. An audit of current resident was completed to ensure that side rail assessment and physician orders were ir place for resident with side rails on 11/15/19 by Director of Nursing/ Designee. 3. Director of Nursing/Designee re-educated facility licensed nurses on 10/18/19 on proper post fall documentation, timely quarterly assessments including elopement assessments, and following physicians orders for side rails. Any nurse not receiving education by AOC date will be educated prior to their return to work.	11/15/19 11/1519 11/15/19 11/15/19 11/15/19 11/15/19 11/15/19 11/15/19 11/15/19

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F 689	Continued From page 8 surveyor noted that Resident #32 had been documented as having a fall on 7/6/19 at 10 pm. There was post fall documentation noted on 7/7/19 at 11pm, 7/9/19 at 7:30 pm and 7/9/19 at 10:30 pm. The surveyor notified the DON (director of nursing) of the above post fall documentation as documented above at 2:30 pm on 10/3/19. The DON (director of nursing) stated, "There is to be a post fall documentation in the nursing notes every shift for 72 hours." The surveyor asked the DON if this documentation had occurred every shift for 72 hours for the fall that had occurred on 7/6/19. The DON stated, "According to the documentation in the nursing notes, no it was not." The surveyor asked the DON for a copy of the facility's policy on post fall documentation. The DON provided a copy of the facility's policy titled "Fall Management" on 10/3/19 at 5 pm to the surveyor. The policy read in part, " ...Initiate post fall documentation every shift for 72 hours ..." No further information was provided to the surveyor prior to the exit conference on 10/3/19. 2. The facility staff failed to complete post fall documentation every shift for 72 hours for a fall in which Resident #68 had on 7/10/19. Resident #68 was readmitted to the facility on 12/13/18 with the following diagnoses of, but not limited to anemia, heart failure, anxiety, depression and orthostatic high blood pressure. On the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 9/7/19, the resident was coded as having a BIMS (Brief	F 689	4. Director of Nursing/Designee to complete Quality Improvement Monitoring of timely post fall Documentation, quarterly assessments are timely and following Physicians orders for side rails. This will be complete weekly x 6, monthly x 2 and as needed. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule to be modified based on findings.	11/15/19

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F 689	Continued From page 9 Interview for Mental Status) score of 2 out of a possible score of 15. Resident #68 was also coded a requiring total dependence of 1 staff member for bathing and requires extensive assistance of 1 staff member for dressing and personal hygiene. During the clinical record review on 10/3/19, it was noted by the surveyor that Resident #68 had a fall documented on 7/10/19. The following dates and times reflected the staff's post fall documentation for the fall that occurred on 7/10/19: 7/10/19 at 1930 (7:30 pm), 7/11/19 at 0910 (9:10 am) and 2120 (9.20 pm), 7/12/19 at 1100 (11:00 am) and 2300 (11:00 pm). The surveyor notified the DON (director of nursing) of the above documented findings on 10/3/19 at 1 pm in the conference room. The surveyor requested and received copies of the facility's policy titled "Fall Management" on 10/3/19 at 5 pm. The policy read in part, " ...Initiate post fall documentation every shift for 72 hours ..." No further information was provided to the surveyor prior to the exit conference on 10/3/19. 3. The facility staff failed to complete post fall documentation every shift for 72 hours when Resident #26 had (3) falls which occurred on 6/26/19, 8/3/19 and 8/11/19. Resident #26 was admitted to the facility on 4/22/19 with the following diagnoses of, but not limited to high blood pressure, diabetes, dementia, depression and psychotic disorder. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of	F 689		

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F 689	Continued From page 10 7/11/19, the resident was coded as having short term and long term memory problems. Resident #26 was also coded as requiring extensive assistance of 2 staff members for dressing, personal hygiene and is totally dependent on 2 staff members for bathing. During the clinical record review on 10/3/19, the surveyor noted documentation on 6/26/19, 8/3/19 and 8/11/19 that Resident #26 have had a fall. After this documentation noted by the surveyor, there was no further documentation following these dates to have follow up of these falls. At 1 pm, the surveyor notified the DON (director of nursing) of the above documented findings. The DON stated, "It's our policy to document every shift for 72 hours after a resident has a fall. The surveyor requested and received the facility's policy titled "Fall Management" on 10/3/19 at 5 pm. The policy read in part, " ...Initiate post fall documentation every shift for 72 hours ..." No further information was provided to the surveyor prior to the exit conference on 10/3/19. 4. For Resident #62, the facility failed to place side rails on the bed per physician order dated 6/08/19. Resident #62's face sheet listed an admission date of 6/15/18 and a readmission date of 6/08/19. The Resident's diagnosis list indicated diagnoses, which included, but not limited to fracture of unspecified part of the neck of the right femur with routine healing, fracture of unspecified part of right clavicle with routine healing, pressure ulcer of left heel, generalized muscle weakness, dysphagia, cognitive communication deficit, squamous cell carcinoma of the skin, pulmonary	F 689		

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F 689	Continued From page 11 fibrosis, chronic obstructive pulmonary disease, vascular dementia, major depressive disorder and essential hypertension. The most recent 90 day MDS (minimum data set) with an ARD (assessment reference date) of 9/04/19 assessed the resident with impaired short and long term memory with signs of delirium. Resident #62 was also coded as requiring extensive assistance of two or more staff members for bed mobility and dressing. The Side Rail Evaluation dated 6/30/19 states the resident "uses side rails for turning and positioning in bed". The 9/04/19 signed physician order summary includes an order for "2 ¼ Side Rails for Bed Mobility and Positioning". This order is present on the September Treatment Administration Record and signed each shift. On 10/02/19 at approximately 2:35 pm, the surveyor observed Resident #62 sitting in a wheelchair and the resident's bed to be without side rails. The concern of Resident #62 not having 2 ¼ side rails on the bed as ordered was discussed with the administrative staff (administrator and director of nursing) during a meeting on 10/02/19 at approximately 5:15 pm. On 10/03/19 at approximately 8:20 am, the director of nursing stated a side rail assessment was completed on 10/02/19 for Resident #62 which indicated the resident no longer required side rails and the physician's order was discontinued. No further information was provided prior to exit	F 689		

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	495348	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 12 conference on 10/03/19. 5. For Resident #67, the facility failed to assess for the use of a wanderguard. Resident #67's face sheet listed an admission date of 8/28/17. The Resident's diagnosis list indicated diagnoses, which included, but not limited to osteoarthritis of the left hip, osteoporosis, muscle weakness, cognitive communication deficit, unspecified psychosis, dementia, major depressive disorder, and delusional disorder. The most recent annual MDS (minimum data set) with an ARD (assessment reference date) of 9/06/19 assessed the resident with impaired short and long term memory with signs of delirium. Resident #67 was also coded as requiring extensive assistance of two or more staff members for dressing, personal hygiene and requiring physical help of two or more staff members for bathing. Resident #67 was coded as using a wander/elopement alarm daily. The 9/04/19 signed physician order summary includes an order for "Wanderguard to (R) ankle due to decreased safety awareness - check placement every shift". On 10/02/19 at approximately 11:28 am, surveyor observed a wanderguard to Resident #67's right ankle. The most recent Elopement Risk Evaluation completed on 9/10/17 determined resident to be "at risk" for elopement. The surveyor requested and was provided with a copy of a facility policy entitled "Elopement Risk" which read in part, "It is	F 689		

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F 689	Continued From page 13 the policy of the company that on admission and quarterly, all residents will be assessed for elopement risk". The concern of Resident #67 not being assessed for elopement risk quarterly was discussed with administrative staff (administrator and director of nursing) during a meeting on 10/02/19 at approximately 5:15 pm. On 10/03/19 at approximately 8:50 am, surveyor met with the director of nursing who stated Resident #67's Elopement Risk Evaluation was completed last night. The director of nursing stated that the Elopement Risk Evaluation should have been completed quarterly but staff had failed to do so. An Elopement Risk Evaluation was completed on 10/02/19 after the surveyor notified the administrative team of this in the conference on 10/02/19. No further information was provided prior to exit conference on 10/03/18. 6. For Resident # 72, facility staff failed to assess and document the resident's condition after a fall. 10/01/19 09:08 AM Resident had a fall 8/2/19. SBAR (Situation/Backbround/AssessmentRecommendation) assessment in record. Fall 7/28 (self transfer for toileting) SBAR assessment present in record. MDS (Minimum Data Set) ARD (Assessment Reference Date) 6/11: locomotion on and off the unit 1/2 (1 person assist); ambulate with walker or wheelchair; unable to transfer to and from toilet or bed without assistance.	F 689		

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F 689	Continued From page 14 7/28 fall-- no documentation of follow-up. Next nursing note was 8/1. 8/2 fall-- no documentation of followup. Time and situation of fall is not documented on SBAR or in nurse's notes. The documentation is not clear regarding who completed the SBAR. 10/02/19 11:oo AM spoke with director of nursing about the 8/2 fall. She stated that the nurses told her they had been instructed to put all fall documentation on the SBAR form and not in the nurse's notes. She said she would check the incident reports for time and situation details about the fall. 11:32 DON reported that the incident reports directed the reader to the nurse's notes for details about the incident.	F 689	1.Resident #67 behavior flow sheet was updated to include target behaviors of striking out/hitting others and paranoid statements. 2. The Medical Director was notified of the failure to update Resident #67 behavior flow sheet. No new recommendations were made at this time.	11/15/19 11/15/19
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, facility staff failed to ensure that a resident who displays or is diagnosed with dementia, receives the appropriate treatment and services by monitoring targeted behaviors associated with the use of an antipsychotic medication for 1 of 21 residents in the survey sample (Resident #67). The findings included: For Resident #67 the facility failed to monitor	F 744	3. An audit of the behavior flow sheets was completed on 11/15/19 to ensure that targeted behaviors are documented on the behavior flow sheet. 4. On 10/18/19, Director of Nursing/Designee re-educated facility licensed nurses regarding utilizing targeted behaviors on behavior flow sheet. Any nurse not receiving education by AOC date will be educated prior to their return to work. 5.Director of Nursing/Designee to complete Quality Improvement Monitoring of utilizing targeted behaviors on behavior flow sheet. This will be complete weekly x 6, monthly x 2 and as needed. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule to be modified based on findings.	11/15/19 11/15/19 11/15/19

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F 744	Continued From page 15 targeted behaviors associated with the use of Zyprexa, an antipsychotic medication. Resident #67's face sheet listed an admission date of 8/28/17. The Resident's diagnosis list indicated diagnoses, which included, but not limited to osteoarthritis of the left hip, osteoporosis, muscle weakness, cognitive communication deficit, unspecified psychosis, dementia, major depressive disorder, and delusional disorder. The most recent annual MDS (minimum data set) with an ARD (assessment reference date) of 9/06/19 assessed the resident with impaired short and long term memory with signs of delirium. Resident #67 was also coded as requiring extensive assistance of two or more staff members for dressing, personal hygiene and requiring physical help of two or more staff members for bathing. The 9/04/19 signed physician order summary includes an order for Zyprexa (generic: Olanzapine) 5mg take I tablet by mouth every day at 1700 (5:00 pm) for GDR (gradual dose reduction) caused increased paranoia, med refusals and violent behavior. The September 2019 "Behavior/Intervention Monthly Flow Record" indicates the target behaviors for the use of Zyprexa are "refusal of meds" and "refusal of care". The concern of Resident #67 not being monitored for the symptoms of paranoia and violent behavior associated with the use of Zyprexa was discussed with the administrative staff (administrator and director of nursing) during a	F 744		

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F 744	Continued From page 16 meeting on 10/02/19 at approximately 5:15 pm. On 10/03/19 at approximately 8:55 am, the director of nursing stated the Resident's Behavior Monitoring log for Zyprexa has been revised to reflect monitoring for violent outburst. No further information was provided prior to exit conference on 10/03/19.	F 744		
F 758 SS=D	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; (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;	F 758	1. On 10/3/19 new order was obtained to continue Ativan 1mg. PRN for 14 days and then discontinue for resident #7. On 10/3/19 a new order was obtained to discontinue Ativan PRN for Resident #69. 2. Failure to obtain stop dates for as needed psychotropic medication was reviewed by the Medical director. No new interventions recommended at this time. 3. An audit was completed to assure that psychotropic medications had a stop dates. 4. The Licensed Nurses were reeducated regarding the importance of obtaining a stop date for psychotropic drugs. Any nurse not receiving education by AOC date will be educated prior to their return to work. 5.Director of Nursing/Designee to complete Quality Improvement Monitoring of utilizing stop dates for PRN Psychotropic medications. This will be complete weekly x 6, monthly x 2 and as needed. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule to be modified based on findings.	11/15/19 11/15/19 11/15/19 11/15/19 11/15/19 11/15/19

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F 758	Continued From page 17 §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. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, facility staff failed to have a stop date for an as needed psychotropic medication for 2 of 21 residents in the survey sample (Residents #7 and 69). The findings included: 1. The facility staff failed to ensure that PRN (as needed) orders for psychotropic drugs are limited to 14 days except by having a stop date for an as needed psychotropic medication for Resident #7. The psychotropic medication was Ativan. Resident #7 was admitted to the facility on 6/20/19 with the diagnoses of, but not limited to,	F 758		

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F 758	Continued From page 18 stroke, atrial fibrillation, heart failure, high blood pressure, Alzheimer's disease, anxiety disorder and depression. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/27/19, the resident was coded as having memory problems in her short term and long-term memory problems. Resident #26 was also coded as requiring extensive assistance of 2 staff members for bathing and personal hygiene and totally dependent on 2 staff members for bathing. During the clinical record review on 10/3/19, the surveyor noted a physician's order dated and timed for 6/20/19 at 2330 (11:30 pm) for Resident #7 which read "Ativan 1 mg (milligram). Give one tablet by mouth three times a day as needed for agitation or anxiety." There was no stop date or time for this medication to be discontinued. The surveyor notified the DON (director of nursing) of the above documented findings on 10/3/19 at 2 pm. The DON stated, "We will have to get that fixed. I haven't been here long and wasn't aware that this was going on." The surveyor notified the DON and administrator of the above documented findings on 10/3/19 at approximately 3 pm. No further information was provided to the surveyor prior to the exit conference on 10/3/19. 2. The facility staff failed to have a stop date for an as needed psychotropic medication for Resident #69. The psychotropic medication was Ativan. Resident #69 was admitted to the facility on 12/21/18 with the following diagnoses of, but not	F 758		

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F 758	Continued From page 19 limited to high blood pressure, dementia, seizure disorder, depression and psychotic disorder. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 9/7/19, the resident was coded as having short term and long-term memory problems and was severely impaired in making daily decisions. Resident #69 was also coded as requiring extensive assistance of 2 staff members for dressing and personal hygiene and was totally dependent on 2 staff members for bathing. During the clinical record review on 10/3/19, the surveyor noted the following order: Lorazepam (Ativan) 0.5 mg (milligram) " ...Take 1 tab every 4 hours (May crush) as needed ...for signs of anxiety, increased agitation or seizure activity ..." This order had originally been given to staff on 4/12/19 and was present on the Physician Order Sheets (POS) for the months of August, September and October 2019. There was no stop date or time for this medication to be discontinued. The surveyor notified the DON (director of nursing) of the above documented findings on 10/3/19 at 2 pm. The DON stated, "We will have to get that fixed. I haven't been here long and wasn't aware that this was going on." The surveyor notified the DON and administrator of the above documented findings on 10/3/19 at approximately 3 pm. No further information was provided to the surveyor prior to the exit conference on 10/3/19.	F 758		
F 804 SS=F	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2)	F 804		

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F 804	Continued From page 20 §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility failed to provide food and drink that is palatable, attractive, and served at a safe and appetizing temperature. The findings included: The facility failed to hold and serve food at a safe temperature of 135 degrees F or higher on the steam table. On 9/30/19 at approximately 11:20 am, the surveyor observed dietary staff member #1 obtain food temperatures from the steam table. Food temperatures obtained were as follows: Roasted Potatoes 153.5 F Green Beans 193.1 F Green Beans (Puree) 134.4 F Pasta Noodles - 154.6 F Pasta Sauce 168.4 F Breaded Chicken Patty 129.6 F Breaded Chicken Patty (Ground) 127.7 F Chicken Parmesan (Puree) 141.9 F Mashed Potatoes approximately 54.0 F Dietary staff member #1 reheated the mashed potatoes to a temperature of 150.1 F and	F 804	1. The food temperatures are monitored by the dietary Supervisor/designee to ensure the food is at a safe temperature of 135 degrees. 2. The Medical director was notified of unsafe food temperatures on 10/11/19. 3. An audit of food temperatures will be done daily by the Dietary supervisor to ensure the food is served at a safe temperature of 135 degrees. 4. The dietary staff was re-educated on the importance of serving food at a safe temperature of 135 degrees on 10/5/19 by the dietary supervisor. 5..Dietary Supervisor/designee will complete the Quality Improvement Monitoring of serving safe food temperatures of 135 degrees. This will be complete weekly x 6, monthly x 2 and as needed. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule to be modified based on findings.	11/15/19 11/15/19 11/15/19 11/15/19 11/15/19

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F 804	Continued From page 21 returned to the steam table and began plating lunch meals. No additional food items were reheated. The surveyor asked Dietary staff member #1 what the food temperatures on the steam table should be, dietary staff member #1 stated "145 degrees". The concern of not holding and serving food at a safe temperature was discussed with the administrative team (administrator and director of nursing) during a meeting on 10/02/19 at approximately 5:15 pm. On 10/03/19 at approximately 8:30 am, the dietary service manager was notified of the above documented findings. The dietary services manager stated that the employee will be given more education on the process when food temperatures do not meet the expected temperatures while on the steam table. No further information was provided prior to exit conference on 10/03/19.	F 804		

Commonwealth of Virginia

Owens, Lakia <lakia.owens@vdh.virginia.gov>

Fwd: Skyline Manor Nursing & Rehab Std Recert Survey PWQ 10-08-2019, EID # H2J921

1 message

Walker, Joyce <joycea.walker@vdh.virginia.gov> Wed, Oct 23, 2019 at 9:53 AM
To: Owens Lakia hbk22693 <lakia.owens@vdh.virginia.gov>

Attached are the LSC recertification survey reports. **Note: LSC reports are in ACO and LSC data entry information is completed. Close certification kit after health data entry is complete.**

If you have any questions, please let me know.

Thanks!☺

Joyce A. Walker, Aspen Coordinator
Office of Licensure & Certification
Virginia Department of Health
9960 Mayland Drive - Suite 401
Henrico, Virginia 23233-1463
Telephone: (804) 367-2129
Fax: (804) 527-4502
Email: joycea.walker@vdh.virginia.gov

---------- Forwarded message ---------
From: **Code Life Safety, rr** <lsc@vdfp.virginia.gov>
Date: Tue, Oct 22, 2019 at 1:54 PM
Subject: Skyline Manor Nursing & Rehab Std Recert Survey PWQ 10-08-2019, EID # H2J921
To: LSC (VDH) <lsc@vdh.virginia.gov>, rr Code Life Safety <lsc@vdfp.virginia.gov>

6 attachments

- **670 Skyline Nursing and Rehab 10.08.2019-totaled.pdf** 31K
- **2567 Skyline Nuring and Rehab - B1 - 10.08.2019.pdf** 19K
- **VDH Letter - Skyline Nursing and Rehab 10.08.2019.pdf** 70K
- **2567 Skyline Nuring and Rehab - B2 - 10.08.2019.pdf** 19K
- **EXISTING 2012 Health Care Booklet CMS2786R-Bldg 0102--signed-signed.pdf** 3073K
- **EXISTING 2012 Health Care Booklet CMS2786R -Bldg 0202-signed-signed.pdf** 3071K

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

FORM APPROVED

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
495348	SKYLINE NURSING & REHABILITATION CENTER

Type of Survey (Select all that apply)

I H

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

A

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. 20696	10/08/2019	10/08/2019	1.00	0.00	4.00	0.00	2.00	2.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 2.50

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 2.50

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**

Total Hours: 14

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
	495348	A. BUILDING **01** B. WING _____	**10/08/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLINE NURSING & REHABILITATION CENT	**237 FRANKLIN PIKE ROAD. SE FLOYD, VA 24091**

(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
K 000	INITIAL COMMENTS Surveyor: 20696 Construction Type: II (111) Description of Structure: The facility is a one story with basement building with masonry exterior and foundation walls, protected steel bar joists and metal roof decking with concrete slab floors. Sprinkler Status: The facility is fully sprinklered with a NFPA 13 system of wet and dry pipe systems. The systems are supplied by municipal water. An unannounced routine Life Safety Code survey was conducted 10/08/2019 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2012 Existing regulations. The facility was in compliance with the Requirements for Participation Medicare and Medicaid. No violations were observed at this time.	K 000		

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

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